This report describes the work of the World Health Organization in the South-East Asia Region during the period 1 January–31 December 2018. It highlights the achievements in public health and WHO’s contribution to achieving the Organization’s strategic objectives through collaborative activities. This report will be useful for all those interested in health development in the Region.
The work of WHO in the South-East Asia Region

Report of the Regional Director

1 January–31 December 2018
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<td>ACT</td>
<td>artemisinin-based combination therapy</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AEFI</td>
<td>adverse events following immunization</td>
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<tr>
<td>AFP</td>
<td>acute flaccid paralysis</td>
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<tr>
<td>AIIMS</td>
<td>All India Institute of Medical Sciences</td>
</tr>
<tr>
<td>AMR</td>
<td>antimicrobial resistance</td>
</tr>
<tr>
<td>ANM</td>
<td>auxiliary nurse midwife</td>
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<tr>
<td>APA</td>
<td>annual performance agreement</td>
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<td>APQN</td>
<td>Asia Pacific Quality Network</td>
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<tr>
<td>APL</td>
<td>assistive product list</td>
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<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>bOPV</td>
<td>bivalent oral polio vaccine</td>
</tr>
<tr>
<td>CBHC</td>
<td>community-based health care</td>
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<td>CCS</td>
<td>(WHO) country cooperation strategy</td>
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<tr>
<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<td>CRS</td>
<td>congenital rubella syndrome</td>
</tr>
<tr>
<td>CSO</td>
<td>civil society organization</td>
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<td>CVD</td>
<td>cardiovascular disease</td>
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<tr>
<td>DFAT</td>
<td>Department of Foreign Affairs and Trade</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DPT</td>
<td>diphtheria–pertussis–tetanus</td>
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<tr>
<td>DPR Korea</td>
<td>Democratic People's Republic of Korea</td>
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<td>EID</td>
<td>emerging infectious disease</td>
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<td>EMT</td>
<td>emergency medical team</td>
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<tr>
<td>EMTCT</td>
<td>elimination of mother-to-child transmission</td>
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<td>EOC</td>
<td>emergency operations centre</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>ERAR</td>
<td>emergency response to artemisinin resistance</td>
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<td>EWARS</td>
<td>early warning alert and response system</td>
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<td>FAO</td>
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<td>FENSA</td>
<td>Framework of engagement with non-State actors</td>
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<td>FETP</td>
<td>Field Epidemiology Training Programme</td>
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<td>FHB</td>
<td>Family Health Bureau</td>
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<tr>
<td>fIPV</td>
<td>fractional inactivated polio vaccine</td>
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<td>FP</td>
<td>family planning</td>
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<tr>
<td>Gavi</td>
<td>Gavi, the Vaccine Alliance</td>
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<td>GHSA</td>
<td>Global Health Security Agenda</td>
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<tr>
<td>GIS</td>
<td>Geographical Information System</td>
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<td>GISRS</td>
<td>WHO Global Influenza Surveillance and Response System</td>
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<td>GLAAS</td>
<td>UN Global Analysis and Assessment of Sanitation and Drinking Water</td>
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<td>GLASS</td>
<td>Global Antimicrobial Resistance Surveillance System</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>GMS</td>
<td>Greater Mekong Subregion</td>
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<td>GPW</td>
<td>General Programme of Work (of WHO)</td>
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<td>HEOC</td>
<td>health emergency operations centre</td>
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<td>HiAP</td>
<td>Health in All policies</td>
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<td>HIS</td>
<td>health information system</td>
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<tr>
<td>HIV/AIDS</td>
<td>human immunodeficiency virus/acquired immune deficiency syndrome</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HNAP</td>
<td>health national adaptation plan</td>
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<td>HNPSDP</td>
<td>Health, Nutrition, and Population Sector Development Plan</td>
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<td>HPV</td>
<td>human papillomavirus</td>
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<tr>
<td>HRH</td>
<td>human resources for health</td>
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<td>ICC</td>
<td>Interagency Coordination Committee on Immunization</td>
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<tr>
<td>icddr,b</td>
<td>International Centre for Diarrhoeal Disease Research, Bangladesh</td>
</tr>
<tr>
<td>ICT</td>
<td>information and communications technology</td>
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<tr>
<td>IDA</td>
<td>ivermectin, diethylcarbamazine citrate and albendazole</td>
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<tr>
<td>IEC</td>
<td>information, education and communication</td>
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<tr>
<td>IEHK</td>
<td>interagency emergency health kit</td>
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<tr>
<td>IHIP</td>
<td>Integrated Health Information Platform</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations (2005)</td>
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<tr>
<td>ILI</td>
<td>influenza-like illness</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>IMNCI</td>
<td>Integrated Management of Newborn and Childhood Illnesses</td>
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<tr>
<td>IPC</td>
<td>infection protection and control</td>
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<td>IPD</td>
<td>(WHO) Immunization Preventable Disease Programme</td>
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<tr>
<td>IPV</td>
<td>inactivated polio vaccine</td>
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<tr>
<td>IT</td>
<td>information technology</td>
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<td>ITAG</td>
<td>Immunization Technical Advisory Group</td>
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<td>IVD</td>
<td>Immunization and Vaccines Development</td>
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<td>JE</td>
<td>Japanese encephalitis</td>
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<td>JEE</td>
<td>joint external evaluation</td>
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<td>JMM</td>
<td>joint monitoring mission</td>
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<td>LF</td>
<td>lymphatic filariasis</td>
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<td>LLIN</td>
<td>long-lasting insecticidal net</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MCK</td>
<td>medical camp kit</td>
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<tr>
<td>MCV</td>
<td>measles-containing vaccine</td>
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<td>MDA</td>
<td>mass drug administration</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MDR-TB</td>
<td>multidrug-resistant TB</td>
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<td>MDT</td>
<td>multidrug therapy</td>
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<td>mhGAP</td>
<td>WHO Mental Health Gap Action Programme</td>
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<td>mhGAP-IG</td>
<td>WHO Mental Health GAP Intervention Guide</td>
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<td>MMR</td>
<td>measles–mumps–rubella</td>
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<td>MNT</td>
<td>maternal and neonatal tetanus</td>
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<td>MoA</td>
<td>memorandum of agreement</td>
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<td>MoF</td>
<td>Ministry of Finance</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MoHNIM</td>
<td>Ministry of Health, Nutrition and Indigenous Medicine</td>
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<td>MoHP</td>
<td>Ministry of Health and Population</td>
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<td>MoHS</td>
<td>Ministry of Health and Sports</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MoU</td>
<td>memorandum of understanding</td>
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<td>MPDSR</td>
<td>maternal and perinatal death surveillance and response</td>
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<tr>
<td>MR</td>
<td>measles and rubella</td>
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<tr>
<td>NAP</td>
<td>national action plan</td>
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<tr>
<td>NAPHS</td>
<td>National Action Plan for Health Security</td>
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<td>NATA</td>
<td>National Authority on Tobacco and Alcohol</td>
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<td>NCDC</td>
<td>National Centre for Disease Control (India)</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NHAs</td>
<td>National Health Accounts</td>
</tr>
<tr>
<td>NHI</td>
<td>national health insurance</td>
</tr>
<tr>
<td>NIP</td>
<td>National Immunization Programme</td>
</tr>
<tr>
<td>NITAG</td>
<td>National Immunization Technical Advisory Group</td>
</tr>
<tr>
<td>NMCP</td>
<td>National Malaria Control Programme</td>
</tr>
<tr>
<td>NMRA</td>
<td>National Medicine Regulatory Authority</td>
</tr>
<tr>
<td>NIPIPP</td>
<td>National Pandemic Influenza Preparedness and Response Plan</td>
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<tr>
<td>NPM</td>
<td>nurse practitioner in midwifery</td>
</tr>
<tr>
<td>NSP</td>
<td>National Polio Surveillance Project</td>
</tr>
<tr>
<td>NRA</td>
<td>National Regulatory Authority</td>
</tr>
<tr>
<td>NSACP</td>
<td>national STD/AIDS control programme</td>
</tr>
<tr>
<td>NSP</td>
<td>national strategic plan</td>
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<tr>
<td>NTD</td>
<td>neglected tropical disease</td>
</tr>
<tr>
<td>NTP</td>
<td>national TB programme</td>
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<tr>
<td>OIE</td>
<td>World Organisation for Animal Health</td>
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<td>OOP</td>
<td>out of pocket</td>
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<tr>
<td>PCV</td>
<td>pneumococcal conjugate vaccine</td>
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<tr>
<td>PEN</td>
<td>Package of Essential NCD Interventions</td>
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<tr>
<td>Penta</td>
<td>pentavalent vaccine</td>
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<tr>
<td>PIP</td>
<td>pandemic influenza preparedness</td>
</tr>
<tr>
<td>PIPP</td>
<td>pandemic influenza preparedness plan</td>
</tr>
<tr>
<td>PKDL</td>
<td>post-kala-azar dermal leishmanias</td>
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<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
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<tr>
<td>PM-JAY</td>
<td>Pradhan Mantri Jan Arogya Yojana</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
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<tr>
<td>POCQI</td>
<td>point-of-care quality improvement</td>
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<td>PPE</td>
<td>personal protective equipment</td>
</tr>
<tr>
<td>PrEp</td>
<td>pre-exposure prophylaxis</td>
</tr>
<tr>
<td>RCV</td>
<td>rubella-containing vaccine</td>
</tr>
<tr>
<td>RGoB</td>
<td>Royal Government of Bhutan</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, newborn, child and adolescent health</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office (of WHO)</td>
</tr>
<tr>
<td>RRT</td>
<td>rapid response team</td>
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<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SEA</td>
<td>South-East Asia (Region of WHO)</td>
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</tbody>
</table>

**Abbreviations:**
- **SDGs**: Sustainable Development Goals
- **SEA**: South-East Asia (Region of WHO)
The WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, on a visit to the maternity ward at the Government Health Facility, Naypyitaw
Universal health coverage: The road ahead

This report of the work of WHO in the South-East Asia Region provides an overview of what the Organization and its Member States and partners have achieved in the past year. I will follow a similar line in this introduction, with a focus on the Region’s Flagship Priority Programmes, and on our progress in recent years.

But I will also look ahead, providing depth to a conversation that has already begun, and which will continue to mature. That conversation is about universal health coverage (UHC), the pursuit of which is central to WHO’s work in the Region and beyond.

When discussing UHC, I usually focus on two components – human resources for health and access to medical products. We will examine recent achievements in both areas shortly. But before we do, let us widen the scope and consider the subject more broadly.

UHC is the bedrock of health policy in each of the Region’s Member States. It provides unity of purpose and an integrated approach to achieving health for all. As outlined in the Region’s Flagship Priorities, and in WHO’s Thirteenth General Programme of Work (GPW), the pursuit of UHC reflects the Organization’s commitment to achieving better health outcomes for all people everywhere. It is also an expression of our commitment to equity and human rights.
I am certain readers of this report will have heard UHC referred to as “the single most powerful concept that public health has to offer”. Indeed, that it may be – but only if it inspires governments and their partners to fully grasp the obstacles to universal access and financial protection. And let us be clear: Universality means everyone, including ethnic and religious minorities, migrants and those living on the margins of society. It also means services must be equally available and accessible as a right to all, irrespective of gender or sexual orientation. Notably, those services include affordable and safe medicines, adequate pain relief and palliative care, as well as long-term care for older persons.

We must be similarly clear about how we define financial protection. Yes, financial protection is about providing insurance and reducing out-of-pocket payments. But it is also about improving the provision of health care, in access to medical education and health sector employment, and in the procurement of medicines and equipment.

Moving forward, it is imperative we consider and act on ideas in their fullest sense. This is especially true for the concept of “Leaving no one behind” – the guiding maxim of the health and development sector more broadly. Unless we are courageous in identifying and remedying inequities, the phrase will become devoid of meaning. The same is true for UHC. Uncritically aligning all that is going on in health care with UHC is not only mistaken; it also has the potential to undermine an idea that, at its core, calls for bold, dynamic and well-calibrated policy-making. To harness the potential of both concepts, rather than business as usual, we must pursue business unusual. That requires new ways of thinking and acting. It also requires making hard choices and backing them with steadfast resolve.

Member States are poised for progress. As the country briefs in Part II of this report show, political support for UHC across the Region is strong. The same is true at the global level. WHO’s Transformation Agenda, which is at the heart of the Director-General’s reforms, aims to ensure that the Organization is better equipped to support its Member States achieve the path-breaking change needed. To that end, the United Nations’ High-Level Meeting on UHC in September holds great promise, with Thailand representing our Region as one of two co-facilitators.

As you review the substantial achievements documented herein – many from 2018, and many made over the past five years – I invite you to join me in looking to the future. This is especially important as we update the Flagship Priorities, contribute to the GPW’s “triple billion” targets, and stay on track to achieve the Sustainable Development Goals (SDGs). To help you do that, I here frame three questions, each corresponding to a core component of the Region’s succinct but powerful vision: “Sustain. Accelerate. Innovate”.

 someday: First: How can we sustain the gains we have made? The re-emergence of polio, maternal and neonatal tetanus and a range of communicable diseases is possible. Vigilance is needed to prevent this happening. We must also protect against antimicrobial resistance (AMR) and guard increases in financial protection. These are but a few examples. The list is potentially very long.
Second: *How can we accelerate progress towards the goals and objectives we have agreed upon*? What can we do to scale up interventions that we know to be effective? How can we overcome the bureaucratic hurdles that stand in the way of effective implementation? And how can we nurture the partnerships that turn pilot projects into large-scale implementation and ultimately social movements? Each of these questions must be addressed as a matter of priority.

And third: *How can we innovate in ways that will enhance the way we work and the results we achieve*? Harnessing the benefits and mitigating the risks of new technology is part of the picture, but there is much, much more to consider. Innovation means new ways of thinking about familiar problems. It means abandoning tired ideas that have outlived their utility. And it means devising new and imaginative ways of delivering services, empowering people to advance their own health and the health of others and finding better ways to communicate risk in times of crisis.

**Universal health coverage: The road travelled**

WHO’s work in the Region is guided by the 2030 Sustainable Development Agenda and the achievement of the SDGs, as well as the strategies and targets agreed on by Member States in the GPW.

Taken together, these objectives are broad. Member State needs are vast. Our resources are finite. Indeed, WHO’s financial contributions are miniscule in comparison to the combined resources of governments, the private sector and civil society. That requires us to be both strategic and catalytic, including by marshaling WHO’s unsurpassed technical expertise and convening power to support Member States and facilitate and leverage action by others. In doing so, we must make hard choices and be selective.

*Lighting the inaugural lamp at the celebration of the World Health Day 2018 global event in Colombo*
As readers will know, when in 2013 I came before the Region’s Member States as a candidate for the post of Regional Director, I outlined my vision of how the Regional Office could best fulfil its mandate. In doing so, I presented my “One by Four” vision and strategy aimed at building a more responsive, accountable and inclusive WHO in the Region.

Soon after, the Regional Office, in consultation with Member States, identified seven Flagship Priorities (later to become eight), that would define the Region’s focus, and where WHO would most vigorously apply its technical expertise, convening power and advocacy. The Flagship Priorities have been a powerful means to do that, and to enhance accountability and help break down silos. They have also been successful in contributing to the Region’s progressive realization of UHC. I am certain the updated Priorities will continue to serve that function, which is reflected in the following areas and achievements.

Measles elimination and rubella control

My tenure as Regional Director began with one of the biggest public health achievements of the decade: In March 2014, the South-East Asia Region was certified polio-free. While this was a massive victory in itself, it allowed the Region to harness existing infrastructure, including country networks of highly skilled workers, to embark on another ambitious project: eliminating measles and controlling rubella, the pursuit of which would increase immunization coverage more generally.

Progress has been solid. By the beginning of 2017, the rubella vaccine was part of a combination vaccine in eight of the Region’s Member States. It is now part of the routine immunization programme in 10. By the end of 2018, each of the Region’s Member States had introduced two doses of measles-containing vaccine in their routine immunization programme. Case-based surveillance for measles and rubella is now taking place Regionwide.

These and other initiatives have delivered real change. In 2018 the Democratic People’s Republic of Korea and Timor-Leste were verified as having eliminated endemic measles. Bhutan and Maldives sustained their elimination status. Sri Lanka is the latest addition. Six Member States – Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste – are now verified as having controlled rubella and congenital rubella syndrome.
Given these achievements, the Region will soon add measles and rubella elimination by 2023 to its list. To ensure that happens, focus must be sustained, with a commitment to moving immunization coverage in one direction – forward. Among other things, that requires increased attention to reaching the unreached and underserved. It also requires overcoming the challenge of vaccine-hesitancy.

Prevention and control of noncommunicable diseases

Noncommunicable Diseases (NCDs) are one of the Region’s most pressing threats to public health. Regionwide, NCDs account for 55% of all deaths. In the next decade that figure is anticipated to increase by 21% – a significant concern given two thirds of the Region’s NCD-related deaths are premature.

The problem has been – and continues to be – tackled with firm resolve. The South-East Asia Regional NCD Action Plan, for example, has 10 regional targets. Each is to be achieved by 2025. The Plan’s targets are bold, from a 30% relative reduction in the prevalence of tobacco use in people over 15 years to a halt in the rise of obesity and diabetes. The targets are, however, attainable, especially given the momentum provided by the Colombo Declaration, which was endorsed by all Member States at the Regional Committee in 2016,
and which calls for a focus on strengthening health systems to accelerate the delivery of NCD services at the primary level.

In my travels throughout the Region in recent years, it has been clear that NCD services are reaching more people than ever. That is due in large part to the fact that all Member States have now developed multisectoral action plans aimed at implementing a whole-of-society approach to reversing the NCD epidemic. The WHO Package for Essential Noncommunicable Disease (PEN) Interventions, which has been implemented in several Member States, and is being pursued in others on a pilot basis, has likewise been of immense value in extending the reach of NCD services.

Importantly, in 2018 our Region continued its progress in implementing tobacco control policies, with cost-effective “best buys” such as graphic health warnings on tobacco packs and increased taxation. In fact, our Region is now the global leader in enforcing health warnings on tobacco packs, with countries such as Nepal and Timor-Leste having the world’s largest graphic health warnings, while Myanmar accelerates its implementation of the WHO Framework Convention on Tobacco Control. Almost all of the Region’s Member States are now Parties to the Framework – a significant achievement as the Region strives to address its cancer burden, with tobacco-related cancers accounting for 22% of all cancer deaths.

More broadly, last year’s third High-level Meeting on NCDs at the UN General Assembly will facilitate the Region’s momentum, especially in areas such as mental health and cancer prevention and control. We must harness that momentum, draw on our achievements and continue to go from strength to strength.

As we look ahead, that point cannot be emphasized enough. When it comes to preventing and controlling NCDs, we really must accelerate progress and – quite crucially – innovate. While new approaches to service delivery are impressive, we must ensure the same spirit of innovation is applied to the many determinants of health people face, including by eliminating trans-fats, reducing salt content and promoting exercise through health-informed urban development among other strategies.

The unfinished MDG agenda: ending preventable maternal, newborn and child deaths with a focus on neonatal deaths

In 2014, as the Millennium Development Goal (MDG) era drew to a close, several of the Region’s Member States appeared unlikely to reach the targets for MDGs 4 and 5 on maternal and child mortality. If success was to be achieved, the Region had to significantly increase its annual rate of mortality reduction from 4.9% for maternal mortality and 3.9% for under-five mortality. More worrying was the fact that neonatal mortality remained stubbornly high, while progress to reduce it was slow. Addressing the unfinished MDG agenda, with a specific focus on neonatal mortality, had to be a priority.
The Region’s focus paid off. By 2016, all bar one of the Region’s Member States had achieved the MDG 4 target, which was to reduce under-five mortality by two thirds from 1990 to 2015. In the same period, neonatal mortality was reduced by 54%. Though MDG 5 target A – a 75% reduction in maternal mortality – has been achieved by just nine countries globally, I’m proud to say that three of those countries are from the South-East Asia Region. In addition, in 2016 the Region was validated to have eliminated maternal and neonatal tetanus, a massive achievement that it has maintained.

Given the Region’s progress, increased attention is now being paid to ensuring every newborn survives the first 28 days of life. To that end, the WHO-created Technical Advisory Group (TAG) on Women’s and Children’s Health, which started its work in 2015, is guiding governments, partners and other stakeholders on how best to accelerate action.

The TAG is also doing the groundwork to achieve the Sustainable Development Goals. At present, the Democratic People’s Republic of Korea, Indonesia, Maldives, Sri Lanka and Thailand have already achieved the SDG targets for neonatal and under-five mortality. Maldives, Sri Lanka and Thailand have done the same for maternal mortality.

Significantly, Regionwide focus has catalyzed political commitment towards improving the quality of care at health facilities. For example, national networks of hospitals have been established across the Region to improve maternal and newborn care, while a birth defect surveillance network is now operational in several Member States. As our Region continues to improve the health of mothers, mothers-to-be, newborns, children and adolescents, WHO remains committed to supporting Member States as they make smart, high-impact investments aimed at hastening progress.

**Universal health coverage with a focus on human resources for health and essential medicines**

In low- and middle-income countries across the world, out-of-pocket payment for health care services are often high. They can also be catastrophic. In the South-East Asia Region, the lion’s share of out-of-pocket expenditure is on medicines. To change that, WHO has been urging Member States to scale up access to financial protection and to ensure the provision of a package of quality essential care services. UHC, with its three dimensions of access, affordability and quality, is the most important, game-changing innovation to do that.
Human resources are critical to UHC’s progressive realization. At present, many Member States struggle to provide adequate numbers of health workers and to ensure they are of high quality and have an appropriate skills mix. They also struggle with the challenge of rural retention. The pursuit of UHC is an opportunity to address these challenges, and to provide financial risk protection and access to essential health services for all. In that sense, UHC is an opportunity to build health care systems that are based on human rights and social justice.

Across the Region, crucial advances have been made, particularly in increasing access to safe, high-quality medical products. Since 2016, the South-East Asia Regulatory Network has been harmonizing regional cooperation on medical product regulation, helping ensure all drugs and medical devices produced and sold in the Region are safe and accessible.

Significant advances are also being made with regard to tracking progress. In 2018, for example, Member States began monitoring the health-related SDGs, including the essential services coverage index and financial risk protection. Encouragingly, three Member States have above-global median levels of service coverage and financial protection. Moreover, the Region’s decade for strengthening human resources for health, which began in 2014, is beginning to show results – a trend that must continue.

Indeed, as we maintain our forward momentum, accelerating progress – particularly on reducing out-of-pocket expenditure, as well as finding out who is missing out and why – is crucial. So too is making full use of key innovations, especially when it comes to using new technologies such as e-health to overcome systemic bottlenecks and to mobilize and inspire creative partnerships.
Building national capacity for preventing and combating antimicrobial resistance

For the past 70 years, antimicrobial drugs have been a mainstay of modern medicine. Their irrational use in both human and animal health, however, has led to the emergence and spread of antimicrobial resistance, which is making the treatment of even basic infections increasingly difficult. It is with good reason that AMR is often regarded as the world’s greatest threat to the control of communicable diseases, as well as to overall health security.

The Region has been pro-active in combating the problem. As early as 2011, the Region’s health ministers called for concerted action against AMR via the Jaipur Declaration on Antimicrobial Resistance. We continue to assist Member States implement it. In 2014, the battle against AMR was made a Flagship Priority. We continue to support Member States pursue it. And in 2015, the Regional Committee passed a key resolution on AMR prevention and control. We continue to work with Member States to realize it.

Our joint efforts are paying off. By 2018, all 11 of the Region’s Member States had developed a National Action Plan to address AMR, with each one aligned with the Global Action Plan to tackle Antimicrobial Resistance. The plans are being implemented with firm resolve, with all Member States monitoring progress. Notably, important efforts have been made to improve AMR surveillance, with nine Member States enrolling in the WHO-led Global Antimicrobial Resistance Surveillance System (GLASS). The GLASS enables them to share information on national AMR trends, and standardizes AMR surveillance globally.

As the South-East Asia Region continues to forge ahead, ongoing advocacy and engagement will be critical to sustaining momentum. So too will be efforts to strengthen the One Health approach, including via the regional Tripartite mechanism – a joint

Event organized by the Regional Office, including a panel discussion, on World Health Day 2018
collaboration between WHO, the Food and Agriculture Organization of the United Nations (FAO) and the World Organization for Animal Health (OIE).

Scaling up capacity development in emergency risk management

The South-East Asia Region is highly susceptible to acute public health emergencies, including from natural hazards such as floods, cyclones and earthquakes, as well as human-induced threats and outbreaks of emerging and re-emerging diseases. Over the past decade, the Region accounted for approximately 27% of all global mortality due to disasters. Like each of the Region’s Flagship Priorities, scaling up capacity in emergency risk management has been – and continues to be – a critical imperative.

In recent years, the South-East Asia Regional Health Emergency Fund (SEARHEF), as well as the globally acclaimed “12 Benchmarks for Emergency Preparedness and Response”, have served us well. So too have efforts to build strong health systems while integrating them into wider systems of preparedness and response. The creation of the global WHO Health Emergencies Programme in 2016 has meanwhile complemented and accelerated the Region’s progress.

On that score, the decision in 2016 to expand the SEARHEF to invest in emergency preparedness, not just response, was a crucial step. Vital to leveraging the Fund’s promise, however, is identifying where needs are most pressing. The fact that almost all Member States have now conducted periodic assessments on capacities for emergency risk preparedness will help do that. So too will the fact that eight Member States have now conducted joint external evaluations (JEEs) on core capacities for the International Health Regulations (2005), while all of them have been assessing IHR core capacities on an annual basis.

Ultimately, however, preparedness and response capacities can only truly be tested in real time. The response to Nepal’s 2015 earthquake, and to the many floods, cyclones and earthquakes across the Region that have occurred since, are testimony to the Region’s progress. Likewise is the ongoing response to the influx in 2017 of hundreds of thousands of vulnerable people into Cox’s Bazar, Bangladesh.

As strong as the Region’s advances have been, however, there are opportunities to make further gains. That includes by strengthening epidemiological and laboratory surveillance, at the same time as enhancing buy-in for key initiatives across sectors. It also includes building the capacity of Emergency Medical Teams and increasing investment in the SEARHEF’s funding stream for preparedness. And while progress in developing national action plans is positive, implementing them will be possible only if they are adequately funded. Too many are not.
Finishing the task of eliminating diseases on the verge of elimination

Several neglected tropical diseases (NTDs) in the Region, including leprosy, visceral leishmaniasis (kala-azar), schistosomiasis and lymphatic filariasis, have been selected for elimination, and yaws for eradication, by 2020. Including the elimination and eradication of these diseases within the portfolio of the Regional Flagship Priorities in 2014 has resulted in them becoming national priorities, leading to rapid gains and numerous successes.

In 2016, for example, India was declared yaws-free. Maldives and Sri Lanka eliminated lymphatic filariasis as a public health problem. Not long after, Thailand achieved the same.

Progress has continued. In 2018, Nepal became the first country in the Region to be validated for the elimination of trachoma. By the end of the year, the elimination target for kala-azar was achieved in all endemic districts in Nepal, all upazilas in Bangladesh and 93% of blocks in India. Indonesia has meanwhile reduced the prevalence of schistosomiasis to very low levels.

These accomplishments reflect Member States’ political commitment, the strength of national NTD programmes and the tireless efforts of those working for them. They also reflect the wisdom of adopting a multifaceted approach to NTDs that addresses marginalization, stigma and poverty, at the same time as carrying out the necessary medical interventions.

Complacency, however, is not an option. History tells us that NTDs, just like diseases such as measles and rubella, can return with a vengeance as and if attention lapses. To continue our forward trajectory, among other interventions, we must accelerate the roll-out of triple drug therapy to eliminate lymphatic filariasis. We should also harness smartphone technology for the purposes of data collection and surveillance.
Ending TB by 2030

Tuberculosis (TB) has long threatened human health. Our battle against it continues. Every year, millions of people continue to die from TB. Many more fall ill to the disease. The challenge of reaching the global target of ending TB by 2030 requires bold action and an accelerated response. It is for this reason that in 2017 I added an eighth Flagship Priority: “Accelerating efforts to end TB by 2030”. The need to do so is clear. Our Region is home to around 44% of global TB incidence and 50% of associated mortality. Drug resistance has also emerged as a major challenge.

Since the Flagship Programme was launched in 2017, significant progress has been made, from improved notification to decreased mortality and a doubling of the budget allocated to TB in the Region as a whole. The Region has also demonstrated global leadership in galvanizing political commitment, including via key regional initiatives such as the 2017 “Delhi Call for Action”, which underscored how best to accelerate progress against TB, and the 2018 “Statement of Action”, which highlighted the need to intensify efforts to combat the scourge.

Notably, the South-East Asia Region was well represented at the first ever UN General Assembly High-Level Meeting on TB, where a political declaration – “United to End Tuberculosis: An Urgent Global Response to a Global Epidemic” – was adopted to accelerate action to tackle the disease. All Member States of the Region are pursuing key targets aligned with the goal of ending TB by 2030.

*Launch of the Delhi Declaration at the Delhi End-TB Summit, New Delhi*
To achieve that ambitious goal, WHO will continue to support Member States keep TB high on the political agenda and mobilize the necessary resources to end the menace once and for all. In other words, we will support Member States to both accelerate and innovate, including by making new diagnostics that can test large populations more widely available, rolling out new drugs to combat multidrug-resistant TB, intensifying active case finding and addressing latent TB infection among other interventions.

**Universal health coverage: Partners on the road**

As one of the world’s most populous and diverse Regions, we can be proud of the progress made, the outcomes achieved, and the lives saved and improved in recent years due to the Flagship Priorities’ targeted focus.

But let us also not forget the many other achievements. This includes Maldives and Sri Lanka being certified malaria-free in 2015 and 2016 respectively, Thailand eliminating mother-to-child HIV and syphilis in 2016, and Maldives achieving that this year. Most recently, it also includes the verification of Bangladesh, Bhutan, Nepal and Thailand as having controlled hepatitis B. We do indeed have a lot to celebrate.

Still, we must be clear about the myriad challenges and threats ahead. These range from the health impacts of climate change, ageing populations, AMR and environmental pollution to roads and vehicles that kill and maim, foods that do little to nourish those that eat them, and commerce that promotes life-threatening products.
As we look to the future, two things stand out. First, the roads we travel are interconnected. We can no longer think about health services in isolation from other sectoral influences that determine whether people live long and healthy lives. And second, while WHO brings powerful assets to the table, we cannot work alone. The active creation and nurturing of partnerships at multiple levels, for multiple purposes, must shape the way we operate moving forward.

As we do that, and as our journey together continues, I am committed to supporting the UN Secretary-General’s reforms and to ensuring that WHO has a strong and consistent presence in the UN Country Team. I look forward to working with regional and national partners to fuel fresh thinking about primary health care services, as well as the quality of health systems and financing strategies, to create more equitable and efficient frontline services.

That outcome must be core to our focus. No one – and I mean no one – can be left behind. Moving forward, I am firmly convinced that by setting ambitious goals, providing strong, responsive leadership, and creating partnerships that value all contributions, we will sustain our achievements, accelerate progress and harness the full power of innovation. Indeed, we will make rapid and lasting gains in our quest to ensure healthy lives and promote well-being for all at all ages.
Bangladesh

Highlights

- Bangladesh controls rubella and congenital rubella syndrome (CRS).
- Bangladesh becomes the first country in the world to have a government-endorsed polio transition plan.
- The government adopts the Multisectoral Action Plan for the Prevention and Control of NCDs.
- The Ministry of Health and Family Welfare (MoHFW) launches the National Strategy for Cervical Cancer Prevention and Control.
- WHO continues to lead the ongoing health response to the Rohingya refugee crisis.
- Evaluation of community-based health-care services was conducted with WHO support.

Introduction

Following on from Bangladesh’s success in achieving almost all the MDGs, progress towards achieving the SDGs continued to gain momentum in 2018. Coordinators for each of the 17 priority areas, including health, were designated and they will periodically report to the government.

In an important development, Bangladesh – which is globally recognized for its successful polio programme – became the first
country to have a government-endorsed polio transition plan. The country was also verified as having controlled rubella and CRS, a reflection of the country’s strong immunization programme.

Owing to the growing NCD burden, which accounts for 67% of all deaths, WHO supported the government to adopt the multisectoral Action Plan for the Prevention and Control of NCDs.

Bangladesh also moved during the year to replace its century-old law on mental health, the Lunacy Act 1912, with the groundbreaking Mental Health Act 2018. This was a critical step forward in recognizing and realizing the rights of people with mental health illnesses.

As in the previous year, the entire WHO Country Office remained fully involved in the Rohingya response. WHO continued its emergency response operations in Cox’s Bazar, supporting the MoHFW and coordinating the health sector response.

Every year, Bangladesh is affected by various types of emergencies, from floods to cyclones. In 2018, the country strengthened its ability to respond to such disasters with the development of a national health sector emergency preparedness and response plan.

Key activities and achievements in 2018

Bangladesh becomes the first country to have a government-endorsed polio transition plan

Bangladesh became polio-free in 2006, and to maintain its status, the country has developed a network of surveillance and immunization officers who provide support to the government in areas of surveillance, immunization, new vaccine introduction and emergency response. In addition, Bangladesh introduced the inactivated polio vaccine (IPV) in 2015 and the fractional IPV (fIPV) in 2017 into its routine immunization programme.
Bangladesh developed its polio transition plan in line with the resolution passed by the Seventy-first World Health Assembly, which was endorsed by the Interagency Coordination Committee on Immunization (ICC) in May. This is the first transition plan to be endorsed by a government, and demonstrates the commitment of Bangladesh towards polio eradication. The plan was developed through extensive consultative meetings with different sectors of the government and numerous international partners, including WHO and The United Nations Children’s Fund (UNICEF). Given the huge investment in the country’s polio programme, the plan paves the way for the health sector to redirect funds, resources, networks and equipment to fight other communicable diseases. The transition pathway will occur in three phases, with clear objectives, until 2027. The programme management and monitoring unit (MMU) of the MoHFW will be the lead agency in implementing the plan.

**Strengthening efforts to eliminate lymphatic filariasis**

For the first time in the country, the National Strategic Plan for Lymphatic Filariasis Elimination (2018–2025) was developed in collaboration with the WHO Country Office, the National Programme for Elimination of Lymphatic Filariasis (NPELF), and other key stakeholders. The Plan will serve as a guidance to sustain the gains of the NPELF, with the goal of preparing and submitting the LF elimination validation dossier in 2020.

The Plan focuses on surveillance and response measures to further reduce disease prevalence and incidence, and to enhance patient services to alleviate suffering from the disease. Key activities will include post-mass drug administration (MDA) surveillance (it was stopped in 2013), conducting transmission assessment surveys in all endemic districts, identifying villages with residual infection, implementing effective interventions, and quality morbidity management and disability prevention. The Plan also highlights the importance of integration of post-validation programme activities into the regular health-care system.

**Strengthening efforts to combat NCDs, including cervical cancer**

In 2018, Bangladesh took several important steps towards combating NCDs, which are responsible for 67% of all deaths in the country. With support from the WHO Country Office, the government adopted the Multisectoral Action Plan for the Prevention and Control of NCDs (2018–2025), which involves almost 30 ministries and agencies. The Plan has been divided into four strategic areas: advocacy, leadership and partnerships; health promotion and risk reduction; health systems strengthening for early detection and management of NCDs and their risk factors; and surveillance, monitoring, evaluation and research.
Following the adoption of the Plan, the first meeting of the National Multisectoral NCD Coordination Committee (NMNCC) was held in November. Chaired by the Minister of Health and Family Welfare, the meeting led to several key decisions, which will be critical in ensuring the effective roll-out of the Plan, including increasing human resources for the secretariat of the NMNCC; signing a memorandum of understanding with ministries of education and local governments; and establishing local multisectoral coordination committees.

In an important step towards tackling the high burden of cervical cancer – which is the second most common cancer among women in the country – the MoHFW launched the National Strategy for Cervical Cancer Prevention and Control (2017–2022) with WHO support. The Strategy aims to strengthen cancer control through the introduction of a human papillomavirus (HPV) vaccination programme and implementing population-based cervical cancer screening and treatment through the public health-care system.

**Transforming mental health services**

More than 6 million people experience depressive disorders and 7 million people have anxiety disorders in Bangladesh. In recent years, mental health has received increased attention because of the Rohingya crisis as well as the designation of the Prime Minister’s daughter, Ms Saima Wazed Hossain, as the WHO South-East Asia (SEA) Region’s “Champion for Autism” in 2017.

In 2018, with WHO technical support, the Mental Health Act 2018 replaced the 106-year-old colonial-era Lunacy Act 1912. The new law is a critical step forward in establishing the rights of patients with mental health illnesses. The law establishes the framework for providing care to patients, protecting their rights and their overall welfare.

**Evaluation of community-based health-care services**

In 2018, the WHO Country Office undertook an independent evaluation of community-based health-care (CBHC) services in Bangladesh. The purpose of the evaluation was to assess how CBHC is contributing towards achieving the 4th Health Population and Nutrition Sector Programme goals and whether primary health-care services are being delivered effectively through CBHCs.

The evaluation found that the CBHC approach, which also includes community clinics, has the potential to contribute to both the achievement of UHC as well as meeting the SDGs. It found that the 13 079 community clinics are generally functioning as the first point of contact for people in rural Bangladesh but that the majority of patients sought curative care rather than preventive and promotive services. The evaluation also found that the number
of visits to community clinics increased from 56 million in 2014 to 88 million in 2017, indicating that cost and geography was not a barrier to using the services. However, the evaluation identified several operational challenges, including gaps in human resources, infrastructure, equipment, supportive supervision and mentoring. WHO will continue to work with the MoHFW to strengthen CBHC.

**Strengthening emergency preparedness and response**

WHO facilitated the development of a new National Health Sector Emergency Preparedness and Response Plan. The Plan, which was developed by 76 focal points from numerous humanitarian agencies, ministries and NGOs, ensures an agreed framework of response for all hazards for effective, appropriate and timely action in emergencies. It includes hazard and risk analysis, minimum preparedness actions according to the Inter-Agency Standing Committee (IASC) guidelines, and scenario-based public health impacts and interventions.

In addition to developing the Plan, WHO also conducted training workshops and simulation exercises to improve local capacity for preparedness and response in case of an emergency.

Also, interagency emergency health kits (IEHK) along with other medical supplies, including water purification tablets, anti-snake venom and antibiotics, were prepositioned at Dhaka Central Medical Store Depot and other divisional medical sub-depots to maintain an emergency buffer stock.

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**Box 1. Bangladesh achieves rubella control**

In 2018, Bangladesh was verified as having controlled rubella and CRS two years ahead of the regional target. This was possible through high-level commitment, several rounds of high-quality supplementary immunization activities, sensitive surveillance and well-performed routine immunization coverage.

Having introduced the measles–rubella (MR) vaccine in 2012 and adding the second dose into its routine immunization programme in 2015, the government reaffirmed its commitment to an MR-free Bangladesh by collaborating with the Bangladesh Paediatric Association to advocate for achieving the elimination target. After the successful MR campaign in 2014, a follow-up campaign targeting children aged 9 months to 10 years is planned for 2019. The greatest challenge to achieving elimination targets by 2020 is to ensure at least 95% coverage for both doses of MR vaccine.
Addressing nutrition-related issues

While impressive progress has been made in combating undernutrition by reducing child stunting by almost half since the mid-1990s, the country is experiencing a rise in overnutrition and diet-related NCDs, particularly among young adults.

In 2018, the WHO Country Office supported the government to adopt the Second National Plan of Action for Nutrition (2016–2025). The goal is to improve the nutritional status of all citizens and reduce all forms of malnutrition, with a focus on children, adolescent girls, pregnant women and lactating mothers through a multisectoral response.

With WHO support, the Bangladesh National Nutrition Council (BNNC) provided orientation to relevant ministries on the Plan which is expected to not only contribute towards achieving national targets related to nutrition, but also global targets.

Partnerships

WHO continues to lead and coordinate the health sector response to the Rohingya crisis, which brings together more than 100 local and international health partners. WHO also continues its strong relationship with the MoHFW and the government, supporting the
Box 2. WHO’s interventions in Cox’s Bazar

In 2018, WHO continued its emergency response in Cox’s Bazar, supporting the MoHWF, and leading and coordinating the health sector work, which brings together more than 100 health partners. WHO serves as the Secretariat to the Emergency Coordination Committee set up by the government to lead the health response to address the needs of nearly 1.3 million Rohingya refugees and their host population. WHO is also co-leading the health sector of the Inter-Sector Coordination Group and is the chair of the Health Development Partners’ Forum in Dhaka.

In 2018, the health sector continued to focus on reducing morbidity and mortality among Rohingya refugees by coordinating the provision of emergency health-care services, medicines, vaccines and supplies, and by preparing to mitigate and respond to public health risks.

Some of WHO’s key interventions in Cox’s Bazar included the following:

- meeting the SPHERE standards, a set of international principles and minimum humanitarian standards, on health facility utilization;
- establishing an early warning alert and response system (EWARS) in 76% of health facilities;
- leading the roll-out of five mass immunization campaigns targeting both Rohingya refugees and the host population, which delivered nearly 2.3 million vaccine doses;
- averting a potential cholera outbreak;
- providing over 220 metric tons of essential medicines, supplies and equipment;
- setting up a water testing laboratory and six rounds of water quality surveillance;
- providing mental health and psychosocial support (MHPSS) services in primary care facilities through training for non-specialists;
- establishing a field laboratory in Cox’s Bazar;
- coordinating health sector contingency planning for monsoons and cyclones;
- coordinating the development of health sector minimum standards for primary health services;
- undertaking technical review missions for MHPSS, TB, essential medicines, NCD and vector-borne diseases;
- rolling out five mass immunization campaigns against cholera and other vaccine-preventable diseases (VPDs).

Vaccination in Cox’s Bazar in 2018

<table>
<thead>
<tr>
<th>Vaccination campaigns</th>
<th>Date of campaign in 2018</th>
<th>Antigen &amp; target age group</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>Host community penta/Td campaign</td>
<td>1 January, 13–17 January &amp; 17–22 February 2018</td>
<td>Penta – 1 to &lt;7 years &amp; Td – 7 to &lt;15 years</td>
<td>213 233</td>
</tr>
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<td>Penta, bOPV/Td campaign (second round)</td>
<td>27 January–10 February 2018</td>
<td>Penta, bOPV – 6 weeks to &lt;7 years</td>
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<tr>
<td>Penta/Td campaign (third round)</td>
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<tr>
<td>OCV campaign (May 2018 round) (+ host community)</td>
<td>6–13 May 2018</td>
<td>&gt;1 year</td>
<td>879 273</td>
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<tr>
<td>OCV campaign (Nov–Dec 2018 round) (+ host community)</td>
<td>17 Nov–13 Dec 2018</td>
<td>&gt;1 year</td>
<td>364 686</td>
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*bOPV: bivalent oral poliovirus; OCV: oral cholera vaccine; penta: pentavalent vaccine; Td: tetanus-diphtheria*
development of numerous key activities, policies and strategic plans. In addition, WHO is also collaborating with other UN agencies, including the United Nations Population Fund (UNFPA) to strengthen Bangladesh’s health systems structure, and with UNICEF on vaccination campaigns. WHO also partnered with the United States Pharmacopeia (USP) to strengthen the Directorate-General of Drug Administration (DGDA), the national regulatory authority for medicines and pharmaceutical products. Under the Coalition of Interested Partners platform, WHO and USP are supporting the DGDA to strengthen laboratory and regulatory capacities to ensure quality, safety and efficacy of medicines and other pharmaceutical products. WHO continues to engage with local institutes and agencies, including supporting the National Institute on Mental Health to conduct a mental health survey.

Looking ahead

While WHO will continue its operations in Cox’s Bazar in 2019, the challenge will be to sustain activities due to funding restraints. As Bangladesh continues to face the threat of natural disasters, emergency preparedness and response activities will be a priority. These include workshops, capacity-building and prepositioning of medicines and medical equipment. In 2019, another major priority will be to work with the government to increase its capability to strengthen the delivery of high-quality health-care services and limit out-of-pocket (OOP) health expenditure. In the area of NCDs, the Multisectoral Action Plan for NCD Control and Prevention will be rolled out and a mental health policy developed, which will outline how mental health services are delivered to the people.

Another major activity will be to build on Bangladesh’s successful immunization programme and work with the government to improve vaccination coverage and strengthen surveillance, with a particular focus on not vaccinated populations.
Bhutan

Highlights

- Bhutan achieves control of rubella and CRS two years ahead of the regional target of 2020.
- WHO convenes high-level parliamentary forum on accelerating the prevention and control of NCDs. The forum adopts an outcome document with a vision of achieving a ‘Happy and Healthy Bhutan by 2030’.
- The Ministry of Health establishes the health emergency operations centre (HEOC) with WHO support.
- Bhutan accelerates progress on ending TB by 2030 by implementing a shorter MDR-TB regimen and updating several treatment guidelines.

Introduction

Bhutan is well known for its unique development philosophy of “Gross National Happiness”. The four key pillars supporting this philosophy include: good governance, preservation and promotion of cultural values, equitable and sustainable socioeconomic development, and conservation of the natural environment.
In 2018, the country completed its third parliamentary elections, with the new government assuming office in October. Health-care improvement and health-care reforms emerged as a top priority for the new administration.

In this context, the role of WHO as the lead health and development partner in supporting the Royal Government of Bhutan (RGoB) has become even more crucial. The RGoB is committed to achieving UHC by improving equitable access to quality health-care services free of charge, as enshrined in the Constitution.

As WHO continues to provide strategic, technical and financial support to strengthen the capacity of Bhutan’s health system, several key goals were achieved in 2018, including the control of rubella and CRS.

Nevertheless, while progress in combating communicable diseases continues to accelerate, the increasing burden of NCDs, emerging infectious diseases (EIDs) and adverse health impacts of climate change are posing a complex and wide range of challenges to the health sector.

As such, there is a need to strengthen the health system as a whole, particularly in the area of human resources for health.

**Key activities and achievements in 2018**

**Controlling rubella and CRS**

Following on from becoming one of the first two countries in the WHO SEA Region to eliminate measles, Bhutan was verified as having controlled rubella and CRS in 2018. It achieved this goal two years ahead of the regional target of 2020.

*With the Bhutan delegation at the Seventy-first session of the Regional Committee, New Delhi*
Bhutan, along with Maldives and Timor-Leste, are the first three countries in the Region to have achieved both elimination of measles and control of rubella and CRS.

The importance and urgency of controlling rubella was felt after an outbreak of the disease in 2003. A mass immunization programme was undertaken in 2006, which resulted in the establishment of 1495 immunization posts and over 330 000 children and women of childbearing age being vaccinated. Following the initial immunization campaign, the MoH introduced the rubella vaccine into Bhutan’s routine immunization programme. Children were given two doses of the vaccine, one at 9 months of age and the other at 2 years of age. In 2016, the MR vaccine was replaced by the measles–mumps–rubella (MMR) vaccine. With a second mass immunization campaign conducted in late 2017, Bhutan was on the home stretch.

Bhutan’s achievement is not only a result of sustained coverage in excess of 90% of both doses of the vaccine, but also the result of sensitive case-based, laboratory-supported rubella surveillance and strong relationships with partners, including WHO, Gavi, the Vaccine Alliance and UNICEF.

**Accelerating efforts to tackle communicable diseases**

In 2018, Bhutan made important strides in tackling its communicable disease burden.

While Bhutan remains a low TB burden country, MDR-TB and HIV/TB coinfection have emerged as public health problems and the burden is increasing. The Ministry of Health
(MoH) launched updated guidelines on the programmatic management of drug-resistant TB, with WHO Country Office support. The country also implemented the WHO-recommended shorter MDR-TB treatment regimen, which coincided with World TB Day on 24 March 2018.

With WHO support, the capacity was strengthened of health workers to use improved methods for diagnosing and treating TB. Health workers were trained in clinical management, case detection, data collection and analysis, and epidemiology. Moreover, WHO conducted training for medical officers on the guidelines for treating drug-susceptible TB and patient care.

Meanwhile, the WHO County Office supported the MoH to review and update its guidelines for the management of viral hepatitis. The guidelines address issues related to screening, investigations, treatment and care of patients with hepatitis, with particular focus on chronic hepatitis B and C. They also propose decentralization of health-care services for hepatitis patients, given the limited number of specialists in the country. It is hoped that the guidelines will further accelerate action against hepatitis after a nationwide serosurvey conducted in 2017 found a decreasing trend in hepatitis B and C prevalence among the general population.

To raise more awareness about hepatitis, the WHO Country Office supported the celebration of World Hepatitis Day in July 2018.

WHO also supported the development of the country’s first National Leprosy Strategic Plan (2018–2023), which was developed in line with the principles of the Global Leprosy Strategy. At the end of implementing Bhutan’s Plan, it is expected that the country will have achieved the target of sustaining the elimination status of leprosy, further reduced the burden of leprosy, and also implemented a good surveillance system for monitoring leprosy cases and primary drug resistance. However, a major challenge going forward will be securing dedicated financial resources for programme-related activities.

**Strengthening Bhutan’s health systems**

Realizing the need to enhance research capacity and the need to have evidence-based policy, planning and practices for a strong health system, the MoH with WHO support has been striving towards building the research capacity of health-care providers. In a key development, WHO supported the implementation of Bhutan’s Structured and Mentoring Approach to Research Training (B SMART) to foster a strong research culture. All four modules of the second B SMART were completed in late 2018. The 13 health researchers, with the support of their mentors, developed and published 13 studies on various health issues, including dengue fever, knowledge, attitude and preventive practices, and epidemiological characteristics of attempted suicide cases.

Meanwhile, Bhutan continued its transition from a paper-based health information system (HIS) to an electronic (e-health) system with the development of the National
Box 3. High-level advocacy on accelerating prevention and control of NCDs

After the new government assumed office in October, the MoH with support from the WHO Country Office organized a high-level advocacy and Parliamentarians’ Forum to accelerate the prevention and control of NCDs under the theme ‘Happy and Healthy Bhutan by 2030’. The Forum, which was held in December, was attended by the Speaker of the National Assembly, members of Parliament including the Health Minister, civil society organizations (CSOs), and academia. The Forum underscored the urgent need to accelerate the NCD response as a national priority.

The Forum endorsed an outcome document with clear strategic areas of action for the NCD response in Bhutan. The document, published by the WHO Country Office, the MoH and the RGoB, makes 11 recommendations to achieve a ‘Happy and Healthy Bhutan by 2030’. Some of the recommendations include line ministries and government agencies responsible for tobacco, alcohol, diet and nutrition, physical activity and mental health; strengthening holistic healthy lifestyle interventions in schools; and enforcing the existing laws and strengthening regulatory measures for the effective control of tobacco and alcohol.

e-Health Strategy, with WHO Country Office support. The Strategy defines a roadmap for interoperability among different HIS from the peripheral to the national level.

As part of Bhutan’s ongoing efforts towards strengthening blood-related systems and services in the country, the National Strategic Plan for Blood Safety was developed. The Plan, which aims to ensure a quality blood transfusion system, is in line with the National Blood Policy, supported by WHO. In addition to ensuring quality and safety with blood transfusion, the Plan also seeks to upgrade blood safety information. It will also improve the app by including in it more features that will help effective blood collection, transfusion processes and sufficiency.

Visit to the Basic Health Unit II, Paro
In addition, the Medicines Act and Medicines Regulations were also revised with support from WHO to incorporate numerous new regulatory provisions, including regulation of medical devices, blood and blood products, health supplements and oversight of clinical trials. In 2018, while 22 new medicines were added to the list of essential medicines in the country, 12 others were deleted.

To enhance the capacity for drug analysis, WHO supported the training of officials from the National Drug Testing Laboratory (NDTL). The training led to the promotion of quality testing of a wide range of medicinal products in Bhutan.

**Tackling antimicrobial resistance**

To address the growing threat of AMR in Bhutan, the National Action Plan on Antimicrobial Resistance 2018–2022 was launched in 2018 with WHO support. The Plan was developed with various sectors to ensure a multisectoral role in combating AMR under the One Health approach. The Plan has seven objectives. These are: (i) to establish a governance structure to spearhead AMR activities; (ii) to promote rational use of antimicrobial agents at all levels of health care and veterinary settings; (iii) to institute a surveillance and monitoring system on AMR and antimicrobial use; (iv) to create and promote awareness on AMR through educational and public campaigns; (v) to establish and promote a system of research on AMR; (vi) to foster national and international collaboration; and (vii) to strengthen the control and regulatory systems.

**Partnerships**

Some examples of collaborative relationships that the WHO Country Office has fostered include the following:

- The WHO Country Office continues to partner closely with other UN agencies, international NGOs, CSOs and academia on various health initiatives. Such
examples include partnering with UNICEF to carry out supplementary immunization activities (SIAs) and with the United Nations Development Programme (UNDP) on climate change-related initiatives. Moreover, as part of an agreement with the Royal University of Bhutan, visiting WHO Country Office consultants deliver talks on public health to students.

○ The WHO Country Office also continues to work closely with various ministries aside from the MoH to strengthen Bhutan’s health systems and health outcomes. This includes working with the Ministry of Education and the Ministry of Agriculture and Forests.

○ WHO continues to work with UNDP and UNICEF on the UN Partnership to Promote the Rights of Persons with Disabilities (UNPRPD) to help advance the rights of people with disabilities.

Looking ahead

Some of the activities that the WHO Country Office will focus on in 2019 and beyond include the following:

○ Bhutan is gearing up to eliminate malaria after having recorded only 40 cases in 2018. A series of activities are planned, with WHO support, to enable the country to achieve malaria-free certification by 2020. These include strengthening the surveillance system; supporting health-care workers in rural communities to educate the public; continuing vector control activities in high-risk areas; and helping to prepare a dossier for the validation process. Bhutan is also striving for verification of the elimination of LF.

○ WHO will continue to strengthen Bhutan’s capacity to respond to disease outbreaks by providing training to local staff and equipment to the national laboratory. The Country Office will also focus on increasing and strengthening the country’s human resources capacity by providing fellowships and training for workers from the field level to those at the managerial level.

○ As requested by the RGoB, the WHO Country Office will support Bhutan’s efforts to combat cervical cancer by helping to scale up screening and reach all eligible girls with the HPV vaccine.

○ WHO will provide technical support to help Bhutan achieve the recommendations made at the Parliamentarians’ Forum to accelerate the prevention and control of NCDs.
Democratic People’s Republic of Korea

Highlights

- The Democratic People’s Republic of Korea is verified as having eliminated measles.
- Funds and the approval of Gavi to introduce rubella vaccine into the national immunization schedule have been secured.
- WHO supports review of the undergraduate and postgraduate medical education system.
- The country mobilizes funds from the Central Emergency Response Fund (CERF) for diagnosis of drug-susceptible TB and treatment of MDR-TB.
- The country sustains its decline in malaria cases, with a further 33% decrease in 2018.
- A standard essential package of services for frontline primary care has been developed.
Introduction

The Democratic People’s Republic of Korea (DPR Korea) has faced significant public health challenges, which continue to be largely associated with external geopolitical factors. These include international economic sanctions that have affected the country’s ability to secure adequate financing for medicines and equipment, which are essential for providing quality health care. The year 2018 was challenging for the country, following the unexpected withdrawal of the Global Fund. The Global Fund was the only source of funding for the country’s TB and malaria control programmes. However, despite its sudden withdrawal, WHO was able to immediately line up assistance from different sources to ensure continuation of TB services until 2020.

Despite these challenges, which also include the threat of natural disasters, the country has been able to sustain high and equitable coverage for childhood immunization in 2018 and improve access to health-care services for women and children, particularly related to obstetric care and services under the Integrated Management of Newborn and Childhood Illnesses (IMNCI) programme.
In 2018, DPR Korea achieved a significant milestone when it was verified by WHO as having eliminated measles, two years ahead of the regional target. In addition, despite withdrawal of the funding by the Global Fund, the country continued to record a significant decline in malaria cases, keeping it on track to achieve elimination status by 2025.

Nevertheless, although the country has an extensive health infrastructure and a high human resources for health (HRH) ratio, challenges remain in ensuring that health facilities are adequately equipped and essential medical equipment is available.

**Key activities and achievements in 2018**

**Ensuring access to diagnosis and treatment of tuberculosis**

Following the sudden withdrawal of Global Fund support in June 2018, the TB control programme faced tremendous challenges.

TB is a major public health issue in DPR Korea, with a prevalence rate of 641 per 100,000. Moreover, MDR-TB is also an increasing problem with an estimated 4100 new cases every year.

Despite the withdrawal of the Global Fund, DPR Korea was able to continue its TB control programme without disruption. The country secured a US$ 2.3 million grant from CERF to procure MDR-TB drugs for 1200 patients, and this will be available in 2019. The grant will also be used for diagnosis of drug-susceptible TB. The country also negotiated with the Global Fund to provide MDR-TB treatment for 500 patients and to procure first-line drugs using the unspent balance. As a result of these efforts, the country was able to increase the proportion of MDR-TB patients on treatment from 15% in 2017 to 55% in 2018. With support from the WHO Country Office, the Ministry of Public Health (MoPH) began work on the introduction of a shorter regimen for MDR-TB into the draft national guidelines by the National TB Control Programme (NTP).

Moreover, the WHO Country Office, with support from WHO headquarters, the Regional Office and the Stop TB partnership, was able to secure paediatric TB medicine stocks for almost 10,000 children until the first quarter of 2020.

Looking ahead, despite the country’s efforts to combat TB, there is considerable concern that the recent progress in improving diagnosis and treatment may be reversed.

**Working towards malaria elimination**

The incidence of malaria continues to decline in DPR Korea, with 3089 cases reported in 2018. This is a decrease of more than 30% compared with the previous year.
In 2018, the National Malaria Elimination Strategy (2018–2022) was launched with WHO support. The Strategy has a bold vision to interrupt local malaria transmission by 2022 and achieve malaria elimination by 2025. The Strategy prioritizes ensuring universal and sustained access to key malaria interventions, including the distribution of long-lasting insecticidal nets (LLINs), mass primaquine preventive treatment (MPTT), quality diagnosis and treatment in high-risk areas.

The National Guidelines for Malaria Surveillance and Response in the Elimination Phase were also developed with WHO technical support. The Guidelines ensure case-based surveillance, investigation of foci and appropriate mitigation for elimination of cases.

Despite DPR Korea’s continued efforts to reduce malaria incidence, the National Malaria Programme (NMP) faces an uncertain future following the withdrawal of funding from the Global Fund. As such, there is an urgent need to secure funds for continuing malaria elimination initiatives, including securing prophylaxis and diagnostics. DPR Korea does not want history to repeat itself after it witnessed a resurgence of the disease in 2001, despite achieving elimination in the 1970s.

**Fig. 1: Number of malaria cases and malaria incidence reported during 2010–2018**

![Graph showing number of malaria cases and incidence from 2010 to 2018.](image)

**Source:** Malaria epidemiological data, MoPH, DPR Korea

**Further strides in the control of vaccine-preventable diseases**

In 2018, DPR Korea joined three other countries in the SEA Region in achieving measles elimination (see Box 5).

Another important milestone was the approval by Gavi of an application for support for the introduction of the MR vaccine into the country’s national immunization schedule.
Box 5. Democratic People’s Republic of Korea eliminates measles

In a significant win against childhood killer diseases, in 2018 DPR Korea was verified for eliminating measles, two years ahead of the regional target.

The Regional Verification Commission, an independent body of experts that met in Delhi over three days between 31 July and 2 August, verified that DPR Korea has interrupted transmission of indigenous measles for more than three years. DPR Korea achieved this milestone thanks to the effective implementation of measles elimination strategies, political will, strong partnerships with WHO and other actors, strong health infrastructure and meticulous planning by the Ministry of Public Health (MoPH).

The last big outbreak of measles was in 2007 in which the MoPH reported 3597 cases, including four deaths. With support from WHO and UNICEF, an emergency nationwide SIA was conducted covering more than 16 million people aged between 6 months and 45 years. A second dose of measles-containing vaccine (MCV) was incorporated into the national immunization schedule following the SIA. In collaboration with the WHO Country Office and other UN agencies, the MoPH was able to sustain high immunization coverage in addition to effective surveillance and disease data reporting.

DPR Korea now looks ahead to controlling rubella and CRS by 2020.

Trend in MCV 1 and MCV 2 coverage and laboratory-confirmed measles cases reported in DPR Korea since 2002

This followed recommendations from the South-East Asia Regional Immunization Technical Advisory Group (ITAG) to replace the MCV vaccine with the MR vaccine.

WHO, in collaboration with UNICEF, and supported by Gavi’s Targeted Country Assistance (TCA) funding window, conducted two national consultations to plan for a nationwide MR immunization campaign targeting children between 9 months and 15 years of age. This would take place in the third quarter of 2019.

Source: Five-Year National Strategic Plan (2018–2022) on measles elimination and control of rubella/CRS, MoPH, DPR Korea
In addition, the WHO Country Office supported the MoPH to develop the 5-year National Strategic Plan (NSP) on measles elimination and control of rubella/CRS. The new NSP (2018–2022) is an extension of the previous NSP and includes strategies required for tracking the country’s progress towards achieving elimination of measles (achieved in 2018) and control of rubella and CRS in DPR Korea by 2020, with future sustainability.

In July 2018, the WHO Country Office facilitated a review of DPR Korea’s Expanded Programme on Immunization (EPI)/VPDs. The review made several recommendations on how to sustain high immunization coverage. Such recommendations include providing a heating system for cold chain equipment rooms and immunization clinics during winter and to conduct disease-burden and cost–benefit analysis studies for rotavirus and pneumococcal diseases.

**Strengthening health systems to combat noncommunicable diseases**

In April 2018, the WHO Country Office supported a mission to review DPR Korea’s capacity to diagnose, screen and treat cancer, and provide palliative care. The mission consisted
of international experts from Apollo Hospitals in India, the National Cancer Institute of Thailand, and WHO staff from headquarters and the regional offices for South-East Asia and Europe. The mission reviewed the major continuum of care in cancer management with the aim of strengthening cancer management in the country.

In a key step towards the management of cardiovascular diseases (CVD) and diabetes, the WHO Country Office supported the MoPH to update its Guidelines for Integrated Management of Cardiovascular Disease and Diabetes in Clinics and Ri-hospitals. The Guidelines, which are in the final stages, incorporate lessons learnt from the PEN package pilot.

**Improving the skills and knowledge of health-care professionals**

In 2018, DPR Korea took significant steps towards strengthening its HRH, which was geared towards building the country’s capacity to produce quality medical graduates and bolstering the clinical skills of frontline health workers.

To this end, a review of the country’s medical education system, led by WHO, was conducted in July. The purpose of the review was to assess undergraduate and postgraduate medical education and identify ways in which the system can be improved in line with global and regional experiences. As part of the review, a national workshop – involving national education experts, MoPH functionaries and officials from Kim Il Sung University – was conducted where WHO experts discussed different models of the medical curriculum, accreditation and licensing mechanisms.

In addition, WHO supported the development of the Essential Health Care Service Package. The Package standardizes frontline services to be delivered at the primary health care level, including a standard list of equipment, medicines and diagnostics. It also includes a list of services to be provided, including prevention and management of communicable diseases and NCDs, maternal and child health, and other general health services.

**Benchmarking regulatory capacity to ensure the quality of locally produced and imported health commodities**

In October 2018, WHO supported an assessment of self-benchmarking of the national regulatory authority and scoping mission for local manufacturing using WHO’s Global Benchmarking Tool (GBT). The GBT is the primary means by which WHO objectively evaluates regulatory systems. The purpose of the mission, which comprised experts from the WHO Country Office, Regional Office and headquarters, as well as United Nations Industrial Development Organization (UNIDO), was to improve access to quality medicines through an institutional development plan for strengthening the national regulatory authority.
Box 6. Prompt response to the seasonal influenza outbreak

Trend in reported influenza cases by week
(excluding # reported for the period 1 February 2017 to 22 January 2018)

Source: Weekly data reported to WHO by MoPH during the influenza outbreak

In January 2018, the MoPH reported an increase in influenza-like illness (ILI) cases. Between 1 December 2017 and 1 March 2018, more than 295,500 ILI cases and 548 cases of severe acute respiratory infections (SARI) were recorded. This was a significant increase in cases compared with the same period in previous years. Following an internal risk assessment (IRA) carried out by the WHO Country Office, Regional Office and headquarters, WHO’s response was shaped to minimize the spread of the outbreak; mitigate morbidity and mortality; prevent influenza among health workers; and continue surveillance. As such, WHO’s response to the influenza outbreak included the following activities:

- conducting weekly technical meetings with the MoPH to assist in interpreting surveillance data;
- establishing a weekly reporting system for assessing the intensity of transmission and severity of seasonal influenza cases;
- sharing communication materials and guidelines with the MoPH to contain seasonal influenza outbreaks and clinical management of patients;
- mobilizing and delivering 60,000 tablets of oseltamivir (antiviral) for patient management;
- supplying 140,000 vials of ceftriaxone, 125,000 vials of ampicillin, 150,000 tablets and 5,000 bottles of paracetamol for patient management;
- drawing up a contingency plan to supplement additional requirements of laboratory supplies and logistics through the Regional Office, WHO Country Office for the People’s Republic of China, and the Global Influenza Surveillance and Response System (GISRS) at WHO headquarters.

Several lessons were learnt from the outbreak, which was declared over on 1 March 2018. These included the need to strengthen the laboratory capacity of the National Influenza Centre, in addition to the need to develop policies for seasonal influenza vaccinations and the need to stockpile antivirals, essential antibiotics and personal protective equipment (PPE). Following the outbreak, WHO supported the MoPH to update its National Pandemic Influenza Preparedness and Response Plan (NPIP).
Strengthening capabilities to prepare and respond to emergencies

Recognizing that staff could be exposed to biological, radiological, chemical and nuclear hazards, and that knowledge about specific prevention measures was limited, WHO headquarters in collaboration with the Country Office and the WHO Health Emergency Programme at the Regional Office developed a training package for Country Office staff. The training programme took place in August in Bangkok, Thailand, and involved Thailand’s MoPH and the chemical department of the Royal Thai Army, which shared its expertise and experience.

Meanwhile, in late August, tropical storm Soulik caused extremely heavy rainfall, which resulted in heavy flooding in several provinces. In response, WHO conducted a rapid-impact health assessment and two field assessments that focused on the status of immunization, antenatal care, communicable diseases, and water and sanitation. The assessments led the health sector to initiate a response to the health effects of the flooding.

WHO also supported mobilization of SEARHEF to respond to critical health needs, including the shortage of basic essential medicines, prevention of communicable diseases and ensuring access to safe drinking water. To this end, WHO procured and delivered comprehensive IHEKs and an essential package of medicines and equipment for Ri hospitals and county hospitals, and procured water-testing kits.

Partnerships

WHO works closely with other health sector partners with an in-country presence in DPR Korea, which consists primarily of UN agencies including UNICEF, UNFPA and the Food and Agriculture Organization (FAO). In addition, it also collaborates with the International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of the Red Cross (ICRC) and international NGOs implementing European Union projects and, of course, the MoPH.

Some examples of how WHO collaborates with partners are listed below:

- WHO supports the MoPH in scaling up PEN interventions for NCDs and strengthening health information management and emergency preparedness and response.
- In the absence of the Global Fund, WHO is collaborating with the Stop TB initiative and other partners for ensuring the smooth supply of TB medicines and diagnostics.
- WHO serves as a member of the Humanitarian Cluster Team (HCT) comprising UN partners that coordinate humanitarian responses in the country. WHO chairs the HCT’s Health Sector Working Group and facilitates its coordination meetings.
Looking ahead

Key activities that WHO will support in 2019 include the following:

- ensuring TB diagnosis and treatment for drug-susceptible TB as well as MDR-TB patients;
- introducing MR vaccine into the country’s routine immunization schedule;
- working with other UN agencies to improve quality home-based at risk pregnancy screening and home delivery by skilled birth attendants to address maternal mortality; and
- launching tobacco-free initiatives targeting restaurants.

The Regional Director at a reception hosted by H.E. Mr Kye Chun Yong, Ambassador Extraordinary and Plenipotentiary, Embassy of DPR Korea, New Delhi
India

Highlights

- Health takes centrestage, putting India firmly on the path of UHC with the launch of the Ayushman Bharat programme. The Programme aims to address health holistically through its twin components – health and wellness centres and the Pradhan Mantri Jan Arogya Yojana (PM-JAY) – for financial protection when seeking secondary and tertiary care.

- The Prime Minister, H.E. Mr Narendra Modi, announces India’s commitment to ending TB by 2025, five years ahead of the global target.

- India launches new guidelines on midwifery and announces a cadre of nurse practitioner in midwifery (NPM) to ensure quality health care for every mother and newborn.

- The MoHFW and WHO sign a memorandum of agreement (MoA) that facilitates the government’s commitment to further strengthen the partnership, especially for an expanded role of the National Polio Surveillance Project (NPSP) and the WHO Revised National Tuberculosis Control Programme Technical Support Network.

- The National Viral Hepatitis Control Programme with a comprehensive plan covering hepatitis A, B, C, D and E is launched.

- India launches the Integrated Health Information Platform (IHIP), a web-enabled nationwide near-real-time electronic information system for health that provides a single operating picture with highly granular geospatial information for managing disease outbreaks and related resources.

Introduction

The year 2018 was a remarkable year for health in India. The government launched the path-breaking Ayushman Bharat programme, in tune with the World Health Day theme of UHC.

The provision of health and wellness centres brings primary health care closer to the people, especially those in rural and poor areas, and PM-JAY, the health protection scheme, is aimed at preventing catastrophic health expenditure on secondary and tertiary care. WHO continued to support the country’s immunization, TB, HIV/AIDS and NTDs programmes and population-based screening for NCDs.

AMR was also high on the priority list. To this end, the Chief Minister of Kerala state launched the Kerala Antimicrobial Resistance Strategic Action Plan (KARSAP), the first of its kind in India. Developed with WHO support, the Plan provides the blueprint for other states to develop a similar policy. In collaboration with the National Centre for Disease Control (NCDC), WHO finalized the National Guidelines for Infection Prevention and Control, which will contribute to the containment of AMR, as well as prevention and control of emerging infectious diseases such as Nipah virus and Ebola virus diseases in health-care facilities.

In May, Kerala reported an outbreak of Nipah virus disease that claimed 21 lives. With timely reporting and response from the central and state governments, coupled with a strong health system, the outbreak was swiftly contained.
Meanwhile, technology has become an enabler in the health sector and is being successfully used for health intelligence to guide policy. For example, 2018 saw the design and launch of an IHIP: a comprehensive information system to monitor data being collected at health facilities and laboratories in both the public and private sectors across the country.

A high point of the year was the first official visit of the WHO Director-General, Dr Tedros Adhanom Ghebreyesus. Sharing the platform with the Prime Minister, H.E. Mr Narendra Modi, at the Delhi End TB Summit, the Director-General reiterated the Organization’s commitment towards a TB-free India. It was at this summit that the Prime Minister announced India’s commitment to ending the epidemic by 2025.

**Key activities and achievements in 2018**

**Ramping up efforts to end TB**

In 2018, the government announced its commitment to end TB by 2025. As part of its commitment, several initiatives to accelerate progress towards this ambitious goal were launched.

The Prime Minister, H.E. Mr Narendra Modi, launched the direct benefit transfer initiative, the Nikshay Poshan Yojana, which provides nutritional support to TB patients and aims to reduce OOP expenditure.

The initiative, supported by WHO, provides INR 500 per month to TB patients undergoing treatment in both the public and private sectors. In 2018, over 1 million patients received direct benefits into their bank accounts.

In its efforts to end TB, India also developed several incentives and regulatory measures to engage the private sector. This included an incentive of INR 1000 to be given to private providers who notify the government of confirmed TB cases and share the treatment outcomes of patients.

India has also begun to implement key interventions as part of its National Strategic Plan for Tuberculosis Elimination 2017–2025. This includes active case-finding, screening for and counselling on tobacco use, addressing comorbidities such as diabetes, large-scale community engagement with national-, state- and district-level TB forums, and training of TB champions.

Meanwhile, to facilitate the scale up of bedaquiline and delamanid and the treatment of mono- and polydrug resistance, capacity for first-line and second-line line probe assays (LPAs) as well adverse drug reaction monitoring mechanisms were strengthened. In addition, universal drug susceptibility testing was rolled out across the country to identify resistance to rifampicin.
The WHO Country Office is collaborating with a World Bank TB project worth US$ 400 million and, as part of its support to the government, is increasing its existing network of 72 consultants to 148.

**Accelerating progress against HIV/AIDS and hepatitis**

The government launched a comprehensive National Viral Hepatitis Control Programme on World Hepatitis Day. The Programme, which aims to end viral hepatitis by 2030, covers the entire gamut from hepatitis A, B, C, D and E and the whole range of services, from prevention to detection and treatment, including the provision of hepatitis B and C treatment.

For the effective roll-out of the programme, important steps have been taken with WHO support, including the development of standard training modules, training for over 200 master trainers, development of an monitoring and evaluation (M&E) framework, procurement of testing kits and drugs, and the establishment of an intersectoral coordination group at the national level.

Meanwhile, as India moves ahead towards the “90-90-90” targets for HIV treatment by 2020 (90% of people with HIV are aware of their infection; 90% of people diagnosed with HIV are linked to antiretroviral treatment [ART]; and 90% of those on ART adhere to and have undetectable levels of HIV in their blood), based on WHO recommendations, the National AIDS Control Organization (NACO) updated its treatment guidelines. As such, NACO has established modalities to provide routine viral load testing for all patients on ART. This will not only help in earlier and more accurate detection of treatment failure but will also help the programme to quantify the third “90” goal.

WHO is committed to working with the government to strengthen surveillance and M&E, scale up prevention among key populations, including pre-exposure prophylaxis

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**Box 7. India firmly on the path of universal health coverage**

In 2018, the government paved the way for UHC with the launch of the Ayushman Bharat programme. The twin components of the programme encompass preventive, promotive, rehabilitative and curative care, as well as secondary and tertiary care.

The health protection component of the programme, PM-JAY, will reach 100 million poor and vulnerable families (approximately 500 million beneficiaries) providing coverage of up to 500,000 Indian Rupees per family per year for secondary and tertiary hospitalization. The 150,000 health and wellness centres will provide comprehensive primary health care for an expanded range of services including reproductive and child health services, communicable diseases, NCDs, palliative care and elderly care, oral health, ENT care, and basic emergency care.

The WHO Country Office supported both the National Institute for Transforming India (NITI Aayog) and the MoHFW in policy formulation, designing benefits and frontline service delivery models; and in creating capacity to set appropriate pricing and reimbursement levels, and implementing research to refine operational approaches.
(PrEP), diversify testing strategies, and implement differentiated services for patients on ART to achieve the “90-90-90” targets and end the AIDS epidemic by 2030.

Stepping up the fight against NTDs and malaria

To address the stalled progress in reducing the global malaria burden, WHO launched the 10+1 Initiative (high-burden to high-impact: a targeted malaria response) to intensify efforts to reduce malaria cases and deaths, and to get back on track to achieve the targets of the Global Technical Strategy for Malaria 2016–2030. Under the Initiative, WHO has prioritized special support for India, the only country outside of the Africa Region to be given specific focus to accelerate progress against the disease.

In addition, WHO is also supporting the development of India’s National Guidelines on Mosquito and Other Vector Control Response (MVCR) to align with WHO’s Global Vector Control Response. At the state level, with technical support from WHO, the government of Punjab state launched a micro-strategic plan to eliminate malaria from the state by 2020. Based on the experience in Punjab, the model will be rolled out in other low-endemic states of the country.

WHO is actively engaged in the elimination of kala-azar, leprosy and lymphatic filariasis (LF) in India. To accelerate elimination of LF, the government launched the Accelerated Plan for
Elimination of Lymphatic Filariasis. As part of the Plan, the government introduced the three-drug treatment for MDA – known as IDA – which involves ivermectin, diethylcarbamazine citrate and albendazole. IDA has been introduced on a pilot basis in five districts.

Supporting efforts to address NCDs and their risk factors

A key strategy for the prevention and control of NCDs is the strengthening of health systems. In 2018, a multipartner project, the India Hypertension Control Initiative, was launched with support from Resolve to Save Lives, an initiative of Vital Strategies. The project, which aims to reduce morbidity and mortality from CVDs by improving the control of hypertension, is operational in 25 districts in five states, with WHO as one of the key technical and implementing partners. The project will do this through capacity-building of the health system for appropriate management and follow up of patients.

In addition, WHO was a technical partner in the development of the information technology (IT) solution for the government’s population-based NCD screening programme. The IT solution connects health workers, caregivers and decision-makers on a single, integrated platform to improve health-care service delivery. It enables patient-tracking and creates HIS to ensure a continuum of care. The programme has been rolled out in 216 districts across all states and Union Territories, with more than 11 million people being screened.

Meanwhile, the WHO Country Office supported the government in the design, development and field-testing of pictorial health warnings on tobacco product packages. Based on the recommendations of the field study, high-impact images for tobacco package warnings were finalized by the MoHFW and are now displayed on packets. In addition, the quitline number was added to packets and the hotline was subsequently expanded across the whole country.

WHO also worked closely with the government to provide the necessary technical and training assistance for complying with the Protocol to Eliminate Illicit Trade in Tobacco Products under the WHO FCTC.

To address the tobacco supply-side concerns, WHO is supporting the Ministry of Labour and Employment (MoLE) and the National Skill Development Corporation to implement the skill development training programme for bidi rollers across India to assist them in transitioning to an alternative and economically viable livelihood.

To build evidence for policy change on the economics of tobacco and tobacco control, WHO released a report titled *Bidi industry in India: output, employment and wages*. The report found that the bidi industry contributes only 0.65% of the gross value addition by the entire manufacturing industry and its contribution to the national economy is minimal.
Increasing access to medical products

In collaboration with the MoHFW, WHO organized a number of national and international consultations to focus on an important plank of UHC: access to quality and affordable medical products.

The Second World Conference on Access to Medical Products: achieving the SDGs 2030, held in Delhi in October, discussed innovation and manufacturing, regulation and access, financing, the legal landscape, and trade aspects of increasing access to medical products. At the conference, the Information Sharing Platform Gateway for the South-East

Box 8. Saving mothers, saving newborns: recognizing the role of midwifery

To improve the quality of care provided during childbirth and ensure respectful care to pregnant women and newborns, India has taken a momentous decision to create a midwifery cadre and introduce midwifery-led units in public health facilities. With nurses accounting for 38% of the health workforce, rolling out these measures will improve quality, equity and dignity in care, and decongest higher-level facilities. Importantly, this initiative will help reduce maternal and newborn deaths.

The WHO Country Office supported the government by organizing and facilitating midwifery stakeholder consultations and provided evidence on the optimal duration of post-basic midwifery training to achieve the standards of the International Confederation of Midwives. WHO also reviewed the existing nurse practitioner in midwifery curriculum to identify gaps, and facilitated consensus-building on options for certification, regulation and career progression of midwifery practitioners in the country.
Asia Regulatory Network (SEARN) was launched. The Network, which was developed by the Centre for Development of Advanced Computing, will promote regulatory and health collaboration among countries of the SEA Region.

In addition, the Fourth WHO Global Forum on Medical Devices: Increasing Access to Medical Devices, held at Visakhapatnam, in Andhra Pradesh state, was attended by over 1000 delegates from 90 countries. The Forum discussed novel ideas for advancements in medical device technologies without compromising safety and effectiveness.

Furthermore, the national guidance document for states on free diagnostics has been finalized. Also, WHO provided technical and policy support for the pharmacovigilance agenda by setting up safety monitoring systems and regulatory services in public health programmes, including TB, HIV/AIDS and NTDs.

Strengthening health security and emergency response capabilities

The WHO Country Office and the MoHFW have been jointly working on designing an IHIP, which is a comprehensive information system to monitor data being collected at health facilities and laboratories in both the public and private sectors across the country.

The IHIP will help in the early detection of emerging public health threats and can be used to monitor health events during disasters and mass gatherings. It will be deployed at the Kumbh Mela at Prayagraj in early 2019. The IHIP will also allow public health officials to describe and analyse geographical variations in diseases and conduct public health surveillance in the context of the One Health approach.

In 2018, the IHIP was launched in seven states, giving them the ability for near-real-time public health surveillance covering a population of nearly 350 million. By March 2019, the IHIP will be introduced in the remaining 29 states, covering India’s entire population.
The malaria module for case-based entry of the IHIP has been developed and training has been completed in two states. Data will now be collected through the malaria IHIP platform, which will be implemented in all states. At the request of the MoHFW, WHO is supporting the development of a platform for the health management information system (HMIS) of the country.

Meanwhile, WHO responded to severe flooding in Kerala in August, deploying a 32-member team, including TB consultants and cardiovascular health officers. The team specifically worked on establishing linkages with the private sector to report communicable diseases through a mobile-based EWARN and successfully generated early warning signals for leptospirosis, dengue and hepatitis. More than 754 private health facilities were visited, 276 workshops conducted and more than 10 000 cases reported throughout the state. A CERF grant was approved for post-disaster health sector recovery.

WHO also provided technical support to the MoHFW and the Government of Kerala to combat the Nipah virus outbreak in the state. The outbreak was successfully contained through rapid and comprehensive disease surveillance and response, strengthened risk communication and enforcement of hospital infection control practices. To this end, WHO is supporting Kerala to better understand best practices and challenges, and guide future preparedness and response to Nipah virus disease and other outbreaks.

**Accelerating achievements of the Universal Immunization Programme**

India has been polio-free for almost eight years. WHO has continued to maintain a high level of vigilance through robust surveillance for timely detection and response to any threat of polio virus importation.
In 2018, the government approved transition plans for the NPSP to support the intensification of routine immunization, VPD surveillance, introduction of new vaccines, and measles elimination and rubella and CRS control, while simultaneously continuing to maintain robust polio surveillance until global certification.

During the year, India accelerated action towards measles elimination and rubella and CRS control with approximately 225 million children receiving the MR vaccine across 30 states and Union Territories. India also maintained heightened surveillance through the implementation of laboratory-supported, case-based MR surveillance. At the end of 2018, 23 states and Union Territories had transitioned to case-based MR surveillance, and the MR laboratory network was scaled up to include 19 proficient laboratories.

Meanwhile, Mission Indradhanush, an initiative that aims to immunize pregnant women and all children under 2 years against preventable diseases under the Universal Immunization Programme (UIP), continued to make significant progress during the year. In 2018, almost 4 million children and nearly 1 million pregnant women were immunized. Following the implementation of Misson Indradhanush, there has been an 18.5% increase in full immunization coverage compared with corresponding figures for 2015–2016 in the 190 districts covered under the initiative. WHO also supported the introduction of the rotavirus vaccine in 11 states, pneumococcal conjugate vaccine (PCV) in 144 districts of six states and the HPV vaccine in Sikkim and select districts of Punjab. In addition, the typhoid conjugate vaccine (TCV) was launched in Navi Mumbai.

**Guaranteeing health through the life-course**

At the request of the Ministry of Drinking Water and Sanitation, WHO estimated the health gains from the progress made under the government’s Swachh Bharat (Clean India) Mission. According to WHO estimates, assuming that 100% coverage is achieved by October 2019, the Mission will be able to avert up to 300 000 deaths from diarrhoeal disease and protein–energy malnutrition (PEM) since its launch in 2014.

The Partners’ Forum 2018 held in New Delhi in collaboration with MoHFW and the Partnership for Maternal, Newborn and Child Health (PMNCH) was inaugurated by the Prime Minister of India. This reflected the very high level of political commitment towards sustaining momentum on issues related to women’s, children’s and adolescents’ health.

With WHO support, the national technical guidelines on iron and folic acid supplementation were revised and released for states to roll out. The revised technical specifications will not only lead to improved absorption of iron delivered through the programme but also reduce the side-effects. This is likely to have a significant impact on the rate of decline of anaemia in the country and address the problem of hidden hunger in India.
Partnerships

To support the government’s health programmes and initiatives, both at the central and state levels, WHO is working with the MoHFW and a range of other government ministries and agencies, including the Ministry of Drinking Water and Sanitation, Ministry of Women and Child Development and NITI Aayog.

To further strengthen collaborative work in achieving improved health outcomes, WHO signed an MoA with the MoHFW in 2018. This agreement is a recognition of the critical need for, and contribution of, collaborative work by WHO and the government in achieving national, regional and global health outcomes.

The government has also committed to sustaining the WHO-NPSP to 2022 and beyond to support broader public health needs as well as to continue support for the WHO TB consultants’ network.

As the UN technical lead on health, WHO works closely with other UN agencies, which collectively have agreed to, and are working towards, the expected results and strategies outlined in the UN Sustainable Development Framework (UNSDF) 2018–2022. WHO also serves as the convener for the UNSDF Results Working Group II on health, water and sanitation.

In 2018, WHO collaborated with multiple UN agencies, CSOs and NGOs on a range of health programmes. WHO, as the convener of the Health Partners’ Forum, organized several meetings and consultations, which were attended by various UN agencies, embassies, donors and CSOs.

NCDs are one of the important targets being tracked under the UNSDF. WHO is collaborating with UNDP for the development of a joint workplan for NCDs, including tobacco control, and a strategic framework document for future interventions to complement and supplement the efforts of WHO and UNDP.
WHO has signed an agreement with Gavi to support the implementation of the government’s Measles–Rubella Campaign Operational Support Programme. The US$ 7 million grant has designated activities that are being implemented across states undertaking the MR campaign.

**Looking ahead**

WHO will continue to support the government in meeting its health sector reform goals and others laid out in the National Health Policy 2017. The support will be aligned with WHO’s GPW13 and the Country Cooperation Strategy (CCS) for India.

Given India’s population of over 1.3 billion, the country will be an important contributor to achieving the Thirteenth General Programme of Work (GPW13) targets – of 1 billion people reached for each strategic priority: UHC, promoting health and wellness by addressing the determinants of health and protecting the population against health emergencies.

WHO’s overarching role will be to support both the central and state governments in steering increased investments in health in ways that are efficient and that have the greatest impact, based on the best local and global evidence available. A key focus area will be to translate the blueprint for Ayushman Bharat into tangible actions. To this end, WHO will provide support to linking the health and wellness centres with the PM-JAY to ensure a continuum of care.

*The Ihsan Doğramacı Family Health Foundation Prize presented to Professor Vinod Kumar Paul (India) at the Seventy-first World Health Assembly, Geneva*
WHO will continue to support the training of frontline health workers in the diagnosis and management of NCDs. This will include expanding the India Hypertension Control Initiative to 100 districts and rolling out a population-based NCD screening programme. It will also support the delivery of basic mental health services by assisting with a national mental health training programme for non-specialist health workers, and in palliative care and elderly services.

WHO will support India’s goals to become a leader in digital health technologies, including the full roll-out of the IHIP, the establishment of electronic medical records and a unique ID system. The IHIP, once fully functional, will bring about a significant change in disease prevention and control in India, as well as help improve health decision-making and continuity of care.

WHO will also collaborate with the government in building upon successful initiatives such as the Swachh Bharat Mission and expand the focus to improving hygiene practices, promoting environmental cleanliness and reducing household air pollution.

Due to their growing impact on health in India, WHO will also increase its engagement in environmental health and air pollution, suicide prevention and the roll-out of the national NCD action plan. It will continue to provide policy and technical guidance for nutrition and food safety, tobacco control and road safety.

WHO will further step up its support to the national programmes in TB, viral hepatitis, and sexual and reproductive health.

WHO stands committed to strengthening the national and subnational governments’ health emergency preparedness and to provide on-the-ground support during any potential emergencies.
Indonesia

Highlights

- Japanese encephalitis (JE) vaccine was introduced into the routine immunization programme in Bali.
- Indonesian Accreditation Agency for Higher Education in Health was accepted by internationally recognized quality assurance organizations.
- WHO provided high-level advocacy for tobacco taxation.
- Significant progress was made in the elimination of neglected tropical diseases (NTDs).
- WHO Global Benchmarking Tool was used to appraise the National Regulatory Authority (NRA) for vaccine quality assessment.
- Indonesia makes reproductive health-care facilities available for vulnerable populations.
- Stunting was addressed through a multisectoral approach.
- Thirty-eight additional districts were declared malaria-free.
- WHO facilitates HIV treatment at the provincial level.
**Introduction**

Indonesia made significant strides in 2018 in tackling communicable diseases. These included introducing a JE vaccine, intensifying efforts to scale up testing and treatment for HIV and preventing LF and soil-transmitted helminthiasis (STH) through preventive chemotherapy. To address the growing burden of NCDs and their risk factors, WHO continued its high-level advocacy for taxation on tobacco and sugar-sweetened beverages (SSBs.)

At the same time, the government is in the process of developing its National Development Plan (2020–2024) as well as its next Health Sector Strategy (2020–2024). To this end, WHO supported an annual health sector review to identify challenges relating to health development in the country, analyse the current situation, and develop recommendations and policy options in line with the new National Development Plan.

To meet the country’s goal of UHC by 2019, progress was made in 2018 with a 5% increase on the UHC index. Indonesia aspires to focus on the quality of health services, in addition to emphasizing on access to health-care to provide comprehensive health

*With the honourable Health Minister of Indonesia, Dr Nila Farid Moeloek, at the Seventy-first session of the Regional Committee, 2018, New Delhi*
amenities. In 2018, around 207 million Indonesians – more than 80% of the population – were enrolled in the National Health Insurance (NHI) programme.

Nevertheless, the country remains vulnerable to natural disasters and 2018 was no exception. The Sulawesi earthquake in September displaced 100 000 people and claimed 2000 lives. WHO supported the emergency response with substantial prudence.

**Key activities and achievements in 2018**

**Renewed efforts to combat vaccine-preventable diseases**

In 2018, the JE vaccine was introduced following recommendations made by the Indonesian ITAG with WHO’s technical support. A campaign was initially conducted between March and April in Bali, targeting children aged 9 months to 15 years. The campaign, carried out by several ministries with WHO’s technical assistance, resulted in 93% vaccine coverage. Following the immunization campaign, JE vaccine was introduced into Indonesia’s routine immunization programme, and was planned for children aged 10 months and above. Given the recent introduction of the vaccine, only 20.2% coverage was achieved in 2018. The aim for 2019 is more than 95% coverage in Bali.

Meanwhile, with the aim of reaching the regional target of eliminating measles and controlling rubella by 2020, the government conducted the second phase of SIAs. About 144 districts achieved coverage at or above the target level of 95%. The MoH, in collaboration with WHO, worked with the Indonesian Paediatric Society to form subnational committees on adverse events following immunization (AEFI) in all 28 provinces to manage cases and promote the campaign. Prior to the campaign, WHO worked with the media to spread the message about the benefits of the vaccine. Over the two phases of the campaign, 58.4 million children were reached, achieving 87% coverage of the target population. Despite the best efforts, the campaign did not meet its target, primarily due to vaccine hesitancy.

**Improving access to reproductive health services for vulnerable and marginalized populations**

In 2017, the MoH, with WHO’s support, developed Guidelines on Reproductive Health Care Services for People with Disabilities. The landmark guidelines were piloted in one district in 2018, which involved training 100 health workers from five hospitals and 32 primary health care centres to improve their capacity to provide reproductive health services for people with disabilities. The programme will be extended to an additional four cities in 2019.

Meanwhile, to ensure access to sexual and reproductive health care for people in prisons, the MoH, in collaboration with the Ministry of Law and Human Rights (MoLHR),
developed Guidelines on Reproductive Health Care Equity for people from vulnerable and marginalized groups, with a specific focus on prisoners. In this context, WHO organized one coordination meeting and two workshops to further discuss the timeline, service requirements and cross-sector involvements regarding the implementation. Implementation of the Guidelines was initiated in 2018 with an assessment of the primary sexual and reproductive health problems prisoners face.

Certification of the Indonesian Accreditation Agency for Higher Education in Health

The Indonesian Accreditation Agency for Higher Education in Health (IAAHEH), called LAM-PTKes in Bahasa Indonesia, is an independent body that began operating in 2015 to conduct accreditation for higher education programmes in various health professions. Its mission is to achieve global quality standards for higher education in health. To gain the reputation as a trustworthy accreditation agency, LAM-PTKes attained recognition from two international independent bodies. In 2018, with WHO’s financial and technical support, LAM-PTKes successfully completed the process of acceptance into the Asia Pacific Quality Network (APQN) and the World Federation for Medical Education (WFME), for nursing and medical degrees, respectively.
LAM-PTKes anticipates that joining the APQN and the WFME will have a positive impact on health education in Indonesia, particularly in the areas of exchanging ideas and expertise; enhancing institutional capabilities; and in promoting communication and cooperation between international agencies and institutions.

**Intensifying efforts to reduce stunting prevalence through policy**

In 2018, 30.8% of children under 5 years of age were classified as being stunted. Given such alarming figures, WHO supported several ministries to develop a policy guideline to coordinate the prevention of stunting through a multisectoral approach at the subnational level. The purpose of the guideline is to increase multisectoral awareness about the causes of stunting. Moreover, the government also allocated funding to sectors other than health to tackle the problem. In practice, if a case of stunting is diagnosed within a family, a multisectoral team will assess the household and provide necessary support, ranging from additional food allocations to better toilet and sanitation facilities.

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**Box 9. WHO: A catalyst for multisectoral engagement on health taxes in Indonesia**

In 2017, the Ministry of Finance (MoF) approved new regulations to increase tobacco taxes, while also simplifying tax rates. To continue this momentum, in 2018, WHO pursued high-level policy advocacy for taxes on tobacco and SSBs by participating in national, regional and global forums held in Indonesia.

To this end, WHO participated in, proposed technical inputs to, and convened high-level forums during the Association of Southeast Asian Nations (ASEAN) Health Cluster Meetings, the Asia-Pacific Conference on Tobacco or Health (APCTH), the WHO Regional Meeting of NCD Managers and the annual meetings of the International Monetary Fund (IMF) and World Bank. For example, WHO in partnership with Indonesia's MoF convened a side-event on health taxes at the World Bank and IMF annual meetings in Bali, which were chaired by the Indonesian Minister of Health.

In another step forward, WHO catalysed the initiation of a formal coordination platform between the MoH and the MoF to discuss taxation on tobacco and SSBs. WHO and the MoF also reinitiated discussions for an annual tax increase on tobacco and held a bilateral technical meeting on taxation proposals for 2019. The meeting focused on tax rate simulations and econometrics. Teams from WHO headquarters also supported advocacy efforts in a meeting with the Director-General of Indonesia’s MoH on the sidelines of the World Health Assembly.

WHO looks forward to continuing its high-level policy advocacy and multisectoral engagement on health taxes for long-term gains.

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**Enhancing efforts to combat communicable diseases, including NTDs**

During the MDA in 2018, 88.5% of the target population for LF were covered with preventive chemotherapy. In addition, more than 43 million children were covered for STH, almost 95% of the target population.
As part of the campaign, the WHO Country Office rolled out an alternative three-drug treatment, known as IDA, which involves a combination of ivermectin, diethylcarbamazine citrate and albendazole for LF. The MoH is considering adoption of the new combination.

Furthermore, Indonesia released the national roadmap to control and eliminate schistosomiasis by 2025. In-kind drug donations also continued throughout 2018 with WHO receiving almost half a million tablets of praziquantel for Indonesia’s schistosomiasis programme as a donation from Merck and more than 300 000 blisters of multidrug therapy (MDT) for leprosy donated by Novartis, which is a multinational pharmaceutical company.

Meanwhile, in 2018, an additional 38 districts were declared malaria-free. A total of 55% of districts have now been certified as malaria-free by the Minister of Health. In another step forward in combating malaria, the WHO Country Office provided technical assistance to the National Malaria Control Programme (NMCP) to establish the therapeutic efficacy anti-malaria drug surveillance (TES) for dihydroartemisinin-piperaquine (DHP). The surveillance system, which was established at 10 endemic districts throughout the country, aims to detect treatment failure and gene mutation related to drug resistance over time. The results of the surveillance will be informative for establishing the malaria treatment policy.

**Fig. 2:** Number of people screened, and number of positive cases reported by district health offices through the surveillance system, according to province, in 2018

Source: NMCP, 2019
The MoH endorsed a guideline on monitoring insecticide resistance, with support from WHO. Following this, WHO along with the United States Centers for Disease Control and Prevention (US CDC) Atlanta and other partners organized training on monitoring insecticide resistance during 2018.

**Strengthening emergency preparedness and response to the Sulawesi earthquake**

In 2018, the government, with technical support from WHO, developed the National Action Plan for Health Security (NAPHS). The Plan, which aims to accelerate the implementation of IHR core capacities, captures national priorities for health security, brings sectors together, identifies partners and allocates resources for capacity development in health security.

To further strengthen the country’s ability to respond to emergencies, the WHO Country Office developed contingency plans for three provinces and tested such plans in an additional seven provinces. WHO also piloted risk mapping for emerging infectious diseases (EIDs) in three provinces and provided case management training for avian influenza during emergencies in 10 provinces.

In addition, the Global Health Security Agenda (GHSA) Ministerial Meeting was hosted by Indonesia in late 2018. WHO organized a side-event which delivered a key message on the link between the International Health Regulations (IHR) (2005) core capacities and health security and emergency preparedness.

On 28 September 2018, an earthquake struck the Minahasa Peninsula, with its epicentre located in central Sulawesi. The earthquake caused major soil liquefaction and triggered landslides and a tsunami, leading to copious casualties: 2685 deaths were reported by the MoH Centre for Health Crisis, and another 700 persons were reported missing. While 2537 were severely injured, more than 83,000 people received mild injuries. At least 96,000 houses were damaged or destroyed to varying degrees leading to the displacement of about 173,000 people.

WHO responded promptly by providing technical assistance in the management of national health cluster, including emergency medical team coordination, setting up an EWARS and organizing field epidemiology training at primary health care centres. In addition, water quality was regularly monitored to prevent outbreaks of diarrheal diseases. These interventions allowed for surveillance and prompt detection of disease outbreaks.

WHO also provided mental health and psychosocial support that included training health workers at the puskesmas level (community health clinics) on psychological first aid. Interventions involving nutritional requirements were made as well. WHO and other health partners also carried out an MR campaign, providing protection to about 36,000 children.
**National Regulatory Authority (NRA) assessed through WHO Global Benchmarking Tool**

WHO completed a benchmarking assessment of the status of the Indonesian vaccine regulatory system using the WHO Global Benchmarking Tool (GBT). The National Agency of Drug and Food Control (NADFC) was found to have a well-established regulatory system.

Indonesia, as a large vaccine-producing country, is currently supplying several vaccines to UN agencies. The result of the benchmarking assessment that was performed reflects the growing maturity of the Indonesian NRA, stemming from a concerted effort by the government, in consultation with WHO, to build capacity and capability of the NRA over the past few years.

**Advancing the agenda to control tuberculosis and strengthen HIV treatment**

Indonesia is a country with a large private health sector that is not yet firmly linked to the reporting network of the National TB Programme (NTP). In 2018, the results of the country’s first national TB inventory study were released at a national consensus meeting. The purpose of the study, which was supported by WHO, was to directly measure the level of
underreporting of detected TB cases to the national TB surveillance system and to identify best practice methods for addressing TB underreporting. The study found that the overall level of underreporting of detected TB cases was estimated to be 41%. The collected data also enabled Indonesia to perform a more accurate estimation for TB incidence in the country. The new national TB incidence estimation (1,020,000 in 2016 according to the Global Health Observatory) is being used as a reference to develop Indonesia’s National Roadmap to Eliminate TB by 2030.

Meanwhile, the “Test and Treat all” policy – which was adopted in 2017 and calls for all individuals who test positive for HIV to obtain access to treatment with antiretroviral (ARVs) – was implemented in 2018. The implementation of the policy marks an important step forward for Indonesia, as the previous policy limited eligibility for access to ART to people with a certain minimum CD4 count. At the same time, the Prevention of Mother-to-Child transmission of HIV, syphilis and hepatitis B (PMTCT) service guidelines were also revised, which now mandate that every pregnant woman be tested for HIV, syphilis and hepatitis B.

As part of the country’s adoption of the fast-track targets of “90-90-90” by 2027, Indonesia developed a fast-track manual aimed at local-level implementation. To support its implementation, WHO deployed technical staff at four provinces in Java to help build the capacity of provincial health offices. In addition, WHO provided technical assistance for developing the methodology for the HIV Drug Resistance Survey to gather evidence on emerging resistance against HIV drugs and to work on building a drug resistance surveillance system.

**Partnerships**

WHO has mobilized resources for and provided technical support to the Government of Indonesia through strong collaboration with myriad partners, including UN agencies (e.g. FAO, World Organisation for Animal Health [OIE], UNICEF, UNFPA), bilateral aid agencies (e.g. Department of Foreign Affairs and Trade [DFAT], United States Agency for International Development [USAID], CDC), global funders (e.g. Gavi, Gates Foundation), in addition to various government agencies at different levels, as well as local universities, NGOs, pharmaceutical companies and CSOs. Some activities based on these partnerships include the following:

- WHO, in collaboration with the MoH, DFAT, local universities and the Kirby Institute in Australia will implement HATI studies in four cities aiming to fast-track HIV treatment.

- For the introduction and implementation of assisted partner notification for HIV testing, WHO has collaborated with the MoH and UNFPA.

- WHO is part of a strong tripartite One-Health partnership between OIE, FAO and WHO. The agencies worked together to carry out a joint risk assessment for zoonotic diseases.
WHO continues its partnership with pharmaceutical companies, including GlaxoSmithKline (GSK), Merck and Eisai, which donate medicines against VBDs, while Novartis has pledged to supply multidrug therapy (MDT) for leprosy.

WHO continues its strong partnerships with DFAT, CDC, USAID and Gavi to forge a strong alliance in the area of VPDs.

Looking ahead

Persisting on the path of quality improvement in health-care services to achieve UHC, WHO will support the development of the National Quality Policy and Strategy (NQPS). The implementation of the National Health Workforce Account (NHWA) 2030 is also high
on the agenda, which will standardize the architecture and interoperability of health workforce information, and track HRH policy performance. Importantly, in 2019, Indonesia aims to achieve a major milestone: 100% coverage of health insurance. The WHO Health Emergencies Programme will focus on implementation of the NAPHS, including emergency preparedness and emergency medical team coordination. To this end, the team will continue to develop pandemic influenza preparedness plans at the subnational level and will also carry out a comprehensive assessment of the surveillance system.
Maldives

Highlights

○ Maldives launches its National Strategic Plan to End TB by 2022.
○ WHO Country Office partners with several ministries to launch “Saafu Raajje – Clean Maldives” and the “Vector Control Campaign”.
○ Maldives controls rubella and CRS.
○ WHO supports the introduction of diphtheria–pertussis–tetanus (DPT) booster in Maldives’ routine immunization programme.
○ The President of Maldives inaugurates the National Symposium on Traditional and Alternative Medicine.
○ Malé city urban primary health care centre is awarded the WHO World No Tobacco Day Award.
○ WHO launches its CCS 2018–2022.

Introduction

The Republic of Maldives faced a tumultuous 2018. A state of emergency was declared at the beginning of the year following the release of several political prisoners. H.E. Mr Ibrahim Mohamed Solih was elected President of the Republic of Maldives during the year. A new minister of health was appointed, along with two State ministers and two deputy ministers.
The politically charged environment posed a challenge for the WHO Country Office to sustain its operations and activities. The situation affected WHO’s pace of project implementation at the Country Office level.

Despite the challenges, Maldives continued with its impressive work in eliminating communicable diseases after it was verified as having controlled rubella and CRS.

The President also launched his "100 Days Programme". This included 15 health pledges, such as introducing the HPV vaccine for girls between 10 and 14 years of age, and implementing the country’s national policy and strategy on mental health.

The year 2018 also marked the launch of a new WHO CCS (2018–2022), the fourth strategic collaboration between WHO and the Government of Maldives. This builds on GPW13, factors in mainstreaming of the SDGs, and addresses cross-cutting and intersectoral challenges to the environmental and social determinants of health.

The priority areas of this CCS are: (i) transforming health systems with a focus on UHC and fostering multisectoral engagement beyond the health sector; (ii) promoting well-being with a focus on tackling NCDs and their determinants; (iii) promoting resilience and enhancing preparedness to respond to health threats, and fast-tracking elimination of diseases; and (iv) protecting what matters most, with an emphasis on sustaining the gains achieved along with a firm focus on climate change and young people.

The four priority areas address some of the critical public health challenges facing Maldives in its unique context: an upper-middle-income small island state that ensures UHC for its population but is increasingly faced with new problems, such as the growing epidemic of NCDs and its vulnerability to climate change.

**Key activities and achievements in 2018**

**Confronting communicable diseases head on**

In 2018, the MoH, with WHO support, launched the National Strategic Plan to End TB by 2022. The Strategy aims to reduce new cases by 50% and mortality by 70% by 2022. Although Maldives has a low TB burden, efforts to increase access to diagnostic services and active case-finding is a priority.

Meanwhile, Maldives catalysed awareness on World AIDS Day by launching a “Know your status” campaign. The campaign encourages people to undergo voluntary counselling and HIV testing. High-level dignitaries, including the Vice-President of the country and the WHO Country Representative, underwent public HIV testing in an attempt to address the stigma surrounding HIV. Maldives also announced the development of a multisectoral coordination mechanism for HIV and hepatitis, which aims to ensure that diagnostic and treatment services are available across the country.
While Maldives achieved leprosy elimination in 1997, the country is now embarking on its vision of a leprosy-free country. To this end, WHO facilitated a training of local doctors and other health-care providers on the management of leprosy. The three-day training with experts from Schieffelin Institute of Health Research (Karigiri) at Vellore, India, focused on the key strategic pillars of the Global Leprosy Strategy.

**Tackling vaccine-preventable diseases**

Following its success in eliminating measles in 2017, Maldives achieved another milestone in 2018: controlling rubella and CRS, two years ahead of the regional target of 2020. This was the result of several key initiatives, including ensuring high immunization coverage, evidence-based technical advice from the Maldives Technical Advisory Group on Immunization (MTAGI), and support of partners such as UNICEF and CSOs.

As part of the country’s efforts to expand the basket of available vaccines, the WHO Country Office worked with the MoH to introduce a DPT booster for all 4-year-old children.

WHO also facilitated the development of the country’s first immunization policy based on recommendations by MTAGI and lessons learnt from other countries.

To assess the burden of rotavirus, WHO supported capacity-building of the laboratory at Indira Gandhi Memorial Hospital (IGMH), Malé to confirm the diagnosis of the disease.

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**Box 10. #MVENDTB: H.E. President of Maldives launches the National Strategic Plan to End TB by 2022**

Following the ‘Delhi Call for Action’ to End TB in the SEA Region by 2030, Maldives demonstrated robust political commitment, with His Excellency President Abdulla Yameen Abdul Gayoom launching the National Strategic Plan for Ending TB by 2022.

- The launch was attended by all Cabinet Ministers along with heads and representatives of public and private sector corporations and organizations, professional associations, civil society and UN agencies. The Strategic Plan for Ending TB was developed with technical support from WHO. It lays out effective interventions and guidelines to reduce the incidence of TB in Maldives by 50% and deaths due to TB by 75% by 2022.

- Maldives has, over the years, maintained high rates of TB case detection and treatment. About 150–200 new cases are diagnosed every year with a small number of these being drug-resistant TB cases. The Strategic Plan suggests building on these strengths and introducing newer activities such as active finding of TB cases, enhancing laboratory services, and ensuring the screening of migrant and high-risk populations. The Strategic Plan also takes into account emerging gaps in the TB programme, such as underreporting, underdiagnosis (especially of childhood TB) and lower treatment compliance.

- In 2016, a total of 169 cases of TB were notified in the Maldives. WHO is committed to providing support to the Government of Maldives for effective interventions, such as accelerating case detection and mass prevention measures, and advocating for the Call for Action.
through the WHO Collaborating Centre at the Christian Medical College & Hospital in Vellore, India. WHO also partnered with UNICEF to support training in surveillance and immunization for focal points from atolls and the Malé region.

Improving access to safe blood transfusion and treatment for patients with thalassaemia

The WHO Country Office supported the development of a National Blood Policy to strengthen Maldives’ ability to provide a safe and adequate supply of blood and blood products for patients requiring transfusion. The policy focuses on increasing awareness of and education on the importance of safe blood, and upgrading blood storage at various levels.

WHO also supported the preparation of the *Guidelines on the clinical use of blood* and provided technical support for the development of a training package for health workers on the treatment of thalassaemia. Moreover, WHO played a key role in mapping transfusion services throughout the country – the first step towards establishing an efficient blood transfusion service.
Expanding UHC with traditional and alternative medicine

In 2018, Maldives took important steps towards expanding UHC by examining ways in which it can widen the basket of services and improve the quality of care.

To this end, the WHO Country Office supported the Maldives Food and Drug Authority (MFDA) and MoH in organizing the National Symposium on Traditional and Alternative Medicine in Maldives. The Symposium, which was held as part of the President’s “100 days Programme”, was attended by government officials, traditional practitioners, WHO staff and academics. Following the Symposium, the Country Office assisted in developing a roadmap for adding traditional medicine to the country’s essential service package. As a result, the government recommended the creation of a Department of Traditional and Alternative Medicine within the MoH.

In addition, the Quality Assurance and Regulation Division (QARD) of the MoH launched the guidelines on health-care quality standards with technical assistance from WHO. The guidelines are a product of several rounds of stakeholders’ consultations and field visits to all categories of national public and private health-care facilities. WHO also assisted QARD to develop standard treatment guidelines (STGs), of which 45 have so far been finalized.

Taking the bull by the horns: #BeatNCDs – the fight continues

After the adoption and roll-out of the WHO PEN interventions for primary health care in three atolls in 2017, three more atolls were added to this list in 2018. More than 100 health-care workers were also trained in the PEN package. Given the unique geography of the country, an innovative peer approach for capacity-building was initiated, which involves training by master trainers from Malé of doctors and nurses at the atoll and regional hospital levels, who then return to their islands to train more staff. At the same time, WHO is at the pilot stage of developing a mobile application for the PEN package, the first in the Region.

Dhamana Veshi, an urban primary health care centre in Malé, was awarded the WHO World No Tobacco Day Award for its tobacco control efforts. It is the only centre in the country offering tobacco cessation services.

Enhancing emergency preparedness and readiness to respond

To strengthen country preparedness, an HEOC has been established at the MoH. Support provided by WHO includes a mondopad, satellite communication equipment and a mobile generator, in addition to laptops and training provided to the MoH. The WHO Country Office is also engaged in piloting a cheaper version of the HEOC that could be replicated across the country. In another step forward to strengthen Maldives’ preparedness and response to future public health emergencies, the National Health Emergency Operations Plan was launched by the MoH in 2018.
Tackling climate change and enhancing system resilience

Maldives is witnessing a surge in vehicle ownership with the expansion of roads and this brings with it the challenges of waste management and sustainable energy supply. In 2018, as part of the President’s “100 Days Programme”, a campaign called “Saafu Raajje – Clean Maldives” was launched with WHO support. More than 5000 people in Malé participated in a nationwide street-cleaning campaign. In addition, Maldives became the first country in the Region to join the “Breathelife Campaign”. The campaign, led by WHO, the United Nations Environment Programme (UNEP), and the Climate & Clean Air Coalition (CCAC), aims to mobilize cities and individuals to protect people’s health and the planet from the effects of air pollution. The WHO Country Office also supported the development of the National Health Adaptation Plan, in line with the Malé Declaration on Building Health Systems Resilience to Climate Change.

In an important step towards halting the spread of VBDs in the country, the “Vector Control Campaign” was jointly launched by WHO, several ministries and environmental agencies. In addition, over 100 health-care workers were trained in vector control and awareness.

Sustaining excellence in reproductive, newborn and child health

The MoH, with support from WHO, finalized and launched the national family planning guidelines. At the same time, a mobile app for determining medical eligibility criteria was also developed, which assists health workers to make important decisions related to family planning devices. WHO trained 70 nurses, nurse-midwives and public health workers from across all 19 atolls on the new guidelines.

WHO also took the initiative to support the Indira Gandhi Memorial Hospital and the MoH to introduce the Preterm Care Birth Package, a standardized package that aims to improve preterm care. Around 30 nurses and doctors were trained on the package by staff from the Regional Office and All India Institute of Medical Sciences (AIIMS) in New Delhi. The WHO Country Office continued to support surveillance for birth defects and, to this end, helped organize a refresher training for staff from 14 health facilities.

WCO supported the workshop on Point-of-Care Quality Improvement (POCQI), focusing on newborn care. More than 70 providers from central, regional/atoll and island health facilities were trained.

Special Recognition Award of the Government of Maldives

The then Vice-President of the country, H.E. Abdulla Jihad, conferred a "Special Recognition Award" on the WHO Maldives Country Office for extensive and exemplary support to the
National Drug Agency on the International Day against Drug Abuse and Illicit Trafficking. The WHO Country Office continues to provide technical support to the Agency and collaborates across various programmes, such as HIV/AIDS control, development of standard operating procedures (SOPs), etc.

**Partnerships**

Ongoing partnerships are key, given the central position of health in all SDGs and WHO’s mission to “promote health, keep the world safe and serve the vulnerable”. The WHO Country Office continued its engagement with various sectors and stakeholders to address complex health issues. Some key examples are given below:

- **Sustaining political commitment at the highest level.** Following the election of a new President in 2018, WHO collaborated with the government to shape the health agenda. As part of the President’s “100 Days Programme”, several health priorities were included, such as strengthening health services to eliminate TB by 2022 and introducing the human papillomavirus (HPV) vaccine. WHO and the MoH also continued their collaboration, which saw the launch of several new guidelines and policies, and the new WHO CCS in 2018.

- **Health beyond the health sector.** WHO has provided technical support to develop and implement a range of programmes in partnership with various ministries. For example, WHO worked with the Ministry of Environment to launch “Saafu Raajje – Clean Maldives” and the “Vector Control Campaign”. WHO also continues to work with ministries on other health activities, such as promoting healthy lifestyles and tobacco control.

- **Fostering new partnerships with academia.** The Country Office has collaborated with several national and international academic institutions. For example, Health Care Without Harm, a global leader in promoting green health facilities, and WHO jointly developed the “Maldives Green Climate–Smart Hospitals Policy and Strategies.” WHO has also been partnering with Maldives National University to study the prevalence of STH and AMR. Meanwhile, medical and nursing associations and councils are increasingly being engaged to develop relevant curricula and treatment guidelines.

- **Working with non-State actors.** Within the Framework of engagement with non-State actors (FENSA), WHO continues to engage in various endeavours with CSOs such as the Society for Health Education (SHE), Maldives Red Crescent (MRC), Diabetic Society, Maldives NCD Alliance, Tiny Hearts and Cancer Society, especially for advocacy or reaching the vulnerable. Migrant health and right to health are some of the key issues being addressed through such partnerships.

- **Engaging diplomatic missions.** WHO has shared information about its work, especially about local activities and advocacy events, including visits by ambassadors of resident embassies to the WHO Country Office. This has resulted in increased engagement with diplomatic missions.
Strengthened relationship with UN agencies. WHO continues to collaborate with several UN agencies, including participating in implementing the UN Development Assistance Framework (UNDAF); working with UNICEF to share immunization data and develop Maldives’ National Health Emergency Operations Plan; and with UNDP on climate change activities. In addition, Maldives has also participated in the fifth cycle of the WHO–UN Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS). The Country Office is the sectoral lead of the United Nations Country Team (UNCT) Contingency Plan and directs emergency preparedness and response efforts of the UNCT. In addition, it also leads the Joint UN Team on HIV and AIDS (JUNTA).

Looking ahead

Some major developments that will be seen in Maldives in collaboration with WHO in 2019 and beyond are as follows:

- Maldives hopes to eliminate mother-to-child transmission (EMTCT) of HIV and syphilis and hepatitis among children less than 5 years of age.
The WHO Country Office will support the MoH in introducing the HPV vaccine in the country’s routine immunization programme.

An HRH registry and online portal will be launched by mid-2019.

The WHO Country Office will support the DHIS-2 to be rolled out throughout the country.

Standard treatment guidelines for 70 conditions will be finalized and disseminated as part of Maldives’ health-care quality standards.

TB diagnostic and treatment services will be further strengthened as part of the goal to end TB by 2022.

National Health Accounts for 2015–2017 and the Public Health Expenditure Review Report will be finalized and disseminated.

The Road Safety Campaign and National Road Safety Action Plan will be launched.

BreatheLife Campaign will be launched with provision for regular monitoring of air quality in Greater Malé.

A study on AMR prevalence in the country will be completed.
Myanmar

Highlights

- The WHO Country Office provides humanitarian support and life-saving health services in the conflict-affected area of Rakhine State and in multiple flood-affected areas during the monsoon season.

- WHO supports the Ministry of Health and Sports (MoHS) in the development of strategic plans for HRH, health financing and access to essential medicines. The plans are aimed at paving the way for the country to realize its goal of UHC by 2030.

- Myanmar adds JE vaccine into its national immunization programme.

- The country has secured increased financing from domestic and development partners to fight HIV, TB and malaria.

- The MoHS, with support from WHO and partners, develops a costed NAPHS.

Introduction

In 2018, Myanmar continued to build on its achievements from the previous year in terms of accelerating progress on the control of communicable diseases, reproductive, maternal, child and adolescent health, and expanding its national immunization programme.
With WHO support, the country initiated two critical public health initiatives: a comprehensive cervical cancer programme and the launch of the WHO FCTC 2030 project. Another major public health achievement during the year was the introduction of the JE vaccine into the country’s immunization programme.

Another notable achievement was the launch of the country’s first costed, five-year NAPHS (2018–2022), which aims to intensify and maintain Myanmar’s capacity for prevention, rapid detection, verification and response to health risks.

The provision of emergency support also featured prominently in 2018 as a result of seasonal monsoon floods affecting several states and regions, and the ongoing conflict in Rakhine State.

**Key activities and achievements in 2018**

**Strengthening health systems to achieve UHC**

Following the launch of the National Health Plan 2017–2021 that established a vision for UHC for Myanmar, several strategic plans were developed in 2018 to strengthen core areas of the health system.

With WHO support, the MoHS endorsed the Human Resources for Health Strategy (see Box 12). In another important step, WHO is also supporting the development of a rural retention action plan to improve incentives for health staff in rural areas, where most of the country’s population lives.

Work on Myanmar’s Health Financing Strategy (2019–2028) was initiated with WHO support after broad-based consultations with various stakeholders and ministries. The Strategy will pave the way forward for two critical areas of UHC: social protection to improve equity and reduce Myanmar’s high OOP expenditure on health, and strategic purchasing to improve efficacy in service provision, including engaging with ethnic health organizations (EHOs) and the private sector.

To support inclusive consultation and alignment of partners, subgroups under the Health Systems Strengthening Technical Strategy Group (HSS TSG) have been established, with WHO Country Office support. The four HSS subgroups include: health financing, HRH, HIS, and procurement and supply chain management. Each subgroup has representation from all stakeholders and partners, and meets under an MoHS Chair supported by a Secretariat.
Addressing antimicrobial resistance

In 2018, the WHO Country Office supported the implementation of the National Action Plan for AMR based on the “One Health“ approach.

A key element of the Plan is ongoing collaboration among different sectors and stakeholders, including health, agriculture, education, the pharmaceutical industry and the private sector. The aim of the Plan is to strengthen surveillance and multistakeholder engagement, foster collaboration between the animal and human sectors, and strengthen laboratory capabilities to detect AMR. In this context, WHO facilitated the establishment of a national multisectoral steering committee to govern and coordinate the implementation of AMR control activities.

In 2018, two permanent secretaries from the MoHS and the Ministry of Agriculture, Livestock and Irrigation signed a landmark joint statement to combat AMR. The statement demonstrated the high-level commitment from two key ministries to curb this growing health threat.

To improve understanding and awareness of AMR, the WHO Country Office, in tandem with national health authorities and other partners, held several events (including information sessions) during the World Antibiotics Awareness Week (WAAW). The WHO Country Office also worked closely with media outlets prior to the events to increase coverage.
Improving health security

In 2018, the government and partners took several steps towards strengthening public health emergency preparedness, detection and response capacities. It launched the costed National Action Plan for Health Security (2018–2022), following numerous workshops and technical meetings with the relevant ministries and stakeholders, with WHO support. The five-year plan was developed to prevent, protect, control and respond to the spread of disease internationally and within Myanmar, in line with IHR (2005). The Plan covers 19 key technical areas under four strategic categories of prevent, detect, respond, and other IHR-related hazards and points of entry.

WHO also continued to support capacity-strengthening of the laboratory to detect infectious diseases and the laboratory quality management system.

As part of institution-building, WHO, along with the US CDC, supported Myanmar in developing a nine-month course for intermediate-level field epidemiologists. The intensive training programme includes topics such as the prevention and control of zoonotic diseases and strengthening the national food safety management system.
As part of influenza pandemic and seasonal outbreak preparedness, work began on the creation of an ILI and SARI surveillance system, with WHO support.

In addition, WHO provided 7100 doses of seasonal influenza vaccines to the national health authorities for high-risk health-care workers.

**Combating Myanmar’s high tuberculosis burden**

Myanmar is classified by WHO as one of 30 high-TB burden countries, with a triple high burden of TB, HIV-associated TB and MDR-TB. In 2018, significant progress was made towards the objectives of the National TB Strategic Plan (2016–2020), including fostering regional and global collaboration; the introduction of mandatory TB case notification; and the completion of the 4th National TB Prevalence Survey.

The introduction of mandatory case notification with GeneXpert machines will not only improve the quality of TB surveillance but will also improve the detection of MDR-TB. The pilot introduction in four townships with different partners in the private sector showed promising results.

Meanwhile, the NTP successfully conducted a national prevalence survey in 138 sites across the country. While the results are yet to be released, initial analysis suggests a lower

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**Box 13. Expanding and strengthening the national immunization programme**

In 2018 the MoHS, in collaboration with WHO and partners, added the JE vaccine to its routine immunization programme. The vaccine was added into the country’s immunization schedule following the successful implementation of a JE campaign that reached almost 13 million children in 2017.

In another important step forward in expanding the immunization basket, the MoHS and Gavi’s independent review committee approved the introduction in 2020 of the HPV and rotavirus vaccine.

In 2018, Myanmar, with WHO support, also improved immunization coverage with a focus on children living in hard-to-reach and conflict-affected areas. Guided by the ‘Reaching Every District’ strategy, WHO supported training on bottom–up microplanning with local communities, ministry staff and health-care providers.

To strengthen immunization service delivery in urban slums and among migrant communities, the MoHS developed an urban immunization strategy. The strategy, which will be implemented in 2019, includes expanding fixed posts equipped with vaccine storage facilities and regular outreach services. WHO will continue to facilitate coordination between the MoHS and ethnic health organizations to provide immunization services in ethnic and hard-to-reach-areas, including conflict areas.

In a move to improve Myanmar’s AEFI surveillance system, WHO provided training to health staff at the state and regional level across the country to improve the capacity on advanced causality assessment and supported a simulation activity for field investigation of AEFI.

WHO also worked with the National Certification Committee for Polio Eradication (NCCPE) to improve its institutional capacity and continued to provide technical support to the environmental surveillance system to detect circulating polioviruses.
prevalence of culture-positive TB and rifampicin-resistant cases compared with 2009–2010. To this end, the MoHS continues to expand the use of a shorter regimen for MDR-TB with active TB drug-safety monitoring and management of new and repurposed medicines.

Following WHO advocacy, the MoHS secured additional investment from the Global Fund and the Access to Health Fund. The additional financing will support the development of an urban strategy to provide testing, care and treatment to the urban poor and migrant population, with a focus on poor townships in Yangon.

**WHO provides emergency and health assistance to areas in need**

Seasonal monsoon floods affected several states and regions in Myanmar in July 2018, displacing an estimated 150 000 people and killing 32. The floods also damaged 72 government health facilities.

Under the emergency health response project funded by the CERF, WHO provided support to almost 25 000 people. This included the provision of three IEHKs, three cholera kits, 1000 life jackets and support to mobilize 40 mobile clinic teams from the MoHS.

Another emergency that followed was an overflow of the Swar Chaung Dam in the Bago Region, which caused extensive flooding. WHO supported an additional 21 mobile health teams serving more than 100 000 people.

WHO also continued to work closely with the MoHS to provide emergency health assistance to the conflict-affected population in Rakhine State. WHO advocated for
and supported the MoHS in the monitoring and implementation of the health-related recommendations of the independent Rakhine Advisory Commission, a framework that looks into the development of the health system in the State.

WHO, with CERF support, enabled six mobile health teams to serve over 20 700 people over six months in Maungdaw township. In addition, the SEARHEF supported WHO’s response by enabling 11 additional mobile health teams to serve 37 500 people in three other townships over the course of six months.

Other key WHO initiatives included supporting a central-level review and evaluation meeting on EWARS with the objective of improving the existing EWARS system so that it can be implemented across all disaster-affected areas. In Rakhine State, WHO also supported the statewide mapping of HRH to better understand resource gaps. Using geographical information system (GIS) technology and on-the-ground verification, WHO documented areas where health facilities are not available as part of efforts to ensure that the entire population has access to basic health services.

Accelerating progress on communicable diseases

Myanmar is one of 35 fast-track priority countries set to achieve the “90-90-90” targets for HIV treatment by 2020. Approximately 220 000 people are living with HIV and the prevalence is 0.57%. The epidemic is characterized as a concentrated epidemic with an estimated 75% of new infections occurring in five states/regions.

In 2018, WHO supported the development of tailored state and regional HIV operational plans for each of the five priority states/regions, in consultation with local communities and stakeholders.

In addition, to avoid fragmentation and ensure sustainability, the provision of ART was transitioned to the public health sector from NGOs.

Meanwhile, the MoHS continued to advance hepatitis C treatment in the public sector using direct-acting antivirals. In 2018, treatment expanded to an additional three referral hospitals, bringing the total to 13 designated hospitals offering hepatitis C treatment.
Myanmar also continued to make significant progress towards reducing its malaria burden. Between 2012 and 2017, reported cases declined by 82% and deaths reduced by 93%, largely due to universal access to malaria services, improved surveillance, partnership and coordination.

To reflect the accelerated progress, the MoHS revised its National Strategic Plan for Intensifying Malaria Control and Accelerating Progress towards Malaria Elimination (2016–2020), which decentralizes malaria elimination at the township level with the aim of eliminating *P. falciparum* by 2025 and all forms of malaria by 2030.

In addition, WHO supported strengthening of the electronic reporting system with a pilot carried out on a DHIS-2 in four townships.

More than 18,000 malaria village health volunteers are being transformed into Integrated Community Malaria Volunteers to have a wider reach. In a bid to eliminate malaria from the Greater Mekong Subregion (GMS), WHO supported cross-border collaboration with the People’s Republic of China and Thailand.

**Accelerating efforts to tackle NCDs**

The country’s first National Conference on Tobacco Control and the Prevention of NCDs was held with WHO support in July 2018. The Conference, which was attended by local and international experts, representatives from non-health sectors, parliamentarians, and subnational leaders, was the first step towards improving NCD interventions at the state and regional levels.

Myanmar has been selected as one of 15 countries worldwide to receive dedicated and financial support to accelerate the implementation of the WHO FCTC. The FCTC 2030 initiative was launched by the MoHS, WHO and UNDP in June. Following this, the FCTC plan and investment case were launched in December. To this end, WHO is working with stakeholders to explore mechanisms to improve knowledge, introduce cessation programmes and set up regulatory frameworks.

Following a successful pilot of the Myanmar Epilepsy Initiative, a new phase was launched, which expands epilepsy care and support services to the state and regional level. Unique in the Region, the initiative is an effective way to address the mental health treatment gap by providing epilepsy care services at the grass-roots level, based on the WHO Mental Health Gap Action Programme (mhGAP) intervention guidelines. Capacity building of state-level health-care providers was completed in Mon State in 2018, with two additional states to follow in 2019.

The national health authorities completed the country’s first-ever, nationwide micronutrient and dietary food consumption survey, with technical support from WHO. The aim of the survey was to better understand the micronutrient status and food consumption...
patterns of different key populations, including under-five children, school-aged children, adolescent girls, women of reproductive age, pregnant women, lactating women and adult men. WHO and partners supported the MoHS to develop the Multisectoral National Plan of Action for Nutrition (2018–2023). The Plan aims to address under- and overnutrition through a coordinated multisectoral approach.

Improving reproductive, maternal, newborn, child and adolescent health

A key development in 2018 was the country’s first National Sexual and Reproductive Health and Rights (SRHR) Policy. The Policy, which was developed with partners, including WHO and UNICEF, aims to provide an inclusive framework to guide subsequent strategic plans, clinical guidelines, care pathways, and service delivery guidelines and protocols that take a rights-based approach to service delivery of sexual and reproductive health.

In 2017, the UN Joint Global Programme on Cervical Cancer Prevention and Control selected Myanmar as one of six countries globally to build a sustainable high-quality national cervical cancer control programme. With WHO support, in 2018, the MoHS developed guidelines on the secondary prevention of cervical cancer for public sector health facilities. To assist with the implementation of the guidelines, WHO will promote training and job aids in 2019. WHO also supported preparations to introduce the HPV vaccine in 2020.

Partnerships

WHO continues to provide Secretariat functions for the Myanmar Health Sector Coordination Committee (M-HSCC). The M-HSCC is the formal health sector coordinating body chaired by the Union Minister for Health and Sports, with 35 members from government, multilateral and bilateral agencies, NGOs, private sector, academia, Parliament and civil society.

In addition to coordinating within the sector, WHO actively collaborates across sectors and borders. Such examples include working with the MoHS, the Ministry of Agriculture, Livestock and Irrigation, the Ministry of Education and the Ministry of Planning and Finance on diverse issues, from AMR to zoonotic diseases, malaria and tobacco control.

Cross-border collaboration is essential to addressing infectious diseases. Since 2017, WHO has collaborated with GMS countries and the People’s Republic of China to eliminate malaria in the region. Myanmar’s NAPHS emphasizes a regional and cross-border approach to combating infectious diseases and underlines the importance of timely information-sharing and coordinated interventions between Thailand and Myanmar.

Given the fragmented health system in Myanmar, WHO collaborates with nongovernment entities, including the private sector and ethnic health organizations,
to provide essential services. For example, WHO worked with private sector doctors to introduce mandatory TB reporting and with EHOs to provide immunization.

Looking ahead

Programmes and technical areas that WHO will focus on in 2019 and beyond include the following:

- Strengthening health cluster coordination in Kachin and Shan states to improve humanitarian health service provision, including supporting the implementation of the EWARS for communicable diseases surveillance.
- Continuing to provide technical support for the implementation of the health-related recommendations of the Rakhine Advisory Commission.
- In terms of health systems strengthening, a review of the HRH will be completed and the health financing strategy will be finalized and launched. Furthermore, the HIS will be improved, and the surveillance system strengthened for notifiable diseases.
- Improving immunization coverage through investment in expanding coverage of hard-to-reach populations and the urban poor. This also includes a nationwide MR campaign planned for October 2019.
- Finalizing the WHO CCS 2019–2023 which will be aligned with the objectives outlined in the National Health Plan as well as WHO’s GPW13.
- International reviews of Myanmar’s malaria, TB and HIV programmes.
Nepal

Highlights

- Nepal becomes the first country in the SEA Region to eliminate trachoma.
- Nepal achieved the rubella control target two years ahead of the regional goal.
- Nepal introduces fractional (intradermal) two-dose schedule of fIPV in its routine immunization programme.
- Nepal enacts the Public Health Service Act and the Safe Motherhood and Reproductive Health Rights Act.
- A basic health service package is defined to facilitate local governments in prioritizing health service delivery to fulfil the Constitutional mandate.
- Nepal launches its first TB prevalence survey.

Introduction

Nepal is continuing its period of transition to a new federalized (decentralized) State, as mandated in the 2015 Constitution. The Constitution divided power between three tiers of government – federal, provincial and local.
The ongoing transition to a federal system has required Nepal to make major changes in how its health system is structured and managed.

In 2018, the structure and terms of reference of different divisions and centres within the Ministry of Health and Population (MoHP) were redefined at the federal level. Meanwhile, at the provincial level, laboratories, health training centres and medical stores have been set up. In addition, provincial health offices have been expanded to all 77 districts across Nepal to provide technical assistance at the local level.

To enact the provisions of the Constitution – which guarantees basic health as a fundamental right of all people in Nepal – the government has defined a number of policy and legal frameworks. In 2018, two key acts were enacted: the Public Health Service Act and the Safe Motherhood and Reproductive Health Rights Act. The MoHP has also defined a basic health services package (BHSP), which lists the different primary health services and interventions that will be provided free of cost to every Nepalese citizen. Meanwhile, the minimum service standards for hospitals, primary health care centres and health posts have also been developed.

While Nepal has faced myriad obstacles in the past 20 years, including two devastating earthquakes and a decade-long civil war, the country is making significant headway in combating communicable diseases. A major achievement in 2018 was the elimination of trachoma, making Nepal the first country in the SEA Region to defeat the world’s leading infectious cause of blindness. Nepal was also certified by WHO as having controlled rubella two years ahead of the regional goal.

**Key activities and achievements**

**Maintaining high immunity against vaccine-preventable diseases**

With support from WHO and other partners, Nepal has a strong national immunization programme, which has achieved impressive goals in recent years.

In 2018, the country was certified as having achieved rubella and CRS control, one year ahead of its national target and two years ahead of the regional target.

In 2014, Nepal achieved polio-free status. In 2018, to ensure ongoing protection against the disease, Nepal introduced two-dose fractional inactivated polio vaccine (fIPV) in its routine immunization programme. The introduction of fIPV is the result of collaboration between the government, WHO and UNICEF, and follows the training of 16 000 health workers in 5000 health facilities, and a readiness assessment by the WHO Immunization Preventable Disease (IPD) Programme.
Measuring Nepal’s tuberculosis burden

In Nepal, there is uncertainty about the number of TB cases and TB-related deaths. In 2017, TB incidence was estimated to be 152 per 100,000 population.

In 2018, the government, with technical support from WHO and partners, initiated Nepal’s first national TB prevalence survey. The survey, which follows a WHO standard methodology, is screening an estimated 58,000 individuals from 99 clusters, representing the diverse and challenging geography of Nepal. The country is among the first to use Xpert MTB/RIF, a rapid TB diagnostic and antibiotic sensitivity test, for the survey. The paperless survey is being completed with real-time data directly uploaded from the field to a central database.

A midterm review led by WHO concluded that the survey is of high technical quality, with effective community mobilization and a high participation rate, and strong collaboration with different stakeholders. Once the survey is completed in 2019, it will provide Nepal with a direct measure of its TB burden and useful information on the health-seeking behaviour of people with TB symptoms and health service utilization practices.

Progress in addressing noncommunicable diseases

In 2018, Nepal doubled the number of districts that have a community mental health package, taking the total to 14 districts out of 75. The programme has been implemented through district hospitals, primary health centres and health posts following training of trainers by the WHO Country Office. Its purpose is to bring mental health services closer to the people and to lower the threshold to access these services.

Another key activity included training health service providers in two provinces on the mhGAP and the mental health Intervention Guide (mhGAP-IG), and building the capacity of hub and satellite hospital networks to plan for, and deliver, mental health services during emergencies. Nepal also completed preparation for its National Mental Health Survey.
in 2019, including translating and adapting mental health tools and training research assistants, supervisors and technical working group members.

In a major step forward, Nepal launched its 2030 WHO FCTC Strategy. While the country has already taken a number of measures to curb tobacco use, including pictorial health warnings covering 90% of tobacco product packets, the Strategy will further the country’s efforts to strengthen the execution of existing policy, strategies and plans related to demand and supply reduction.

Finally, implementation of the WHO PEN for primary health care facilities and health posts was expanded to six more districts in 2018, bringing the total number of districts where PEN has been rolled out to 16. Almost 1200 health workers were trained in 2018 on PEN.

Confronting climate change and air pollution

In 2018, the WHO Country Office continued to support the MoHP to implement the Health National Adaptation Plan (H-NAP). As part of efforts to develop a climate-resilient health system, standardized training manuals on climate change and health were prepared. To ensure a consistent supply of safe water under climate change conditions, government water, sanitation and hygiene (WASH) officials were trained on climate-resilient water safety plans (CR-WSP).

Moreover, in 2018, Nepal and WHO initiated, with funding from the Department for International Development (DFID), a new project to develop climate-resilient water and sanitation services and health systems. The project, which will run until 2022, will focus on improving climate-sensitive disease surveillance and early warning systems, along with climate-resilient water safety and sanitation management.

In 2017, WHO launched the Urban Health Initiative (UHI) to demonstrate to the people of Kathmandu the health benefits of policies and measures to reduce air and environmental pollution. As part of the Initiative, a team from Kathmandu University performed a health and economic analysis on pollution caused by transport, waste, industry and household energy sectors. The WHO Country Office also supported Nepal in preparing its national action plan to implement the WHO guidelines on indoor air quality.

Strengthening emergency preparedness and response

With the establishment of HEOCs in the capital cities of three provinces in 2017, preparedness to respond to public health emergencies at the provincial level has been greatly enhanced. Emergency medical logistics warehouses have been established in four hub hospitals in two provinces, while emergency logistics and supplies such as surgical kits and cholera medicine have also been stored.
Box 14. Nepal beats trachoma

In May 2018, WHO certified Nepal for having eliminated trachoma as a public health problem, making it the first country in the SEA Region to defeat the world’s leading cause of blindness.

Caused by the bacterium *Chlamydia trachomatis* and spread through contact with infective eye or nose discharges, trachoma was the second-leading cause of preventable blindness in Nepal in the 1980s. In 2002, the government established a national trachoma elimination programme. Within just three years of control activities, the prevalence of active trachoma fell by 40%. Nepal continued to make significant progress in its fight against the disease by using a combination of strategies called SAFE (surgery, antibiotics, facial cleanliness and environmental improvement) with WHO guidance.

This included eye surgery for trichiasis, administering antibiotics once a year to everyone living in districts affected by trachoma, promoting regular hand-and-face washing and improving overall cleanliness in the environment. As part of this strategy, approximately 30 000 eye operations were performed and almost 15 million doses of azithromycin distributed. In addition, about 10 000 social volunteers and 16 000 female community health volunteers (FCHVs) were also mobilized to raise awareness and to refer patients.

A series of surveys conducted between 2005 and 2015 showed that active trachoma in children had been reduced to below the elimination prevalence threshold of 5%. Low prevalence has been maintained following the discontinuation of mass antibiotic treatment.

The government played a critical role in this achievement by providing, for example, incentives to local communities and districts to build and maintain latrines and by implementing a trachoma module in the school curriculum.

The country’s achievement is also the result of taking a public–private partnership approach to the elimination of trachoma. Nepal hopes that the lessons learnt from adopting this approach can be used for tackling other public health issues where this model could be useful.
To further strengthen Nepal’s capacity to respond to outbreaks and public health emergencies, field-based medical officers and information management assistants have been deployed by WHO at the provincial level. They are primarily stationed at the HEOCs. This has helped the MoHP to investigate, confirm and contain disease outbreaks.

Following a review of the health sector response to the crash of the US–Bangla Airlines Flight 211 on landing at the airport in Kathmandu in March that killed more than 50 people, the MoHP with the support of the WHO Country Office conducted a Kathmandu Valley-wide disaster drill to test incident management mechanisms on-site and at six hub hospitals in the Valley. Following the drill, a meeting of hub hospital coordinators was organized to familiarize leaders with their responsibilities.

To bolster Nepal’s ability to respond to a public health emergency, WHO and the MoHP supported the National Ambulance Service (NAS) to organize the first “National Conference on Pre-Hospital Care for Emergencies in Nepal”. WHO also supported the MoHP in facilitating the first national conference on “Post-acute Hospital Care”, which addressed the need to integrate post-surgical care, physiotherapy, rehabilitation and palliative care into the health system.

The Country Office also continued its support to other countries in the SEA Region. Three technical officers were deployed to assist the WHO response to the Rohingya crisis in Cox’s Bazar, Bangladesh.
Expanding antimicrobial resistance activities

In 2018, the WHO Country Office with the MoHP conducted training on WHONET (AMR database software) for microbiologists from selected AMR surveillance sites across Nepal. The purpose of the training was to strengthen the management and analysis of microbiology laboratory data with a specific focus on analysis of antimicrobial susceptibility test results. The National Public Health Laboratory (NPHL) was also assisted to enrol in WHO GLASS for the first time and to also submit data. WHONET training was key in enabling Nepal to submit quality data, making it one of the few countries in the SEA Region to do so.

In addition, Nepal was selected as one of the three countries from the Region for the implementation of the “WHO Integrated Global Survey on ESBL (extended spectrum beta-lactamase)-producing *E. coli* Epi X-Tricycle Project”. The “One Health” project, which will be launched in Nepal in 2019, focuses on ESBL *E. coli* as a global indicator for the burden of AMR and aims to strengthen national AMR surveillance.

Box 15. Nepal’s fight against rubella

In August 2018, Nepal was officially certified by the WHO Verification Commission as having controlled rubella and congenital rubella syndrome. During the past decade, the country has achieved a 97% reduction in rubella cases. It achieved this goal two years ahead of the regional target of 2020 and one year ahead of its national target.

The Immunization Preventable Disease unit of the WHO Nepal Country Office (WHO-IPD) provides technical assistance to case-based and laboratory-supported MR surveillance through a nationwide network. Data generated through this surveillance system was a key element in the decision of the Verification Commission for the WHO SEA Region to validate Nepal as having controlled rubella and CRS.

In the pre-vaccination era, more than 1000 infants were born with CRS every year in Nepal. This could lead to children suffering from eye and heart defects, hearing impairments and other lifelong disabilities, including autism.

In 1989, Nepal’s National Immunization Programme (NIP) began delivering one dose of measles vaccine to all infants. In 2013, the country introduced the MR vaccine in its NIP through a nationwide mass immunization campaign covering children aged between nine months and 15 years. Since 2015, the NIP delivers two doses of MR vaccine to all children across Nepal aged between 9 months and 15 months.

As per WHO and UNICEF estimates of national immunization coverage for 2017, Nepal has a high coverage of MR first dose at 90%, while coverage with the second dose is 59%. The NIP is trying to achieve at least 95% coverage of both doses to sustain rubella control and achieve measles elimination. Another MR vaccination campaign has been planned for the last quarter of 2019.
As part of World Antibiotic Awareness Week, an animated video on AMR was produced by the Country Office.

Improving the lives of mothers and babies

In 2018, with WHO Country Office support, the MoHP developed and endorsed the “Postpartum Family Planning (PPFP) Programme Managers’ Guide”. The Guide provides direction for programme managers to integrate PPFP into routine family planning and reproductive health services.

Meanwhile, the government endorsed the Safe Motherhood and Reproductive Health Rights Act. The pathbreaking Act provides guidance for non-discriminatory, free and disabled-friendly reproductive services for adolescents and women. It also includes provision to increase the number of conditions under which abortion is legal and requires all levels of government to ensure that funding is available to fulfil the government’s earlier mandate for free abortion care in public health facilities.

The MoHP expanded the WHO-recommended Maternal and Perinatal Death Surveillance and Response (MPDSR) Programme to three districts and eight hospitals in 2018, bringing the total to 11 districts and 77 hospitals. The Programme enables Nepal to better understand the causes of maternal and newborn deaths, and develop interventions to reduce these.

Accelerating progress towards UHC

In 2018, Nepal took significant steps towards meeting the health-related provisions of the Constitution and to align public health services in the country with the new federal system of government.

Nepal, with technical support from WHO and other partners, endorsed the Public Health Service Act, which reflects the mandate of the country’s Constitution to ensure the right to free basic health services from the state for every citizen. The Act regulates public health services, including basic care, emergency care, specialized and referral health services, and other related areas.

The Act includes a BHSP, which lists the minimum services that are to be provided by each local government to be delivered through health posts and primary health care centres.

Meanwhile, the government continued with the roll-out of its social health insurance scheme that requires all citizens to have health insurance. Families pay an annual premium (Nepalese Rupee 2500 or about US$ 24) while the government covers the cost of premiums for the poor. So far, 36 districts have been included in the scheme, with plans for a nationwide roll-out by 2019.
WHO is also supporting the MoHP to develop an HRH strategic roadmap to assist the government in ensuring the availability of qualified health workers at all levels of the health system.

Meanwhile, as Nepal moved ahead in deciding how health should be financed, it began to develop its health financing strategy (HFS). The process began with the formation of a technical working group (TWG) and steering committee (SC) with WHO’s technical guidance.

The MoHP, with the support of the WHO Country Office, also developed the priority assistive product list (APL). Nepal’s country-specific APL will help the MoHP and its partners in planning the delivery of services related to assistive products and is part of the government’s policy to fulfil the rights of people with disabilities.¹

Strengthening Nepal’s health systems

Nepal expanded training programmes on the standard DHIS-2 to local levels in the new federal context. The concerned personnel in 1200 health facilities registered with the HMIS have been trained on online reporting using the international district-based platform. Of these, more than 700 facilities have begun reporting online on a monthly basis.

With the roll-out of a federalized health system comes the need for a monitoring system. To this end, a guideline has been developed to support a monitoring and evaluation (M&E) process with the aim of developing one system across the three tiers of government.

¹ Priority assistive product list of Nepal: https://www.who.int/phi/implementation/assistive_technology/Final_PriorityAssistiveProductListV2_12062018.pdf
Partnerships

In 2018, Nepal continued with its strong record of collaboration and coordination with partners, including WHO.

The WHO Country Office continues as both Chair and Secretariat of the External Development Partners (EPD) network – a group of UN and bilateral agencies working in health. The EDP network meets twice a month to discuss key health issues, coordinate activities and distribute tasks.

Meanwhile, a new UNDAF 2018–2022, which outlines the priorities for which UN agencies want to jointly support Nepal as it progresses towards achieving the SDGs, is being implemented. The new Framework articulates access to quality basic health services as a priority for all UN agencies.

In collaboration with the Immunization and Vaccines Development (IVD) team in the WHO Regional Office, the WHO-IPD unit forged new partnerships with Gavi, CDC, and USAID to negotiate funding for a surveillance network for rotavirus and intussusception, and for innovative projects on child mortality surveillance. In addition, WHO worked with national and international NGOs, academic institutions and professional societies on various health issues and programmes.
Looking ahead

- **JEE of IHR implementation.** While Nepal has been regularly carrying out three of the four components (annual reporting, after-action review, simulation exercises and voluntary external evaluation) of WHO’s new M&E framework for IHR (2005), it is yet to conduct a JEE. The country is gearing up to conduct the voluntary JEE with WHO support in 2019. This will be followed by the development of the NAPHS.

- **Emergency preparedness and response.** WHO Nepal is looking forward to working jointly with FAO and Public Health England to support the MoHP in designing and piloting a Field Epidemiology Training Programme (FETP) for a nationwide roll-out of the short, standardized training on epidemic and pandemic preparedness and response for decentralized rapid response teams (RRTs). The Country Office will also support the MoHP in establishing HEOCs in four remaining provinces and will work with the Health Emergencies Department in the Regional Office to build capacity and ensure endorsement of the national emergency medical deployment teams that have been constituted.

- **Strengthening sexual and reproductive health.** In 2019, the WHO Country Office will initiate a new project to strengthen sexual and reproductive health. With support from the Buffet Foundation, WHO will work on developing pre-service training on safe abortion practices and related family planning options, in addition to raising awareness around family planning and safe abortions.

- **Strengthening the surveillance system for kala-azar.** A DHIS-2 web-based kala-azar tracker was developed with WHO support in 2018, which will be rolled out at the provincial level in 2019. This web-based surveillance system is expected to strengthen kala-azar surveillance, which is one of the key components for achieving elimination of the disease in the country.

- **Accelerating progress towards measles elimination.** Measles cases declined by 98% between 2013 and 2017. National coverage with the first dose of measles vaccine remains at 90%. Nepal is poised to accelerate this progress by increasing coverage with the second dose of the MR vaccine to at least 90% and conducting a nationwide MR vaccine campaign to cover children aged between 9 and 59 months by the end of 2019.
Sri Lanka

Highlights

- Sri Lanka celebrated World Health Day in the presence of the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, and the Regional Director, Dr Poonam Khetrapal Singh.

- The Ministry of Health, Nutrition and Indigenous Medicine (MoHNIM) is awarded the UN Interagency Task Force Award, recognizing its outstanding contribution to achieving the NCD-related SDGs.

- Sri Lanka accelerates progress on combating NCDs with the development of key strategies such as the National Salt Reduction Strategy.

- WHO declares the country as having controlled rubella and CRS.

- The Cabinet approves the policy for health service delivery for UHC. The policy includes a series of strategies to support public health-care strengthening such as the essential service package, service delivery model, health workforce roadmap and the health financing strategy.

- Sri Lanka strengthens its emergency preparedness by launching the NAPHS.

- The National Youth Camp (Yowun Puraya 2018) attracts 7000 young people nationwide to raise awareness about healthy diets and psychosocial health.
Introduction

The WHO Director-General, Dr Tedros Adhanom Ghebreyesus, and the Regional Director, Dr Poonam Khetrapal Singh, visited Colombo to celebrate World Health Day, marking the country’s seventieth year of independence as well as WHO’s seventieth anniversary. Both the Director-General and the Regional Director used the occasion to acknowledge Sri Lanka’s notable progress towards achieving UHC.

In March, the Sri Lankan Cabinet approved the policy on health service delivery for UHC, which provides the impetus and strategic guidance needed to strengthen the primary health care system, with WHO Country Office support.

In addition, Sri Lanka’s President, H.E. Mr Maithripala Sirisena, was appointed as Commissioner of the High-Level Commission set up by the WHO Director-General to provide strategic guidance on addressing NCDs. The appointment further acknowledged the country’s political commitment to UHC. The year also saw the Minister of Health, Nutrition and Indigenous Medicine, H.E. Dr Rajitha Senaratne, being appointed as Vice-Chair of the WHO Executive Board in Geneva.

The country continued to accelerate progress on combating communicable diseases after being verified as having controlled rubella and CRS, and making substantial progress in reducing its dengue burden. While Sri Lanka continues to make notable progress against NCDs with the development of several key strategies, there has also been a realization that more work needs to be done, particularly in the areas of nutrition, alcohol and tobacco.

*Joint press conference of WHO and the Government of Sri Lanka*
use. Given Sri Lanka’s vulnerability to natural disasters and climate change, the country committed to strengthening its emergency preparedness in 2018 with the development of the NAPHS.

**Key activities and achievements for 2018**

**Sustaining communicable disease control, including NTDs**

Despite being a tropical country, Sri Lanka has made substantial progress in combating communicable diseases, including malaria, LF and neonatal tetanus. In 2018, the country was verified as having controlled both rubella and CRS two years ahead of the regional target. This achievement again highlighted the strength of the health system and the high level of community engagement in disease elimination.

Meanwhile, Sri Lanka declared its commitment to end TB by 2025 at the Global Ministerial Conference on Ending TB and the Delhi End TB Summit. The country also committed to elimination of mother-to-child transmission (EMTCT) of HIV by 2019 and to reach HIV/ AIDS targets by 2025, five years ahead of the global target of 2030.

The WHO Country Office, along with the National STD/AIDS Control Programme (NSACP) and the National Programme for Tuberculosis Control and Chest Diseases (NPTCCD), organized a national consultative workshop in collaboration with partners, supported by the Global Fund. The outcome of the workshop was a roadmap for ending TB and HIV/AIDS, which includes employing GeneXpert machines across the country and using innovative HIV community-based testing mechanisms. Following the workshop, Sri Lanka also began to revise its MDR-TB guidelines.

Meanwhile, following a massive dengue outbreak in 2017, WHO supported the development of an Action Plan on Dengue Control and Prevention. As part of the Plan, the MoHNIM and partners conducted regular reviews and audits and work to improve the skills and capacities of frontline health staff in vector control and case management. The result of this work has been profound. In 2018, there was a 75% reduction in dengue cases and a 90% reduction in related mortality compared with the previous year.

Sustaining leprosy elimination remains a challenge. Although the disease was eliminated as a public health problem from the country in the 1990s, leprosy cases continue to be reported. The WHO Country Office is working to renew capacity building and strengthen monitoring within the anti-leprosy campaign (ALC). To this end, WHO and the ALC together trained central and peripheral health staff on early diagnosis, timely referrals and managing disability through workshops, mentoring, sharing experiences from other countries, and through expert advice from the centre of excellence in Japan.
Addressing the high burden of NCDs

NCDs are the leading cause of death and disability in Sri Lanka. Political commitment and multisectoral cooperation in the country continued in 2018 with the appointment of the President as Commissioner of the High-Level Commission set up by the WHO Director-General to provide guidance on addressing the NCD burden. The MoHNIM was selected for the UN Interagency Task Force Award 2018 in recognition of the country’s contribution to achieving the NCD-related SDGs.

Appointments and awards aside, in 2018 Sri Lanka invited the UN Inter-agency Task Force on the Prevention and Control of NCD (UNIATF) to review the country’s progress on its national multisectoral action plan for the prevention and control of NCDs, the main policy document guiding the country’s approach to NCD control.

The mission concluded that there was a need to further prioritize and scale up evidence-based interventions for NCD control, prevention and management.

Meanwhile, the National Salt Strategy (2018–2022) was launched, with the government setting a target of a 30% reduction in sodium intake by 2025. In a first step towards designing a strategy to control transfats – a major contributor to NCDs – a landscape analysis of the transfat status in the country has been commissioned by the WHO Country Office, which will be completed by two universities.

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2 Data from STEPS 2015
While Sri Lanka has made substantial progress in implementing the WHO FCTC, more work needs to be done. To this end, WHO is working with partners to develop an investment case for tobacco control and to get Cabinet approval for plain packaging and a ban on the sale of single sticks.

On the harmful use of alcohol, WHO is working closely with organizations, including the National Authority on Tobacco and Alcohol (NATA), on issues such as alcohol taxation, which is being considered. With WHO support, a range of training programmes for health professionals are under way on the psychological and social impact of harmful alcohol use.

Promoting road safety through multisectoral action

Road traffic-related incidents cause approximately 3000 deaths per year in Sri Lanka and are the leading cause of death among young people. The country’s goal is to reduce road traffic-related fatalities by improving the quality of and accessibility to road safety data.

To realize this goal, in September the Sri Lanka Accident Data Management System (SLADMS), inspired by the South Korean GIS analysis system, was launched in collaboration with the police and other partners. Tablets and computers were provided to 50 police stations, headquarters and pilot divisions by the WHO Country Office with the support of the Regional Office. The objective of the SLADMS is to have a system for easily recording accidents, avoiding data duplication and reducing delays in emergency care, thereby ultimately saving lives. Starting with four pilot areas, the initiative is to be expanded islandwide.

Preventing suicide and enhancing mental health

In 2018, more than 3000 lives were lost to suicide and thousands more attempted suicide and self-harm. The WHO Country Office ventured into using the performing arts to create awareness about suicide by sponsoring the stage adaptation of Every Brilliant Thing, a Broadway play about the impact suicide can have on the lives of those it touches. The Country Office used the performance to launch guidelines for journalists in English, Sinhala and Tamil. The guidelines aim to provide necessary information and tools to journalists to enable them to report suicides more sensitively and responsibly. These guidelines are being implemented in partnership with the Editor’s Guild of Sri Lanka.

To improve reporting of suicides, a suicide registry and suicidal attempt surveillance system has been initiated as a pilot in one district, with plans to scale it up. Work also began on suicide prevention guidelines with WHO, MoHNIM and other partners, including the Sri Lanka College of Psychiatrists.

As part of the UN peacebuilding programmes in the north and east of the country aimed at post-conflict rehabilitation and development, the Country Office, with provincial
and district health offices and community-based organizations, provided psychological support and linkage to care to those in need in several of the most affected communities.

**Improving the quality of maternal and newborn care, empowering youth and promoting healthy ageing**

While Sri Lanka has already achieved very low maternal and newborn mortality, rates have stagnated in the past decade.

In a bid to further reduce maternal deaths, stillbirths and neonatal deaths, the Country Office supported the Family Health Bureau (FHB) to develop quality of care standards for maternal and neonatal health (MNH) to improve care around birth. The MNH quality-of-care improvement initiative was scaled up to 20 secondary and tertiary care hospitals. WHO also supported the FHB to develop quality-of-care assessment tools, build capacity of health-care workers on assessment techniques and implement quality improvement projects.

Recognizing that women's health is neglected after the reproductive years, WHO supported the Menopause Society of Sri Lanka and the FHB to produce an information booklet for health workers on issues related to menopause along with several educational videos for the public.

Meanwhile, WHO used the opportunity to engage with youth on health and well-being during the National Youth Camp known as Yowun Puraya. More than 7000 young people were reached with key health messages and information.

WHO also engaged with the Ministry of Education to promote healthy diet and physical activity in schools, given the increasing prevalence of obesity and the stubborn pockets of undernutrition in under-five children. To address this double burden of malnutrition, WHO, along with other UN agencies including UNICEF, the World Food Programme (WFP), and the FAO, developed a joint proposal to support the Presidential Task Force on Nutrition to implement the Multisectoral Action Plan on Nutrition. The “Tackling Malnutrition Together” proposal will focus on six districts in five provinces. It has three core focus areas: strengthening advocacy, policy and coordination; greater awareness and understanding of good nutrition and care practices; and improved health service provision and better protocols and nutrition treatment practices.

**Achieving UHC through the reorganization of primary health care**

Sri Lanka delivers health services to all its citizens free at the point of service delivery. The country, however, is now facing the dual challenge of NCDs and an ageing population. Both these transitions require chronic care models for service delivery close to where people live.
Box 16. Leadership and commitment to UHC

The World Health Day event was attended by Sri Lanka’s President, Prime Minister and Health Minister, and the WHO Director-General and the Regional Director for South-East Asia. Their attendance highlighted the high-level leadership and commitment to UHC both at the Member State level and from WHO. The event, which was celebrated outside of Geneva for the first time, highlighted the success of UHC in Sri Lanka while also emphasizing the need for continued political commitment to ensure health and well-being for everyone.

Several initiatives were launched during the event, including the National Policy on Health Care Delivery for Universal Health Coverage, the WHO Country Cooperation Strategy (CCS) for Sri Lanka 2018–2023, an SDG 3 tracker, and an e-health card.

Following the momentum of World Health Day, in collaboration with the Sri Lanka Medical Association, WHO organized a session on UHC in Parliament to reaffirm the commitment of policy-makers to health.

To translate policy into action on the ground, the MoHNIM and WHO organized a two-day conference (UHC TA.lk 2018) in October. The conference, which was attended by 300 national participants and more than 30 international experts, provided insight and inputs into how Sri Lanka can achieve its UHC and primary health care goals. Several ministers along with government officials, academia, CSOs, the WHO Assistant Director-General, the Director for Health Systems Development from the WHO Regional Office and experts from the World Bank, ADB and the Global Fund attended the event. The recommendations of the Conference will guide the finalization of several policies and strategies, including the essential service package, sustainable health sector financing, and the harnessing of technology for better reporting, monitoring, data use and patient empowerment.
Recognizing this need, the government has embarked on a primary health care reorganization to make the necessary changes and improvements to ensure health-care service delivery for emerging health challenges. This is a key step towards realizing the goal of UHC.

As a key technical partner in taking the primary health care reorganization forward, WHO at all three levels is providing support. This includes assisting in developing an essential service package, reviewing the current HR strategy, developing a strategic health financing roadmap for sustainable health sector financing and reducing OOP expenditure, and developing an electronic M&E system.

Meanwhile, WHO and the MoHNIM, in collaboration with the World Bank and Asian Development Bank, and support from the Global Fund, organized a two-day conference on strengthening primary health care and ending TB and AIDS in Sri Lanka, titled “UHC TA.lk”. Following the Conference, a roadmap for fast-tracking evidence-based interventions to end AIDS and TB in Sri Lanka by 2025 was developed. In an important step, the key recommendations from the Conference have been incorporated into the ongoing reorganization of primary health care, including introducing an accreditation system for ensuring quality health care and safety, and improving the health workforce information system.

Improving quality and access to affordable essential medicines

To ensure access to quality and affordable medicines for UHC, WHO supported the National Medicines Regulatory Authority (NMRA) to review existing legislation and regulation of medicines in line with the recommendations of WHO’s Benchmarking of the National Regulatory Authority Global Assessment Tool. In addition, WHO provided technical support to improve and strengthen supply chain management, including innovative solutions to ensure an uninterrupted supply of NCD medicines in all government hospitals, such as the development of a computerized medical supplies management information system (MSMIS) that enables monitoring of stores and surveillance of pharmacy performance.

Protection from health emergencies

Emergencies and disasters are becoming more frequent, diverse and larger in scale globally, and Sri Lanka is no exception.

In 2018, the country made a commitment to further strengthen its core capacities on IHR (2005) through the development of the NAPHS 2019–2023. The Plan will guide relevant stakeholders in the coming five years to strengthen the core capacities to prevent, detect and respond to emergencies, and will strengthen the health security agenda of the Region.
For better preparedness and resilience, and to create a more responsive health system to prevent, mitigate, limit destruction and build back better, WHO worked closely with the Ministry of Disaster Management and the MoHNIM to build the capacity of health staff and military personnel who are generally the first responders during an emergency. District disaster management plans incorporating the revised strategic plan for health sector disaster management were developed for districts in the western and southern provinces – all high-risk areas for repeated floods and landslides.

For preparedness and response to all hazards within the framework of the IHR, WHO worked with key national stakeholders to strengthen human resource capacity and systems capacity for CBRN (chemical, biological, radiological and nuclear) emergency management.

**Addressing the environmental determinants of health**

Safe management of health-care waste (HCW) is vital to control and reduce infections inside a health-care facility and to ensure that the environment outside is well protected. To ensure proper disposal of HCW, the Country Office supported the MoHNIM in revising the Healthcare Waste Management Guidelines, in collaboration with relevant ministries and academia.

*At the 142nd session of the WHO Executive Board, Geneva*
Moreover, the UN Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) was conducted by WHO and the Ministry of City Planning and Water Supplies. The report is useful for monitoring the delivery of sanitation and drinking water services in the country, with special emphasis on the impact of government policies.

In collaboration with the MoHNIM, the Ministry of Environment and academia, WHO conducted an expert review of the guidelines on scaling up health-related articles of the Minamata Convention on Mercury. WHO provided technical assistance in planning for implementation of the recommendations and replacing medical devices that contain mercury.

Partnerships

To implement the WHO CCS for Sri Lanka 2018–2023 and other programmes and initiatives, the Country Office works closely with relevant ministries, national and international partners, UN agencies, CSOs and academia.

The WHO Country Office continues to collaborate with various UN agencies to implement the UNDAF. To promote workers’ health and ensure occupational safety, WHO is working with the International Labour Organization (ILO) to implement the “Working for Health” programme, with funding from the China–UN Peace and Development Grant. To address both undernutrition and obesity among children under 5 years of age, a joint UN Nutrition Proposal was developed in collaboration with the FAO, UNICEF and WFP.

For emergency preparedness and response, WHO engages with the MoHNIM, the Ministry of Public Administration and Disaster Management, the Ministry of Defence, and the Ministry of Mahaweli Development and Environment. Meanwhile, WHO collaborated with Citra Social Innovation Lab to assist the Sri Lanka Traffic Police and Effective Solutions (Pvt) Ltd. to pilot the comprehensive SLADMS. This was the first time WHO, with UNDP support, has collaborated with the Department of Police to address road traffic accidents.

To implement the primary health care reorganization programme, WHO works closely with the World Bank and ADB, both of which have provided health sector loans.

To address key health determinants, WHO works with CSOs, the Ministry of Sports, Chambers of Commerce, academic institutions and the NCD Alliance of Sri Lanka to implement the multisectoral action plan on NCDs.

To promote experiential learning and cross-fertilization, the Country Office continues to work closely with other country offices. In 2018, the WHO Sri Lanka office collaborated with the Timor-Leste Country Office for the twinning agreement on immunization; with the Maldives Country Office on joint programme for external competency assessment of malaria microscopists; and with WHO Bangladesh to address the Rohingya crisis.
Looking ahead

Sri Lanka’s rapidly growing NCD epidemic coupled with health-related ageing problems poses a threat to the hard-earned gains in the health sector. To address this challenge, the country is reorganizing its primary health care system. The WHO Country Office remains committed to supporting the government “to promote health, keep the world safe and serve the vulnerable”.

Sri Lanka’s health sector reforms in many ways match those of WHO globally: improved access to quality essential health services; strengthened country health emergency preparedness; and reduced risk factors through multisectoral approaches.

Looking ahead, primary health care reorganization in Sri Lanka will continue to be the focus of WHO Country Office support to the MoHNIM. In addition, preparedness, mitigation, resilience and rapid response to disasters and emergencies, including AMR will be another key priority, as outlined in the WHO CCS (2018–2023). Addressing the social, cultural, environmental and commercial determinants of health will be a key strategy while moving forward to address the NCD epidemic and promote healthy ageing.
Thailand

Highlights

- The government decides to eliminate trans fats (partially hydrogenated oils) from food products.
- Thailand becomes first middle-income country to introduce plain packaging for tobacco products.
- The Ministry of Public Health (MoPH) and WHO jointly assess Thailand’s Infection Prevention and Control Programme.
- WHO Director-General, Dr Tedros Adhanom Ghebreyesus, makes first official visit to Thailand as co-host of the Prince Mahidol Award Conference, accompanied by the Regional Director, Dr Poonam Khetrapal Singh.
- WHO road traffic fatality estimates in the 4th Global Status Report on Road Safety (GSSRS) for the first time closely correspond with the numbers reported by the Royal Government of Thailand.
- Thirty-five of 77 provinces have been validated as malaria-free by the MoPH.

Introduction

Thailand is a middle-income country and over the years has made remarkable gains in public health. Its accomplishments are globally

However, the country continues to grapple with myriad challenges, including an increasing burden of NCDs, growing AMR and one of the world’s highest rates of road traffic deaths. WHO supports addressing these pressing public health and other challenges through its innovative CCS, which was developed and approved in 2017.

In 2018, WHO launched a unique pooled funding mechanism to fund CCS priority programmes. The six programme areas identified are (i) AMR; (ii) global health diplomacy; (iii) international trade and health; (iv) migrant health; (v) NCDs; and (vi) road safety. As per the pooled funding mechanism, WHO contributes under 30% of the total budget, with the MoPH and several quasi-government agencies contributing the rest. This unique funding model ensures country ownership and leadership of the programmes.

The WHO Director-General, Dr Tedros Adhanom Ghebreyesus, made his first official visit to Thailand in 2018 as one of the co-hosts of the Prince Mahidol Award Conference (PMAC). He was accompanied by the Regional Director for South-East Asia, Dr Poonam Khetrapal Singh. At the Conference, the Director-General highlighted Thailand’s strong track record of UHC and cited it as proof that UHC is achievable by all countries, regardless of income level.

A key achievement in 2018 was that Thailand became the first country in Asia and the first middle-income country to introduce plain packaging for tobacco products. In a bold move in the fight against NCDs, the country also decided to eliminate the production, import and sale of partially hydrogenated oils, as well as food containing them.

*Meeting with honourable Mr Prayut Chan-o-cha, Prime Minister of Thailand, Bangkok*
Key activities and achievements in 2018

Making headway on antimicrobial resistance

Progress continued in 2018 towards the implementation of Thailand’s National Strategic Plan for AMR (2017–2021). The Plan has ambitious goals to reduce morbidity from AMR by 50% by 2022, reduce the use of antibiotics in humans and animals, and increase public awareness of AMR and the appropriate use of antibiotics. AMR has been estimated to be responsible for 38 000 deaths per year in Thailand.

As part of the CCS programme for AMR, work in 2018 included developing competency in antimicrobial stewardship and a competency assessment of community pharmacists in Thailand. This work underwent an external peer-review of the proposed arrangements involving experts from WHO headquarters. In addition, work also continued on establishing baselines to objectively measure the Plan’s goals.

Strengthening infection prevention and control

Infection prevention and control (IPC) is a key component of Thailand’s National Strategic Plan for AMR (2017–2021). In 2018, a joint external assessment of the country’s IPC programme was undertaken by national and international experts using WHO guidelines.

Box 17. Thailand bans partially hydrogenated oils (transfats)

Industrially produced transfats are manufactured by partial hydrogenation of vegetable or fish oils. Globally, industrial transfat intake is estimated to cause 540 000 deaths every year from cardiovascular disease. Industrially produced transfats are contained in hardened vegetable fats such as margarine and are also present in baked and fried foods, including cakes, doughnuts and fries.

Based on surveys carried out in 2007 and 2017 by the Institute of Nutrition at Mahidol University, high levels of transfats were found in popular foods in Thailand. These include doughnut frying fat oil (46.54 g/100 g), shortening (23.34–43.38 g/100 g), and margarine (15.32 g/100g).

In July the government announced a ban on the production, import and sale of partially hydrogenated oils, as well as foods containing them, from January 2019. The decision to ban transfats was the result of open communication among stakeholders, including the Thai FDA and Institute of Nutrition at Mahidol University; strong leadership and commitment of the Thai FDA; strong scientific evidence to support regulatory processes; availability of alternatives that are accessible and affordable; and good technical capacity of local producers.

Elimination of industrially produced transfats from the global food supply has been identified as one of the priority targets in the GPW13. Thailand is one of a growing number of countries to ban industrially produced transfats, illustrating that it is possible to achieve this goal in a middle-income country.

Going forward, the government will closely monitor industry compliance by carrying out periodic surveys to ensure that transfat content is less than 0.5 g per serving. Non-compliance with the law will be punishable by imprisonment for 6 to 24 months and/or a fine ranging from 5000 Thai Baht to 20 000 Thai Bhat (=US$ 150–600).
The purpose of the assessment was to identify how Thailand could strengthen its IPC programme, and by doing so, limit the spread of resistant microorganisms and reduce antimicrobial misuse and overuse. The assessment confirmed that there are adequate IPC activities at the health facility levels but highlighted that these activities were largely carried out by trained infection control nurses who experience insufficient support and have no clear career pathway. The experts recommended that Thailand’s IPC programme be formally mandated and strengthened to align with evidence-based recommendations to support all health facilities, both in the public and private spheres.

**Increasing universal health coverage for migrants**

Ensuring that migrants and their families access UHC is a priority for Thailand and the WHO CCS. Thailand achieved UHC for its citizens in 2002 and, since then, progress has been made in extending it to migrants and their dependents.

Two health insurance schemes are available for migrant workers in Thailand: The Social Security Scheme (SSS), which targets documented migrants working in the formal sector, and the Migrant Health Insurance Scheme (MHIS) which targets all other migrants – documented or otherwise – not covered by the SSS. For the first time in 2018, baseline data revealed that 60% of the 3.3 million documented migrants are enrolled in one of the two health insurance schemes.

However, 40% of documented migrants are without coverage, in addition to an estimated 800 000 undocumented migrants who are eligible for the MHIS. Monitoring
migrant health insurance coverage is one of the critical programme indicators of the WHO CCS Migrant Health Programme. To increase health insurance coverage, the WHO Country Office supported Thailand in 2018 to identify innovative strategies to improve health insurance coverage in migrants, which is one of the key CCS deliverables. To this end, the WHO Country Office is working with the Health System Research Institute to support the MoPH in examining the quality of health insurance data.

Exploring the global health impacts of the Belt and Road Initiative (BRI)

WHO supported the organization of the fifth International Trade and Health Conference on 15–16 November in Bangkok under the theme, “Belt and Road Initiative: Opportunity and Challenges for Health”. The Conference discussed the BRI’s potential impact on health and health systems in Thailand, regionally and beyond. Several messages emerged from the two-day conference including: (i) BRI countries should conduct independent analysis to monitor the impacts from BRI constructions on health and environments; (ii) BRI should shift its focus on health to research and development for specific diseases that are global problems such as HIV/AIDS, TB and malaria; and (iii) BRI has the potential to increase countries’ capacities of disease surveillance, HRH and sustainable responses to public health emergencies.

On track to eliminating malaria by 2026

Thailand is on track to meet its goal of eliminating malaria by 2026. It recorded a reduction of almost half of reported cases in 2018 compared with the previous year. In 2017, Thailand recorded 14,680 malaria cases; by 2018, cases had dropped to 7,219.

On World Malaria Day, Thailand marked its progress by celebrating the fact that 35 of its 77 provinces were malaria-free. Following the successful pilot of integrated drug efficacy surveillance (iDES) in three provinces in 2017, iDES was scaled up to five provinces with active malaria transmission in 2018. After an evaluation by WHO in March, it was decided that iDES – which enables every malaria patient on treatment to be followed up and monitored – will be gradually scaled up to all provinces with active malaria transmission.

Advancing the national NCD agenda

A joint mission of the United Nations Interagency Task Force (UNIATF) on NCDs consisting of representatives from 10 UN agencies and Thai experts was conducted on 28–30 August 2018. The joint mission met with the Prime Minister of Thailand, a number of ministries and government agencies, as well as civil society and academic institutions. The joint mission proposed a set of recommendations designed to take Thailand to the next level of its response to the NCD epidemic. To follow up on the recommendations, a Joint UN Task Force
on NCDs for Thailand has been established with membership from the government and UN agencies. The Task Force will meet twice a year for two years to track progress.

Meanwhile, in another important step to address NCDs, the food industry agreed to set voluntary targets for sodium reduction in packaged foods. The food industry agreed to reduce sodium by 5% in the first year after engagement with the MoPH, civil society groups and academic institutions. The agreement catalyses Thailand’s commitment to reduce sodium consumption by 30% by 2035.

*Fig. 3: Malaria online – patient follow-up*

![Malaria online – patient follow-up](http://malaria.ddc.moph.go.th/malariaR10/index_newversion.php)

The WHO Country Office also catalysed the establishment of a Strategic Technical Advisory Group (STAG) on hypertension to strengthen hypertension care and treatment. Hypertension is a major risk factor for the two leading causes of death in Thailand: stroke and ischaemic heart disease. The Country Office helped convene four STAG meetings in 2018. Because of these meetings, hypertension awareness materials were developed; a social media campaign was launched jointly by the MoPH and WHO; and work on the new hypertension treatment guidelines was completed.
Thai emergency medical teams gearing up for international deployment

The WHO Emergency Medical Teams (EMT) Initiative assists organizations and Member States to build capacity and strengthen health systems by coordinating the deployment of quality-assured medical teams in emergencies. In 2018, WHO supported Thailand to develop its national and international EMTs, through a national sensitization workshop.

WHO also supported other ASEAN countries through the Thai Secretariat on the “Project for Strengthening ASEAN Regional Capacity on Disaster Health Management” – or the ARCH Project – which aims to strengthen regional coordination and cooperation in ASEAN countries on disaster health management.

Making progress on road safety

The MoPH and the WHO Country Office jointly launched the 4th Global Status Report on Road Safety (GSRRS) in December. Thailand had the ninth-highest rate of road fatalities globally in 2018, which is an improvement from the second-highest rate recorded in the 2015 report. But Thailand has the highest global rate of road fatalities among drivers and passengers of motorized two- and three-wheelers. In 2016, more than 22 000 people had lost their lives from road traffic crashes.

For the first time, WHO road traffic fatality estimates in the 4th GSRRS are very close to numbers reported by Thailand. This is the result of successful efforts between WHO and the MoPH to develop software that enables data amalgamation from various sources, such as police, medical insurance and health records. This is a significant step forward in
Thailand’s commitment to reducing road crash deaths because it can now adequately track its progress. With WHO support and advocacy, Thailand has made significant progress since the previous GSRRS in 2015. It substantially strengthened road safety laws in 2016, such as reducing blood alcohol limits to curb drink-driving, reducing local speed limits, and imposing mandatory and strict seat-belt requirements.

**Partnerships**

The WHO Country Office engages regularly with a wide range of national and international partners. Examples of these partnerships in 2018 include the following:

- Collaboration with the Embassy Friends of Road Safety, an alliance of embassies in Thailand led by the Ambassador of the United Kingdom of Great Britain and Norther Ireland. The group continues to help WHO in its road safety advocacy efforts with the Thai Government.
- Among the numerous collaborations with international partners, WHO worked with the CDC and the American Red Cross to support a review of the measles elimination and rubella control programme.
- WHO also works in close partnership with UNICEF, the Thai–US CDC Collaboration and UNAIDS to assist Thailand in maintaining its status as having achieved EMTCT of HIV. To address the issue of adolescent pregnancies and the provision of youth-friendly health-care services, WHO continues its partnership with UNFPA and UNICEF.

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**Box 18. Thailand introduces plain packaging for tobacco products**

In late 2018, Thailand became the first country in Asia and the first middle-income country to adopt plain packaging for tobacco products. The new legislation, which comes into effect in September 2019, further signals Thailand’s vision to curb tobacco use.

The country already has graphic health warnings covering 85% of the package of tobacco products. The introduction of plain packaging – an evidence-based policy advocated by WHO FCTC – is expected to boost the country’s tobacco control efforts targeting current and new users.

In recent years, Thailand has taken strong steps to strengthen tobacco control, including passing the Tobacco Control Act 2017, which enforces 20 years as the minimum age for purchasing tobacco, bans the sale of “loose” cigarette sticks and bans tobacco advertisement, promotion and sponsorship.

There are 11 million smokers in Thailand. A major concern is the high use of tobacco among young people – one in every six Thais aged between 13 and 17 years uses tobacco products. Addressing tobacco is a critical part of Thailand’s efforts to reverse its NCD epidemic, which accounts for over 70% of all deaths. It is also critical to the country fulfilling its economic potential. In 2009, the economic loss from tobacco was estimated to be 0.78% of GDP.

Thailand hopes it has paved the way for similar steps to be taken by other low- and middle-income countries.
Looking ahead

WHO will focus on CCS priority areas, harnessing the intellectual and social capital by collaborating with Thai governmental and nongovernmental partners. Some of the major activities being planned include the following:

- A nationwide survey of IPC activities at health-care facilities will be carried out in 2019 as part of the WHO Global Survey on IPC and Hand Hygiene. In addition, a systems analysis of the arrangements in place for monitoring AMR-related morbidity in Thailand will be carried out.

- WHO will further strengthen multisectoral coordination on NCD action by establishing a UN-led forum for multisectoral engagement chaired by the UN Resident Coordinator. Participants will include representatives from key government ministries (including health, finance, education, labour and civil society) with WHO as the Secretariat.

- In terms of emergency preparedness, Thailand’s emergency medical team system will be formally accredited in 2019 in alignment with WHO's international standards.

- On the road safety agenda, WHO will concentrate on advocating for the completion of the remaining legislative amendments following the strengthening of laws in 2016. WHO will also support the Ministry of Transportation to finalize the recommendations of the Motorcycle Safety Working Group for presentation to the Cabinet.
Timor-Leste

Highlights

- Timor-Leste was declared measles-free and verified for having controlled rubella and CRS.
- Gavi Board approves funding to support the country’s EPI for another five years.
- Timor-Leste makes headway in combating NTDs.
- The twinning partnership for improvement of quality of care between Timor-Leste and China, Macau Special Administrative Region (SAR), is initiated.
- Timor-Leste becomes the newest member of the Codex Alimentarius Commission.
- The JEE for implementing IHR (2005) is conducted successfully.
- Timor-Leste initiates a TB Drug-Resistance Survey (DRS) in pilot districts

Introduction

Since the restoration of Independence in 2002, UHC has been the cornerstone of Timor-Leste’s health sector.
The launch of the government’s flagship primary health care programme, Saúde na Família (Health in the Family), in 2015 was an ambitious step towards achieving UHC. By taking primary health care directly to the people and identifying those who require follow up, the programme aims to overcome barriers of access to health care, especially for the vulnerable, poor, disabled and marginalized. In 2018, the second phase of the programme was launched with WHO support.

In 2018, Timor-Leste achieved two major public health milestones: measles elimination and control of rubella and CRS. Nevertheless, the country continues to bear the burden of communicable diseases, TB, VBDs and NTDs. In response to its growing burden of NCDs, which account for 44% of all deaths, Timor-Leste launched its first-ever Multisectoral National Action Plan for the Prevention and Control of NCDs.

The country is also highly vulnerable to natural disasters such as cyclones and disasters, and climate change. In a bid to increase its capacity to prepare and respond to potential disasters, work on the establishment of an HEOC began.
Key activities and achievements in 2018

Health systems strengthening

In 2018, the second stage of the MoH’s flagship programme, Saúde na Família, began with WHO support. The second round of home visits was launched to bring health care to the household level. This will include home visits, clinical consultations, and treatment and referrals by a mixed team of health personnel. The programme also records every household’s health status, which is entered into a digitalized medical record system.

Meanwhile, the MoH with WHO support, began updating its essential service package to reflect changes in the country’s disease profile. WHO also provided technical support to enable Timor-Leste to measure the coverage of government health services and OOP expenditure as a means to monitor progress towards UHC.

Work also continued on the development of Timor-Leste’s Health Workforce Strategic Plan (2019–2023), a blueprint that will ensure adequate and quality health personnel and optimal distribution of human resources.

In an important step forward in ensuring the availability of quality medicines, WHO supported the training of procurement officials from SAMES, an autonomous agency that is responsible for the procurement of medicines and medical equipment. The purpose of the training was to strengthen the procurement strategy of the agency, which led to the introduction of new protocols.

The “twinning partnership for improvement” (TPI), an initiative between Timor-Leste and China, Macau Special Administrative Region (SAR) was initiated. Timor-Leste expects to collaborate with Macau SAR through this partnership to improve its quality of health care. This partnership enables selected health institution in Timor-Leste to develop effective and sustainable quality improvement in services in partnership with Macao SAR, aiming to catalyse improvements in the quality of health services in other health institutions in the country.

Progress towards tackling communicable diseases, including NTDs

The country’s Integrated NTD Control and Elimination Programme, which aims to eliminate LF and yaws, and control STH by 2021, made important gains in 2018. The third round of MDA against LF and STH achieved 100% geographical coverage and reached 84% of the targeted population. An additional round of MDA for STH was conducted in Dili municipality in October, which achieved 69% coverage.
Meanwhile, the country completed its first yaws endemicity mapping survey, reaching an additional three municipalities in 2018. The survey, which found a prevalence of 0.02%, paved the way for a national consultation, in which staff from WHO headquarters and Regional Office and international experts provided guidance on the next steps to take towards yaws elimination. A dossier has since been created, which recommends awareness campaigns in villages and schools on yaws; developing the capacity of health workers on screening, testing, case management and reporting of yaws cases; establishing an active surveillance on yaws through community health volunteers; and treating all confirmed cases and any active ulcers with a single dose of azithromycin.

Meanwhile, in response to a dengue spike in the country, and with the support of WHO and other partners, the country scaled up vector control and case-management training in 2018. To that end, in collaboration with the Royal Thai embassy in Timor-Leste and the WHO Collaborating Centre for Case Management of Severe Dengue at Queen Sirikit National Institute of Child Health, Thailand, a workshop on dengue case management and vector control was organized for doctors, nurses and vector control workers from all municipalities.

Timor-Leste has the highest TB burden in the SEA Region, with an estimated incidence of 498 per 100 000 population. In adjoining 2018, a pilot drug-resistance survey (DRS)
was conducted in two municipalities adjoining Dili. The pilot DRS, which will be scaled up nationwide, was carried out to understand the logistical challenges in conducting the survey. In addition, a high-level TB advocacy workshop on “Joint actions to halt tuberculosis epidemic in Timor-Leste through partnership and multisectoral coordination” was conducted.

Following the adoption in 2017 of the “test and treat” policy of putting all HIV-positive patients on ART regardless of their CD4 count, the country revised four technical guidelines in 2018. National AIDS Programme staff were trained on the updated documents, including ART and STI handbooks, and HIV, visceral leishmaniasis (VL) and “test and treat” guidelines.

In 2018 a new Global Fund grant commenced that will track two important indicators: PMTCT of HIV and HIV viral load.

**Addressing antimicrobial resistance**

The first public awareness survey on AMR and the use of antibiotics was conducted in May involving more than 1300 people across all 13 municipalities. The survey found significant gaps in knowledge and perceptions on the use of antibiotics. Based on the results, information, education and communication (IEC) materials were designed and disseminated to all health and veterinary facilities across the country.

In addition, the first national multisectoral AMR committee meeting was held in November as part of World Antibiotics Awareness Week (WAAW). The committee, which included members from various ministries, UN agencies such as WHO and OIE, and other health sector partners, discussed actions for implementing the National Action Plan on AMR that was launched in 2017.
Improving nutritional status and ensuring food safety

The Food-Based Dietary Guidelines for the country were launched in 2018. The Guidelines, which were disseminated by WHO, the MoH and other partners, promote healthy eating through the consumption of local and indigenous foods rather than imported foods.

To promote breastfeeding, a national workshop on the Baby Friendly Hospital Initiative (BFHI) was conducted for professionals from national and referral hospitals. Following the workshop, WHO and partners supported the MoH to develop a package of services for newborns and infants, including a training course for maternity staff; setting up a breastfeeding café in the national tertiary care hospital in Dili; and advocacy for the International Code of Marketing of Breast-milk Substitutes.

In an important step towards ensuring food safety, Timor-Leste became the newest member of the Codex Alimentarius Commission (CAC). A workshop was organized for various ministries with WHO technical support, to educate professionals on the functions and structure of the CAC and the responsibilities of national authorities.

With WHO support, the MoH conducted a workshop to strengthen surveillance and response to foodborne diseases in Timor-Leste. WHO continued to support the MoH in increasing awareness on food safety, including food safety training involving schools, local food producers and companies in six municipalities.

Box 20. Strengthening influenza surveillance

The MoH began influenza surveillance in 2016 with support from the WHO Country Office under the pandemic influenza preparedness (PIP) programme. Prior to the programme’s initiation, no surveillance or testing was being conducted for influenza in the country, which causes substantial morbidity and mortality.

The surveillance system now includes five ILI sentinel sites located in Dili municipality. These collect samples from outpatients at community health centres and three SARI sentinel sites in three municipalities collect samples from inpatients.

In 2018, thanks to the support of the programme, the number of specimens collected and tested increased steadily. Importantly, reagents and supplies procured by the Regional Office arrived at the national health laboratory (NHL), further enhancing its capabilities.

In a further bid to strengthen surveillance and the response to influenza, a quality management system workshop was conducted for technical and administrative staff at the NHL with a trainer from Australia using PIP provisions. Training sessions were also held for sentinel site staff for case definition and swab collection.
JEE for implementation of International Health Regulations (2005)

In November, the country’s first JEE for implementing IHR (2005) was conducted by a team of 12 external evaluators together with representatives of several ministries and other relevant government agencies. The JEE covered 19 technical areas such as surveillance, zoonosis and AMR, and identified the need to enhance public health security preparedness, response and action. Importantly, the JEE provided the basis for the development of an NAPHS in the near future.

Strengthening emergency preparedness and response

A number of activities took place in 2018, with WHO support, to further strengthen Timor-Leste’s capacity to respond to an emergency, including a potential infectious disease emergency.

Work on the establishment of an HEOC began in 2018. When it is ready it will be a command and operations centre for public health emergencies, equipped with the necessary ICT and human resources. WHO donated equipment, including monopods and ICT hardware.
In addition, quarterly health cluster emergency coordination meetings were held to discuss current disease outbreaks and disease patterns. WHO also supported the MoH in procuring and stockpiling emergency health products such as IEHKs and medical equipment. The contingency plan and business continuity plans of the WHO Country Office were developed and approved in October.

Responding to climate change

The WHO Country Office supported the MoH to finalize the Environmental Health Strategy. The Strategy promotes intersectoral collaboration and partnership to minimize the risks associated with climate and environmental change and occupational health. In addition, the Country Office supported two workshops with the MoH and partners to develop an H-NAP for climate change and health, which is expected to be finalized in 2019. WHO also continued to support the development of a curriculum for environmental health programmes.

Meanwhile, training for water safety officials was conducted in four municipalities on WSPs. WHO also facilitated the country’s participation in the UN-GLAAS.

Continuing the fight against NCDs and tobacco use

In 2018, Timor-Leste took important steps to combat its NCD burden, improve mental health and combat tobacco use.

To this end, the country launched the Multisectoral Action Plan for the Prevention and Control of NCDs (2018–2021) this was developed following extensive consultations with various agencies and ministries.

Following the roll-out of two pilot PEN interventions for primary health care facilities in two municipalities in 2017, the package was implemented at four community health centres (CHCs) in Dili and Ermera municipalities. Orientation on PEN interventions was also carried out for 13 CHCs from three municipalities. Moreover, PEN dashboards, individual patient records and monthly report forms were distributed to 13 CHCs as part of efforts to expand the PEN programme.

Following the passage of comprehensive national tobacco control legislation in 2016, a multisectoral workshop on implementing the legislation in line with the WHO FCTC was conducted for several ministries, CSOs and other relevant agencies.

In addition, dozens of shopowners and tobacco product importers took part in a sensitization activity that focused on tobacco control legislation and the key relevant provisions of the WHO FCTC. No-smoking stickers and stickers prohibiting the sale of cigarettes to minors were distributed to tobacco outlets in Dili.
Meanwhile, a No-Tobacco advocacy event was conducted targeting the youth – students from universities, government leaders and the general public.

Also, the Mental Health Strategic Plan 2018–2023 was endorsed and launched by the MoH.

**Partnerships**

The WHO Country Office continues to maintain strong partnerships with UN agencies, academia, development partners and CSOs, as well as with government departments and ministries other than the MoH. These include the ministries of education and state administration. A few of the collaborative activities are listed below:

- WHO continued to co-chair the Development Partners Health and Nutrition Group, whose members include multiple UN agencies, bilateral partners such as DFAT, and NGOs represented by Health Alliance International (HAI).
- The Korea International Cooperation Agency (KOICA) continues to financially support Timor-Leste’s NTD control and elimination programme, which is implemented by the WHO Country Office.
- The Country Office collaborated with the Thai embassy to run a workshop on dengue case management and vector control.
- A study on the prevalence and risk factors of rheumatic heart disease was carried out by a joint team of researchers from Australia and Timor-Leste in 2018. To disseminate the findings, the MoH and the WHO Country Office worked with East Timor Hearts Fund and the Menzies School of Health Research to organize a forum to disseminate the findings and discuss ways to strengthen policy.
- WHO and UNFPA collaboration continued with training on joint intrapartum and immediate post-partum care conducted for midwives and doctors.

**Looking ahead**

The WHO Country Office will assist with numerous activities and programmes in 2019 and beyond. These include the following:

- Activities to improve the country’s emergency preparedness and response, which will include the development of an NAPHS; the establishment and operationalization of an HEOC; and the establishment of EMTs.
- Communicable disease control activities include the revision of guidelines on TB, MDR-TB and latent TB; advocating at the government level for investment in TB,
completion of first nationwide TB DRS and End TB Strategy Plan for Timor-Leste by 2030; partnering with Indonesia to hold a cross-border meeting for the control of malaria; and implementing HIV sentinel surveillance. Round 4 of MDA for LF and STH will also be conducted and, importantly, the rotavirus vaccine will be introduced into the country’s routine immunization programme.

- In the area of health systems strengthening, activities include finalizing the essential service package; revision of standard treatment guidelines; and finalizing the HRH Strategy.

- Activities on NCDs will include the development of an alcohol control policy and legislation, and strengthening the tobacco control programme.
Delivering on the Regional Flagship Priorities and beyond

Flagship 1: Measles elimination and rubella control by 2020

Introduction

Significant progress has been made in the fight against measles and rubella since the Sixty-sixth session of the Regional Committee for South-East Asia in 2013 adopted the regional goal of measles elimination and rubella control by 2020 and in 2014, the Regional Director identified “Measles Elimination and Rubella Control by 2020” as one of her Flagship Priorities for the Region. To ensure adequate technical guidance to accelerate progress towards the goal, the Strategic Plan for measles elimination and rubella and CRS control in the South-East Asia Region (2014–2020) has also been developed.

Between 2000 and 2017, there was a 75% reduction in measles mortality. The reduction in mortality, an estimated 23%, was highest between 2014 and 2017. Likewise, there has been significant progress in the fight against rubella and CRS in recent years.
Progress and results in 2018

Major achievements

In 2018, DPR Korea and Timor-Leste were verified as having eliminated endemic measles following an extensive review by the South-East Asia Regional Verification Commission (SEA-RVC). Bhutan and Maldives, the two countries that were verified as having eliminated measles in 2017, sustained their measles elimination status in 2018. Six Member States of the Region – Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste – were verified as having controlled rubella and CRS in 2018, following an at least 95% reduction in rubella incidence since 2008.

Coverage of the first dose of MCV1 in 2017 was 87% compared with 63% in 2000. An additional 200 million children were reached in 2018 through SIAs, primarily in India and Indonesia.

By the end of 2018, all 11 Member States were administering two doses of MCV in their routine immunization programmes. Moreover, 10 Member States have already introduced the rubella-containing vaccine (RCV). Laboratory-supported, case-based surveillance for measles and rubella is now taking place in all 11 Member States, in alignment with the regional guidelines. All Member States also have at least one proficient national laboratory to support surveillance. The Regional Office also facilitated the expansion of the MR laboratory network from 39 laboratories in 2015 to 50 in 2018.

Providing leadership and articulating evidence-based policy

To accelerate progress towards measles elimination and rubella control, effective technical leadership to guide both the Member States and partners continued in 2018.

The implementation of the Strategic Plan for measles elimination and rubella and CRS control in the SEA Region (2014–2020)3 continued to be monitored meticulously. Throughout the year, the Regional Immunization Technical Advisory Group (SEAR-ITAG),4 the apex body to provide guidance on VPDs to Member States in the Region, carefully examined progress reports submitted by Member States as per the Strategic Plan and provided country-specific recommendations based on the evidence provided.

Setting norms and standards – and promoting their implementation

A Regional Surveillance Guide5 on conducting high-quality elimination-standard surveillance for measles, rubella, CRS and other VPDs was developed in 2018. This was the result of a rigorous consultative process with programme officers of Member States,

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4 Available at https://apps.who.int/iris/handle/10665/277458, accessed 5th February 2019
5 Available at https://apps.who.int/iris/handle/10665/277459, accessed 6 February 2019
academia, regional experts and WHO Country Office teams. It is now being used to develop and update national surveillance guides.

In its first meeting in 2016, the SEA-RVC set norms and standards to verify measles elimination and rubella and CRS control. During its meeting in 2018, the Commission verified that Bhutan and Maldives had sustained measles elimination; that DPR Korea and Timor-Leste have achieved measles elimination; and that Bangladesh, Bhutan, DPR Korea, Maldives, Nepal, Sri Lanka and Timor-Leste have controlled rubella.

The Commission also monitored the implementation of norms and standards in Member States through the annual progress report submitted by the National Verification Committees of the 11 Member States. The Commission provided recommendations to accelerate their implementation to achieve the 2020 goal. As part of setting standards and norms, desk and on-site reviews were conducted for all laboratories in the SEA Region measles and rubella laboratory network to ensure that they are proficient.

**Providing technical support and building sustainable institutional capacity**

Notable technical support was provided to the following Member States:

- Bangladesh, to limit the transmission of measles and rubella among the Rohingya population in Cox’s Bazar;
- Bhutan, to conduct molecular epidemiology; respond to an outbreak; and prevent the re-establishment of measles following an importation of the virus. Support was also provided to build sustainable institutional capacity to respond to measles and rubella cases and outbreaks; update surveillance guidelines; develop a post-elimination plan; and enhance laboratory capacity for measles and rubella surveillance;
- DPR Korea, to develop its national strategic plan for measles and rubella elimination and its surveillance guidelines; to strengthen laboratory capacity; and to develop a successful Gavi proposal for MR SIA in the country;
- India, Indonesia and Timor-Leste to ensure the implementation of high-quality MR SIAs by assisting pre-campaign readiness assessments, and intra campaign and post-campaign monitoring;
- Myanmar and Nepal to develop successful Gavi proposals for measles and rubella follow-up SIA;
- Build the capacity of EPI programme managers, surveillance officers and data managers from all 11 Member States on updated surveillance guidelines on

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measles, rubella and CRS as well as data quality assessment through a regional hands-on skills workshop;

- Build the capacity of the MR laboratory network through on-site visits by regional reference laboratories, remote assistance, and through regional training workshops, and including the setting up of quality assurance mechanisms such as proficiency training (PT) panel examination in Member States.

Assessing trends for measles and rubella transmission

A weekly bulletin on laboratory and surveillance performance based on weekly surveillance reports of Member States was prepared in 2018. The bulletin was disseminated to ensure data quality and programme corrective actions.

Immunity profiles for measles by birth cohort up to 40 years of age were generated for all Member States and used to develop plans to close immunity gaps.

Meanwhile, subnational measles and rubella risk assessments were also conducted. The assessments were used by the national verification committees to review progress, support the development of subnational strategies, and prioritize activities.

The annual progress reports developed by the national technical advisory groups and national verification committees formed the basis for assessing trends in measles and rubella transmission. A review of these reports by the IVD of the Regional Office and the triangulation of information in these reports with other available immunization and surveillance data helped to develop country-specific strategic actions.

Generating, translating and disseminating knowledge

There was considerable sharing of information across the Region in 2018. Opportunities for dissemination of key valuable lessons were provided through the following mechanisms:

- A regional workshop for the six most populous countries in the Region (Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand) was conducted to share knowledge and experiences on implementing MR SIAs. A meeting involving the two largest countries in the Region, India and Indonesia, was supported to specifically share details on quality implementation of MR SIAs.

- The process and lessons learnt from countries that have eliminated measles and controlled rubella were documented and published as country-specific “elimination kits”.

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Sharing of lessons learnt was also carried out by inviting EPI programme officers from Bangladesh, Indonesia, Myanmar and Nepal to observe MR SIAs in India, and from India and Nepal to Cox’s Bazar, Bangladesh, to observe vaccination campaigns there.

Shaping the research agenda

The IVD team of the Regional Office facilitated several research agendas to shape the measles and rubella programme. A set of operational research agendas was discussed at the ITAG meeting and agreed on as priority research for the Region. Some of the key research agendas that the Regional Office is closely supporting include:

- operational research on a point-of-care testing device for confirmation of suspected measles cases is ongoing in India, and results are expected in 2019;
- contact assessment of measles cases in India to identify who the first healthcare contact point is, and if the programme should consider revising the current reporting structure;
- a serosurvey to assess the immunity profile for measles and rubella in Bhutan and India; and
- assessment of the differential diagnosis of acute fever and rash in India to help determine if the current target of two non-measles, no-rubella fever and rash per 100 000 population needs any revision, supported by the WHO India Country Office in coordination with the Indian Council of Medical Research.

Box 21. Learning by doing and sharing the lessons learnt

WHO worked with India’s MoHFW and UNICEF to adapt tools to conduct pre-campaign readiness assessments based on global guidelines. This included reviewing readiness on planning, coordination, logistics, as well as communication. The communication tool was not found to be robust during the first phase of the MR SIAs as it was not able to prevent anti-campaign rumours and vaccine hesitancy. Based on lessons learnt during the first phase, the tools were revised, and a robust preparedness assessment was developed for a communication and social mobilization component. This helped to combat rumours, fake news and vaccine hesitancy. The revised tool was applied in other countries in the Region who benefited from this experience. India’s experience is elaborated here: https://apps.who.int/iris/bitstream/handle/10665/273008/WER9327-28.pdf

Challenges, opportunities and next steps

Significant challenges remain to achieving measles elimination and rubella control in the Region. The greatest challenge is to improve routine immunization programmes to ensure that there is greater than 95% coverage with two doses of MR vaccine. Sensitivity of surveillance also remains suboptimal, with underreporting and underestimation of the burden of disease.
A mid-term review of progress towards achieving the regional goal, and to assess the quality of implementation of the strategies laid out in the Strategic Plan for measles elimination and rubella and CRS control in the SEA Region (2014–2020), was conducted in 2017–2018. The purpose of the review was to provide recommendations on how strategies should be refined to accelerate progress towards the 2020 goal. The mid-term review noted with cautious optimism that significant progress had been made across Member States but highlighted that the targets are off-track due to suboptimal implementation of the strategies.

The way forward is to provide high-quality technical support to Member States to support accelerated implementation of the recommendations made by the mid-term review, the 9th ITAG meeting and the 3rd RVC meeting, and to ensure that the recommendations are implemented in a timely fashion.

A high-level consultation has been planned with all Member States and partners to revise the goal for measles elimination and establish a new goal for rubella elimination.

Based on the consultation with partners and Member States, a new Strategic Plan for measles and rubella elimination will have to be developed at the regional level and subsequently adopted by the Member States.

Fig. 4: Number of reported measles cases,* by country, and estimated percentage of children who received their first and second doses of measles-containing vaccine in 2003–2017† in the South-East Asia Region

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Data available at: http://www.who.int/immunization/monitoring_surveillance/data/subject/en

Abbreviations: MCV1-first dose of measles containing vaccine in routine immunization; MCV2- second dose of measles containing vaccine in routine immunization

*Cases of measles reported to WHO and the United Nations Children’s Fund (UNICEF) through the Joint Reporting Form to the Regional Office for South-East Asia

†Data are from WHO and UNICEF estimates for the SEA Region.

§ Others include Bhutan, Bangladesh, DPR Korea, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste
Flagship 2: Prevention of noncommunicable diseases through multisectoral policies and plans, with a focus on “best buys”

Introduction

The year 2018 was significant for continuing with the momentum on the prevention and control of NCDs, which are estimated to account for 64% of all deaths in the SEA Region. In collaboration with other partners, the Regional Office worked diligently to support Member States, including through numerous global, regional and national events and activities.

The third High-Level Meeting on NCDs at the UN General Assembly (UNGA) in 2018 reaffirmed the political commitment that exists to tackle the global NCD epidemic. Heads of government and ministers from the Region’s Member States played a significant role at the meeting. They actively participated in the main sessions, the side-meetings and in the process leading up to it.

The President of Sri Lanka is a co-Chair of the WHO High-Level Commission on NCD Prevention and Control, which provided significant technical inputs to the meeting. The governments of Bangladesh, India, Indonesia, Sri Lanka and Thailand were co-hosts of numerous side-events during the UNGA Week.

The Political Declaration at the High-Level Meeting – “Time to deliver: accelerating our response to address noncommunicable diseases for the health and well-being of present and future generations” – broadens the scope of the commitment from the four major NCDs and four main risk factors (4x4 NCD Agenda\(^\text{10}\)) to now include air pollution and mental health and well-being (5x5 NCD Agenda) as well. The Region, however, is ahead of this movement as household air pollution has been identified as a major NCD risk factor in the Region since 2013. The 5x5 NCD Agenda will help to accelerate movement towards achieving a 25% relative reduction of premature mortality from NCDs by 2025, otherwise known as the 25x25 target.

Progress and results in 2018

Strengthening governance for NCD prevention and mental health

In 2018, the Regional Office provided technical guidance to Member States to establish high-level intersectoral coordination mechanisms and national action plans with well-defined targets that take into account global and regional NCD goals. With support from

\(^{10}\) Four major risks factors (tobacco, harmful use of alcohol, unhealthy diet and insufficient physical activity) and four major diseases (cardiovascular diseases, cancer, diabetes and chronic respiratory diseases)
WHO, all Member States have adopted a multisectoral action plan to address NCDs and have also established a national NCD governance body for multisectoral coordination.

The country capacity survey in 2017 found that all Member States reported common gaps in the implementation of national NCD strategies and plans. Such gaps included competency and skills to coordinate with other sectors; inadequate human and financial resources; divergent sectoral mandates; industry interference; political pressures; and lack of clarity of roles among stakeholders. It also found that the subnational NCD response is still largely limited to the health sector, partially due to the lack of effective functional NCD coordination mechanisms at local levels.

The Regional Office continues to support Member States to address these gaps, such as building up capacity of national NCD coordination units, and raising awareness and commitment across sectors. In this context, a regional meeting was organized for NCD programme managers and policy-makers in Jakarta, Indonesia, in late 2018.

The Regional Office also facilitated UNIATF missions to Thailand to strengthen the implementation of the country’s national NCD strategy. An MoU between the Regional Office and the Thai Health Promotion Foundation was also signed, which aims to strengthen national capacity to address commercial determinants of health as well as national food programmes to promote healthy diets. Meanwhile, the Regional Office worked closely with the WHO Bhutan Country Office to organize the first-ever Parliamentarians’ Forum on NCDs, which led to the adoption of an Outcome Document for a “Happy and Healthy Bhutan by 2030”.

To address mental health, policy-makers were sensitized by the Regional Office about the importance of developing mental health policies and strategies. This led to policy formulations and revisions in the realm of mental health in the Region. Bangladesh, India, Indonesia, Maldives and Timor-Leste developed, updated or revised policies, laws and legislations in line with the Convention on the Rights of Persons with Disabilities and other regional human rights policies. The Regional Office also supported Bangladesh in legislating its first Mental Health Act 2018 and to develop its National Mental Health Policy and a Mental Health Strategic Plan. Bhutan and Timor-Leste were supported to develop a Strategic Plan on Autism Spectrum Disorders and Neurodevelopmental Disorders (ASD&NDD), and the National Mental Health Strategy (2018–2022), respectively. In the area of suicide prevention, Bhutan and Sri Lanka were supported by the Regional Office to establish suicide registries and a hospital-based surveillance system.

**Addressing NCD risk factors**

1. **Tobacco**

The Region continues to have a high burden of tobacco use with about 237 million smokers. This poses a fundamental challenge to achieving the global target of a 30% reduction in
tobacco use by 2030. However, recent surveys are promising: in Bangladesh and India, for example, smoking and smokeless tobacco use among adults has declined.

In 2018, Member States made significant contributions to the Eighth Session of the WHO FCTC Conference of Parties (COP8) held in Geneva. India, as President of the COP Bureau, steered the proceedings successfully and Thailand led Committee A as Chair. The Pre-COP meeting, held in New Delhi, provided the platform to guide Member States to formulate a regional viewpoint on COP8 agenda items.

The Regional Office supported Member States to continue striving towards implementing evidence-based tobacco control policies and cost-effective “best buys” enshrined in the WHO FCTC, WHO MPOWER and the Dili Declaration.

In an important step forward, Thailand became the first country in Asia to enact plain packaging on tobacco packs. The Region is a shining example of the enforcement of health warnings on tobacco packs. Four Member States have been listed in the top five countries out of 118 countries with the highest coverage for graphic health warnings on tobacco packs. Timor-Leste and Nepal at 92.5% and 90% coverage, respectively, are global leaders.

Meanwhile, the Regional Office published a progress report on the implementation of the WHO MPOWER package to further guide countries in strengthening recommended policies and “best buys”. WHO also undertook an independent evaluation of tobacco control policies in all Member States, and the recommendations were shared with them.

A regional workshop was held to support Member States to strengthen initiatives around tobacco cessation programmes and to adopt cost-effective innovative approaches. Technical missions were carried out in Bangladesh, India and Indonesia to support tobacco tax reforms, while WHO provided further assistance to Maldives and Sri Lanka to develop reports on tobacco taxes.

With support from WHO and the Convention Secretariat, Myanmar, Nepal and Sri Lanka joined the FCTC 2030 Project. Needs assessment missions were conducted in Myanmar and Timor-Leste for additional support to implement the FCTC. The Regional Office, with support from the FCTC Global Knowledge Hub, also developed a report on regional mapping of tobacco industry interference, and conducted a national workshop on industry interference in Indonesia.

2. Harmful use of alcohol

To achieve the SDG target on controlling the harmful use of alcohol, WHO is supporting Member States to develop and implement country-specific strategies and action plans, in line with the South-East Asia Regional Action Plan to implement the Global Strategy to Reduce Harmful Use of Alcohol 2014–2025. To this end, an alcohol brief intervention has been included in the SEA Regional PEN package to promote the role of frontline health workforces in addressing the harms from alcohol.
Meanwhile, a rapid situation analysis in Bhutan was conducted by the Regional Office. The analysis examined existing resources as well as infrastructure for screening, management and prevention of suicide, and mental health and alcohol use.

The assessment found that a major problem in Bhutan was the availability, accessibility and affordability of home-brewed alcohol and industrial alcohol. The Regional Office is supporting Bhutan to define the right policy mix for reducing the harmful use of alcohol. In addition, Sri Lanka was supported to develop its national alcohol strategy and action plan, which includes community-based activities.

3. **Unhealthy diets and other nutrition-related issues**

Guided by the Strategic Action Plan to reduce the double burden of malnutrition in the South-East Asia Region (2016–2025), in 2018 WHO provided policy advocacy and technical support to initiate and implement nutrition programmes in Member States.

The Regional Office supported Bangladesh, Bhutan, Thailand and Timor-Leste to scale up the baby-friendly hospital initiative to promote breastfeeding. Sri Lanka and Thailand were also supported to implement the Code of Marketing of Breastmilk Substitutes.

On maternal nutrition, the regional offices for South-East Asia and the Western Pacific jointly organized a biregional symposium on “Double duty actions in the health...
system response to reduce maternal malnutrition” at the International Symposium on Understanding the Double Burden of Malnutrition for Effective Interventions.

In addition, the Regional Workshop on Nutrition Labelling to Promote Healthy Diets, attended by 10 Member States, aimed to advocate, inform and accelerate nutrition labelling of packaged foods. Bangladesh, India, Indonesia and Sri Lanka have strengthened their food labelling policies after the workshop. To support the nutrition of schoolgoing children, an informal network of four countries (Bangladesh, Maldives, Sri Lanka and Thailand) has been created to work together to improve school dietary environments and increase physical activity.

WHO continues to provide technical support to reduce population salt intake in Bangladesh, India, Indonesia, Sri Lanka and Thailand. Action was also initiated on supporting healthy diets through the informal food sector with an initial documentation of available information on this sector and its contribution to dietary risks.

The Regional Office published a key report in collaboration with FAO, WFP and UNICEF on progress towards eliminating hunger and malnutrition. This report is titled “Asia and the Pacific regional overview of food security and nutrition 2018 – accelerating progress towards the SDGs”.

‘Walk the talk’ at the Seventy-first World Health Assembly, Geneva
4. Insufficient physical activity

In 2018, Member States demonstrated regional solidarity and leadership through the adoption of the Global Action Plan on Physical Activity (GAPPA) at the Seventy-first World Health Assembly. The SEA Regional Status Report on Physical Activity was launched during the Seventy-first session of the Regional Committee in September, together with the re-launch of the Global Action Plan for Physical Activity. The “Be the change” initiative was again carried at the session of the Regional Committee, with morning exercise activities led by the delegations of India, Indonesia and Nepal, and energizer exercises during the morning and afternoon breaks. This included activities led by differently abled groups, and the event was themed “Health for All”.

5. Air pollution

WHO data released in 2018 highlighted the continuing significant challenges faced by Member States in the Region in controlling air pollution. Of the 7 million premature deaths each year attributed to air pollution, 34% occur in the SEA Region.

The second Regional Workshop on Air Quality and Health was hosted by the Chulabhorn Research Institute, Bangkok, in June to promote a deeper understanding and better use of available data, and to facilitate the formulation of relevant interventions and national targets, action plans and strategies.

The regional workshop also played an important role in assisting Member States to prepare for the first WHO Global Conference on Air Pollution and Health held in late 2018. All Member States participated actively in the conference and ministers and other high-level participants expressed new national commitments for action. Greater Malé in Maldives and Kathmandu, Nepal, became the first cities in the Region to join the global “Breathelife” communications campaign led by WHO and UNEP.

The double burden on health from both unacceptably high levels of household and ambient air pollution presents particular challenges for Member States in the Region. While 2018 saw progress in most countries with the incorporation of measures to address household air pollution in national NCD action plans and more cities measuring air quality levels, more needs to be done.

The Regional Office has continued to support Member States to implement WHO guidelines for indoor air quality and to support India, Nepal and Myanmar to conduct pilot work and develop the WHO Clean Household Energy Solutions Toolkit. In addition, a module to introduce the importance of household air pollution to primary health care workers was developed as part of the regional training modules on PEN interventions.

Strengthening the advice available to the public on minimizing personal exposures has also been a priority for the Regional Office. This was done through the dissemination...
of material on the website with active support given to country offices. A participatory research project was also initiated, in collaboration with Sri Ramachandra University in Chennai, India, and the University of Edinburgh, United Kingdom, to further investigate the influence of the workplace, residential characteristics and commuting on personal-level exposures to air pollution.

**Strengthening the health system response to NCDs and mental health**

In 2018, WHO made considerable efforts to strengthen NCD and mental health care as an integral part of the health-care system, both in normal and emergency situations. Guided by the Colombo Declaration on “Strengthening health systems to accelerate the delivery of NCD services at the primary health care level”, the Regional Office worked closely with Member States to integrate essential NCD services within health systems, particularly the frontline health services.

Essential medicines and diagnostics for hypertension and blood sugar screening along with individual-level health risk reduction services through tobacco and alcohol brief interventions are now increasingly available in primary health care settings in Member States.

The WHO PEN and healthy lifestyle intervention training modules for primary health care workers were developed and released at the Seventy-first session of the Regional Committee. Member States were oriented about the regional PEN training package at a three-day meeting in October in Dhaka, and consensus was sought on contextualizing and scaling up essential NCD services at the primary health care level.

The scope of the SEA Region PEN training modules have been expanded from conventional NCDs to include strengthening of palliative care and addressing common comorbidities of NCDs and mental disorders, while also covering selective environmental risks.

Meanwhile, in collaboration with Resolve to Save Lives and other partners, WHO organized an informal meeting of stakeholders on scaling up cardiovascular disease management with participants from Bangladesh, India, Nepal, Sri Lanka, Thailand and Timor-Leste.

For cancer prevention and control, WHO provided technical support to Member States, with particular focus on early diagnosis of cervical, breast and oral cancers. The Regional Office also participated in technical missions to DPR Korea, Myanmar and Maldives on cancer control.

To promote access to mental health care, the regional workshop to enhance country capacity for the adaptation and implementation of the mental health gap action programme (mhGAP) version 2.0 was convened in Jakarta, Indonesia. The workshop provided a multidisciplinary and multistakeholder platform to share good practices and
experiences, and to develop a roadmap for each country on how to adapt and accelerate the implementation of mhGAP. The interactive electronic or internet-based (e-) and mobile (m) versions of mhGAP-IG were also introduced.

NCDs and mental health care are often neglected in the humanitarian and health emergency context. In response, a regional document on the integration of NCD care in emergency response and preparedness was launched at the Seventy-first session of the Regional Committee and shared with Member States. The Regional Office contributed to the provision of NCD care in Cox’s Bazar, Bangladesh. In the area of mental health and psychosocial support (MHPSS), WHO conducted a regional capacity-building workshop on mental health in emergencies in Nepal. The objectives of the workshop were to enhance the capacity of the health and emergency management system for providing MHPSS and to introduce MHPSS tools. This workshop was the second in a series as part of WHO’s efforts to incorporate MHPSS into emergencies and disaster risk reduction strategies through a multisectoral collaborative framework. WHO will continue to work with Member States to ensure that MHPSS plans are embedded within a country’s disaster and crisis response programme.

**Strengthening NCD surveillance and information systems**

In 2018, the Regional Office continued to support the implementation of nationwide NCD-STEPs surveys in Member States. The STEPs survey was implemented in Bangladesh, while initial preparations were finalized in Nepal and Sri Lanka.

In partnership with the US CDC and Center for Disease Control Foundation, WHO provided support to generate data to monitor the tobacco epidemic both at the national and regional levels among youth and adults. This was done through the Global Adult and Youth Tobacco surveys (GATS and GYTS).

India and Bangladesh were supported to finalize their report for the second round of the GATS survey, while technical assistance was provided to Bhutan, India, Indonesia, Maldives and Timor-Leste to prepare for the next round of GYTS in 2019.

In addition, the Regional Office facilitated Member States to track their own progress on NCDs through the Global Country Capacity Survey for NCD Prevention and Control.

The launch of the report on *National capacity for prevention and control of noncommunicable diseases in the South-East Asia Region* enabled Member States to assess their progress in areas of public health infrastructure, multisectoral coordination mechanisms, development of policies and action plans, and health system capacity for detection, treatment and care for NCDs.
Challenges, opportunities and next steps

The high-level political momentum to prevent and control NCDs is evident and growing. The third High-Level Meeting on NCDs, the high-level independent NCD Commission and the WHO GPW13 provide unique opportunities, clear policy directions and additional technical tools for NCD prevention and control in the SEA Region.

Expanding the NCD umbrella to cover air pollution and mental health provides a new landscape wherein to work on those co-morbidities across relevant programmes, especially at the national level.

With a clear “best buys” list of interventions, the “know–do” gap is the most significant challenge for this Flagship Priority. Underfunding, a lack of human resources and inadequate action-oriented collaboration across sectors are key challenges. In addition, collective capacity to implement national plans, as well as to address commercial determinants of health, play a major part in the “implementation deficit” situation.

The Regional Office is continuing to streamline and tailor support to overcome these challenges, specifically in strengthening national capacity to implement national action plans and monitor progress. Going forward, the emphasis on collaboration across teams, departments, offices and agencies will further strengthen the efforts of WHO and other development partners to assist endeavours by Member States at the national level.
Flagship 3: The unfinished agenda of the MDGs: ending preventable maternal, newborn and child deaths with a focus on neonatal deaths

Introduction

Progress towards ending preventable maternal, child and neonatal mortality in the Region continued in 2018. The Regional Office worked closely and tirelessly with Member States to expand equitable coverage and improve the quality of care within the framework of universal health care.

The Regional Meeting of Parliamentarians in July kept the health of women, children and adolescents at the centre of UHC, with a call to action for commitment and accountability to improve their health and well-being. Throughout the year, the Regional Office worked with Member States to implement the recommendations of the South-East Asia Regional Technical Advisory Group on Women’s and Children’s Health (SEAR-TAG).

Meanwhile, neonatal and child mortality in the Region continued to decline. According to the 2018 Child Mortality Report 11 of the UN Inter-Agency Group for Mortality Estimation, under-five mortality has declined by 70% since 1990. During the same period, neonatal mortality declined by 60%.

While new global estimates of maternal mortality are expected in 2019, India reported an unprecedented reduction in its maternal mortality ratio in 2018 (national estimated maternal mortality ratio of 130 per 100 000 live births), potentially bringing the Region below its 2015 MDG target 12 (Table 1).

The Regional Office worked with Member States to set their national targets in line with the SDGs and the “Ending Preventable Maternal Mortality (EPMM)” goals and assessed them as per their obstetric transition phase to provide context-specific guidance.

In line with the SDGs Framework and Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030, the Regional Office’s work extends beyond the unfinished survival agenda of maternal, neonatal and child survival. Going forward, it will be important to keep the emphasis on high and equitable coverage along with a high quality of skilled care at birth, and on care of obstetric and newborn complications, to ensure accelerated reduction in mortality.

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11 UNIGME Child mortality report 2018
12 In 2019, the updated estimates by the United Nations Maternal Mortality Estimation Inter-Agency Group (MMIEG) are expected to be released for all 11 SEA Region countries. India, MMR release as per the Sample Registration System (SRS) 2016 report is expected to be factored in and is the basis of the assumption.
Progress and results in 2018

Building a surveillance system

Although stillbirths are similar in incidence as neonatal deaths, they have not received adequate attention. To address this, the Regional Office supported the development of hospital-based surveillance for stillbirths within the ongoing SEAR-Newborn and Birth Defects Database (NBBD) (a joint initiative between the Regional Office and the US CDC). Following the initial implementation in India, the stillbirth surveillance form has been updated to make it consistent with the ICD-PM (WHO application of ICD-10 to deaths during the perinatal period) classification and disseminated to other Member States in the Region.

Strengthening maternal and reproductive health

The Regional Office oriented Member States on the new WHO guidelines for antenatal care and intrapartum care at the regional meeting in 2018, and encouraged Member States to update their national guidelines. Bhutan, Maldives, Myanmar and Thailand were supported to adapt to the new positive pregnancy experience guidelines, which stipulate eight ANC visits instead of four.

Table 1: Status of maternal, newborn and child mortality and stillbirths in the SEA Region, 2018

<table>
<thead>
<tr>
<th>Source</th>
<th>Maternal mortality ratio (per 100 000 live births)</th>
<th>Stillbirth rate (deaths per 1000 births)</th>
<th>Neonatal mortality rate (deaths per 1000 live births)</th>
<th>Under-five mortality rate (deaths per 1000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data year</td>
<td>2015</td>
<td>2015</td>
<td>2017</td>
<td>2017</td>
</tr>
<tr>
<td>Source</td>
<td>MMIEG 2015</td>
<td>Lancet 2015</td>
<td>UNIGME 2018</td>
<td>UNIGME 2018</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>176</td>
<td>25</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Bhutan</td>
<td>148</td>
<td>16</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>82</td>
<td>14</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>India</td>
<td>174 (130 SRS)</td>
<td>23</td>
<td>24</td>
<td>39</td>
</tr>
<tr>
<td>Indonesia</td>
<td>126</td>
<td>13</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Maldives</td>
<td>68</td>
<td>8</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Myanmar</td>
<td>178</td>
<td>20</td>
<td>24</td>
<td>49</td>
</tr>
<tr>
<td>Nepal</td>
<td>258</td>
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<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>30</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Thailand</td>
<td>20</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>215</td>
<td>18</td>
<td>21</td>
<td>48</td>
</tr>
<tr>
<td>SEA Region</td>
<td>164</td>
<td>NA</td>
<td>21*</td>
<td>36</td>
</tr>
</tbody>
</table>

- Achieved SDG/EPMM/ENAP/Global Strategy Target in 2018
- Expected to achieve the SDG/EPMM/ENAP/Global Strategy Target by 2030
- Need to increase its current efforts and attain faster annual reduction (ARR)

* According to Levels and trends in child mortality 2018, p. 41
All 11 Member States were supported by the Regional Office to undertake the WHO RMNCAH Policy Survey. An analysis of the survey identified gaps and needs, which ultimately guided the SEAR-TAG meeting on maternal health and stillbirths. Moreover, the Regional Office prepared country factsheets for RMNCAH, including recent mortality and coverage data, and analysed trends over time to enable Member States to consider strategies for expanding coverage levels with a focus on equity.

Meanwhile, cervical cancer elimination was announced as a Global Flagship Priority by the Director-General. In 2018, the SEA Region became the first region to conduct a training of trainers using the regional training package to expand initiatives in the early detection and treatment of cervical cancer in 10 Member States.

Systematic analyses of a maternal death and contributing factors can help to identify health systems barriers and inspire local solutions to prevent such deaths. In 2018, WHO worked with Member States to progressively expand maternal death surveillance and response (MDSR) programmes. Member States were also supported to adopt national guidelines, provide training of MDSR at the central, zonal and district levels, and to establish zonal- and district-level MDSR committees.

**Refocusing family planning**

To refocus family planning (FP) as a strategy for maternal and neonatal survival, WHO undertook a country-wise assessment of laws and policies on FP, trends on FP coverage and projections on growth in contraceptive users, and its subsequent impact on maternal deaths across the Region. The assessment found that increased investments are urgently needed to meet the demand for contraception to progress towards the achievement of universal access to sexual and reproductive health and rights (SRHR).

The Regional Office supported Member States to identify national total fertility targets and assisted Bhutan, Sri Lanka, Nepal, Indonesia and Maldives to revise their national guidelines on FP. Indonesia was also supported to adapt the WHO medical eligibility criteria (MEC) wheel, which establishes benchmarks on who is eligible for different contraceptive methods, into the Bahasa language. Indonesia also developed a mobile app for the MEC wheel for health-care workers.

Given that 6 million women in the Region are estimated to suffer complications from unsafe abortion each year, a regional proposal on safe abortion care (SAC) and post-abortion care (PAC) as an integral component of UHC for SRHR was developed. Nepal and India were supported to prepare their own country proposals, which were used to mobilize a four-year grant.

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13 WHO RMNCAH Policy Survey 2018
Strengthening newborn and child health care

To strengthen national programmes for newborn and child health, the Improving Newborn and Child Health: A Strategic Framework (2018–2022) was released at the Regional Committee session in September. The Framework, prepared in collaboration with H6 partners, identifies the need to work beyond the survival agenda for the “thrive” and “transform” objectives of the Global Strategy, including childhood malnutrition and stunting, and the prevention of child abuse and violence.

About 41% of newborn mortality is attributed to preterm birth complications. An intercountry meeting was held among high-priority Member States (Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste) to provide the latest research evidence and strategies for large-scale implementation of “kangaroo” mother care to improve survival of preterm and low-birth-weight babies. Country delegates and partners adopted the “zero separation policy” to ensure that mothers and their babies are always kept together even in the setting of special newborn care units (Fig. 5).

Fig. 5: Scaling up kangaroo mother care to improve survival of preterm babies

Quality improvement of health-care services

Given the importance of good-quality health-care services in saving the lives of mothers and newborns, the Regional Office, in collaboration with partners, has been working with Member States to implement the regional model of quality improvement. The POCQI methodology, which strives to improve the quality of care for mothers and newborns at the time of birth in health facilities, has been introduced in nine Member States through regional and national training workshops. More than 200 hospitals in these Member States are practising a quality improvement approach in labour rooms and special newborn care units.

In 2018, the POCQI coaching guide was prepared to support on-the-job supervision of health-care teams to build their capacity of continuous quality improvement. The POCQI
programme management guide was also prepared to support the implementation of QI programmes within district and provincial health systems. The POCQI model, which was developed by the Regional Office, was introduced into the Global Quality Equity Dignity (QED) Network to enable other Regions to benefit from it.

**Prevention and control of birth defects**

The Regional Office, in collaboration with the US CDC, continued to support a live, online database for newborns, birth defects and stillbirths (SEAR-NBBD) in Member States. A regional meeting was held to review the progress in surveillance systems for birth defects and the prevention plans of Member States with the goal of strengthening good-quality surveillance.

**Strengthening adolescent health services**

To strengthen the implementation of national adolescent health programmes, the Strategic Guidance on Accelerating Actions for Adolescent Health in the South-East Asia Region (2018–2022), developed in collaboration with H6 partners, was launched at the Regional Committee session. The guidance, which is in line with the global Accelerated Action for Health of Adolescents (AA-HA!), provides direction to Member States to build upon existing national adolescent health programmes.

In 2018, the Regional Office supported India and Sri Lanka to strengthen adolescent health services and their implementation. To this end, a learning model for low-performing districts was developed in India, which plays to local strengths.

Going forward, a rapid assessment of the implementation status of national adolescent health and school health programmes will be commissioned in 2019.

**Challenges, opportunities and next steps**

Member States have achieved significant reductions in maternal, newborn and child mortality over the past decade. This Regional Flagship Priority has also provided much-needed impetus to harmonize accelerated actions in Member States.

To sustain the gains and further accelerate mortality reduction, a rapid expansion of evidence-based life-saving interventions, especially to reach unreached populations, is required. Member States need to expand health service delivery infrastructure and use innovative approaches in underserved areas to overcome geographical, financial and social barriers.

They also need an adequate number of skilled health workers, such as midwives, who can provide good-quality care at the time of birth, in addition to enhanced financing for RMNCAH and financial protection mechanisms.
WHO and partners will continue to advocate for mobilizing domestic health spending and to ensure adequate health infrastructure, including skilled health workforce towards UHC for RMNCAH services. Member States have committed to implementing the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) and to take actions to address the changing epidemiology (emerging causes of deaths like birth defects, injuries in children, and indirect causes of maternal mortality), and emerging priorities including universal access to sexual and reproductive health, stillbirths and early childhood development.
**Flagship 4: Universal health coverage, with a focus on human resources for health and access to medicines**

**Introduction**

Universal health coverage (UHC) is about all people getting the health care they need, without suffering financial hardship. In 2018, global events helped keep the political spotlight on UHC in the Region, including on World Health Day, which had UHC as its theme.\(^{14}\)

World Health Day was marked by multiple national events in the Region. The Regional Director called for UHC to become “business unusual” in the SEA Region, with a need for better regional data and evidence.\(^{15}\)

In October 2018, 40 years after the Alma-Ata Declaration, there was renewed commitment to primary health care expressed by global leaders at the Global Conference on Primary Health Care in Astana, Kazakhstan. The Astana Declaration positions PHC as the cornerstone to achieving UHC.\(^{16}\)

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\(^{15}\) Khetrapal Singh P, Travis P. Universal health coverage in the World Health Organization South-East Asia Region: how can we make it “business unusual”, SEAJPH. April 2018, 7 (1).

\(^{16}\) Declaration of Astana on Primary Health Care, 2018.
The Regional Office’s paper for the Conference in Astana – “Primary Health Care at forty: Reflections from South-East Asia” – explored linkages, past progress and future transitions needed to respond to changing health needs in today’s Region.17

Looking ahead, UHC is firmly embedded in WHO’s future work. One of three targets of the WHO GPW13 is to have 1 billion more people benefiting from UHC by 2024.

Progress and results in 2018

Analysis of service coverage and financial protection

For the first time, Member States’ UHC status for both the SDG UHC indicators 3.8.1 and 3.8.2 was reported using agreed methods and the most recent national data available.18 Fig. 6 shows that three Member States – in the top right quadrant of the graphic – have median levels of service coverage and financial protection above the global median.

Fig. 6: Where are we now on UHC? Health service coverage and financial protection in the SEA Region

However, a major challenge is that the most recent data are not that recent: some financial protection data are eight years old. The Seventy-first session of the Regional

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Committee called for more frequent data collection on financial protection and greater country capacity to do the analysis – these are priorities for the Regional Office in 2019.

**Improving access to frontline services**

In 2018, the Regional Office projected the likely levels of essential health service coverage in 2030, based on rates of progress in service coverage since 2010. The projections show that only four Member States are likely to reach more than 80% coverage, unless there is significant acceleration.

To this end, the Regional Office in 2019 will compile national data on the use of health services along with trends over time, to establish the extent to which essential health services are being delivered at the appropriate level of care.

*Fig. 7: Looking forward: prospects for reaching UHC by 2030 in the SEA Region, based on current trends*
Increasing the health workforce

Health services cannot be delivered without health workers. The commitment to a “Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024” is beginning to show results, according to the second review of progress in 2018.\(^\text{19}\)

But while eight countries now exceed the original WHO HRH density threshold for the MDGs, nine are below the newer WHO HRH density threshold for achieving SDG3.

As a result, more innovative strategies are needed, including reinforcing the links between HRH strategies on rural retention and transformative education, and service delivery reforms, especially of frontline services.

The 2018 review concluded that in order to accelerate progress on UHC, more attention to frontline health workers is needed to support their performance as well as accurately count their numbers. This will help refocus attention on increasing the utilization of frontline services, where most essential health services can be safely delivered.\(^\text{20}\) All of this needs good HRH governance and better documentation of experience in implementing strategic priorities.

Responses to governance questions in the 2018 review are provided in the Fig. 8.

**Fig. 8: HRH governance related questions in the 2018 survey, and responses**

<table>
<thead>
<tr>
<th>Existence of institutional mechanisms or bodies to coordinate an intersectoral health workforce agenda</th>
<th>BAN</th>
<th>BHU</th>
<th>DPRK</th>
<th>IND</th>
<th>INO</th>
<th>MAV</th>
<th>MMR</th>
<th>NEP</th>
<th>SRL</th>
<th>THA</th>
<th>TLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Partly</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Existence of a health workforce unit in the Ministry of Health responsible for developing and monitoring policies and plans on health workforce |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | No | Partly |

| Existence of mechanisms and models for health workforce planning |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | No | Partly |

*Source: Country data reported to WHO Regional Office, 2018*

During 2018, both Myanmar and Thailand explored the creation of HRH units. Efforts were made by all countries to improve regional knowledge on transformative education and rural retention. The findings from multicountry case studies on rural retention will be


available in 2019 and so will the results of the surveys for the Global Code of Practice on the International Recruitment of Health Personnel, in which nine Member States participated.

**Regional collaboration on access to essential medicines**

The Delhi Declaration on Improving Access to Essential Medical Products in the Region and Beyond was endorsed by all ministers of health at the Seventy-first session of the Regional Committee. The Declaration identifies specific actions to improve the financing, procurement, pricing and appropriate use of medical products, supported by competent regulatory authorities and information systems. It reinforces regional collaboration in procurement, regulation and price transparency. The Regional Office’s priorities are aligned with those in the new global roadmap on access to medicines and vaccines.

**Improving quality of medical products**

SEARN promotes collaboration, convergence and reliance in medical product regulation to improve quality. In 2018, SEARN launched its information-sharing platform (see Fig. 9). Six national regulatory authorities completed self-assessment exercises using the WHO global benchmarking tool and are now developing institutional development plans.

*Fig. 9: SEARN information-sharing platform*

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Improving access to medical products

A first step in collective procurement within the Region was taken in 2018 as seven Member States joined the initiative for the Coordinated Procurement of Antidotes (iCAPS).23 Orders have now been placed by four Member States.

An analysis of financial protection in eight Member States, published in the WHO Bulletin, found that spending on medicines was the main component of OOP spending in all but one of the Member States analysed. This is not a new finding, but the fact that OOP expenditure on medicine remains high, despite national policies being introduced to make medicines more available, suggests that further actions are needed to support progress towards UHC.24

Strengthening monitoring and accountability for results

A key commitment in the Sustainable Development Agenda is to “leave no one behind”. The 2018 regional report on progress on UHC and SDGs drew attention to what is known about trends in inequalities in essential service coverage from limited available data. The report found that urban–rural inequalities in sanitation coverage had narrowed in around half the Member States between 2005 and 2015, but not in the others. It also found that inequalities in antenatal care coverage by income group among the six Member States with data had narrowed in most to some degree. Much more attention is needed to track inequalities, and encouragingly, this has become a priority in many Member States as well as being a focus for future WHO work.

Challenges, opportunities and next steps

The UHC Flagship, with its focus on strengthening the health workforce and access to medicines, has helped to keep the political spotlight on these two regional challenges. To

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23 Initiative for Coordinated Antidotes Procurement in the South-East Asia Region (http://icaps.strikingly.com/, accessed on 20 May 2019).

sustain progress, attention on improving data on both health workers and medicines will continue.

In 2019, key efforts will be made to measure the availability and price of essential medicines in frontline facilities, using the new WHO application. This has begun in Bangladesh and other Member States will follow. Increased attention will also be given to finding better ways to count frontline health workers, and to support HRH governance, including through the development of HRH units that can provide overall strategic direction for health workforce development. Moreover, there will also be intensified actions on ways to improve the use and performance of frontline – or primary care – facilities. There is an increasingly urgent need for health services to shift from delivering mostly episodic care towards continuing care, and from considering primary-level care in isolation to addressing frontline and hospital services together.

The “digital revolution” means there are new opportunities for innovation using new technologies, along with developing fresh approaches for community engagement. There is also a need to accelerate improvements in the quality of care, which was emphasized in a recent *Lancet* study. This found that in low- and middle-income countries, poor-quality care is now a bigger barrier to reducing mortality than insufficient access.²⁵

The High-Level Meeting on UHC at the UN General Assembly in September 2019 will be a critical event to increase engagement levels with other sectors and stakeholders in the push for UHC.

*Launch of the ‘Life TV’ Channel, a dedicated health channel for the Sri Lankan people, on the occasion of a Global Event on World Health Day 2018, Colombo*

Flagship 5: Building national capacity for preventing and combating antimicrobial resistance

Introduction

Antimicrobial resistance continues to be on the global agenda at the highest level through the adoption of several World Health Assembly resolutions and the UN resolution at the UN General Assembly in 2016. All 11 Member States of the SEA Region have fulfilled their commitment to have a national action plan (NAP) on AMR in place by 2017 that is aligned with the Global Action Plan (GAP). By the end of 2018, 112 countries globally had finalized their NAPs.

Fig. 10: Percentage of countries who have finalized NAP

The First National Forum on AMR on the occasion of Prince Mahidol Award Ceremony 2018, Bangkok
However, despite progress in action and planning, there is a shortage of national estimates on the burden of AMR in terms of morbidity, mortality, economics and its societal effects in the Region. Moreover, the extent of transmission of AMR from and to the environment, and from the animal sector to humans, is still not adequately measured and understood.

Progress and results in 2018

Implementing and monitoring of national action plans on AMR

In 2018, two main activities relating to the implementation and monitoring of NAPs of Member States on AMR were completed.

In July, back-to-back intercountry meetings to review the implementation of AMR NAPs were held in Bangkok, Thailand. The meetings were attended by national stakeholders from sectors, including human health, agriculture and the environment from all 11 Member States. The meetings were facilitated by five departments of the Regional Office, in addition to WHO headquarters and country offices as well as by FAO, OIE and UNEP.

These ground-breaking meetings took a One Health approach to AMR and sought to review and update the NAPs. In 2019, the Regional Office will help Member States to update and implement their NAPs.

The second activity for monitoring NAP implementation is a self-assessment questionnaire for Member States that was developed by WHO, FAO and OIE. Fig. 11 shows that there was 100% compliance by all Member States in the Region for 2016–2017 and 2017–2018.

Fig. 11: Percentage of AMR self-assessment responses, 2016–2017 and 2017–2018
Meanwhile, a separate study was carried out to assess how closely the NAPs of the 11 Member States are aligned with the Global Action Plan on AMR and its five strategic objectives. This will assist the Regional Office in refining its regional strategies to meet the needs of GAP while also accounting for unique regional contexts.

The 2017–2018 AMR self-assessment survey shows the results of training activities in the Region as below:

(a) Training in the human health sector:
- One Member State has continuing professional development (CPD) opportunities nationwide.
- Five Member States have covered AMR in pre-service training and/or specific courses for health workers.
- Three Member States have only ad-hoc training courses.
- Two Member States have not yet conducted any training activity.

(b) Training in the veterinary sector:
- Three Member States have CPD opportunities available.
- One Member State has covered AMR in some pre-service training.

_Laying the foundation stone for the new buildings of the National Institute of Malaria Research, New Delhi_
Four Member States have only ad-hoc training courses.

Three Member States have not yet conducted any training activity.

(c) Training in the farming sector:

Six Member States have only ad-hoc training courses.

Five Member States have not yet conducted any training activity.

Raising awareness and understanding of AMR

The Regional Office organized the World Antibiotic Awareness Week (WAAW) 2018 from 12 to 18 November 2018. WHO launched the new WAAW 2018 website (https://www.who.int/campaigns/world-antibiotic-awareness-week/world-antibiotic-awareness-week-2018) and highlighted the numerous advocacy materials available along with the events planned to increase awareness of antibiotic resistance. The website served as an important resource for Member States in planning and organizing national-level WAAW activities.

Ten out of 11 Member States participated in WAAW as indicated in the WAAW interactive map prepared by WHO headquarters. The map shows the Region’s participation in comparison with Member States in other regions (a total of 75 out of 194 countries).

WAAW awareness activities, which were conducted by government agencies, health institutions, other stakeholders and WHO country offices, included the display of IEC material, technical workshops, social media coverage, media coverage, talk shows and lectures on AMR for medical and health students at universities. In addition, the Regional Office was also actively involved in the planning and delivery of WHO’s input into the Regional TripartitePlus Coordination Team’s WAAW awareness-raising activities in Bangkok, Thailand (Fig. 12).

Fig. 12: World Antibiotic Awareness Week (WAAW) activities in 2018

As of 15 November 2018
Strengthening AMR surveillance

The Regional Office has continued to support Member States to centralize national AMR data from different sectors using the WHO-led GLASS. This enables Member States to share information on their national AMR trends and also standardizes AMR surveillance globally.

By the end of 2018, nine out of 11 Member States in the Region had enrolled in GLASS. The chart below shows that the Region’s Member States have the highest participation in GLASS compared with other WHO Regions. For GLASS enrolment, the global target was 30% by 2018, and nine of the regions 11 Member States are enrolled.

*Fig. 13: Percentage of Member States that have enrolled for GLASS, 2018*

In another key step, Member States were also supported to build laboratory capacity in the detection and characterization (including quality and biosafety in laboratories) of AMR in pathogens of human importance. To this end, national reference laboratory assessments were conducted in Bangladesh, Bhutan, Nepal and Maldives.

The Regional AMR External Quality Assurance Programme (EQAP) was continued in 2018 with the help of a WHO collaborating centre in Thailand.

WHO is also implementing an Advisory Group for Integrated Surveillance of Antimicrobial Resistance (AGISAR) – managed extended-spectrum beta-lactamase (ESBL) *E. coli* (EC) tricycle project in pilot countries. ESBL-EC are diverse and universal microorganisms that cross barriers between humans, animals and the environment, and are responsible for high morbidity and mortality in humans. The project seeks to establish an integrated surveillance system to monitor ESBL-producing *E. coli* in humans, food and the environment, and to develop a simple and standardized methodology to isolate and monitor ESBL-producing *E. coli*. In 2018, the Regional Office worked with India, Indonesia and Nepal to begin studies to identify determinants of ESBL resistance genes, adding an
epidemiological component (Epi-X) to compare ESBL-\textit{E. coli} with ESBL-free \textit{E. coli}, and to try and determine plausible transmission pathways.

**Monitoring the use of antibiotic consumption in humans**

In 2018, the Regional Office conducted retrospective analyses on the extent and patterns of antibiotic use in humans in Bangladesh, India, Indonesia, Sri Lanka and Thailand. WHO also provided technical support to these Member States to analyse AMR data as a first step towards establishing national antimicrobial monitoring consumption systems. In addition, these Member States were introduced to a recently developed WHO methodology for monitoring antimicrobial consumption in humans, along with technical guidelines.

Some activities carried out during 2018 on antibiotic consumption include the following:

- Following the training provided in all 11 Member States on the use of the WHO methodology to monitor antimicrobial consumption in 2017, three Member States are developing their national consumption systems. One Member State completed the first antimicrobial consumption report in late 2018 following an integrated data collection operation covering both animal and human health.

- In May 2018, one Member State adopted the Access/Watch/Reserve (AWaRe) classification in its national medicines list, with other Member States due to follow. Member States are also developing policies to implement antimicrobial stewardship programmes.

- The AWaRE classification was used within the One Health approach in one Member State in the Region to revise national regulations and rules on the use of antibiotics for human and animal health, and to update the existing ban on antibiotic use for growth promotion in animals.

- The first integrated national survey by Thailand on antimicrobial consumption was completed in the last quarter of 2018. In addition, Bangladesh undertook major regulatory reforms to control and prevent the misuse of critical antibiotics for humans and in the animal sectors.

The Regional Office is reviewing regulations and regulators for AMR with the aim of sharing best practices in regulation as part of the development of the SEARN. In future, an analysis of the gaps between regulations and compliance monitoring and enforcement will be carried out.

**Reducing infections and the need for consumption of antimicrobials**

In 2018, the typhoid conjugate vaccine project was initiated in India. As part of the project, surveillance for enteric fever was launched in five hospitals and at one laboratory in Mumbai,
India. Preliminary information on AMR from the project (as of 30 September 2018) found that nearly 40% of typhi isolates showed reduced susceptibility or frank resistance to ciprofloxacin but that no isolate showed resistance to ceftriaxone – an important parameter to monitor given the large outbreak of extensively drug-resistant (XDR) typhoid in Pakistan.

Environmental control is critical for preventing the spread of AMR. Over the past decade, and through cross-programmatic cooperation, the Regional Office has supported the improvement of hygiene in health-care facilities in 10 of the 11 Member States via recurrent training and technical advisories. Seven Member States have a dedicated policy on biomedical waste management, which includes the provision of WASH services.

Bhutan, India, Indonesia, Maldives, Myanmar, Nepal and Sri Lanka now have vaccination programmes for their health workforce, some of which are mandatory. In collaboration with UNICEF, the Regional Office has started to implement the WASHFIT instrument, a technical assessment tool that follows a risk-based management approach to reduce environmental contamination with residues and resistant bacteria – potential drivers of AMR.

**Strengthening regional coordination for AMR**

The year 2018 was significant for strengthening global and regional coordination mechanisms required to combat AMR. The Regional Office is represented in the FAO Regional Office in Bangkok. Along with the subregional office of OIE and the Regional Office of UNEP – both also located in Bangkok – it is increasingly promoting intersectoral coordination at the country level to control AMR. These offices are in the process of developing a Joint Regional Workplan on AMR and are seeking to institutionalize the One Health approach in Member States. This Regional Tripartite Plus Coordination Team is in line with the aims of the United Nations Interagency Coordination Group (IACG) and with the definition proposed by the Global Tripartite Secretariat.

Meanwhile, the Global Tripartite for One Health reaffirmed their commitment to working together on AMR through a revised MoU, which welcomed the inclusion of important new partners, such as UNEP, to strengthen the coordinated multisectoral response that is required to address AMR. The Tripartite in the SEA Region has already been working closely with UNEP on a variety of awareness-raising and review activities. Collaboration on research and surveillance is next on the agenda.

**AMR-related research**

As a key step to expanding AMR-related research, a study is being carried out to understand the presence of antibiotic residues and resistant bacteria in wastewater and in fish and vegetables grown with wastewater in the East Kolkata wetlands of India and their risks to human health. Meanwhile, the Regional Office is also in the process of developing a pilot project with one Member State to carry out a one-off sampling of antibiotic residues
and AMR at critical control points in the environment from antibiotic manufacture, use and disposal in the human and animal sectors. This includes the design of a sampling procedure and the use of information in a multisectoral risk assessment and management framework for AMR, which is being developed in order to help countries prioritize AMR interventions and identify data gaps. This work is being done in conjunction with the joint risk assessment work being carried out by the Tripartite.

Challenges, opportunities and next steps

Numerous challenges remain to controlling AMR in the Region. These include facilitating a multisectoral approach and high-level governance under One Health, a lack of involvement by the agricultural and environmental health sectors in NAPs, limited human and financial resources, lack of prioritization and poor regulation, and large knowledge gaps. To this end, there is a need for strong multisectoral collaboration, a need to improve AMR awareness and to strengthen surveillance and research.

Drawing on the lessons learned and experiences gained in implementing AMR control activities in Member States in 2018, the Regional Office will focus on the following activities in 2019:

- to support Member States to accelerate implementation of their NAPs for combating AMR;
- to find a better way to support Member States to prioritize national laboratory systems to incorporate an AMR laboratory strategy within the national health laboratory strategies. Implementing NAPs will also need to include infection prevention and control in an integrated manner. To this end, close monitoring of surveillance systems and the dissemination of information for action will be required;
- to strengthen linkages at the country level between plans for combating AMR and plans for UHC, health security and multisectoral action;
- to provide technical support to the South-East Asia Regulators’ Network for strengthening the ability of regulatory authorities to regulate and monitor the use of antibiotics; and
- to continue to strengthen the One Health Tripartite partnership between the regional offices of FAO, OIE, WHO and UNEP. This will include harmonizing methods of surveillance of antimicrobial use and AMR between the human health, animal health and environment sectors.
Flagship 6: Scaling up capacity development in emergency risk management in Member States

Introduction

The SEA Region is highly vulnerable to different types of emergencies and disasters, including from natural hazards such as floods, cyclones, earthquakes, heat waves and drought, in addition to human-induced hazards and outbreaks of infectious diseases and emerging and re-emerging diseases. Some of the major health emergencies that occurred in 2018 in the Region, along with the response from WHO, are listed below:

Table 2. Major health emergencies in the WHO SEA Region, 2018

<table>
<thead>
<tr>
<th>Event/emergency</th>
<th>Country</th>
<th>Status/grade</th>
<th>Morbidity/mortality</th>
<th>Response from WHO Regional Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rohingya crisis</td>
<td>Cox’s Bazar, Bangladesh</td>
<td>Protracted 3</td>
<td>911 000 Rohingya refugees (215,796 families)</td>
<td>1.24 million people targeted for health assistance</td>
</tr>
<tr>
<td>Myanmar Rakhine conflict</td>
<td>Myanmar</td>
<td>Protracted 2</td>
<td></td>
<td>SEARHEF support</td>
</tr>
<tr>
<td>Floods after Cyclone Soulik</td>
<td>DPR Korea</td>
<td>Ungraded</td>
<td>76 deaths, &gt;10,000 displaced, 75 missing</td>
<td>SEARHEF support</td>
</tr>
<tr>
<td>Kerala floods</td>
<td>India</td>
<td>Ungraded</td>
<td>486 deaths, 85,000 displaced</td>
<td>WCO* deployment; support for post-disaster needs assessment</td>
</tr>
<tr>
<td>Nipah virus attack</td>
<td>India</td>
<td>Ungraded</td>
<td>21 deaths and 23 cases</td>
<td>WCO and RO*: support for documentation</td>
</tr>
<tr>
<td>Sulawesi earthquake</td>
<td>Indonesia</td>
<td>Grade 1</td>
<td>2,685 deaths, 2,537 severely injured, 173,000 displaced</td>
<td>WCO and RO deployment, CERF support</td>
</tr>
<tr>
<td>Lombok earthquake</td>
<td>Indonesia</td>
<td>Ungraded</td>
<td>90 deaths, 200 injured</td>
<td>WCO deployment</td>
</tr>
<tr>
<td>Sunda Strait tsunami</td>
<td>Indonesia</td>
<td>Ungraded</td>
<td></td>
<td>WCO deployment</td>
</tr>
</tbody>
</table>

*WCO: WHO Country Office; RO: Regional Office

Progress and results in 2018

The Regional Director identified “Scaling up capacity development in emergency risk management” as one of the Regional Flagship Priorities in 2014. The Global WHO Health Emergencies Programme (WHE), created in 2016, was successfully rolled out in early 2017. Both developments have further accelerated capacity development in this area in all 11 Member States of the Region throughout 2018.
The five key areas of work and expected outcomes of this Flagship Programme are as follows:

1. Advocate: increase awareness among partners on health issues and the role of the health sector in emergencies.

2. Manage: improve information and knowledge related to emergency risk management in the health sector for all types of hazards.

3. Support: strengthen the capacities of Member States to prevent, prepare for, respond to and recover from emergencies across all hazards as a result of technical and operational support.

4. Prepare and respond: put in place systems and procedures in Member States to prevent, prepare for and respond to public health emergencies.

5. Engage: relevant partners in all aspects of WHO’s work in emergency risk management.

Progress in each of these areas of work is summarized below.

ADVOCATE: Increased awareness among key partners on health issues and the role of the health sector in emergencies in the Region

A major milestone in 2018 was the e-publication Building for change – good practices in health emergencies in South-East Asia. This was released at the Regional Committee session in September. Despite its vulnerabilities, the Region has been a source of good practices and innovations for managing risks better. This was a timely and much-needed effort to identify and document good practices in the area of emergencies in the Region through a dynamic e-publication.

Each best practice that has been included represents an important aspect of health sector emergency preparedness and response implemented in Member States in the past few years. Stories that highlight learning, initiatives and innovations from recent disasters and health emergencies in the Region were packaged to present how Member States prepare for, respond to and recover from such events. Categorized broadly under the themes of “Risk reduction”, “Readiness”, “Response” and “Recovery”, the e-publication is presented in a format that easily combines various material in different media forms – including video, photographs, case studies and interviews – in order to showcase these best practices. The publication is accessible online at http://www.searo.who.int/about/administration_structure/whe/en/.

MANAGE: Improved information and knowledge related to emergency risk management in the health sector for all types of hazards
Detection, verification and assessment (DVA) of alerts

Adhering to the IHR (2005) framework, WHO conducted event-based surveillance for the detection of global and national health risks. News and social media provide WHO with potentially important information for public health intelligence. Since the establishment of the WHO Health Emergencies Programme (WHE) in 2016, public health intelligence has been restored as one of the central functions for which detected events are systematically verified, assessed for its potential to spread and severely impact, and finally recorded in collaboration with national authorities. The report below summarizes the results of the detection, verification and assessment in 2018 in an attempt to characterize public health events that were reported in the media across the SEA Region.

During 1 April 2017–7 March 2019, a total of 1030 “signals” (outbreak events reported in the media) related to public health incidences and human deaths were captured from all 11 Member States through the new WHO electronic public health intelligence platform, which is also called “Epidemic Intelligence from Open Sources” or EIOS. Signals were then reviewed for duplication and relevance, and then verified and assessed. Of these 1030 “signals”, 86 were confirmed as public health events of national importance. Important variations were observed according to the hazard type (Fig. 14) and country of occurrence (Fig. 15).

Infectious diseases, including zoonotic diseases, made up 57% of the events compared with 34% natural or human-induced disaster-related events. Among the infectious disease events, the most common diseases/syndromes included acute febrile syndrome, acute fever and rash syndrome, and acute watery diarrhoeal syndrome.
**Fig. 14:** Classification of emergency events that occurred in SEA Region countries between 1 April 2017 and 7 March 2019

Infectious hazards etiology: Acute Hepatitis A, Cutaneous Antiviruses, Chikungunya, Cholera, CCHF, Dengue, Dogflu, Eliphiatheria, H5N1, HIV, Influenza A (H1N1), avian and animal, Japanese Encephalitis, KFD, Leptospirosis, Malaria, Measles, Nipah Virus, Poliomyelitis (Acute paralytic, Vaccine associated), Typhoid Fever, Variola, Unknown or unspecified, Zika Virus

**Fig. 15:** Distribution of emergency events during 2018

*Source: WHO EMS (as of 01 March 2019)*
In 2018, nine major public health emergencies\textsuperscript{26} were reported. Two were reported in both Indonesia and India, in addition to the persisting Rohingya crisis in Bangladesh.

Under IHR (2005), two major events required rapid information-sharing for their potential of being an emergency of international concern. This included the Nipah virus outbreak in Kerala, India, and the vaccine-derived polio virus (VDPV)\textsubscript{1} outbreak in West Papua, Indonesia.

The WHE is in the process of expanding its scope of detection of events to include common events that make the news but which have limited risk of spreading, such as major traffic accidents and urban incidents, including building collapses and fires.

\textbf{SUPPORT:} Strengthening the capacities of Member States to prevent, prepare for, respond to and recover from emergencies across all hazards

\textbf{Strengthening of IHR implementation in the Region}

The IHR (2005) is the legally binding instrument to help prevent, detect and respond to multiple threats from various hazards.

In 2018, all 11 Member States of the Region reported on their IHR capacities through the State Parties Annual Reporting (SPAR) mechanism. Eight Member States completed the joint external evaluation (JEE) by the end of 2018 and two more will follow in 2019.

Following the identification of gaps and priorities during the assessments, five Member States (Indonesia, Maldives, Myanmar, Sri Lanka and Thailand) have developed their NAPHS for implementation of IHR. Bangladesh, Bhutan and Timor-Leste will develop their NAPHS in 2019.

To further guide, support and facilitate improvements in IHR implementation, the Regional Office has scheduled a regional consultation with Member States and

\textsuperscript{26} Defined as emergencies that disrupted the community with substantial death toll or related to the emergence of a high-threat pathogen
partners in March 2019. The consultation will develop and finalize a draft of the Regional Strategic Plan to Strengthen Public Health Preparedness and Response 2019–2023. It has been prepared based on regional priorities and has been aligned with the Global Strategic Plan to Improve Public Health Preparedness and Response 2018–2023 that was presented to the Seventy-first World Health Assembly in 2018.

**SEARHEF evaluation**

The sixth meeting of the Working Group for the governance of SEARHEF in 2017 recommended that, as the Fund reaches its tenth year, the Secretariat should undertake an evaluation of its utilization and impact. This evaluation was also prioritized by the Regional Director as one of the areas of work to be evaluated in 2018. The evaluation criteria included relevance, effectiveness, efficiency, sustainability and impact. The Regional Office, as the Secretariat of the Fund, contracted an external evaluation agency to undertake the work. The key findings of the evaluation included the following:

- Despite the availability of other funding sources such as the CERF and the Contingency Fund for Emergencies (CFE), SEARHEF stands apart as it is a regional fund exclusively for the 11 Member States of the Region. SEARHEF is more easily accessible than other global funds with similar objectives, and is the preferred source of funding for a majority of the most critical emergencies with greater degree of severity occurring in the Region.

- SEARHEF proved to be adequate in supporting the population in coping with disasters. Its flexibility to address needs specific to contexts and emergencies was well demonstrated as it was used for various activities.

- About 41% of SEARHEF requests were approved within 24 hours for rapid acute-onset emergencies. Responses for protracted emergencies were also evaluated and sent across promptly within the needed time period.

- SEARHEF’s impact (measured in terms of output and outcome) was significant because it added unique value to the emergency response to 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 has resulted in controlling the adverse effects of an emergency.

- With increasing health threats to the Region, a funding mechanism such as SEARHEF that allows for rapid response becomes imperative. There is a need to apply other resource mobilization mechanisms to add to the corpus of the Fund.

**PREPARE AND RESPOND:** Systems and procedures in Member States are in place to prevent, prepare for and respond to public health emergencies
Operational review and transition in the Cox’s Bazar Rohingya crisis response

The WHO response to the ongoing Rohingya crisis in Cox’s Bazar, Bangladesh, underwent a thorough operational review in October 2018 by a team composed of representatives from all three levels of WHO. The review, which is standard practice for Grade 3 emergencies, followed a transparent and participatory methodology.

The Regional Office has supported the implementation of the recommendations from the review, which include: the development of an administrative SOP for the WHO emergency suboffice; endorsement of a systems-strengthening-oriented WHO operational plan for 2019 by the MoHFW; recruitment of key staff for a review of the role of operational partnerships in the response; a review of the EWARS system; updating the business continuity plan for the WHO emergency sub-office and Health Sector Contingency Plan for the

Box 23. Cox’s Bazar: laboratory strengthening for influenza and other high-threat pathogens

In April 2018, the Regional Office established a public health laboratory in Cox’s Bazar to support health-care services for the Rohingya response. The laboratory was created within 60 days and involved setting up essential equipment, refurbishing of laboratory space, and recruiting and training staff.

It initially began with molecular testing of diphtheria, which included screening for toxin genes to rapidly detect cases and facilitate quicker control measures. It was then further equipped with influenza reverse transcriptase polymerase chain reaction (RT-PCR) assay for the detection and characterization of influenza viruses to initiate influenza surveillance among the Rohingya population. This also enabled the testing of respiratory specimens from patients with ILL and SARI from the Cox’s Bazar district sentinel site as a part of the National Influenza Surveillance Programme.

The on-site laboratory reduced the time of testing and transportation costs and, along with competent staff and optimal storage capacity, enabled the temporary storage of specimens and the testing and sharing of viruses with the National Influenza Centre (NIC) at the Institute of Epidemiology Disease Control and Research (IEDCR).

The laboratory has also been equipped with molecular testing for chikungunya, dengue and Zika viruses, and immunological diagnosis of hepatitis (A, B, C and E), leptospirosis, rotavirus, pertussis and scrub typhus.

Currently, the laboratory is working to establish a diagnostic microbiology facility for the identification of deadly bacterial diseases with antimicrobial susceptibility testing to combat the challenges posed by MDR bacterial pathogens. Lastly, efforts have also been made to implement a laboratory referral system for health facilities to enhance infectious disease surveillance with epidemic potential among the Rohingya population.
monsoon and cyclone season; establishment of a dedicated team\footnote{The team is called the Technical Emergency Reference Network (TERN). This team also exists in the Regional Office.} in the country office in Bangladesh to work closely with the Cox’s Bazar team; and the initiation of broad-reaching work on documentation and research to provide lessons for future emergency responses.

**Resolution on strengthening of EMTs by the Regional Committee**

Experiences from health emergencies in the Region have shown that following a sudden-onset disaster, a large number of EMTs often arrive in the affected country to provide care to patients with traumatic injuries and other life-threatening conditions. In many situations, it was found that the deployment of these teams was not based on assessed needs and that there was wide variation in their capacities, competencies and adherence to professional ethics. As such, there is a lack of quality-assured, internationally classified and/or nationally accredited EMTs in the Region.

In 2018, a mapping of EMTs in the Region was reviewed to show the various types of EMTs in Member States. This, as well as other issues, were discussed during the Regional Consultation in June which attracted more than 60 participants from all 11 Member States of the Region, including representatives from the ministries of health and defence and civil society organizations.

The recommendations from the consultation were presented for consideration at the Regional Committee session in September. A resolution was passed and endorsed by the Regional Committee to strengthen EMTs in Member States. This includes the establishment of a Regional EMT Working Group with its secretariat at the Regional Office. This Working Group will oversee and guide strengthening and implementation of EMTs in line with the WHO Classification and Minimum Standards. Teams from Indonesia, Sri Lanka and Thailand joined the quality assurance and classification process coordinated by the WHO EMT Initiative.
Operational readiness training

As part of the emergency reform and establishment of the new WHE, the Regional Director has designated strengthening capacity in the Region to respond to emergencies from all hazards as a Flagship Priority. To this end, the Regional Office has developed a series of training programmes conducted in 2017–2018 on operational readiness, which comprises four training modules. Two training workshops on administration and business processes, and information and communication were, completing the four modules of readiness training.

The training design focuses on an on-the-job adult learning approach, which employs multiple active learning methods that include interactive discussions, group work based on real-time scenarios, learning through sharing of experiences, and table-top simulation exercises applying the topics presented. This unique capacity-building model was designed to facilitate quick learning, build on several modules, provide opportunities to meet colleagues away from office, help in team-building with an in-built evaluation mechanism to measure impact and change, and improve WHO country offices.

Pandemic influenza preparedness

Pandemic influenza remains an important threat globally, and especially so in the SEA Region. The PIP Framework, a partnership between the pharmaceutical industry and WHO, has begun capacity development in several Member States of the Region to help support six major output areas. The output areas include laboratory and epidemiological surveillance; burden of influenza disease determinations; vaccine regulatory capacity; vaccine deployment capability; risk communications; and PIP plans, updates and revisions. In 2018, there were several achievements in the PIP framework among the Member States which are presented below.

In November 2018, experts from the Regional Office and the US CDC organized a review on SARI and ILI surveillance conducted by the Royal Centre for Disease Control (RCDC) with a visit to one of the sentinel site hospitals in Thimphu, Bhutan. During this time, a comprehensive review of the country’s new vaccination policy was carried out.

The virology laboratory at the RCDC under the Ministry of Health is striving to become the National Influenza Centre (NIC) under GISRIS. To this end, the Regional Office is providing peripheral technical support to enhance this process. An introductory training on the WHO laboratory quality management system was conducted for all RCDC staff.

The observations were presented to the MoH, which led to discussions on inputs and recommendations from the laboratory assessment, the surveillance review and vaccination policy review with the aim of strengthening overall influenza-related activities in Bhutan.

ENGAGE: Relevant partners in all aspects of WHO’s work in emergency risk management
Operational partnerships

In November 2018, a team of 10 members from the SEA Region took part in the health cluster coordination training for current and potential health cluster coordinators and information managers in Divonne, France. The team, familiarized with the necessary operational and technical concepts, will contribute to stronger surge capacity in the Region and will be able to assist as resource persons for ongoing capacity-building exercises.

Meanwhile, the Global Outbreak and Response Network (GOARN) has expanded further with a total of seven partner organizations in the Region. The Network will be further expanded and strengthened in the coming year with specific human and financial resources now in place for a strong and sustained expansion effort in target Member States.

Box 24. DPR Korea: improved cooperation for PIP and retaining active NIC status

In 2018, significant efforts from the Regional Office and the Country Office for the Democratic People’s Republic of Korea enabled increased cooperation with the country to improve pandemic preparedness. To this end, the MoPH has taken initiatives to update the country’s pandemic preparedness plan. A multi-stakeholder meeting was also held for influenza preparedness involving the MoPH, the Ministry of Agriculture, the State Quality Supervision Committee, the Veterinary Institute and the Anti-Zoonotic Institute.

For the first time, IILI and SARI surveillance EPI data from November 2018 was shared with FluNet, a global web-based tool for influenza virological surveillance, to supplement laboratory data. Meanwhile, the MoPH has requested WHO to support the Central Hygiene and Anti-Epidemic Institute (NIC-DPR Korea) to retain its NIC designation under WHO’s Global Influenza Surveillance and Response System (GISRS). Subsequently, technical staff from the country office assessed IILI sentinel sites and the NIC to support their work. Discussions on virus and information-sharing is ongoing.

To strengthen laboratory activities, staff from NIC-DPR Korea underwent a comprehensive training at the public health laboratory services branch of the Centre for Health Protection at the Department of Health in the Hong Kong Special Administrative Region (SAR). A workshop was conducted on self-benchmarking of the National Regulatory Authority with the Regional Office, WHO headquarters and the United Nations Industrial Development Organization (UNIDO). In 2019, the Regional Office is planning to complete influenza laboratory assessments and on-site training to strengthen surveillance.

Bhutan: support to introduce influenza vaccine and RCDC to achieve NIC status under GISRIS

The burden of influenza study in Bhutan in 2015–2016 confirmed the global association of influenza viruses with severe respiratory illnesses requiring hospitalization, highlighting the need for seasonal influenza vaccination to prevent complications in high-risk groups.

In a key step, the Regional Office is collaborating with the US CDC, the Task Force on Global Health and the Partnership for Influenza Vaccine Introduction to introduce influenza vaccination to health-care workers and pregnant women in Bhutan.
Challenges, opportunities and next steps

One of the biggest challenges in implementing this Flagship Programme is limited resource allocation for the WHE programme in the Region, compounded by the fact that funding through assessed contributions is released in tranches. This uncertainty of resources hampers the ability to have a fully staffed WHE team at both the Regional Office and at country offices.

Leveraging ICT, mainstreaming mobile diagnostics for emergency settings, tactical pre-positioning of medicines and supplies, knowledge-sharing by building communities of practice, and operational research are some strategic opportunities to strengthen the capacity for responding to public health emergencies in the Region.

Going forward, the Regional Office will prioritize building on IHR core capacities, adopting an integrated approach to pandemic preparedness and NAPHS, building a cadre of WHO-certified EMTs in the Region, and homing in on new strategic directions to handle other threats such as chemical, biological and radionuclear events or extreme weather occurrences due to climate change.
Flagship 7: Finishing the task of eliminating diseases on the verge of elimination

Introduction

Neglected tropical diseases (NTDs) are a diverse group of infectious diseases and conditions that affect millions of people from poor communities in the developing world. While some of these diseases are fatal if untreated, others may cause lifelong disabilities and disfigurement, leading to high levels of stigma and social isolation.

There are 20 diseases and conditions under this umbrella, some of which are targeted for eradication or elimination as a public health problem, either at the global or regional level.

The SEA Region has the world’s second-highest burden of NTDs taken as a whole, and the largest number of cases globally of several NTDs. In the past few years, the Region has made tremendous progress towards eliminating NTDs, changing the global NTD landscape significantly.

Progress and results in 2018

Advocacy activities on NTDs

The achievement of elimination targets and other milestones are celebrated in the Region to recognize the strong political commitment of Member States and the tireless efforts of national programmes. The celebrations also provide an opportunity to encourage other Member States to accelerate their progress. The elimination of trachoma as a public health problem in Nepal was recognized at a side-event on Public Health Achievements in the Region at the Seventy-first session of the Regional Committee for South-East Asia in New Delhi in September 2018. A celebration event was subsequently held in Kathmandu, where the Regional Director handed over special commemorative plaques to the government and key partner NGOs that implemented trachoma elimination activities in Nepal.

Trachoma

In 2018, Nepal became the first Member State in the Region to be validated for elimination of trachoma as a public health problem. India and Myanmar are the two other Member States in the Region where trachoma is endemic. Both Member States are progressing towards achieving the elimination target by 2020. To this end, Myanmar is preparing for the pre-validation survey and India is preparing to achieve the target for follicular trachomatous inflammation.
Lymphatic filariasis

WHO’s new triple-drug MDA regimen, which adds ivermectin to the currently used two drugs (diethylcarbamazine [DEC] and albendazole), is being introduced in the Region to fast-track the elimination of LF. In 2018, India became the first Member State in the Region to introduce the new regimen. Indonesia and Timor-Leste will follow next.

MDA was provided to 252.7 million of the 516.4 million people requiring treatment in the Region, achieving a coverage of 76.4%. Treatment was provided in 315 of the 387 districts in five Member States that require MDA.

Three of the nine Member States in the Region where LF is endemic (Maldives, Sri Lanka and Thailand) have eliminated LF as a public health problem. Bangladesh is under post-MDA surveillance while MDA is continuing in five Member States (India, Indonesia, Myanmar, Nepal and Timor-Leste).

In 2018, the Region continued to scale down MDA with 62% of endemic districts meeting the criteria and stopping MDA by the end of 2018 (Fig. 16).

Fig. 16: Status of LF-endemic districts/implementation units (IUs) in the Region, as of 31 December 2018

Source: Various programme reports
Visceral leishmaniasis (kala-azar)

Visceral leishmaniasis is endemic in Bangladesh, India and Nepal with a few sporadic cases seen in Bhutan and Thailand. The disease is targeted for elimination as a public health problem in the SEA Region by 2020. Elimination is defined as achieving an incidence of less than 1 per 10 000 population at the district level in Nepal and at the subdistrict level in both Bangladesh and India. In recent years, control efforts in all three Member States have resulted in a significant decrease in the number of new cases of visceral leishmaniasis.

By the end of 2018, the elimination target was achieved in all endemic districts in Nepal and upazilas in Bangladesh, and 93% of endemic blocks in India. However, a formerly non-endemic district in Nepal reported cases that crossed the elimination threshold. This reflected an important challenge that is faced by all endemic Member States. To this end, the Regional Office is working with Nepal’s kala-azar elimination programme to investigate the cases detected in non-endemic areas to better understand the disease epidemiology and transmission dynamics. WHO continues to provide ambisome injections to treat all diagnosed patients and ad-hoc support to meet the urgent need of diagnostics and other medicines as requested (Fig. 17).
Schistosomiasis

Two remote districts of Indonesia’s Central Sulawesi province are endemic for schistosomiasis. In 2018, the Government of Indonesia revised its strategic plan and set a target to interrupt transmission, moving away from the previous target of eliminating the disease as a public health problem.

The new plan is a detailed three-pillar (commitment of government at central, province and district level; an integrated schistosomiasis control programme; and community engagement) multisectoral plan with MDA, using praziquantel for the entire population over the age of 4 years, together with health education, environmental management and agro-engineering interventions.

In 2018, Myanmar recorded a schistosomiasis outbreak. WHO, along with partners, supported the MoHS to investigate and establish endemicity to develop an elimination plan for the country.

Yaws

In 2018, the two Member States endemic for yaws in the Region (Indonesia and Timor-Leste) made significant progress towards achieving the goals of their yaws eradication programmes. Indonesia completed community treatment in all yaws-endemic districts and villages. With Indonesia entering the post-treatment surveillance phase, yaws surveillance and the M&E system are being strengthened to meet the verification requirement.

Source: Various programme reports 2018  * provisional data
Meanwhile, Timor-Leste completed its first national yaws prevalence survey to confirm the country’s endemicity status. Unexpectedly, only two positive cases were found using the rapid diagnostic test. With this progress, Timor-Leste will move directly to the surveillance phase as there is no requirement for MDA. The Regional Office is working closely with the MoH to build capacity and strengthen Timor-Leste’s surveillance system.

**Leprosy**

The Region continues to bear the highest burden of leprosy globally, with 153,487 new cases and 3.3 grade 2 disability cases per million reported in 2017. However, the Region is heterogeneous in terms of its leprosy burden, with India and Indonesia among the highest-burden countries in the world, and DPR Korea, Maldives and Bhutan being very low-burden countries.

**Box 25. Major achievements in the elimination of neglected tropical diseases in the SEA Region in 2018**

- Validation of elimination of trachoma as a public health problem in Nepal
- Completion of the national yaws prevalence survey in Timor-Leste
- Introduction of triple-drug MDA to accelerate LF elimination
- Sustained and continued progress in LF and VL elimination.

In 2018, key achievements included India and Sri Lanka making progress in repealing discriminatory laws against people affected by leprosy. In addition, low-burden countries in the Region are embarking on a more ambitious target of achieving zero leprosy status and WHO is working closely with Member States to provide technical support for this goal. Going forward, intensified efforts are required in high-burden Member States to further reduce the leprosy burden and achieve the disability target set forth in the Global Leprosy Strategy 2016–2020.

**Challenges, opportunities and next steps**

Some of the challenges in the Region on eliminating and sustaining achievements include the following:

- Poor compliance and low treatment coverage of LF is consistently seen in some districts, mostly urban.

- New districts are failing the LF transmission assessment survey, requiring these to be put on continued MDA intervention.
Delays in reporting, poor quality of data, and the inability to take timely corrective measures based on local data persist.

There has been emergence of visceral leishmaniasis in new foci in all three major endemic Member States.

Some of the opportunities and next steps:

- NTDs continue to be a Regional Flagship Programme, which provides a unique opportunity for continued political dialogue and sustained commitment.
- The triple-drug MDA with secured donation of the new drugs will help accelerate LF elimination programmes;
- Many LF-endemic districts are completing the required number of MDA rounds enabling programmes to complete the required survey and focus on remaining districts;
- Trachoma elimination in India and Myanmar is at the last phase; and elimination as a public health problem is within reach.

Visiting a patient at her residence in Soi Phra Chen Community, Bangkok
Flagship 8: Accelerating efforts to end TB by 2030

Introduction

The SEA Region is home to 26% of the world’s population and accounts for 44% of the global TB incidence. In 2017, an estimated 4.4 million people contracted TB, of whom approximately 638,000 died. Treatment success for new and relapsed TB cases was 75% (for those initiated on treatment in 2016), which was one of the lowest rates among the WHO regions.

Drug-resistant TB has also emerged as a major challenge in the Region. It is estimated that there were 192,000 rifampicin-resistant (RR) and multidrug-resistant TB (MDR-TB) cases in 2017, accounting for more than 34% of the global burden of drug-resistant cases. Of the estimated 192,000 cases, less than 52,000 were notified in the same year.

Six out of the 30 high TB (and MDR-TB) burden countries are in the SEA Region: Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Myanmar and Thailand.  

Fig. 18: TB burden in the WHO SEA Region

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Progress and results in 2018

In 2018, significant steps were taken in the Region towards ending TB. To bolster political commitment, WHO collaborated with India’s MoHFW and partners to organize the Delhi End TB Summit in March 2018. At the Summit, all Member States adopted a Statement of Action to operationalize the Delhi Call for Action. Similarly, the Statement also called upon the international community and partners to enhance their support for the Region towards the full implementation of the Delhi Call for Action. Some of the key tasks included in the Statement of Action are as follows:

- Lead implementation of the national TB responses in countries by an empowered national initiative that reports to the highest levels of government in Member States.
- Increase budgetary and human resource allocations by governments as well as by their global, domestic and other partners to ensure that national TB plans are fully funded.
- Enable the best possible care to each and every person, including migrants, the aged and other high-risk populations, living with any form of TB (through newer strategies).
- Supplement medical care for TB with social and financial protection in a holistic manner.

Meanwhile, the Region was well represented at the first-ever UN General Assembly High-Level Meeting on Tuberculosis. The High-Level Meeting, which was attended by the

Field visit to the Soi Phra Chen Community, Bangkok
UN Secretary-General, the President of the UN General Assembly, several ministers of health from around the world, the Chair of the Stop TB Partnership, and a TB survivor from India, was co-organized by WHO. A political declaration was adopted at the meeting which calls for:

- successfully treating 40 million people with TB globally, including 3.5 million children, by 2022;
- successfully treating 1.5 million people with drug-resistant TB globally, including 115,000 children with drug-resistant TB, by 2022;
- preventing TB for those most at risk of falling ill, so that at least 30 million people globally — including 4 million under-five children, 20 million other household contacts, and 6 million people living with HIV — receive preventive treatment by 2022; and
- increasing overall global investments for ending TB, reaching at least US$ 13 billion a year by 2022.

Given that the SEA Region contributes almost half of the global burden of TB, it is expected that 18 million patients will be diagnosed and treated, including 1.5 million children, between 2018 and 2022; and that over 500,000 DR-TB patients will be successfully treated during the same period; and over 10 million people will be provided preventive TB treatment.

At the High-Level Meeting, a side-event on “Fast Tracking Strategies for Ending TB in South-East Asia by 2030” was co-hosted by the Regional Office, the governments of Indonesia, Maldives and Sri Lanka, and the Forum for Stop TB Partnership Indonesia. In...
addition, a leadership side-event on “Breaking the Barriers to End TB – Bending the Curve” was also organized by the Regional Office, the ministries of health of India, Indonesia, Sri Lanka and Maldives, the Stop TB Partnership, the Global Fund and UNAIDS. The purpose of the meeting was to demonstrate the commitment of the leaders of the Region, to highlight the specific needs of the Region in ending TB, and to discuss opportunities for partnership.

The Regional Director outlined three concrete ways to support Member States in translating the joint regional commitment into action. These included: knowing that active case detection among high-risk groups is fundamental to ending TB; given the importance of managing latent TB infection, developing a time-bound action plan to cover all groups at risk of contracting TB; and lastly, all partners together supporting the supply of first-line drugs via South–South cooperation, as India has offered to do.

Meanwhile, in 2018, the Regional Office also provided technical and monitoring support to all 11 Member States. This included the following:

**Strategic information support**

- The Regional Office worked on modelling exercises for the management of latent TB infection. The model quantifies the resource gap and supports Member States to understand the prevention coverage targets that need to be met when implementing the new WHO guidance on latent TB infection treatment.
- An analysis of resource needs and gaps in the Region to guide Member States for additional investments needed to “End TB” was published and disseminated during the Delhi End TB Summit.

**Technical support**

- The Regional Office supported Member States in their preparations to participate in several high-level events, including the World Health Assembly and the High-Level Meeting on TB at the United Nations.
- Bangladesh, Bhutan, DPR Korea, Nepal, Sri Lanka and Timor-Leste were supported to revise and update their TB programme guidelines in line with WHO guidelines.
- The Regional Office organized workshops for Member States to build capacity on molecular tests for diagnosis of DR-TB as well as active drug safety monitoring and management. In addition, national consultations on ending TB (and HIV) were also facilitated in Sri Lanka, while country support missions were organized in all 11 Member States in 2018.
- A regional workshop on the transition plan for implementing recent WHO guidance on DR-TB and latent TB infection was organized in late 2018. Ten out of 11 Member States participated, in addition to CSOs, the Global Drug...
Facility, USAID, MSF (Médecins Sans Frontières), the Union, FIND (Foundation for Innovative New Diagnostics) and WHO Collaborating Centres. Other partners such as the Global Fund and the TB Alliance joined remotely. Based on technical presentations and extensive deliberations, Member States drafted plans for implementation of recommended diagnostics and treatment protocol for DR-TB and latent TB infection.

Country support missions

- The Regional Office supported a mid-term review of national prevalence surveys in Nepal and Myanmar.
- MDR-TB support missions were held in nine Member States of the Region through the regional Green Light Committee mechanism.

Community engagement

For enhanced community engagement in TB and DR-TB control, modules for strengthening capacity for community-based organizations are being developed and have been peer reviewed. The Regional Office will hold a stakeholders’ review meeting in 2019.

Some of the key programme performance achievements in the Region include the following:

*Improved access:* the number of cases notified increased to 2.9 million in 2017, nearly 10% more than 2016.

*Improved care:* estimates of mortality in TB patients decreased to 652,000 in 2017 from 710,000 in 2016.

*Increased financing:* budget allocation for TB nearly doubled between 2016 and 2018.

*Ambitious targets:* Member States have targets that are aligned with ending TB before 2030.

*Updated policies:* Member States have adapted and adopted the recent policy updates from WHO.

Challenges, opportunities and next steps

Major challenges to TB control in the Region remain.

- There is a funding gap of more than US$ 1 billion for TB programmes to fully implement the strategies needed to end TB.

- The slow decline in incidence rates in Member States: at the current rate of 1.5%–2% decline, no Member State will be able to achieve the End TB targets.
It is expected that only two Member States in the Region will be able to meet the targets of “zero catastrophic costs” for TB-affected families by 2020.

The slow uptake of new tools and guidelines, specifically those related to latent TB infection management, remains an impediment.

The ambitious targets laid down at the UN High-Level Meeting have to be translated into country goals and incorporated in the national plans.

Some of the opportunities and prerequisites for next steps are as follows:

- Political commitment at the highest levels of governments in Member States towards ending TB must be unwavering.

- The UN High-Level Meeting’s Political Declaration lays down ambitious targets and commits to the mobilization of resources. The Regional Office will support Member States in adopting targets for TB control in accordance with the agreed goals at the High-Level Meeting. Progress on this will be monitored through a high-level multisectoral committee.

- The adoption of a MultiSectoral Accountability Framework that is being developed by WHO must be supported.

- The Regional Office will support Member States in resource needs assessments and the mobilization of adequate domestic and international resources.

- WHO will provide technical assistance for the adoption of and transition to new WHO guidelines for the management of MDR-TB and latent TB infection. The Regional Office will also provide technical support for fast-tracking of interventions aimed at strengthening TB services, accelerated case detection through innovative approaches, identifying full funding needs, community engagement and management of latent TB infection.

- Member States will be supported to carry out hotspot mapping and estimate local disease burden in addition to increasing community engagement.
Beyond the Flagship Priorities

Brief update on other programmes of public health importance

In addition to the focus in the Region on the Flagship Priorities, there are other important public health issues that are being addressed with equal seriousness. The following section highlights some of the key issues as well as progress and challenges in addressing them.

1. The Global Leprosy Programme (GLP)

Since 2005, WHO’s Global Leprosy Programme has been housed at the Regional Office for South-East Asia where a small team is overseeing leprosy control efforts across the globe in coordination with the six regions and the country offices in major endemic countries.

The leprosy epidemic is now characterized by a slow decline in the number of new cases detected. On the positive side, the number of new cases with disabilities is also falling, which has resulted in a changed perception that leprosy is not necessarily associated with deformities.

In 2018, the Nippon Foundation continued to be the principal financial source to help the GLP to fulfil its mandate. It provided a grant of US$ 2.3 million to support routine leprosy activities at the global, regional and country levels. In addition, eligible countries benefited from grants from the Bangkok Declaration Special Fund and the Special Fund for Extraordinary Circumstances.

In 2018, monitoring the epidemic was improved by the introduction of a DHIS-2-based data collection system. Global monitoring of national leprosy data was more complete than ever before: reports were received from 160 Member States in six regions, including all endemic countries except South Sudan. A total of 211,009 new leprosy cases were detected globally in 2017. This makes leprosy one of the most common NTDs. The overall majority of cases was detected in the WHO SEA Region (153,487 cases), particularly in India and Indonesia. Significant numbers were also reported from Brazil (26,875 cases) and sub-Saharan Africa (20,758 cases). The registered prevalence rate globally and in all Member States (except Brazil) was well below 1 per 10,000 population, the benchmark for elimination as a public health problem. However, in both high- and low-burden countries, pockets have been identified with high prevalence and/or case-detection rates (Fig. 19).

While the proportion of multibacillary cases has remained stable, the proportion of new cases with visible deformities reduced to less than 6% in 2017, resulting in a global rate of 1.6 per million population. This figure brings us closer to the global target of less than 1 case per million.
At the normative level, in 2018, WHO published evidence-based *Guidelines for the diagnosis, treatment and prevention of leprosy*. Meanwhile, WHO’s position paper on the use of Bacillus Calmette–Guérin (BCG) for the first time acknowledged its protective effect on leprosy and recommended to continue providing the vaccine at birth in leprosy-endemic areas.

Meanwhile, an informal consultation was held to provide advice on the management of reactions, neuritis and prevention of disabilities. This re-emphasized the need for periodic nerve function assessment as part of good clinical practice. A working group was subsequently created to develop a simple algorithm for use by frontline health workers.

Five years after the International Leprosy Summit, the GLP convened a meeting to review the special projects that were launched to foster innovation. These focused on the application of existing tools to mop up known pockets of higher endemicity, and expand mapping and strengthen surveillance, including for drug-resistant cases. The meeting highlighted the need to research new tools, particularly for diagnostics and prophylaxis, as a requirement to accelerate leprosy control in low-burden settings.

In addition, in 2018, the GLP reaffirmed its technical leadership role in global leprosy control in coordination with longstanding and new stakeholders. These include...
the International Federation of Anti-Leprosy Associations, the International Leprosy Association, the Novartis Foundation, the Global Partnership for Zero Leprosy and the United Nations Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members.

Various opportunities were used to advocate for leprosy at global and regional events, which was significantly bolstered by Mr Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy Elimination, whose mandate was renewed in 2018.

An important challenge is that the global leprosy burden is defined too narrowly in medical terms. This narrow terminology neglects the huge number of people who require care after cure, and also does not take into account populations at higher risk of acquiring the disease.

However, the emphasis on human rights and stigma reduction, and the changing perception of leprosy, provide opportunities for better integration and outreach to the remaining pockets.

Since leprosy is on the decline in most areas, it means national programmes will need to adapt to the changed, low-burden situation. Together with the dwindling number of experts, this poses major challenges on how to move forward to provide necessary diagnosis, treatment and prevention services, as well as sustaining awareness and advocacy.

To address this, WHO in collaboration with partners is designing new innovative tools and instruments tailored to this changing context. Examples include the promotion of e-learning, digital health, mapping and georeferencing.

There is a nascent demand by Member States to create a mechanism for validation by WHO for having achieved a leprosy-free status at the national or subnational level. The GLP will explore ways of validating such situations, considering the possibility of sporadic cases occurring even many years after local transmission has ceased, as well as imported cases.

Although AMR is not a major problem in most settings, resistance to first-line leprosy medicines has been documented. AMR for other diseases, however, is prominent on the health agenda, and having leprosy included on the list of these will help to better address this issue. Though MDT continues to demonstrate its robustness, going forward, improving treatment regimens (such as shorter regimens) will need to be pursued. Novel TB drugs could provide an opportunity for being efficacious for leprosy. With regard to diagnostics, clinical diagnostic capacity is increasingly challenging. Capacity for slit-skin smears varies between Member States and may need to be supported again.

In recent years, the increased alignment and expansion of global partners for NTDs as well as for leprosy poses potential opportunities for moving leprosy control forward in the
changing context. This, combined with signs of increased funding, including from domestic resources in endemic countries, is promising. This will allow the development of new tools as well as in addressing the areas insufficiently taken care of in the past in addition to issues related to care after cure, stigma reduction, social rehabilitation and inclusion.

2. HIV/AIDS: a downward trend in cases and deaths

The SEA Region has an estimated 3.5 million people living with HIV. About 99% of HIV infections are concentrated in five Member States with India alone accounting for 60% of HIV cases in the Region. While the overall prevalence of HIV in the Region is low (0.3%), certain key populations such as men who have sex with men, people who inject drugs and sex workers, are disproportionately affected.

New HIV infections, however, are declining in most Member States, driven by strong prevention programmes and a rapid scale up of ART (Fig. 20). However, the pace of decline has plateaued. In 2017, there were an estimated 157,000 new infections, representing 8.3% of new HIV infections worldwide.

Fig 20: New HIV infections in the SEA Region, 2014–2017

Source: www.aidsdatahub.org based on UNAIDS 2018 HIV estimates

The Region has shown significant decline in AIDS-related deaths by 40% between 2010 and 2017 and this will continue to decline given the increased ART coverage (see Fig. 21).
Treatment coverage increased from 47% to 51% over the past year, based on the Global AIDS Monitoring report. This is slightly below the global average but is likely to increase significantly over the next year as all Member States have adopted the “Treat All” approach advocated by WHO in the updated ART guidelines. This policy will also help to prevent transmission of the virus, leading to further declines in new infections and a reduction in the number of AIDS-related deaths.

Recent success stories in HIV control in the SEA Region

**Region adopts WHO differentiated care model**

WHO recommended a differentiated care model, for patients stable on ART. India became the first country in the Region to fully adopt the model which led to increased retention in care and efficiency in health service delivery.

The model includes three key components: multi-month prescriptions (MMP) for three months to stable patients as defined by WHO; intensified adherence counselling for the initial three months of ART; and community-led ART dispensation through selected care and support centres managed by networks of people living with HIV (PLHIV) as well NGOs.

**Enhancing linkage to and retention in care**

Linking all those found positive and retaining them in care is an important component of ensuring that people continue to get full benefits of ART and do not develop drug resistance.

To this end, India launched “Mission Sampark” to extend the benefits of the “Test and Treat All” policy and reach out to all those “who are aware of their HIV-positive status”...
but “are not on ART”. The Mission adopted a two-pronged strategy: data cleaning as well as enhanced outreach activities. It focused on patients in pre-ART care who had not yet initiated ART and on patients who were on ART but who were lost to follow up. The Mission achieved huge success: almost 90% of patients newly diagnosed with HIV in 2018 were linked to ART and almost 47 000 patients lost to follow up were brought back to care. WHO provided technical support to Mission Sampark and, based on its experience, there are plans to have similar programmes in other Member States.

**Accelerating self-care interventions for the prevention of HIV**

WHO has recommended HIV self-testing and PrEP as ways to empower communities and key populations to know their HIV status and protect them from acquiring HIV.

Many Member States in the Region are having consultations to adopt these interventions. Thailand has taken the lead on PrEP by launching the “Princess PrEP” programme to increase access to free PrEP. India also completed a successful community-led pilot project among sex workers in two states, which showed good adherence, retention and zero transmission of HIV among sex workers using PrEP. Indonesia is also moving ahead on a pilot for PrEP. The Regional Office has been providing technical support to Member States on this new prevention tool and it is part of the WHO UNAIDS Regional Advisory Group on PrEP.

**Elimination of mother-to-child transmission of HIV and congenital syphilis**

Thailand was certified for maintaining its status of having eliminated mother-to-child transmission of HIV and syphilis (by the Global Validation Committee). The country achieved validation in 2016 and has applied for the requisite maintenance of validation that is required after two years. Meanwhile, Maldives successfully submitted its national validation report on EMTCT of HIV and syphilis. The Regional Office supported a successful visit by the regional validation team to Maldives. Its report has been submitted to the Global Validation Advisory Committee at WHO headquarters.

**Integrating disease responses for HIV, TB and hepatitis**

As part of efforts to align eliminating HIV, TB and hepatitis, the Regional Office supported India’s National AIDS Control Organization to create a high-level committee to suggest the ways forward to integrate the HIV and TB programmes. The key objectives of the committee were to discuss how to sustain the current HIV response while bringing it out of isolation. Subsequently, the committee discussed adopting a policy of selective integration of its biomedical services into the general health system. Ways to use the implementation strategies of the HIV/AIDS programmes to improve the coverage, quality and delivery of services for TB, hepatitis and other communicable disease programmes was also discussed.
Moving ahead on hepatitis

The SEA Region is home to an estimated 39 million people living with chronic hepatitis B infection and 10 million people with chronic hepatitis C. Viral hepatitis accounts for over 410 000 deaths in the Region every year. In 2017, the Regional Action Plan for Hepatitis (2016–2021) was adopted by Member States at the Seventieth session of the Regional Committee.

Hepatitis A and E – water- and food-borne infections – have largely been controlled due to improvements in water, sanitation and hygiene. However, multiple outbreaks of these diseases continue to be reported across the Region. Every year, hepatitis A causes more than 5500 deaths and hepatitis E nearly 32 000, with mortality from these two viruses heavily concentrated in Bangladesh, India and Nepal.

The Regional Office is focusing on building capacity within Member States on issues related to burden estimation, developing national action plans, adopting/adapting WHO treatment guidelines, and building the capacity of health-care providers on diagnosis and treatment of hepatitis. In addition, the Regional Office is also focused on increasing awareness about hepatitis, as one in 10 people do not know their status. Mr Amitabh Bachchan, the globally renowned Bollywood actor, is WHO Goodwill Ambassador for Hepatitis in the Region. Building partnerships with stakeholders and involving other programmes such as injection safety and hepatitis B immunization is also being given due importance. A five-pronged strategy followed by the Regional Office is depicted in Fig. 22.

**Fig. 22: Five key interventions for hepatitis elimination**

| Increase | Birth dose vaccine coverage for preventing hepatitis B |
| Ensure | use of ReUse Prevention / Sharp Injury Prevention Syringes to ensure safe injection practices |
| Assure | Safe blood for elimination of hepatitis B / C transmission |
| Improve | sanitation, water and food safety for elimination of hepatitis E related mortality |
| Scale up | testing and treatment for hepatitis B & C |

In 2018, the Regional Office supported India, Indonesia, Myanmar and Nepal to develop their national action plans for viral hepatitis. The Regional Office also helped Bhutan strengthen its hepatitis B surveillance along with developing treatment guidelines and an action plan.
Meanwhile, on World Hepatitis Day, India launched its National Action Plan for Hepatitis. The Plan, which focuses on hepatitis C, has been designed in an integrated manner within the existing health system for cost efficiency and sustainability. The plan for hepatitis B will be launched in early 2019. In addition, a campaign to increase the hepatitis B vaccine birth dose was launched by the Municipal Corporation of Greater Mumbai along with WHO, the Mumbai Liver foundation and the Federation of Obstetric and Gynaecological Societies of India. The Regional Office also worked with two WHO collaborating centres in India to develop and finalize training modules for training on hepatitis B and C. The Regional Office also partnered with “Treat Asia” and the WHO Regional Office for the Western Pacific to train Member States on hepatitis B and C diagnosis and treatment.

In another key step, the Regional Office for South-East Asia along with its counterpart in the Western Pacific Region and the Coalition to Eradicate Viral Hepatitis in the Asia-Pacific organized a WHO satellite session during the Twenty-seventh Annual Conference of the Asia-Pacific Association for the Study of the Liver. The session aimed to link policymakers, public health specialists, clinicians, hepatologists and gastroenterologists with professional associations, NGOs, CBOs and others working on hepatitis.

Moving ahead, the Regional Office will continue to work with Member States to develop costed national plans and enhance access to diagnostics and drugs through the South-East Asia Network.

3. Accelerating action on combating malaria

There are 1.6 billion people at risk of malaria in the SEA Region—the second largest contributor to the global malaria burden. Malaria is endemic in nine out of 11 Member States of the Region, accounting for nearly 70% of the burden of the disease outside of Africa.

Table 3: Estimated malaria cases by WHO region, 2017
(Estimated cases are shown with 95% upper and lower confidence intervals)

<table>
<thead>
<tr>
<th></th>
<th>Number of cases (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>African</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>184 500</td>
</tr>
<tr>
<td>Estimated total</td>
<td>200 500</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>243 600</td>
</tr>
</tbody>
</table>

| Estimated P. vivax       |          |          |                     |                  |                  |          |
| Lower 95% CI             | 19       | 648      | 1 162               | 2 881            | 330             | 5 720    |
| Estimated total          | 701      | 723      | 1 366               | 4 200            | 523             | 7 510    |
| Upper 95% CI             | 2 197    | 843      | 1 773               | 5 900            | 774             | 9 900    |
| Proportion of P. vivax cases | 0.3%  | 74.1%    | 31.0%               | 37.2%            | 28.1%           | 3.4%     |

CI: confidence interval; P. vivax: Plasmodium vivax; WHO: World Health Organization
Source: World Malaria Report 2018
In 2018, the SEA Region continued to see its malaria incidence rate fall. It recorded the largest decline globally, while other regions recorded either little progress or an increase in the incidence rate.

Reported confirmed cases decreased from 2.67 million in 2010 to 1.23 million in 2017 and deaths decreased from 2421 in 2010 to 299 in 2017, according to the World Malaria Report 2018. In spite of being the highest-burden country of the Region, India witnessed a 23% decline in reported cases in just one year from 2016 to 2017.

Bhutan and Timor-Leste – the two Member States identified by WHO as having the potential to eliminate malaria by 2020 – continued to rapidly progress towards elimination and are likely to achieve their targets. Provisional data from 2018 suggests they did not record any indigenous malaria case throughout the year.

Meanwhile, seven out of the nine Member States where malaria is endemic are on target to achieve more than a 40% reduction in case incidence by 2020. India and Indonesia are on track for a 20%-40% reduction. As a result of the massive reduction in malaria in the Region, all Member States are aiming to eliminate malaria by 2030, at the latest.

In an important step in 2018, the countries of the GMS signed a “Ministerial Call for Action to Eliminate Malaria in the Greater Mekong Subregion” before 2030 at a side-event at the Seventy-first World Health Assembly. The call is a response to the emerging antimalarial drug resistance and highlighted the importance of a country-led and country-owned response to malaria and UHC. Two Member States of the SEA Region, Myanmar and Thailand, were signatories to this Call for Action.

With the objective of making the Ministerial Declaration on Accelerating and Sustaining Malaria Elimination in the SEA Region operational, malaria elimination was made an agenda item for discussions at the Regional Committee Session for South-East Asia in September, following a 10-year hiatus. This led to a resolution on the elimination of malaria along with the control of dengue, chikungunya and Zika virus.

In parallel, the publication *An urgent front: cross-border collaboration to secure a malaria-free South-East Asia Region* was launched to emphasize the importance of cross-border action to eliminate malaria.

With malaria elimination efforts gaining momentum in the Region, multiple activities were carried out by the Regional Office in 2018 in sync with the increasing demands from Member States for support.

These included numerous national and intercountry training programmes and workshops for capacity-building; technical support for the scaling up surveillance and coverage of prevention, diagnosis and treatment; and support to establish a DHIS-2-based malaria module for data management in several Member States. Other activities included a surveillance review in Nepal; training on surveillance in Bangladesh in collaboration...
with the Global Malaria Programme; and an assessment of the prevention of vector-borne diseases in the Rohingya camps in Bangladesh.

Reaching communities at risk, providing them access to current malaria interventions and actively engaging with communities in eliminating malaria is critical to attaining national and regional goals. Ongoing and relevant operational research will help find solutions to adapt the currently available technical tools to local contexts so that appropriate responses are carried out.

4. Immunization and vaccine development

The South-East Asia Regional Vaccine Action Plan (SEARVAP) 2016–2020 charts the vision of the Region becoming free of VPDs, and all Member States in it providing to their citizens equitable access to high-quality, safe, efficacious, affordable vaccines and immunization services throughout the life-course. The Regional Vaccine Action Plan includes a series of goals and objectives for immunization and the control of VPDs. All progress made in the Region on immunization is measured against the eight SEARVAP goals.

In 2018, the Regional Office continued to provide technical leadership to Member States and partners.

During the ninth meeting of the Regional ITAG, progress reports submitted by the national immunization technical advisory groups of all Member States as per the Regional Vaccine Action Plan goals were examined and country-specific recommendations provided. Member States will provide an update on the status of implementation of these recommendations during the tenth meeting the regional ITAG in 2019.

Meanwhile, the Regional Office held a consultation at the regional-level meeting on the prevention of cervical cancer with HPV vaccination. Providing leadership to partners and setting norms for VPD surveillance and outbreak response in emergencies was another major area of work in 2018. Technical leadership was provided to respond to the diphtheria outbreaks in the Region, most notably in Cox’s Bazar, Bangladesh.

The Regional Certification Committee for Polio Eradication (RCCPE) in 2018 continued to set norms and standards for sustaining the polio-free status of the Region. At its meeting in 2018, the RCCPE introduced a new polio risk assessment framework to guide programmatic decisions as well as reviewed the annual report submitted by each Member State.

Similarly, the South-East Asia Regional Verification Commission (SEA-RVC) for Measles Elimination and Rubella/CRS Control reviewed programmatic standards in all Member

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29 Ninth SEAR ITAG meeting report (https://apps.who.int/iris/handle/10665/277458, accessed 5 February 2019)
States and provided recommendations to accelerate action to achieve the 2020 goal of measles elimination and rubella/CRS control.31

A “Regional Surveillance Guide”32 on conducting high-quality elimination-standard surveillance for key VPDs was also developed, following a rigorous consultative process with programme officers of Member States, members of academia, regional experts and WHO country offices.

Technical support was also given to Member States to ensure high immunization coverage and equity; and to strengthen immunization systems. The Democratic People’s Republic of Korea was provided support to develop its National Strategic Plan for Measles and Rubella Elimination. Several Member States were also supported to carry out MR SIAs.

In addition, the Regional Office supported acute flaccid paralysis (AFP) surveillance in several Member States and the reintroduction of IPV that had faced stock-outs in 2017. It also provided technical support to develop and finalize polio transition plans in five Member States that witnessed a decrease in polio funding.

The Regional Office also provided guidance to Member States to switch from the tetanus toxoid (TT) vaccine to the Td vaccine, and to implement the booster dose for Td in five Member States; supported the introduction of JE vaccination in Myanmar and Bali province of Indonesia; and provided technical support to conduct a hepatitis B serosurvey in Bhutan along with planning such a survey in two other Member States. To this end, cross-learning and experience-sharing was critical.

The introduction of several new vaccines was technically and programmatically supported in 2018. This included the introduction of the HPV vaccine in selected districts of Bangladesh, India, Indonesia and Nepal; the PCV in parts of India and Indonesia; and the rotavirus vaccine in several states of India and which is also scheduled to be introduced in Bangladesh, Nepal and Thailand.

Finally, some of the major research agendas that the Regional Office supported in 2018 included:

- innovative approaches to strengthen routine immunization, including evaluation of current initiatives;
- demand generation and dealing with vaccine hesitancy;
- causality assessment of AEFI s;
- surveillance for priority VPDs;
- IVB and rotavirus surveillance; and

Box 26. Sustaining maternal and neonatal tetanus elimination in Timor-Leste

Elimination of maternal and neonatal tetanus (MNT) in 2016 was a major public health achievement in the SEA Region. Maintaining elimination status will require continued strengthening of routine immunization activities for both pregnant women and children; maintaining and increasing access to clean deliveries; and reliable neonatal tetanus (NT) surveillance.

MNT elimination in Timor-Leste was confirmed in 2012 through the formal validation process of WHO. This represented an important public health success and contributed to regional MNT elimination in 2016. Prior immunization levels had been raised through a national TT campaign targeting all women aged 12–49 years.

Member States are expected to regularly review their MNT elimination status after validation and, in 2018, the Ministry of Health in Timor-Leste conducted a joint assessment with WHO and UNICEF.

Following a desk review of relevant risk indicators, the activity was conducted in three municipalities (two with low performance and one with good performance) at district health offices, referral hospitals and health centres.

Key findings included the impressive progress made in the last few years in establishing and improving health infrastructure through community health centres and health posts, all of which led to better access and use of services in challenging environments.

This resulted in the routine performance of MNT elimination core risk indicators, which was at over 80% typhoid–tetanus protection of pregnant women, over 90% antenatal care coverage (first visit) and improved skilled birth attendance in the visited municipalities. Neonatal tetanus is integrated with VPD surveillance and no municipality reported >1 NT case per 1000 live births in the last three years. Findings from the data review and field assessments in the two lower-performing municipalities are compatible with sustaining MNT elimination in them and, by extension, the whole of Timor-Leste.
operational research on a point-of-care testing device for confirmation of suspected measles cases in India.

Looking forward, the Regional Office will continue to provide high-quality technical support to Member States for the accelerated implementation of the Regional Vaccine Action Plan for higher coverage and equity for routine immunization. Following the launch of GPW13 there is a need to update and align it with the Regional Vaccine Action Plan 2016–2020. Work is also needed to develop the next vaccine action plan and a subsequent alignment of national action plans with the regional plan.
This report describes the work of the World Health Organization in the South-East Asia Region during the period 1 January–31 December 2018. It highlights the achievements in public health and WHO’s contribution to achieving the Organization’s strategic objectives through collaborative activities. This report will be useful for all those interested in health development in the Region.