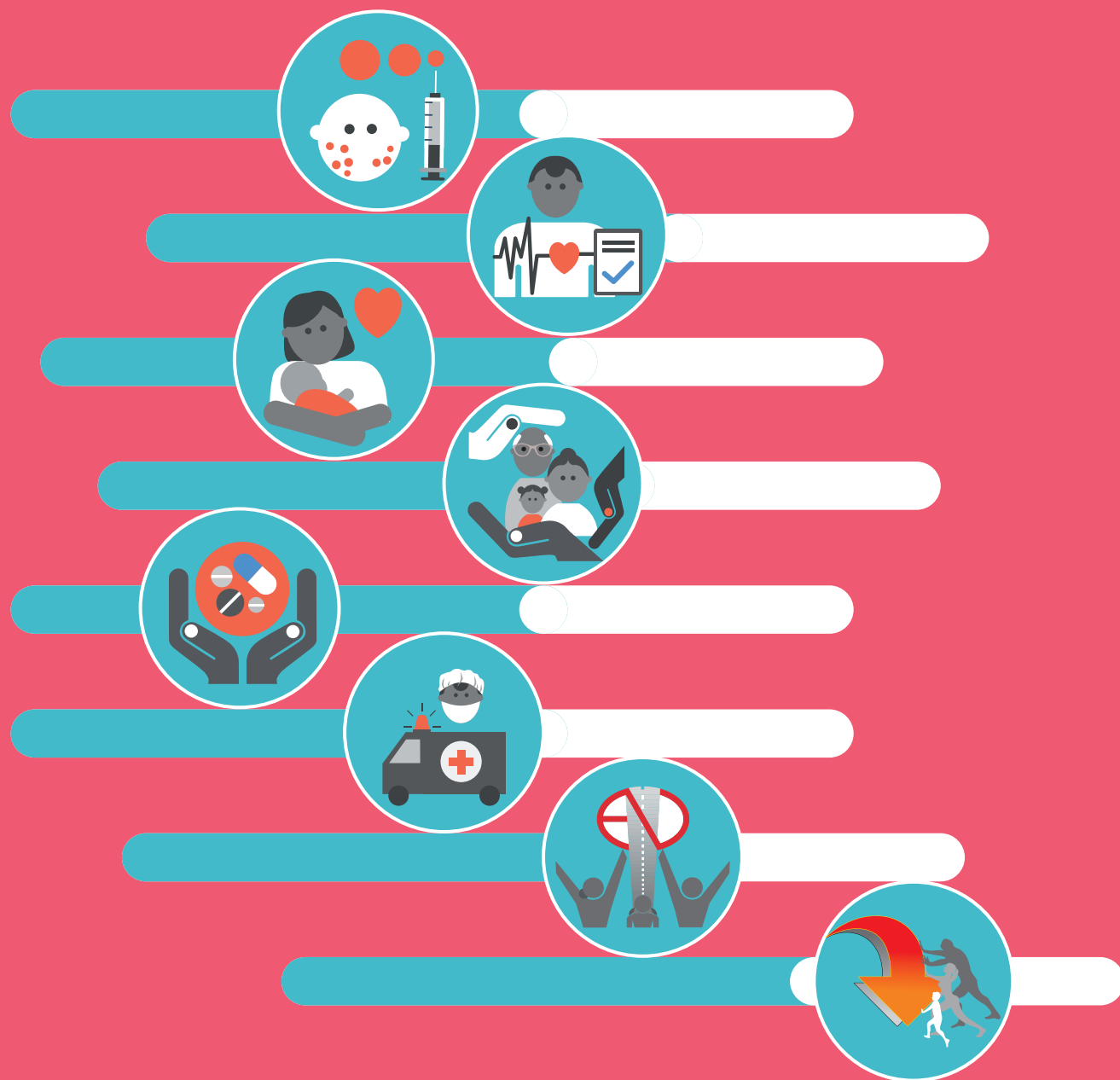


Evaluation of implementation of Regional Flagship Areas in the WHO South-East Asia Region 2014–2018



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World Health
Organization
REGIONAL OFFICE FOR
South-East Asia

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Evaluation of Implementation of Regional Flagship Areas in the WHO South-East Asia Region 2014–2018

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List of abbreviations

AEFI	Adverse Event following Immunization
AMR	Antimicrobial Resistance
APSED	Asia Pacific Strategy for Emerging Diseases
B SMART	Bhutan's Structured and Mentoring Approach to Research Training
BHTF	Bhutan Health Trust Fund
CRS	Congenital Rubella Syndrome
DIPECHO	Disaster Preparedness Programme of the European Commission Humanitarian Office
DPM	Director Programme Management
EMG	Evaluation Management Group
EML	Essential Medicine List
EmOC	Emergency Obstetric care
EMT	Emergency Medical Team
EPI	Extended Programmes of Immunization
EQA	External Quality Assurance
FAO	Food and Agriculture Organization of the United Nations
FETP	Field Epidemiology Training Programme
GAP	Global Action Plan
GAPPA	Global Action Plan on Physical Activity
GATS	Global Adult Tobacco Survey
GLASS	Global Antimicrobial Resistance Surveillance System
GMRLN	Global Measles and Rubella Laboratory Network
GPW 12	Twelfth General Programme of Work
GPW 13	Thirteenth General Programme of Work
GSHS	Global School-Based Student Health Survey
GYTS	Global Youth Tobacco Survey
HEOC	Health Emergency Operating Centre
HiAP	Health-in-All Policies
HITAP	Health Intervention and Technology Assessment Programme
HRH	Human Resources for Health
HSS	Health System Strengthening
IASC	Inter-Agency Standing Committee

iCAPS	Initiative for Coordinated Antidotes Procurement in the South-East Asia Region
IEHK	Inter-Agency Emergency Health Kit
IHR	International Health Regulations
IOAC	Independent Oversight and Advisory Committee
ITAG	Immunization Technical Advisory Group
JEE	Joint External Evaluation
JMM	Joint Monitoring Mission
LMICs	Low-to-Middle-Income Countries
M&E	Monitoring and Evaluation
MCV	Measles-containing Vaccine
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MHIS	Migrant Health Insurance Scheme
MLM	Mid-Level Managers
MPDSR	Maternal and Perinatal Death Surveillance and Response
MR	Measles and Rubella
MTR	Mid-Term Review
NAPHS	National Action Plan for Health Security
NAP	National Action Plan
NATA	National Authority on Tobacco and Alcohol
NCD	Non-Communicable Disease
NFPs	National Focal Points
NGOs	Non-Governmental Organizations
NLs	National Laboratories
NMAP	National Multisectoral Action Plan
NSP	National Strategic Plan
NVCs	National Verification Committees
OHT	OneHealth Tool
OOPE	Out-of-Pocket Expenditure
PAC	Post-Abortion Care
PHC	Primary Healthcare
PEN	Package for Essential Non-communicable Diseases (of WHO)
POCQI	Point of Care Quality Improvement
PPC	Programme Planning and Coordination
RCV	Rubella-containing Vaccine

REES+I	Relevance, Effectiveness, Efficiency, Sustainability and Impact
RI	Routine Immunization
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RRLs	Regional Reference Laboratories
SAC	Safe Abortion Care
SDGs	Sustainable Development Goals
SEA Region	South-East Asia Region
SEA-RVAP	The South-East Asia Regional Vaccine Action Plan
SEA-RVC	The South-East Asia Regional Verification Commission
SIAs	Supplementary Immunization Activities
SLMA	Sri Lanka Medical Association
SOP	Standard Operating Procedure
STEPS	STEPwise approach to surveillance
TAG	Technical Advisory Group
TAS	Transmission Assessment Survey
TERN	Technical Emergency Reference Network
ToC	Theory of Change
TrACSS	Tripartite AMR Country Self-assessment Survey
TWGs	Technical Working Groups
UHC	Universal Health Coverage
UN WOMEN	The United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
Urban HEART	Urban Health Equity Assessment and Response Tool
VL	Visceral Leishmaniasis
VPD	Vaccine-Preventable Disease
vSHOC	Virtual Strategic Health Operations Centre
WAAW	World Antibiotic Awareness Week
WEDS	WHO Emergency District Support
WHE	WHO Health Emergencies programme
WHO	World Health Organization
WHO-SEARO	World Health Organization Regional Office for South-East Asia

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Executive summary

Introduction

The World Health Organization (WHO) is responsible for providing leadership on global health matters, shaping the global health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. Given the large geographic scope and diverse needs of Member States, it's important that WHO clearly defines its vision and priorities at the global, regional and country level. After assuming office in 2014, the Regional Director of SEA Region provided a clear strategic vision that would match the 11 Member States of the SEA Region and align with their health priorities and those of the Twelfth General Programme of Work (GPW 12). This subsequently led to a focus on four strategic directions (1 by 4 strategy): persistent and emerging epidemiological challenges, strengthening emergency risk management for sustainable development, advancing the universal health coverage by building robust health systems and bringing the regional voice to the larger global health agenda.

The Region has been able to address many health priorities with limited resources. It became polio-free, reduced child and maternal deaths and lowered rates of HIV/AIDS, tuberculosis (TB), and malaria infections by 2014. However, Member States still needed to work as effectively as possible and health had to be placed on the highest political agenda in these countries. The Regional Director, therefore, went a step further and qualified specific initiatives as Regional Flagship Areas, which were meant to bring focus to WHO's work and provide a framework for accountability. Thus, the seven Regional Flagship Areas were finalized and launched in 2014. Despite putting strategic plans and resources in place, TB remained a constant challenge for the Region, which bears the burden of almost 45% of global cases, and just two countries (India and Indonesia) accounting for 37% of the global TB burden. This required bold action and an accelerated response, and, therefore, in 2017, TB was added as the eighth Regional Flagship Area.

Thus, WHO took a step towards bringing the attention of the SEA Region to the following areas:

- Eliminating measles and controlling rubella by 2020;
- Preventing non-communicable diseases (NCDs) through multisectoral policies and plans with a focus on "best buys";
- The unfinished Millennium Development Goals (MDG) agenda: ending preventable maternal, newborn and child deaths with focus on neonatal deaths;
- Universal health coverage with a focus on human resources for health and essential medicines;
- Building national capacity for preventing and combating antimicrobial resistance;

- Scaling up capacity development in emergency risk management in countries;
- Finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis, schistosomiasis, yaws); and
- Accelerating efforts to end TB by 2030.

Evaluation purpose and methodology

Purpose: This external evaluation for the SEA Region was undertaken with an objective to assess the relevance, effectiveness and efficiency of WHO's role in the progress of and impact on these Regional Flagship Areas from 2014 to 2018. Further, the report includes findings and recommendations on how to sustain gains, accelerate action and pilot innovative approaches for the Region in the eight Regional Flagship Areas. The objectives of this evaluation are laid out below:

- (a) Documenting the regional progress of each flagship's implementation, identifying achievements and success stories, best practices and key challenges encountered, and, to the extent possible, its outcomes or impact; and
- (b) Making evidence-based recommendations on the way forward to sustain gains, accelerate action and innovate where needed at the country and regional levels to achieve the impact targets of the Thirteenth General Programme of Work (GPW 13) and the Sustainable Development Goals (SDGs).

The intended primary audience for the evaluation are decision makers at WHO, both at the regional and country levels, along with Ministry of Health stakeholders in Member States. This evaluation is expected to provide an opportunity for WHO to learn from its prior work and results at all levels of the organization (global, regional and country level). This will enable the organization to enhance accountability and learnings for future planning and to support the Regional Office as it considers continuing the implementation of these eight Regional Flagship Areas until 2023.

Methodology: The overall course of evaluation has been designed and implemented using the Theory of Change and Relevance, Effectiveness, Efficiency, Sustainability and Impact (REES+I) framework approach. The evaluation employed a mixed-method (qualitative–quantitative) approach (more focused on qualitative methods), which provided a holistic view of the flagships. A two-pronged study design was developed. The components were as follows:

- **Secondary Review:** The study focused on secondary review through an in-depth literature review covering data and reports (over 120 documents) published from 2014 to 2018. This also included an analysis of the already published monitoring data for each flagship.
- **Primary Evaluation:** In-depth interviews with 351 stakeholders were conducted to assess the processes of change across outputs and outcomes, document the achievements and challenges under the Regional Flagship Areas and ascertain the level of perceived attribution to the prioritization exercise that is the flagship. A Likert scale was also administered to external stakeholders to get their perspective on the impact that the Regional Flagship Areas had on WHO's contribution across key thematic areas at the Member State level.

A purposive sampling approach was adopted to identify stakeholders from WHO, ministries of health, technical partners and donors for in-depth interviews. Selected stakeholders were involved in planning and policy development, administrative and technical leads of each flagship. The interviews provided information on their subjective experience from 2014 to 2018. Although most of the interviews were

conducted in person, some were done on video or the telephone, and a few were over emails, as written responses to open-ended questions. This was done to ensure maximum coverage despite travel restrictions due to the COVID-19 pandemic. The quantitative method consisting of Likert scale questionnaires was administered to non-WHO stakeholders to rate the organization's performance across key thematic areas and was analysed as a percentage distribution. Qualitative data was analysed using a hybrid approach (a mix of grounded theory and framework analysis) using the Atlas.ti software. The qualitative analysis was presented as a narrative, and word clouds (using codes that emerged most frequently) were developed to provide a snapshot and conclude the evaluation. The primary data findings from key informant interviews were triangulated with secondary research findings.

Evaluation findings

Under the umbrella of Regional Flagship Areas (flagships), the WHO-SEARO ensured the development of technical and operational frameworks for these focus areas to attain goals and sustain their gains in the Region. The flagships provided targeted focus and have been responsible for a series of remarkable achievements. The thrust given by the flagships was also reflected at the Member State level in the form of accomplishments achieved with the collaboration of WHO, ministries of health and technical partners and donors. Through the flagships, the Regional Office supported all Member States by developing strategies for technical assistance, monitoring and evaluation, capacity building initiatives and surveillance, and by encouraging scientific research and development. The assistance and advocacy efforts of WHO were critical to leveraging additional sources and mobilizing funds and logistical support. The flagships are aligned with the priorities of the Member States, with a strong vision and purposefulness, and thus reinforce the focus of ministries of health, WHO country offices and development partners.

Measles elimination and rubella control by 2020: In September 2013, at the 66th session of the Regional Committee (SEA/RC66/R5), the SEA Region adopted the goal of eliminating measles and controlling rubella/congenital rubella syndrome (CRS) by 2020. Making measles elimination and rubella control one of the Regional Flagship Areas gave momentum to initiatives with these goals, and, consequently, made most stakeholders from inside and outside the ministries of health in Member States and development partners aware of WHO's focus on these childhood killer diseases. The Strategic Plan for Measles Elimination and Rubella/CRS Control 2014–2022 was developed to provide technical guidance. The South-East Asia Regional Vaccine Action Plan 2016–2020 (SEA-RVAP) has incorporated measles elimination and rubella/CRS control as one of its eight goals. The Regional Verification Commission for Measles Elimination and Rubella/CRS Control for South-East Asia (SEA-RVC) was established in 2016. All countries in the Region are administering two doses of the measles-containing vaccine (MCV) under their routine immunization programmes and 10 countries have introduced the rubella-containing vaccine (RCV) in their programme. Focused efforts have helped increase coverage, improve surveillance and strengthen laboratory capacity. Five countries in the SEA Region – Bhutan, Democratic People's Republic of Korea (DPR Korea), Maldives, Timor-Leste and Sri Lanka – have been verified by the SEA-RVC as having eliminated endemic measles. Similarly, six countries in the Region – Bangladesh, Bhutan, Maldives, Nepal, Timor-Leste and Sri Lanka – have been verified as having controlled rubella and CRS. In addition, the Regional Office supported the development of post-elimination sustainability plans for countries that have achieved the elimination of measles and rubella/CRS control status. As per the midterm review of the strategic plan conducted in 2017, the Region will be unable to achieve its targets due to the suboptimal implementation of strategies in the remaining six countries (Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand).

Hence, revised targets to eliminate measles and rubella by 2023 were finalized through a high-level consultation in 2019.

Prevention of NCDs through multisectoral policies and plans with a focus on best buys: The second flagship focusing on NCDs has brought visibility to the ever increasing mortality and morbidity impact of these diseases in Member States. It also supported countries in their national efforts and helped build regional momentum to accelerate their response to implementing best buys in the case of NCDs. The progress was supported by the establishment of an inter-ministerial committee for the prevention of NCDs and the formulation of a technical working group (TWG) for each risk factor. Overall, the Region has shown significant progress, as each Member State developed and adopted the National Multisectoral Action Plan (NMAP) by 2018. Furthermore, monitoring and evaluation activities, such as risk factor surveys and national targets for the prevention and control of NCDs aimed to implement a whole-of-society approach to reversing the NCD epidemic. Member States such as Thailand adopted measures to reduce determinants and behavioural risk factors, and promote health-seeking behaviours, which led to a reduction in the percentage of NCDs in the population. Other Member States have developed guidelines for the management and availability of basic diagnostics and medicines for NCDs at the primary health care level. NCDs have also been integrated into emergency response and preparedness in 2018. The NCDs flagship has been a catalyst to accelerate action alongside the global momentum generated by the high-level meeting of the General Assembly on the Prevention and Control of NCDs (September 2013). However, there are many challenges associated with this flagship, such as suboptimal evidence-based interventions, industry interference, subnational coordination with other stakeholders, and implementation-level challenges. Despite the support for the programme, underfunding and a shortage of human resources across sectors remain a challenge. The lack of clarity of roles among stakeholders has weakened multisectoral coordination and affected the sustainability of the progress made till date. Thus, it is imperative to have strong multisectoral collaboration, advocate for adequate budget allocation and mobilize high-level political attention. A more comprehensive monitoring framework should be developed, with yearly targets to track progress and evidence-based research to ensure the sustainability of achievements and further progress.

The unfinished MDG agenda: ending preventable maternal, newborn and child deaths with focus on neonatal deaths: To address the unfinished MDG agenda, the Region identified “ending preventable maternal, newborn and child deaths with focus on neonatal deaths” as one of the eight Regional Flagship Areas. It brought focus on newborn mortality in a concerted manner that had not been previously covered by the MDGs. A technical advisory group (TAG) on women’s and children’s health guides governments, partners and other stakeholders on how best to accelerate action. The regional strategic frameworks supported the updating of national strategies, helping Member States to increase coverage and address inequities, thus accelerating a reduction in mortality in the period evaluated (2014–2018). The Region has made remarkable progress in reducing maternal and under-five mortality. DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand have already achieved the global SDG targets for neonatal and under-five mortality, while Maldives, Sri Lanka and Thailand have done the same for maternal mortality. The major challenges that persist in this flagship include inequitable access to services, improper infrastructure, low financial allocation for reproductive, maternal, newborn, child, adolescent health (RMNCAH) and inadequate surveillance. Despite persistent challenges, the Region has made progress showing national commitments, however, a few Member States are unlikely to meet the SDG targets by 2030.

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

Considering the challenges of human resources for health (HRH) (shortage of manpower, inequitable distribution and retention, among others) and essential medicines, the SEA Region reaffirmed and extended its commitment towards universal health coverage (UHC) by translating global initiatives. Articulating it this way helped make both these issues health priorities in Member States, along with the overall drive of Member States to achieve UHC. Even so, the flagship accelerated and focused their efforts towards UHC. In 2014, the Regional Office provided strategic direction to Member States through the strategic document, *Decade for Strengthening Human Resources for Health in the South-East Asia Region 2015–2024*. The Regional Office has supported Member States in the inclusion of national mechanisms for health workforce planning. As a result, 10 Member States have reported on HRH strategies, with India being the exception, and five countries (Bangladesh, Myanmar, Nepal, Thailand and Timor-Leste) have updated their strategies since 2016. Member States achieved varied levels of success in intersectoral collaboration; only six SEA Region countries have institutional mechanisms to coordinate an intersectoral health workforce agenda.

The convening power of the WHO bought the Region together under the South-East Asia Regulatory Network (SEARN) to establish better regional mechanisms to negotiate better prices for supplies. WHO also supports Member States to update their essential medicine list (EML) every two years. Since 2017, seven countries have updated their national EMLs. The major steps taken by WHO to ensure equity include drafting strategic documents in countries such as Bhutan, advocating a basic health service package in Nepal and analysing the gender implications of all priority programs in Thailand, among others. Member States have limited data on their health workforces, with most data only reflecting the public sector health workforce. This matters most in those countries with a large private health sector like India, Indonesia and Bangladesh. Also, medicines remain a major source of out-of-pocket payments and lead to catastrophic health expenditure. Limited attempts have been made by countries to ensure equitable access to health services for the migrant and refugee populations who are at the most risk of being excluded from healthcare.

Building national capacity for preventing and combating antimicrobial resistance (AMR):

According to a WHO-conducted qualitative risk assessment, the SEA Region is possibly at the highest risk globally for the emergence and spread of AMR. Instituting AMR as a Regional Flagship Area brought much-needed focus, attention and resources to this emerging and quickly evolving public health concern. With WHO's support, all Member States developed National Action Plans (NAPs) in alignment with the Global Action Plan (GAP) on AMR. Multipronged NAPs laid the roadmap for priority issues of governance and multisectoral coordination, AMR surveillance, capacity building, gaps in knowledge and the strengthening of systems. Member States, with support from WHO, conducted activities across these domain areas, and achieved progress in implementing the five strategic objectives as per the GAP and NAPs. In addition to the development of NAPs, all Member States were reporting to the Tripartite AMR Country Self-assessment Survey (TrACSS) and 10 of the 11 Member States enrolled in the Global Antimicrobial Resistance Surveillance System (GLASS), an achievement for the Region during the evaluation period. However, to combat AMR in the Region, Member States faced multiple challenges. These include facilitating a multisectoral approach and high-level governance under the OneHealth agenda, limited involvement by the animal, agricultural and environmental health sectors in NAPs, minimal human and financial resources to implement the NAPs in totality, a lack of prioritization, poor regulation (especially where large private sectors exist), and large knowledge and data gaps around the AMR burden and surveillance of it. Additional efforts are required to mainstream

AMR into the political agenda at the country level. There is a need to strengthen multisectoral collaboration, improve AMR awareness, advocate for higher budget allocation, and strengthen surveillance and evidence-based research.

Scaling up capacity development in emergency risk management in countries: The SEA Region is vulnerable to various health and non-health emergencies, which created the need for the Member States to bring a sharp focus on emergency preparedness and risk management. WHO played a coordinating role to ensure the compliance of Member States with global standards and frameworks, and, together with its partners, helped countries to build their capacities. WHO's support to Member States was enhanced by the establishment of health emergency operating centres (HEOCs) and funding mechanisms such as the South-East Asia Regional Health Emergency Fund (SEARHEF) that allowed for rapid response during emergencies. The Regional Office supported Member States in conducting comprehensive assessments of the core capacities for emergencies using a monitoring and evaluation (M&E) framework, which included joint external evaluation (JEE) and State Party Annual Reporting (SPAR) followed by an after-action review and simulation exercises. All Member States reported on their International Health Regulations (IHR) capacities through the SPAR mechanism. Eight Member States (Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste) completed the JEE and five Member States (Indonesia, Maldives, Myanmar, Sri Lanka and Thailand) each developed a National Action Plan for Health Security (NAPHS) to implement IHR by the end of 2018. However, several challenges present themselves when it comes to managing emergencies. These include limited operational partnerships, limited human resources capacity, inadequate funds for emergency preparedness and the unavailability of quality data on emergencies. The Region must prioritize building IHR core capacities, adopt an integrated approach to pandemic preparedness and NAPHS, build a cadre of WHO-certified emergency medical teams (EMTs) in the Region and strengthen capacity to handle other threats such as chemical, biological and radio nuclear events. Further, there is a need to prepare health systems for extreme weather occurrences due to climate change.

Finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis, schistosomiasis and yaws): The SEA Region is affected disproportionately by some diseases, with 67% of all new leprosy cases and 60% of all new cases of visceral leishmaniasis (VL) worldwide occurring in the Region. In addition, an estimated 850 million inhabitants are at risk of contracting lymphatic filariasis (LF). This flagship was leveraged to enhance the inflow of resources to eliminate neglected tropical diseases (NTDs) in the Region. Through this flagship, WHO supported the formulation of various directives for NTDs at the country level across all Member States. Introducing new treatment regimes in Member States and supporting their implementation helped increase the efficiency of the NTD elimination programme in these countries. Strong advocacy efforts were made at the regional level to allocate more resources to the ministries of health to help expand the programme and accelerate interventions. In addition, free drugs were provided for LF, VL, leprosy and schistosomiasis in all endemic countries through donation programs. Some support on diagnostics for LF and VL programmes was also provided. WHO helped build the capacity of national programme staff and strengthen surveillance systems for NTDs across Member States. Through the evaluation period, the Region's progress in eliminating NTDs has been significant: Maldives (2016), Sri Lanka (2016) and Thailand (2017) eliminated LF; India was declared yaws free (2016) and Nepal eliminated trachoma (2018). In 2018, Bhutan, DPR Korea and Maldives have reported less than 20 new leprosy cases annually and have progressed towards a zero-leprosy status. However, several challenges such as limited resources and inadequate political commitment during post-elimination surveillance, insufficient procurement systems resulting in longer lead time and limited suppliers for NTDs drugs, and poor data

management affected the successful implementation of NTDs programs under this flagship in Member States.

Accelerating efforts to end TB by 2030: While Member States were already working on TB care and control, the Region's declaration of TB as a Regional Flagship Area in 2017 after the ministerial meeting in New Delhi accelerated ongoing efforts. With this flagship, it was evident that TB was being accorded more weight and primacy than before through leadership, on-the-ground action, and strengthening collaboration and partnership. WHO's role as an important technical arm to the ministry, where they also monitored the other partners and encouraged them to report to the technical working groups (TWGs), was emphasized. WHO contributed significantly by providing technical support, which has been instrumental in presenting the goal of ending TB to the highest authorities. Countries like India and Indonesia worked for the highest level of commitment from the government by eliciting rigorous responses from the prime minister's and the president's offices respectively in both the countries. Significant accomplishments were seen in areas like policy regulation and strengthening, resource allocation, disease surveillance, and monitoring and evaluation. Building a sustainable, systemic response that remains stable despite diverse changes in country scenarios has included setting up clear mechanisms (such as technical and other committees). With multi-drug-resistant TB being such a huge challenge, WHO drug resistance surveys were seen as a very significant and important initiative across the Member States. WHO country offices have also been successful in working with other donors and technical partners at the country level and initiated close collaboration amongst diverse stakeholders. However, some persistent challenges hindered the smooth implementation of the flagship, such as inadequate quantities of testing machines (and, where there are enough machines, some of them were not operational), the low technical capacity of the existing human resources, service delivery-challenges, and a changing political and administrative environment.

Conclusion and the way forward

Regional Flagship Areas provided acceleration and thrust to the key health priorities of the SEA Region. WHO has made significant contributions towards the flagships through highly acknowledged technical assistance, which has led to the achievement of improved health outcomes. It is important to acknowledge the game-changing progress that has been made in the Region since the launch of flagship priorities in 2014. Five countries have now eliminated measles, six have controlled rubella. All 11 SEA Region countries are implementing national action plans to tackle NCDs as well as AMR. Region-wide, the coverage and quality of health services are stronger than ever, while the unfinished MDG agenda has now been finished with a focus on reaching new targets under the SDGs. Emergency risk management proceeds apace, while the battle to eliminate diseases on the verge of elimination is being won. The drive to end TB has gathered unprecedented momentum.

In addition to the existence of flagships, multiple other factors such as political will and support from ministries of health and a commensurate increase in funding, institutional capacity, and the health systems of upper-to-middle-income countries have driven the advancement towards targets, with flagships playing a catalytic role. Despite the achievements, some key challenges persist in the implementation of the flagships (discussed flagship-wise in Section 3). A stronger leadership role was anticipated from WHO in political advocacy, fund mobilization, enabling the Member States to generate evidence through research and innovation, and refocus in areas such as equity, inter-flagship collaboration and multisectoral coordination.

To attain the commitments of the triple billion target laid out in GPW 13 and the SDGs, the drive towards these imperatives is possible through the transformation of regional and country priorities and the required revision of the flagships. Thus, to pave the way for the success achieved and to improve further based on the lessons learned, the Region's Member States have now endorsed version 2.0 of the Regional Flagship Areas at the 2019 Regional Committee meeting in New Delhi, India. These flagships should continue to provide a results-based focus for the Member States to work on and improve the health outcomes of the countries in a concerted manner. The changes recognize the progress made thus far and orient a renewed focus on regional priorities until 2023. The Region must ensure that each Regional Flagship Area is pursued with vigour as per the Region's quest to sustain its achievements, accelerate progress and harness the full power of innovation.

Recommendations

Based on the evaluation findings and the key challenges identified, the following recommendations are proposed:

Recommendations for WHO Secretariat

- (a) **Revisit the scope of Regional Flagship Areas with following additions:**
 - Including additional areas such as dengue (under the flagship focusing on NTDs), malnutrition leading to stunting (under the maternal and child health flagship), and migrant health (under the flagship focusing on UHC and emergency preparedness) to provide the necessary attention and impetus to these issues. These are areas where WHO is already supporting the ministries of health across several Member States and additional focus and resources would be beneficial.
 - The flagships need to formally set the conditions and provisions for equity to increase access and barriers of care (catering to hard-to-reach populations, geographical access, gender, etc.). This would help in integrating equity related interventions into the Regional Flagship Areas.
- (b) **Develop a standardized monitoring and evaluation framework:** The framework will ensure that stakeholders have performance data for decision-making as well as to track progress across Member States for each of the flagships. This can be through:
 - Regular reviews and independent evaluations for each of the flagships.
 - Standard templates for monitoring and reporting across all countries.
 - Periodic (annual) sensitization workshops for WHO country offices and Ministry of Health officials.
 - Defined targets as per the monitoring and evaluation framework.
- (c) **Accelerate efforts for advocacy initiatives:** WHO may consider accelerating their efforts towards the political advocacy which will garner political commitment and will lead to improved ownership and increased investment from Member States. This can be done by:
 - Considering establishing a regional flagship caucus with representation from parliamentarians, civil society organizations and community representatives.

- Accelerating efforts to engage with the private sector and encourage integration with the public sector.
- (d) **Establish a funds mobilization strategy:** WHO could establish a funds mobilization strategy (customized to country context) that assesses future funding needs and identifies specific actions to address any potential shortfalls and improve donor management relationships.
- (e) Develop a multisectoral accountability framework: WHO could leverage its convening power to support Member States in effective multisectoral collaboration with key actors both within and outside the health sector. The Organization could:
- Conduct a comprehensive partner and donor landscaping, and map and engage with key ministries, other than the ministries of health.
 - Develop a multisectoral accountability framework for each of the flagships at country level that will clearly lay down the roles and responsibilities of each of the partners.
- (f) **Strengthen Member States' capacity for evidence-based research:** Research will not only promote the development of guidelines and plans relevant to country context, but also build the country's capacity to invest in research and innovation.
- WHO could form a research network across the Region involving academia and institutions from all Member States, which can be further supplemented by WHO's technical expertise at the regional and country level.
- (g) **Strengthen human resource capacity in WHO country offices:** it is suggested that the Regional Office assess the current staffing and skills mix in WHO country offices in the light of the new flagship priorities, addressing gaps in relevant areas and providing capacity building opportunities to existing staff.

Recommendations for health ministries and Member States

- (a) **Enhance efforts to ensure sustainability:** For programmes and projects that are donor funded, ministries of health are encouraged to develop country-specific implementation plans with a feasible exit plan and increase efforts to build the capacity of the health workforce using digital platforms and module-based learning.
- (b) Encourage programme specific external evaluations: Member States should plan programme-specific external evaluations and reviews such as JEEs and joint monitoring missions (JMMs) which will guide them through improved policy planning, customized strategic plans and focused implementation of activities.
- (c) Lead multisectoral collaboration: Ministries of health should lead multisectoral collaboration efforts by developing a multisectoral accountability framework with support from WHO, and actively engage with other ministries and non-health actors in critical areas such as NCDs, AMR, UHC and migrant health.
- (d) **Increase funding for the health sector:** Overall, Member States are encouraged to invest more in the health sector. The expenditure should focus on the treatment and prevention of diseases, for example, addressing latent TB infections, airborne infection control measures, early diagnosis and screening.

Section 1: Introduction

The SEA Region is one of the six WHO Regions and includes 11 Member States: Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. According to the *Report of Regional Director – The Work of WHO in the South-East Asia Region, 2014*, the Region houses more than one-fourth of the world’s population and accounts for a disproportionate percentage of the global disease burden. SEA Region Member States are afflicted with a triple burden of disease – infectious diseases, non-communicable diseases and injuries. The Region accounts for the highest proportion of global mortality (26%) and, due to relatively younger ages at death, the second-highest percentage of total years of life lost (30%). It accounts for ~40% of the global poor and ~30% of the global disease burden¹, with a disproportionate share of tuberculosis (44%)², deaths due to non-communicable diseases (55%)³, maternal deaths (23.5%)⁴ and under-five-year-old mortality (33.6%)⁵. Moreover, the government health spending as a proportion of the GDP is lower than the global average, and out-of-pocket expenditure (OOPE) as a proportion of total health expenditure is higher, which places tremendous financial burden on individuals and families. Taking all the WHO Member States of the SEA Region together, the total health expenditure as a percentage of GDP is lower than any other WHO Region.⁶

These statistics suggested the need to ensure a clear strategic direction to WHO’s work and for it to match its priorities to those defined in GPW 12, in consultation with Member States. This further led to several advocacy and strategic measures being implemented by the WHO-SEARO. In 2014, Dr Poonam Khetrpal Singh, Regional Director for WHO South-East Asia put forth a game-changing 1 by 4 vision and strategy that aimed at increasing the responsiveness, accountability and inclusiveness of WHO-SEARO and ensuring the clear definition of four strategic directions:

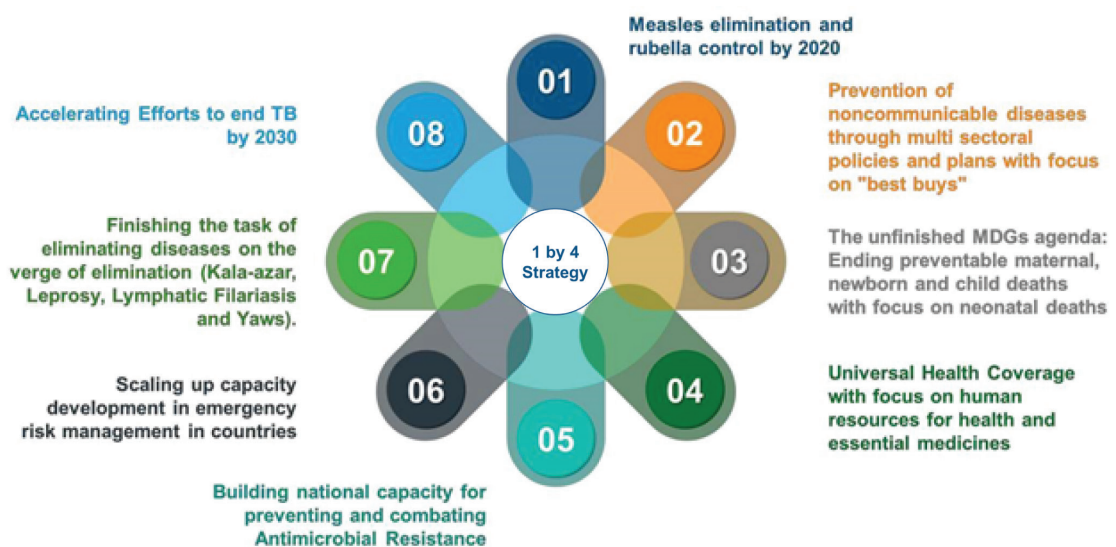
- 1 Dhillon PK, Jeemon P, Arora NK, Mathur P, Maskey M, Sukirna RD, Prabhakaran D. Status of epidemiology in the WHO South-East Asia region: burden of disease, determinants of health and epidemiological research, workforce and training capacity. *International journal of epidemiology*. 2012 Jun 1;41(3):847-60, p.38
- 2 World Health Organization. [Internet]. [cited 31 May 2020]. Available from: <https://www.who.int/southeastasia/health>.
- 3 World Health Organization. *The work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January-31 December 2017*. World Health Organization. Regional Office for South-East Asia. 2018.
- 4 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. *Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. World Health Organization. 2014. [Internet]. 2014 [cited 31 May 2020]. Available from: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/2015>
- 5 World health Organization. *Under 5 mortality, Global Health Observatory*. World Health Organization; 2018 [Internet]. [cited 31 May 2020]. Available from: https://www.who.int/gho/child_health/mortality/under_five_who_region_situation/en
- 6 Majumder MA. Economics of healthcare financing in WHO South East Asia Region. *South East Asia Journal of Public Health*. 2012;2(2):3-4

- (a) addressing the persisting and emerging epidemiological and demographic challenges
- (b) advancing universal health coverage and robust health systems
- (c) strengthening emergency risk management for sustainable development
- (d) articulating a strong regional voice in the global health agenda

These four themes provide the overarching vision for WHO's work in the SEA Region but are necessarily broad. Thus, in order to tackle the unfinished agenda of the MDGs, move towards the timely attainment of the SDGs target and emphasize specific goals for the Region, the Regional Director proposed the introduction of Regional Flagship Areas. These flagships serve as a means to give sharper focus to WHO's work and to provide a framework for accountability.

In 2014, The Regional Office, in consultation with Member States, launched seven Regional Flagship Areas (which became eight in 2017), in which WHO would primarily apply its technical expertise, convening power (amongst important stakeholders) and advocacy. The flagship focus was intended to help advocate for a more prominent role for the Regional Office to shape public health priorities globally. These flagships were built on existing country initiatives and meant to sustain achievements and accelerate progress with a sense of urgency. Of the eight flagships, some were focused with clear targets and output, and some were very broad and addressed multiple issues, for example, UHC, NCDs and emergency risk management are broad areas for which the flagships provide a strategic direction. Also, the flagships suggested specific areas of focus that might be tailored to a country's needs. AMR issues, which were missing from the agendas of Member States and external partners, were brought forward. Measles and rubella were selected to provide a clear demonstration that, given the right level of political and financial support, major public health problems can be combated. Specific targets were added for NTDs. A focus on neonatal mortality has also been added as a flagship. In 2017, ending TB was added as the eighth flagship due to the significant TB burden in the Region, and to further accelerate the response of the Region to the global target of ending TB by 2030.

Fig. 1: Eight Regional Flagship Areas of the SEA Region



Since their launch, the flagships have prioritized WHO's technical support to Member States, promoted a strong focus on results and accountability, and inspired sustainable and result-oriented national efforts. From a policy and programmatic standpoint, WHO ensures action in the Region by tailoring such plans to individual country contexts and supporting such action in individual countries, so much so that 80% of the Regional Office's resources – both technical and financial – have been focused on these flagships.

Section 2: Evaluation objectives and methodology

2.1 Purpose and objectives of the evaluation

This external evaluation for the SEA Region was undertaken with a main purpose to foster reflection on key accomplishments, challenges, achievements and non-achievements to facilitate organizational learning that would help the Regional Director, her team and WHO partners to better deliver on the commitments made in the 1 by 4 strategy. (See Section 1.0 for details on 1 by 4 strategy).

IQVIA assessed the progress of each Regional Flagship Area, considering the flagship's relevance, effectiveness, efficiency, sustainability and impact at the regional and country levels. Consolidated recommendations of the evaluation will be presented to WHO (regional as well as country offices) and to ministries of health of Member States. The findings are intended to be used to sustain any gains made since the implementation of the flagships, accelerate progress, and identify challenge areas that are ripe for innovation. This evaluation is expected to provide an opportunity to learn from its results at all levels of the Organization. WHO can then usefully inform the development of the future country and regional support through a systematic approach to organizational learning.

The broader objectives of this evaluation are:

- (1) Documenting the regional progress of each flagship's implementation, identifying achievements and success stories, best practices and key challenges encountered, and, to the extent possible, its outcomes or impact; and
- (2) Making evidence-based recommendations on the way forward to sustain gains, accelerate action and innovate where needed at the country and regional levels to achieve the impact targets of GPW 13 and the SDGs.

2.2 Evaluation scope

This evaluation covered all activities undertaken by WHO (WHO-SEARO and WHO country offices) in 11 Member States of the SEA Region, as guided by the eight Regional Flagship Areas from their institution in 2014 until 2018 (one full term of implementation).

The intended primary audience for this evaluation is decision-makers at WHO, both at the regional and country level, along with policymakers of the ministries of health in the Member States. The main expected use for this evaluation is to guide and support the Regional Office as it considers continuing the implementation of these eight Regional Flagship Areas from 2019 to 2023.

2.3 Evaluation questions

The evaluation terms of reference (ToR) identified the evaluation questions as outlined below. The evaluation framework adopted to address these questions is described in the subsequent section (Section 2.4: Evaluation Framework). The evaluation questions were:

- To what extent has the flagship focus and implementation at the country level helped improve the health outcomes, equity, inter-sectoral collaboration, effectiveness and efficiency of WHO's interventions?
- What are the significant achievements and success stories at the country level due to the implementation of flagships (that is, attributable to the priority-setting exercise of establishing Regional Flagship Areas)?
- What have been the key enabling factors and challenges in developing and implementing SEA Region flagships at the country level during the period 2014 to 2018?
- What are the lessons and best practices from different countries and regional technical programs that can be adapted to sustain the gains, accelerate action and innovate where needed at the country and regional level to achieve the impact targets of GPW 13 and the SDGs?

2.4 Evaluation framework

The Relevance, Effectiveness, Efficiency, Sustainability and Impact (REES+I) framework, based on the Development Assistance Committee evaluation criteria, is used to provide structure and direction to the evaluation findings.⁷ The evaluation focuses on the transition of each flagship from outputs to outcomes, trying to identify which mechanism brought about change, and answers the following questions under each criterion (the detailed evaluation framework is provided in the Annexure I):

Relevance: The strategic choices made through the flagship to address the SEA Region's health needs which were aligned with government and partners priorities. It evaluates whether the selection of the flagship was relevant to the country context aligning with their national health priorities.

Effectiveness: WHO's contribution towards addressing the health needs of the country. This includes support in strategic and technical guidance and its uptake by the respective Member States. It measures what changes could be attributed to the implementation of these Regional Flagship Areas.

Efficiency: The contribution of core functions, partnerships and allocation of resources (financial and staffing) in delivering the expected results.

7 Organization for Economic Co-operation and Development. DAC criteria for evaluating development assistance. 2018-2019. The Organization for Economic Co-operation and Development (OECD) [Internet]. [cited 6 March 2020]. Available from: <https://www.oecd.org/dac/evaluation/49756382.pdf>.

Sustainability: The ability of Member States to continue to maintain the programme over time.

Impact: The progress each flagship achieved at the end of the first term and the potentially transformative effects of the interventions.

2.5 Evaluation design

The evaluation employed a mixed method approach, where quantitative information was gathered to complement the qualitative insights. A two-pronged evaluation design was utilized to gather data: secondary review and primary data collection.

2.5.1 Secondary review

With the aim of understanding the evolution of the flagships, as well as to identify the indicators for the logical framework for each of the Regional Flagship Areas for all 11 Member States, the evaluation team undertook an extensive literature review for the period from 2014 to 2018. This included an extensive listing of WHO publications, board and standing committee reports, regional director reports, regional strategic plans, annual reports, press releases, newsletters, articles and publications, a collection of over 120 documents in all. A detailed note of the secondary review methodology and the documents referred to in the secondary review document have been shared in Annexure II and Annexure VIII.

2.5.2 Primary data collection

Key stakeholder interviews were conducted to assess the processes of change across outputs and outcomes, document the achievements and challenges under the flagships and ascertain the level of perceived attribution to the flagships. The participants were selected based on the following selection criteria:

- (1) Stakeholders who are involved in the processes of planning, policy development and implementation across the levels of WHO-SEARO and country offices.
- (2) Respondents from respective ministries of health (administrative and technical leads of each flagship) and from key technical and donor agencies. The key stakeholders were mapped by the evaluation team country wise and flagship wise (see Table 1 for break-up). Based on the matrix provided by the evaluation team, the WHO country offices connected the relevant person with the evaluation team for the interviews.

2.5.2.1 Sample size and data collection process

A total of 211 key stakeholder interviews (some interviews included a team of three to four respondents) were conducted with 351 respondents from WHO, the ministries of health and technical partners (a list of respondents is provided in Annexure VI) to obtain comprehensive information about the programmes and activities. The segregation of the sample country and stakeholder-wise break-up is provided in Table 1. A visit was planned to all the SEA Region Member States, with the exception of DPR Korea, owing to political and administrative constraints. However, in view of the COVID-19 pandemic and subsequent restrictions imposed on travel, the visits had to be cancelled after covering seven countries (which included interviews from some stakeholders in India also). The data

collection strategy for rest of the Member States was then reframed from in-person visits to video and telephonic interviews. To ensure the maximum coverage of intended Member States and respondents, the interview guide (which was redeveloped as an open-ended questionnaire) was emailed to the participants who were not able to participate in any other way. For example, in Bhutan, due to logistic and administrative constraints, telephonic and video interviews were not possible, thus, open-ended questionnaires were sent through email. Field notes and audio recordings (with due written consent from the respondents) were used to capture information during in-person interviews.

After completing in-depth interviews, the respondents (ministries of health and key technical and donor agencies) were requested to fill up a five-point Likert scale questionnaire and rate WHO's performance across key thematic areas. The Likert scale questionnaire was emailed to respondents who were interviewed on video or the telephone.

Table 1: Break-up of primary interviews (stakeholder-wise, country-wise and through different modes)

	WHO Officials	Ministry Officials	Technical/Donor Partners
Regional	27 (17)	0	1 (1)
Bangladesh	10 (7)	5 (2)	3 (2)
Bhutan	5 (7)	13 (10)	2 (2)
DPR Korea	4 (8)	0	2 (2)
India	16 (8)	2 (2)	6 (6)
Indonesia	24 (9)	32 (8)	6 (4)
Maldives	5 (5)	17 (8)	3 (2)
Myanmar	17 (9)	24 (8)	2 (2)
Nepal	14 (8)	14 (12)	6 (4)
Sri Lanka	14 (7)	20 (10)	12 (8)
Thailand	3 (3)	2 (2)	0
Timor-Leste	10 (9)	18 (12)	12 (7)
TOTAL	149 (97)	147 (74)	55 (40)



165 in-person interviews



23 skype / telephonic interviews



23 written responses

2.5.2.2 Development of tools, pilot testing and training

To address the four evaluation questions, evaluation tools were designed as informed by the findings of the secondary review. Separate tools were developed for each category of respondent, namely WHO officials, Ministry of Health officials, and technical partners and donors. (Annexure VII lists the discussion guides used in the evaluation). The draft tools went through a process of rigorous internal validation and modification by public health experts – they were pilot tested with some regional stakeholders, such as the regional advisors and technical team at the SEA Region Office. A self-administered five-point Likert scale questionnaire rating WHO's performance across key thematic areas was also administered to external stakeholders, that is, ministry officials, technical partners and donors. The data collection team was trained to use these guides before they conducted interviews at the Regional Office, which were followed by country visits.

2.5.3 Data analysis and interpretation

Data collection and analysis took place concurrently, directly integrating quality assurance into the approach through course corrections. All audio recordings were transcribed verbatim and three members of the evaluation team read each transcript and compared them with field notes. Further analysis was done using the Atlas.ti software by generating codes, themes and sub-themes. The data was analysed using a hybrid approach of grounded theory and framework analysis to take into consideration both prior themes and themes emerging organically. Data was analysed separately for each flagship and then re-analysed to assess similarities and differences in perceptions and practices across stakeholders and flagships. Intercoder reliability was ascertained, the details of which are in Annexure IV.

The findings from the analyses across the flagships were synthesized in the last stage of the evaluation. The findings were interpreted by triangulating results from the different data sources: secondary review and primary interviews. The primary data among the different sets of stakeholders were also compared with each other to get an idea about the insider (WHO respondents) and outsider (Ministry of Health and technical partner respondents) views of the flagship programme and for triangulation purposes. Quotations related to the perceptions about WHO and flagship contributions in a particular public health area were analysed and grouped under specific codes. Word clouds of codes were then developed based on their groundedness (the number of times a code emerges from the data) and were compared in the report.

2.5.4 Limitations of the evaluation

1. **Accessibility of respondents and resources:** The COVID–19 pandemic and scheduling constraints had an impact on the ability to access respondents. As a result:
 - The medium used for data collection was not uniform: a mix of various interviewing mediums such as in-person, telephone, video and email questionnaires was employed.
 - The coverage of ministry stakeholders in a few Member States (Bangladesh, DPR Korea, India and Thailand) was not as comprehensive as that in other Member States.
2. **Study period constraints**
 - Some interviewees (WHO and ministries of health) who held positions at the time of the evaluation did not hold them during the period under review. Hence, they were asked whether they were authorized and equipped to speak about the evaluation timeframe. Where information was suboptimal, predecessors of such stakeholders were contacted depending on availability. However, this may have resulted in some information and data gaps.
 - The evaluation of the activities under flagships from 2014–2018 took place in 2019–2020. This might have resulted in recall biases in accuracy and completeness of the information obtained from the respondents.

3. Referencing of financial documents

- While overall budget information was facilitated, it was challenging to correlate any such information without closely examining budgetary allocation and spending under each flagship.
- The evaluation did not look into financial or budgeting documents pertaining to the flagships.

4. Secondary review

- Over 120 documents were reviewed, and the review focused primarily on WHO sources of both publications and indicators.
- The secondary review was limited to documents available in English.

2.6 Theory of change⁸

The evaluation team also developed a theory of change (ToC) (Fig. 2) based on the objectives of WHO's flagships and the expected results. The ToC incorporates the relationship between the flagship with combined efforts of WHO, ministries of health and key technical and donor partners towards achieving SDG goals under particular flagships.

8 World Health Organization. Regional Flagship Areas. WHO. 2018 (for outcomes which have been mapped with SDG 3 targets 2030)

Fig. 2: Theory of change for evaluation period (2014-2018)



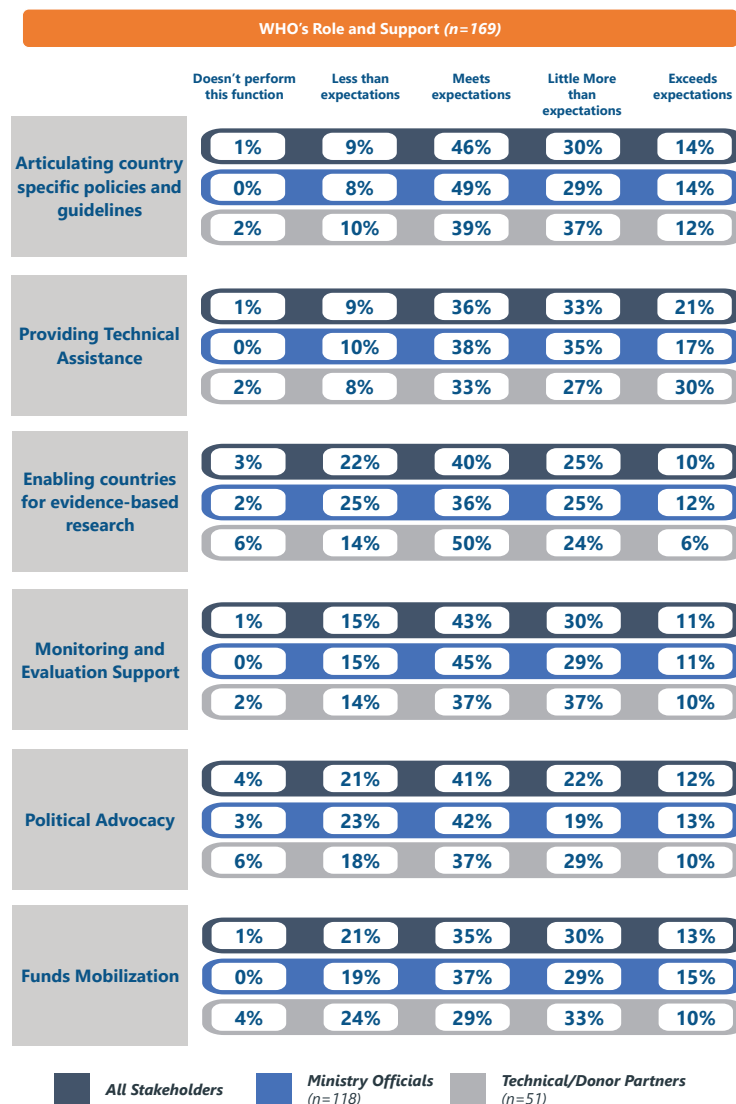
Section 3: Evaluation Findings

The Regional Office ensured the development of technical and operational frameworks for Regional Flagship Areas to attain their goals and sustain gains within the Region. They provided a targeted focus and have been responsible for a series of remarkable achievements, an assessment backed up by the Likert scale findings (as shown in Fig. 3) where 49% of respondents from ministries of health and 39% of technical partners agreed that WHO had met their expectations in contributing to articulating country specific policies and guidelines while 14% of respondents from ministries of health and 12% of technical partners said that WHO exceeded them. It also revealed that most respondents were appreciative towards the technical assistance that WHO provides to Member States as 90% of the respondents said that WHO either met their expectations (36%), performed slightly above expectations (33%) or exceeded them (21%). WHO's efforts to provide monitoring and evaluation support to Member States was also acknowledged as 43% of the total respondents said that WHO met their expectations. However, there were certain areas where the respondents expected more efforts from WHO. These areas include political advocacy, fund mobilization and evidence-based research in Member States. Around one-fourth of the total respondents accorded WHO's performance less than expectations in the areas of political advocacy and evidence-based research. Furthermore, 22% of the total respondents mentioned that WHO's performance for funds mobilization was less than expectations.

The flagships were used as a way of driving a more integrated approach to work across the Regional Office and in the WHO country teams. With finite resources being available across the Member States, the only possible way to meet the goals was efficient planning. To combat this, regional TWGs were formulated for each flagship, and they provided a forum for technical discussion and advice in the respective fields in line with the objectives of that flagship. Similarly, national committees ensured progress at the country level.

With the support of collaborative centres, technical experts, and regional leadership, national program officers have undergone continuous capacity-building workshops, which have helped them translate the knowledge to country-level implementation. The Member States appreciated that the results were measurable because of clearly laid out objectives and monitoring plans. For instance, measles elimination had the clear objective of elimination, and Member States felt that they were associated with each country's pride. It was important to have achievable goals as dividing small financial allocations between an unrealistic number of objectives was pointless. Therefore, the Regional Office ensured country plans and budgets focused on agreed priorities through high-level advocacy. The advocacy efforts for these focus areas increased as information started to spread across all

Fig. 3: Likert scale analysis administered to respondents from ministries of health and technical/donor partners



Member States of the Region. Member States highlighted that most Regional Flagship Areas were pushed drastically, and WHO could claim the credit for the progress made in these areas, such as AMR and emergency response management. In addition, due to the focus on flagships, it was easier to negotiate for improved human resources and additional resources.

Since 2014, the Regional Flagship Areas have shaped global as well as regional health architecture. During the evaluation period, the collaborative efforts of WHO, ministries of health and technical partners helped Member States demonstrate noticeable change: neonatal mortality and maternal mortality have declined across the Region by at least 60% and 70% respectively; eight Member States have eliminated one or more of a gamut of communicable and NTDs; five countries in the Region have eliminated measles; and six have controlled rubella. Consequently, the progress, achievements, initiatives and innovations in the Region will have a significant impact on global health indicators.

The Member States have come up with innovative policies for ensuring an adequate health workforce and reducing OOPe with a wide availability of essential medicines and diagnostics. TB remained a constant challenge for the Region, which bears almost 45% of the global burden, with two countries (India and Indonesia) accounting for 37% of the global TB burden. This required bold action and an accelerated response and, therefore in 2017, Ending TB by 2030 was added as the eighth Regional Flagship Area.

3.1 Measles elimination and rubella control by 2020

Relevance

Making measles elimination and rubella control one of the Regional Flagship Areas re-emphasized WHO's commitment to their eradication by providing much-needed acceleration and additional impetus to activities being executed across Member States.

Measles and rubella are highly infectious childhood diseases and remain a significant cause of mortality and morbidity worldwide. In 2012, measles deaths were estimated at 122 000 globally, 43% of which occurred in the SEA Region.⁹ Rubella, another vaccine-preventable disease, resulted in 103 000 deaths of infants born with CRS globally in 2010, 46% of whom were born in the SEA Region.⁷ To address this high burden, in May 2012, the Sixty-fifth World Health Assembly endorsed a worldwide 10-year vaccine action plan for measles elimination and rubella control. In 2013, to further drive the agenda of eliminating measles and controlling rubella, the Sixty-sixth Regional Committee meeting endorsed a Regional Strategic Plan (2014–2020)⁹ with an emphasis on immunization. The importance of measles elimination and rubella control is a measure of progress towards achieving the MDGs. However, despite this progress, the SEA Region as a whole could not attain the target of MDG 4, of bringing under-five mortality down by two-thirds from 1990 levels.

Before the advent of the flagships, Member States had strategies in place, but they were not as ambitious. After the elimination of measles and control of rubella by 2020 was made one of the initial seven Regional Flagship Areas in 2014, Member State initiatives that aimed to eliminate measles and control rubella were given additional momentum, with clear target-driven approaches. With the advent of the flagships, there has been a strategic shift in approach. Additional resources have been mobilized through technical partners, donors and other UN agencies to complement WHO's efforts. In fact, most of the Member States still need to achieve their elimination status, which has made it a priority on the agendas of ministries of health within Member States, providing them with a strong sense of direction and intent. Thus, declaring it a flagship underscored the commitment and gave additional impetus to the initiatives. The focus on this Regional Flagship Area has resulted in major achievements and significant progress towards attaining regional targets set by 2020.

“The flagship priorities have provided the health sector with a clear sense of direction and purpose and have assisted us to renew our attention on these areas”. – A ministry respondent from Bhutan

⁹ World Health Organization. Strategic plan for measles elimination and rubella and congenital rubella syndrome control in the South-East Asia Region 2014–2020, World Health Organization. 2015

Effectiveness

This flagship was effective in the Member States' commitment and capacity to achieve progress. The evaluation highlighted that the technical support (specifically the adoption of the regional vaccine action plan and strategic plan) that WHO provided enabled Member States to meet the needs of country programs.

Articulation of policy documents, guidelines and directives: During the evaluation period, it was observed that WHO supported Member States in developing policies, strategies, frameworks and guidelines for the elimination of measles and rubella/CRS control. At the regional level, to foster commitment and alignment with global priorities, the Regional Vaccine Action Plan (2016–2020)¹⁰ and the Strategic Plan (2014–2020)⁹ provided directional guidance to the Member States towards their goal. In 2016, a regional guideline for the verification of measles elimination and rubella control¹¹ was formulated and regional surveillance guidelines were updated. Furthermore, respondents from Member States acknowledged WHO's support in the preparation of key documents, guidelines and plans such as national action plans, country situational reports, elimination plans, surveillance guidelines, outbreak response plans, plans for introduction of new vaccines, micro plans, sustainability plans and programme budgets, all of which were instrumental in achieving progress.

Technical assistance: One of the critical areas where WHO supported Member States was in the introduction of two-dose versions of MCV, RCV, or a combination vaccine to increase coverage and close immunity gaps across all Member States. The vaccines were introduced on the recommendation of technical advisory groups such as the Immunization Technical Advisory Group (ITAG) and National ITAG (NITAG) which were formed with WHO's support and proved to be critical for newer policy developments. Further, WHO collaborated with ministries of health to ensure wide coverage during measles and rubella (MR) campaigns by mapping the high-risk areas and developing preparedness assessment tools for improved planning of immunization campaigns. It is critical to note that through these supplementary immunization activities (SIAs), 83 million children in 2015, 68 million in 2016, 107 million in 2017 and 200 million in 2018 were immunized.³

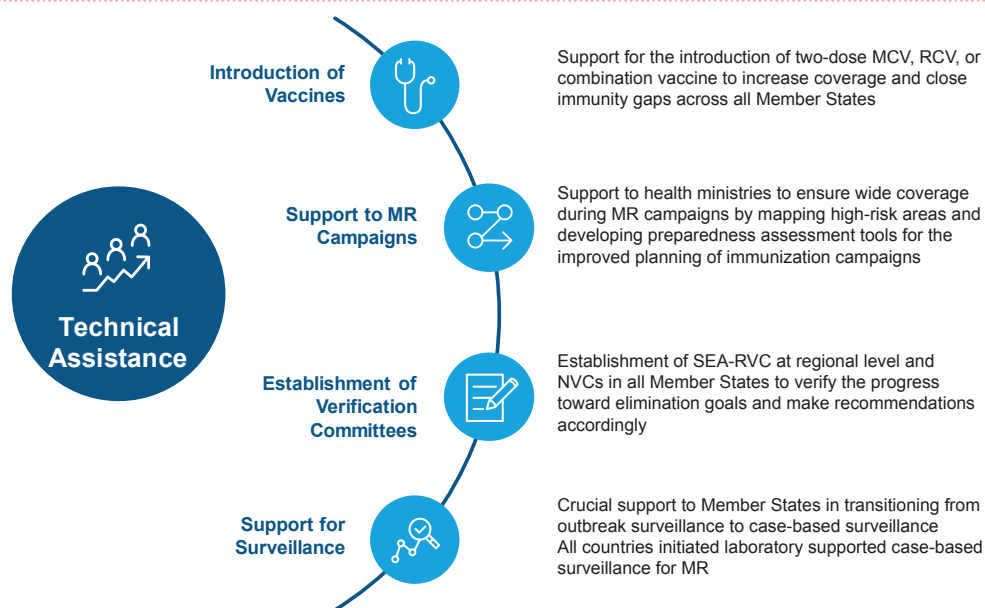
In addition, the SEA-RVC was established in March 2016 to verify the progress in the Region. As of December 2018, the SEA-RVC had held three meetings to review country progress reports on measles elimination and rubella/CRS control submitted by the National Verification Committees (NVCs), and accordingly provided recommendations. All Member States have functional NVCs to review national progress toward elimination goals and make recommendations as to how these goals may be met.

Globally, it is widely accepted that a focus on measles surveillance can help detect populations not reached by immunization systems and, by extension, programme weaknesses. Thus, all Member States were provided support to increase MR surveillance sensitivity to meet elimination standards. Critical support was provided in transitioning from outbreak surveillance to case-based surveillance, and, in some Member States (such as Myanmar), for fever and rash surveillance as well. Five countries

10 World Health Organization. South-East Asia regional vaccine action plan 2016–2020. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/272397>.

11 World Health Organization. Guidelines on verification of Measles Elimination and Rubella/Congenital Rubella Syndrome Control in WHO South East Asia Region. [internet]. 2016 July. Available from: <https://apps.who.int/iris/bitstream/handle/10665/255875/sea-immun-104.pdf?sequence=1&isAllowed=y>

Fig. 4: Key highlights: technical assistance for Flagship 1



(Bangladesh, India, Indonesia, Myanmar and Nepal) used the WHO-supported network of surveillance medical officers first established for polio eradication to conduct measles surveillance. By 2017, all countries in the SEA Region had initiated laboratory supported case-based surveillance for measles and rubella with India and Indonesia still expanding surveillance across the country.

The sensitivity of surveillance is measured using a proxy indicator of the number cases of fever and rash that are caused by neither disease, or a non-measles/non-rubella discard rate of 2 or more per 100 000 people in the population. The sensitivity remains low in the entire Region, at 0.87 per 100 000; Bangladesh, Bhutan, DPR Korea, Maldives, Nepal, Thailand and Timor-Leste have already achieved the target in 2018, while the others are working towards achieving it.¹² India, Indonesia and Myanmar were not meeting their measles surveillance targets, leading to the under-reporting of the exact disease burden and inappropriate immunization response activities. Sri Lanka could not achieve their target and reported a non-measles/non-rubella discard rate of 0.75 in 2018.¹² MR surveillance in the Region is backed up by a WHO-accredited network of 40 measles-rubella laboratories, with at least one proficient laboratory in each of the SEA Region countries, and is supported by a regional reference laboratory (RRL) within the National Institute of Health, Thailand. To ensure that each laboratory is recognized as proficient, an onsite accreditation review of laboratory practices is conducted annually.

Capacity building: Most respondents from Member States stated that WHO played an instrumental role in the capacity building of their laboratories through accreditations, external quality assurance, optimal support for laboratory supplies, support for serological and virologic testing, exposure visits and study tours. Several knowledge- and skill-based training activities were carried out with technical and financial assistance from WHO at national, subnational and regional levels. Training courses were conducted for managers and frontline health workers in national and state/provincial extended

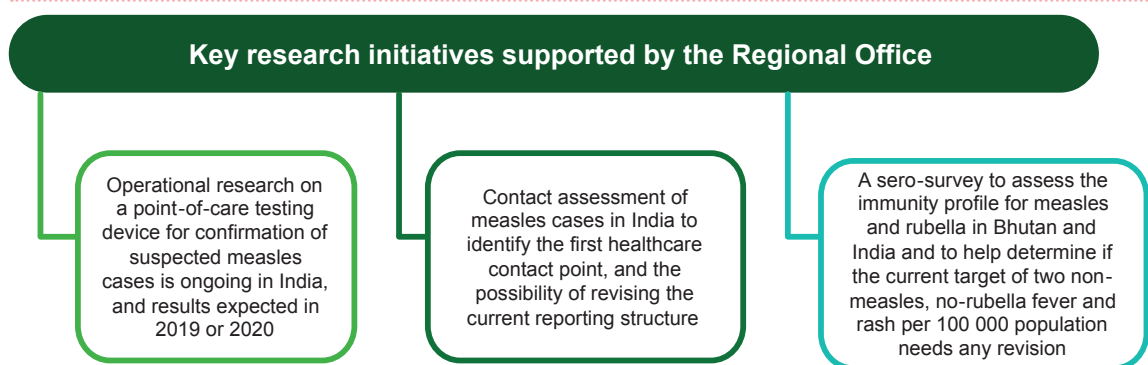
¹² World Health Organization, Measles and Rubella initiative, UNICEF, American Red Cross, United Nations Foundation, CDC. Measles Elimination and Rubella/CRS Control. World Health Organization, South East Asia Region, 14 March 2019.

programmes of immunization (EPI) using WHO's mid-level managers (MLM) training modules and other training resources. The capacity of the MR laboratory network was augmented with on-site visits by regional reference laboratories, remote assistance and regional training workshops. Some of the training during the evaluation timeframe was to strengthen MR surveillance, MR case investigation, molecular testing and proficiency testing.

Monitoring and evaluation: For evidence-based policy and operational support, annual review meetings were conducted both at the regional and national levels by the ITAG, SEA-RVC, NITAG and NVC. This was critical to monitoring progress towards national, regional and global measles elimination and rubella control targets. These meetings informed Member States about technical updates and scientific recommendations. In DPR Korea, apart from WHO reviews, meetings were also conducted by donor and technical partners such as Gavi. A mid-term review (MTR) of the SEA Region Strategic Plan (2014–2020) for measles elimination and rubella/CRS control¹³ was conducted in 2017, with the vision of reaching the 2020 goal. The SEA Region ITAG endorsed the recommendations made by the MTR for implementation across the Region. However, in addition to providing recommendations, the MTR concluded that measles elimination is unlikely to be achieved in the Region due to the sub-optimal implementation of strategies in some countries. In addition, the Regional Office played a significant role in monitoring the external quality assurance (EQA) of the RRLs and national laboratories (NLs).

Research and development, and evidence generation: During the evaluation period, the Region attempted to foster a strong research culture in the immunization programme. In this regard, WHO supported the implementation of Bhutan's Structured and Mentoring Approach to Research Training (B SMART) and a fellowship programme for health professionals in DPR Korea to build specific skills in immunization. Some of the key research agendas the Regional Office supported are shown below^{3,14}:

Fig. 5: Key research initiatives supported by the Regional Office for Flagship 1



In addition to the research initiatives mentioned above, Member States conducted evidence generation activities via collecting data through surveillance and utilizing it further for evidence-based policy making and to close immunity gaps through directive actions.

13 World Health Organization. Midterm review of the "Strategic plan for measles elimination and rubella and congenital rubella syndrome control in the South-East Asia Region: 2014–2020. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2018. Available from: <https://apps.who.int/iris/handle/10665/279993>.

14 World Health Organization. The Work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January–31 December 2018. World Health Organization. Regional Office for South-East Asia. 2019.

Advocacy: Under the aegis of this flagship, WHO conducted advocacy, social mobilization and communication activities to ensure political commitment and community engagement. WHO also worked closely with UNICEF and the health ministries of Member States to spread the message about the benefits of the vaccine and reassurance about any adverse events following immunization (AEFI). In addition, efforts were made to mitigate the myths surrounding immunization (to tackle vaccine hesitancy). For example, in Indonesia, WHO, UNICEF and the Ministry of Health collaborated with religious leaders through the Ministry of Religious Affairs to advocate the benefits of immunization and the availability of immunization services for all socio-economic groups. In 2018, Timor-Leste eliminated measles, with one of the key attributable factors being community mobilization for vaccination, which was brought about by quarterly advocacy meetings with hamlet and village leaders who further led community mobilization in the country. However, vaccine hesitancy is still a persisting issue in the Region, and creates roadblocks to complete immunization coverage. Thus, a comprehensive approach to social mobilization and advocacy both at national and subnational levels, with continued efforts and support from WHO and partners, is required to achieve these goals.



In Indonesia the initiative collaborated with religious leaders to advocate the benefits of immunization. In Timor-Leste, village leaders mobilized the community, which proved to be one of the successful interventions in eliminating measles from the country.

Multisectoral and intersectoral collaboration: Member States have demonstrated that collaborations are crucial to progress and success. This flagship has been successful in collaborating well both within and outside the health system and its partners. Through this flagship, WHO has been working closely with the ministries of health, UNICEF, Gavi and other partners such as local and international non-governmental organizations (NGOs) and ethnic health organizations. Gavi was largely responsible for providing funds to low-to-middle-income countries (LMICs) to procure vaccines, technical assistance and engaging in monitoring and evaluation activities, while UNICEF provided technical assistance and played an important role in driving the Information, Education and Communication (IEC) materials required to tackle big challenges in immunization. Moreover, intersectoral collaboration was noted in Member States where WHO (through the ministries of health) collaborated with various ministries and organizations, such as the ministries of women and child development, the ministries of education, the ministries of human resources, and civil society organizations (Rotary International and Lions), academics institutions, and armed forces. This collaboration played a crucial role in managing vaccine hesitancy, ensuring immunization coverage in hard-to-reach populations and building the capacity frontline workers.

Equity: During the evaluation period, most Member States tailored their strategy to identify and increase coverage among high-risk and vulnerable populations according to their local context, with support from WHO. For instance, Myanmar is implementing the Reaching Every Community (REC) programme, Nepal has coordinated with local self-governments to adopt a search-and-immunize strategy, and Timor-Leste is mapping high-risk areas and vulnerable populations for targeted routine immunization (RI) interventions. Efforts were also made to accelerate, strengthen and support routine immunization and ensure that all children under the age of two and all pregnant women were fully immunized with



Myanmar is implementing Reaching Every Community (REC), Nepal has coordinated with local self-governments to adopt a search and immunize strategy. Timor-Leste is mapping high risk areas and vulnerable populations for targeted RI-interventions.

all vaccines recommended under the national schedule as seen through implementation of Mission Indradhanush in India. Further, other Member States also took action to ensure equitable access. Myanmar tied up with ethnic health organizations to ensure coverage in areas that were hard to reach due to political conflict, and advocacy activities were conducted involving religious leaders in Indonesia, Bangladesh and Maldives. It is critical to note that while equity is being addressed at the policy level by key decision-makers, at the implementation level, a few Member States (Indonesia and Bangladesh) still struggle to ensure equity with respect to immunization, which impedes full coverage.

Efficiency

Flagship implementation requires additional support through increased resource allocation to build robust healthcare delivery mechanisms and disease surveillance systems.

Although there has been some increase in resource allocation in Member States, there is still a need for an additional push to meet flagship targets. As indicated in the midterm review of the strategic plan conducted in 2017¹³, resource constraints might become a major challenge to achieving the elimination goal envisaged in 2020. Sustained budgetary support for regional activities and national government action plans are critical.

Resources saw an increase through a transition plan which integrated trained human resources, technical assistance and re-engineered resources from the polio programme to optimize benefits for both the measles and rubella campaigns, especially in five polio transition Member States (Bangladesh, India, Indonesia, Myanmar and Nepal). In addition, there has been increased investment in cold chain equipment in SEA Region countries using both Gavi and domestic funding. However, there are limited resources and limited support and guidance for establishing extensive subnational laboratory networks in large countries.

Some well-established district-level micro-plans were observed in countries like Bangladesh, Bhutan, DPR Korea, Maldives, Sri Lanka, Thailand and Timor-Leste, which have proved beneficial. Commitment and funds from WHO, Gavi, PATH and the Bill & Melinda Gates Foundation have supported an increase in coverage in many countries. Guidance through committees like SEA Region ITAG, NITAG and verification commissions have helped to evaluate the progress in increasing immunization coverage, surveillance performance, programme issues, and matters related to vaccine quality assurance.

With WHO's assistance and support, additional sources of resource allocation, mobilization of funds and logistical support were found.

Successful partnerships between the Ministry of Health, UNICEF and Gavi in Timor-Leste led to the elimination of measles and control of rubella two years ahead of the regional target. In Bangladesh, WHO supported the government in the identification of low-coverage areas, especially in the urban slums through annual EPI Work Plans. WHO also played a key role in providing technical and financial support to improve the surveillance of vaccine-preventable diseases in Indonesia, including expanding the network of regional laboratories to reduce the dependence on Jakarta. In Myanmar, regional surveillance officers were recruited through WHO for 17 regions in the country.¹⁵ Nepal developed

¹⁵ World Health Organization. The Work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January-31 December 2015. World Health Organization. Regional Office for South-East Asia. 2016.

ambitious goals of providing a basic package of quality health services free of charge in its Health Sector Strategy (2015–2020) and passed a landmark immunization law in January 2016 to ensure the financial sustainability of the immunization programme. Gavi health system strengthening (HSS) covers the bulk of the cost of the MR programme in Bangladesh.¹⁶ Additional resource allocation for MR campaigns came through Gavi HSS funds for immunization to eligible Member States. In November 2015, the Bhutan Health Trust Fund (BHTF) supported supplies of drugs and vaccines for the entire country. The funding was generated through the government but also supported by donors and, more recently, a contribution deducted from employee salaries.

“WHO’s contribution was very imperative both in terms of technical and financial assistance. Given the country’s competing priorities against limited resources and capacity, WHO’s contribution has immensely benefited and complemented Government’s efforts in achieving the elimination targets”. – A health ministry respondent from Bhutan

Sustainability

Sustainability was ensured as the flagship has been an integral part of the national and subnational health plans and their targets, and the immunization and surveillance activities of the Member States.

Various actions were taken to ensure the sustainability of the progress and achievements in the Region, including the formation of SEA Region ITAG, which provides policy guidance to countries on ways to improve and sustain overall high-quality performance. With support from WHO, most of the SEA Region countries have formulated measles outbreak preparedness and response plans. The MR laboratory quality management system ensured the sustained proficiency status of the laboratory network for MR. The development of a draft transition plan with the goal of integrating the assets, activities and best practices of the polio programme into the national immunization programme in five Member States (Bangladesh, India, Indonesia, Myanmar and Nepal) was a step towards attaining sustainability and maximizing gains. In addition, most National Immunization Programmes have also developed a measles elimination sustainability plan. The Regional Office supported the development of post-elimination sustainability plans for the countries that have achieved measles elimination and rubella/CRS control status. To ensure sustainability, the Regional Office also supported the strengthening of surveillance systems in Member States using molecular epidemiology in the laboratories to detect the classification of the origin of imported cases. There has been continuous political support for funding and prioritizing immunization activities across all the Member States, except in Indonesia, which was unable to garner much political support due to internal challenges. The WHO Country Office for Timor-Leste has been able to gain the highest level of political support for immunization from the government, which has contributed towards achieving elimination status within the defined timeframe. Member States like Maldives, Sri Lanka and Thailand have financed most of the immunization expenditure with government funds, and others have shown some commitment towards becoming self-sustainable on immunization activities after donor funding ends.

In a strategic move, the SEA Region Member States have planned to develop transition plans with exit strategies and self-financing costs related to immunization activities with the help of WHO. Myanmar

¹⁶ World Health Organization. The Work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January–31 December 2016. World Health Organization. Regional Office for South-East Asia. 2017.

is gradually increasing financial assistance for immunization and, in Bhutan the Ministry of Health is undertaking pertinent assessments to devise appropriate transition plans. The cost of vaccines in Bhutan is supported by the BHTF. Similarly, Indonesia is planning sustainability by including costs in national and regional budgets. In Bangladesh, an emphasis on building the national capacity to ensure sustainability was observed, through methods such as the participation of government staff in international workshops, surveillance review and SIAs. The advocacy provided by WHO supported these activities. However, in India, it was observed that sustainability isn't the prime concern as 90% of the investments have come directly from the government, with respondents claiming that Gavi funding has been a catalyst.

The inflow of cases through migrant workers has been the biggest challenge to sustainability. WHO is expected to provide continued technical assistance and sustained budgetary support for regional and national activities, develop innovative strategies and models to re-examine the available partner landscape and their engagement models. There is also a need to strengthen monitoring and evaluation systems and surveillance and immunization activities.

“There is no question of sustainability because the MR vaccination program in the country is not partner supported. It is the Government of India’s own funded program, so it’s purely self-driven.” – A ministry official from India

Impact

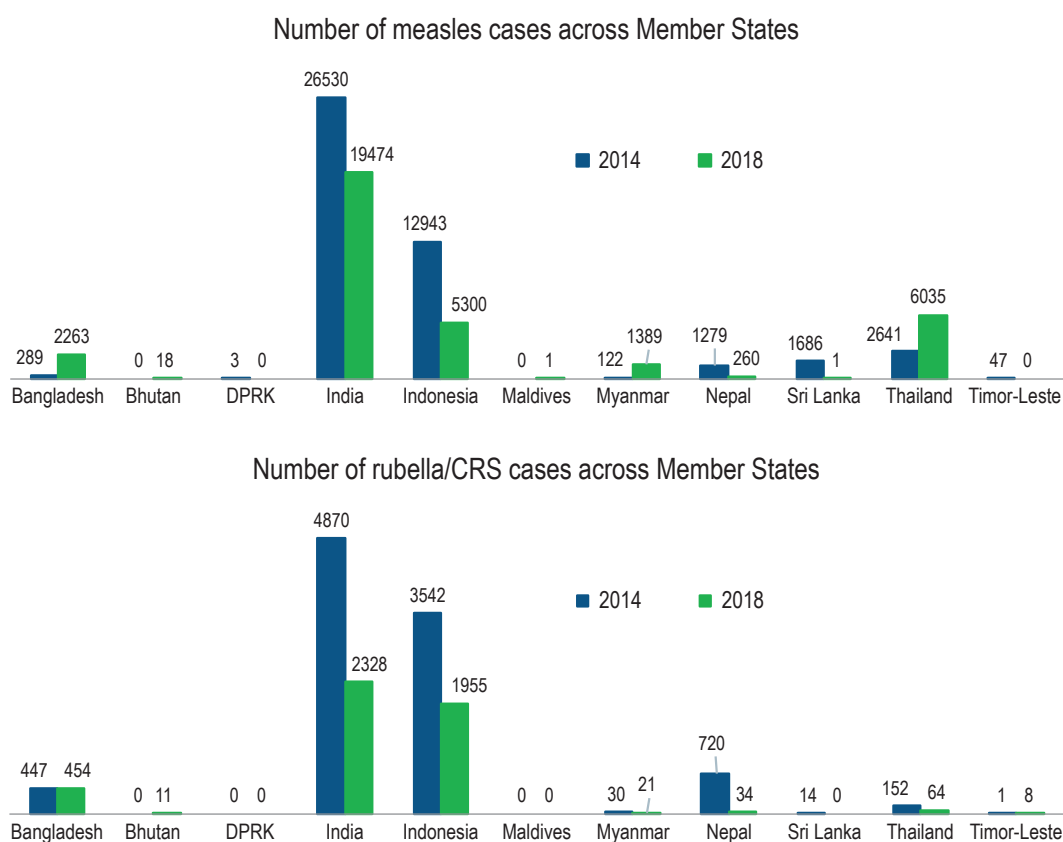
In 2017, four countries were verified by SEA-RVC as having eliminated endemic measles. By 2019, five countries (Bhutan, DPR Korea, Maldives, Sri Lanka and Timor-Leste) had reported measles elimination. Six countries (Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste) have been verified as having controlled rubella and congenital rubella syndrome (CRS).¹⁷

The Region exhibited a 75% reduction in mortality due to measles in 2017 as compared to 2000. It is critical to note that the 23% decline in measles mortality took place between 2014 and 2017. From 2014 to 2016, the estimated number of deaths decreased from 47 000 to 28 000, recording a 41% decline.³ Most Member States exhibited a reduction in the number of measles and rubella cases during the evaluation period. However, countries such as Bangladesh, Myanmar and Thailand showed an increase in cases of measles, which can be attributed to suboptimal immunization coverage supplemented by limited immunization services to migrant populations.^{18,19}

17 World Health Organization. Progress report 2018: Measles elimination and rubella control by 2020; WHO flyer 2018. World Health Organization. Regional Office for South-East Asia. 2018.

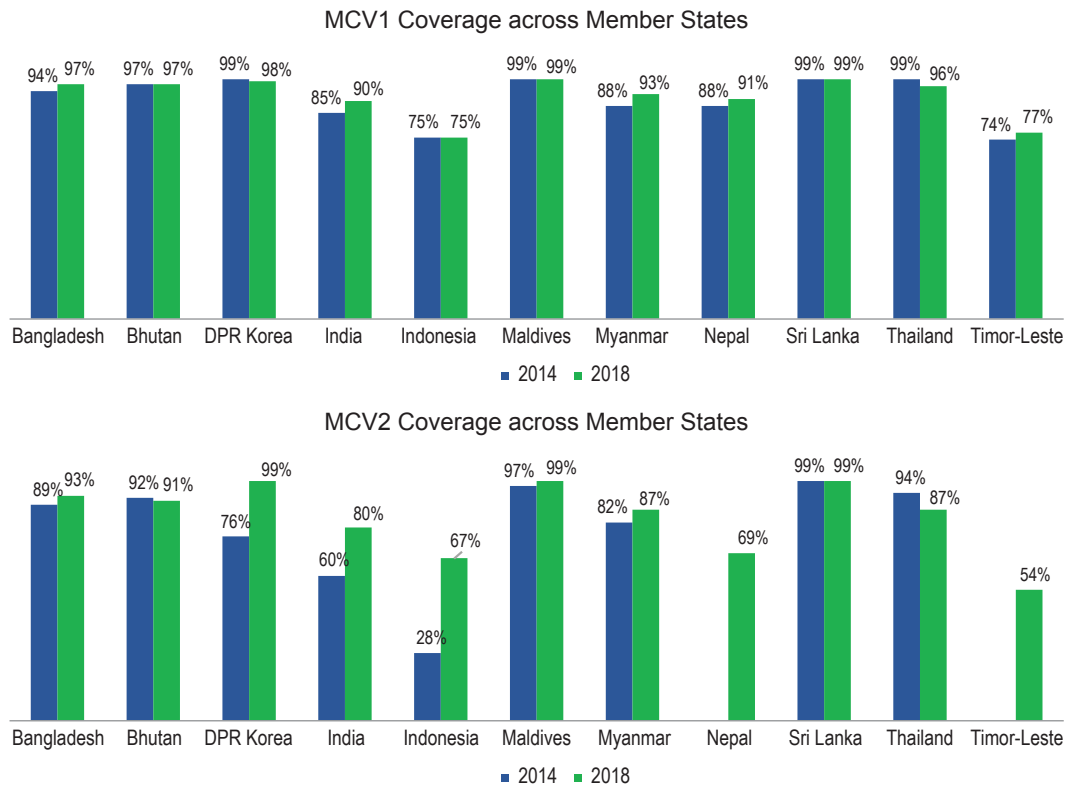
18 Thar AM, Wai KT, Harries AD, Show KL, Mon LL, Lin HH. Reported measles cases, measles-related deaths and measles vaccination coverage in Myanmar from 2014 to 2018. *Tropical Medicine and Health*. 2020 Dec 1;48(1):4.

19 Sultana S. Elimination of measles from Bangladesh: Progression and Challenges ahead. *J Microbiol Exp*. 2017;5(7):00174.

Fig. 6: Number of cases of measles and rubella/CRS in the SEA Region

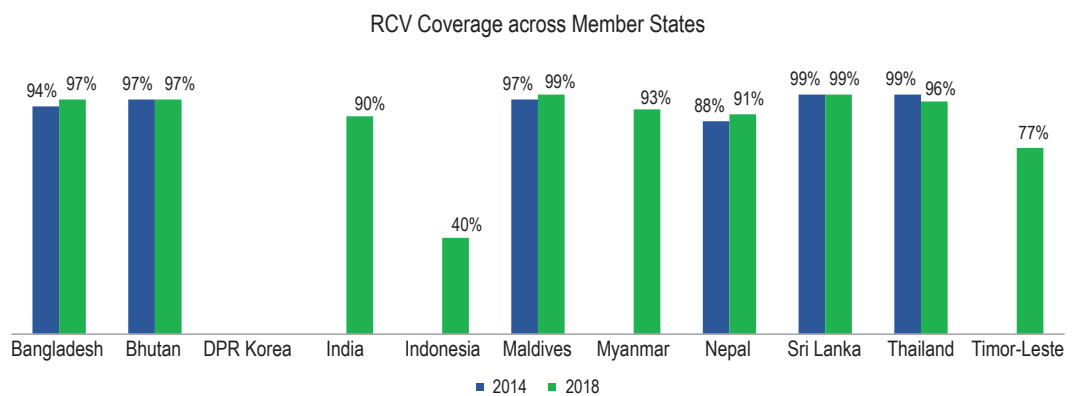
Source: Global Health Observatory, WHO

To reduce the immunity gaps, all 11 Member States administered two doses of MCV, and 10 Member States administered RCV (DPR Korea was yet to introduce RCV in routine immunization) through routine immunization programs. In 2018, the regional coverage of MCV1 was 89%, MCV2 was 80% and RCV was 80% showing a significant improvement since 2014. Bangladesh, Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand achieved more than 95% MCV1 coverage while three Member States (DPR Korea, Maldives and Sri Lanka) had surpassed the target of 95% for MCV2 in 2018, achieving the GPW 13 target of increasing MCV coverage to 90%.

Fig. 7: MCV coverage in the SEA Region

Source: Global Health Observatory, WHO

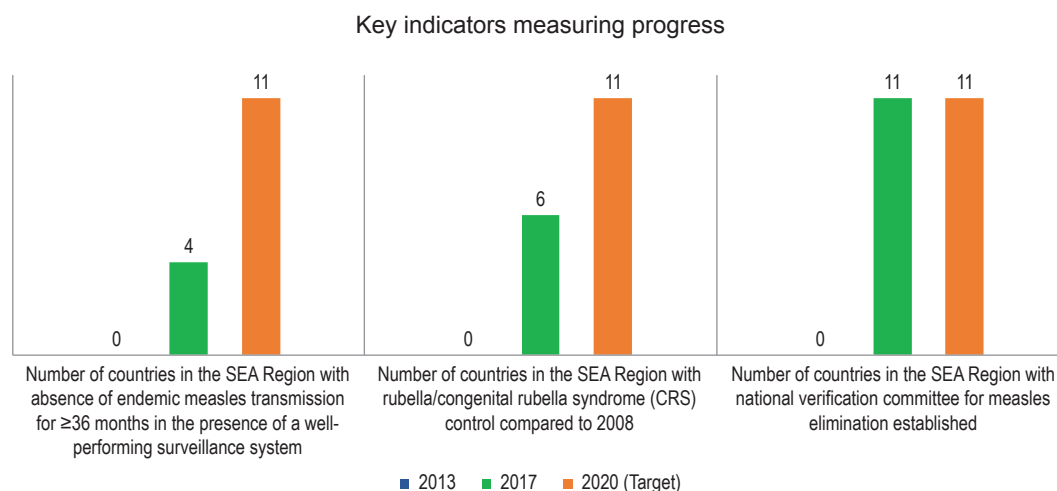
Five countries in the Region (Bangladesh, Bhutan, Maldives Sri Lanka and Thailand) achieved the 95% target for RCV1. The only exception is Thailand, with a very insignificant drop in coverage over the years, which could be due to a change in strategy in 2014, when Thailand changed the MRCV2 schedule to 30 months coupled with an MR campaign to close the immunity gap.¹³

Fig. 8: RCV coverage in the SEA Region

Source: Global Health Observatory, WHO

Despite a significant increase in immunization coverage across Member States, as per the midterm review of the strategic plan conducted in 2017, the Region was unable to achieve its targets due to suboptimal implementation of strategies in the remaining six countries (Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand). Fig. 9 shows the cumulative trend in key indicators showcasing progress during the evaluation period.

Fig. 9: Key indicators measuring progress for Flagship 1



Source: WHO SEARO flagship flyer 2018

There has been an increased impetus in the area of this flagship, which is reflected in improved indicators. These achievements are attributable to the synchronized efforts of WHO, ministries of health and development partners. With the substantial results for the flagship of measles elimination and rubella control across the SEA Region, WHO now proposes an ambitious yet attainable goal of eliminating both measles and rubella with a target of interrupting the transmission of indigenous measles and rubella by 2023.²⁰

Challenges

Immunization coverage: The greatest challenge is improving national immunization programmes and enabling Member States to achieve more than 95% coverage with two doses of MCVs through a routine programme at national and subnational level. Vaccine hesitancy is a persistent issue in the Region, with India and Indonesia posing unique challenges to coverage, potentially because of the absence of a communication strategy at the country level. A few Member States still struggle to ensure equity with respect to immunization, impeding full coverage.

²⁰ World Health Organization. WHO Regional Committee for South-East Asia—Report of the Seventy-second Session. Revising the goal for measles elimination and rubella/congenital rubella syndrome control (Agenda item 8.2, SEA/RC72/7). World Health Organization. Regional Office for South-East Asia. 2019.

Low sensitivity of MR surveillance system: The sensitivity of surveillance remains suboptimal at 0.87 per 100 000, with the under-reporting and under-estimation of the burden of the disease. The measles surveillance targets were not met in India, Indonesia and Myanmar.

Subnational laboratory network: The Regional Office is responsible for supporting the establishment of designated NLs and RRLs under the WHO Global Measles and Rubella Laboratory Network (GMRLN). However, it did not have the resources or the capacity to provide more than limited support and guidance for establishing an extensive subnational laboratory network in large Member States.

Cross-border activities: To interrupt the transmission of the measles virus, the immunization response requires synchronized cross-border activities. The immigration of measles or rubella cases through migrant workers has been a huge challenge because of the absence of an intercountry agreement.

Recommendations

Ensuring optimal surveillance system: There is need for a tailored approach towards strengthening the surveillance system. Every Member State requires multidimensional diagnostics of their immunization system to assess the current state of routine immunization services. Member States should monitor immunity gaps at the national and subnational levels, including adult populations. To increase the sensitivity of the surveillance system, Member States in the SEA Region should shift to broad fever and rash surveillance.

Improving Immunization coverage and reducing the immunity gap: To assess the current state of routine immunization services, Member States should develop a customized approach towards system strengthening with support from the Regional Office. Attention should be paid to high-risk mapping, high quality SIAs and rapid coverage monitoring, with special attention to high-risk regions, districts with poor coverage and the urban poor. All Member States should be encouraged to introduce legislation with regard to school-level checks for immunization. A country-specific (tailored to subnational needs) social mobilization and communications plan for both MR activities under RI and SIA campaigns should be put in place across all Member States. WHO should support and facilitate the systematic mapping of vaccine hesitancy and vaccine resistance and encourage Member States to develop context-specific strategies.

Success Story: Timor-Leste

Timor-Leste became one of the first three countries in the SEA Region to achieve both measles elimination and control of rubella and CRS two years ahead of the regional target. This milestone was achieved only 16 years after the country gained independence. The breakthrough was the addition of the rubella vaccine to the infant immunization schedule, thus replacing the measles vaccine with the measles-rubella vaccine (at nine months), with assistance from WHO. Efforts to reach measles elimination and rubella control included a combination of routine immunization and supplemental vaccination campaigns. A wide age-range immunization campaign was also conducted in 2015 for children between the age of nine months and 15 years, under which more than 484 000 children received the MR vaccine. Success was also due to regular EPI and vaccine-preventable disease reviews in every municipality, monitoring immunization coverage in every village to identify low-performing pockets, and quarterly advocacy meetings with hamlet and village leaders. In addition, all the health posts with electricity were equipped with WHO prequalified ice-lined refrigerators with a Gavi transition plan. With WHO's support, there was a strengthening of case-based MR surveillance and an MR molecular epidemiology laboratory to conduct serological testing for measles and rubella with added support through training and the provision of equipment and reagents. The elimination of measles ahead of the regional target was also the result of the successful partnership between WHO, the Ministry of Health, Gavi, UNICEF and other partners. It is also an illustration of successful intersectoral collaboration between various ministries, including the Ministry of Education and the Ministry of State Administration. It highlights the critical role that village-level community leaders play in community mobilization for vaccination.

3.2 Prevention of NCDs through multisectoral policies and plans with focus on best buys

Relevance

Declaring the prevention of NCDs a Regional Flagship Area brought focus on some key strategies that promote the adoption of the best buys. These strategies include addressing risk factors, strengthening advocacy strategies, primary healthcare delivery focusing on NCDs and accentuating multisectoral coordination creating a best-buy approach.

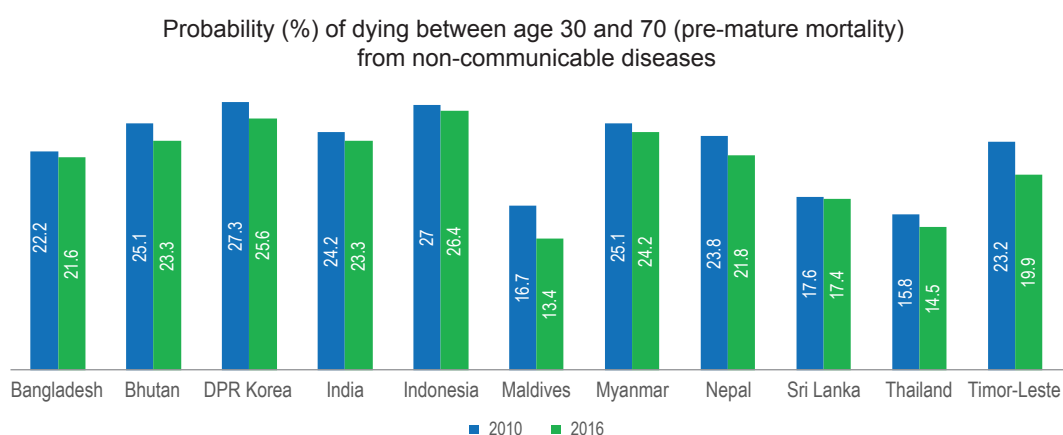
Globally, 41 million deaths (71%) were attributed to NCDs alone in 2016, of which 15 million were premature deaths, occurring between the ages of 30 and 70 years.²¹ Countries in the SEA Region are also struggling with a large number of premature deaths from NCDs, with a very negligible decline in that number over the years as shown in Fig. 10. Deaths due to NCDs are projected to increase by 15% globally between 2010 and 2020.²² In 2013, the World Health Assembly adopted the Global Action

21 World Health Organization. Noncommunicable diseases country profiles 2018. [Internet]. 2018. Available from: <https://apps.who.int/iris/handle/10665/274512>. License: CC BY-NC-SA 3.0 IGO

22 World Health Organization. Global Status Report on Non-Communicable Diseases 2010. World Health Organization. 2011.

Plan for the Prevention and Control of NCDs (2013–2020)²³ and agreed on 25x25 targets: to achieve a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 2025. These diseases, along with their key risk factors, remain the leading cause of death in the SEA Region. The Region is also projected to have 10.4 million deaths from NCDs in 2020,²² which will pose a threat to economic and social development. The increasing burden of NCDs is attributed to determinants such as epidemiologic transition, population ageing, rapid and unplanned urbanization, the negative effects of globalization (such as trade and irresponsible marketing of unhealthy products), low literacy, poverty and inadequate multisectoral coordination.

Fig. 10: Probability (%) of premature mortality due to NCDs in the SEA Region



Source: Global Health Observatory, WHO

In 2013, as a valuable step towards building on global resolutions, the SEA Regional NCDs Action Plan²⁴ was developed with 10 regional targets to be achieved by 2025, which are:

- (1) 25% relative reduction in overall mortality from cardiovascular diseases, cancers, diabetes or chronic respiratory diseases;
- (2) 10% relative reduction in the harmful use of alcohol;
- (3) 30% relative reduction in the prevalence of current tobacco use in persons aged over 15;
- (4) 10% relative reduction in the prevalence of insufficient physical activity;
- (5) 30% relative reduction in the mean population intake of salt/sodium;
- (6) 25% relative reduction in the prevalence of raised blood pressure;
- (7) halt the rise in obesity and diabetes;

23 World Health Organization. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. World Health Organization. [Internet]. 2013. Available from: <https://apps.who.int/iris/handle/10665/94384>

24 World Health Organization. Action Plan for Prevention and Control of noncommunicable diseases in South-East Asia, 2013–2020. World Health Organization. Regional Office for South-East Asia. [Internet]. 2013. Available from: [http://origin.searo.who.int/entity/noncommunicable_diseases/documents/sea-ncd-89\(reduced\).pdf](http://origin.searo.who.int/entity/noncommunicable_diseases/documents/sea-ncd-89(reduced).pdf)

- (8) 50% relative reduction in the proportion of households using solid fuels as the primary source of cooking fuel;
- (9) 50% of eligible people to receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes; and
- (10) 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities.

In addition, to add focus to the growing concern about NCDs in the Region, preventing NCDs with a focus on best buys was included as one of the seven Regional Flagship Areas instituted by the Region in 2014. There are a total of 16 best buys (there were 14 in 2013, which was revised to 16 in 2017)²⁵, which are essentially the most effective, feasible, affordable and cost-effective interventions in any resource setting to prevent and control NCDs. Best buys were undertaken to produce immediate and accelerated results in terms of lives saved, diseases prevented, and heavy costs avoided for curbing tobacco use, the harmful use of alcohol, an unhealthy diet, physical inactivity, cardiovascular disease, diabetes and cancer.

The flagships have prioritized NCDs in the agendas of ministries of health and developmental partners and also reinforced WHO country offices focus. WHO country offices have offered support for technical, operational and financial support. This flagship has helped to utilize certain common strategies across all Member States, with sufficient flexibility to adapt to national frameworks and environments while aligning with national priorities.

“NCDs were already the priority in the country, but definitely WHO has provided a push to the same.” – A Ministry of Health respondent from Bangladesh

Effectiveness

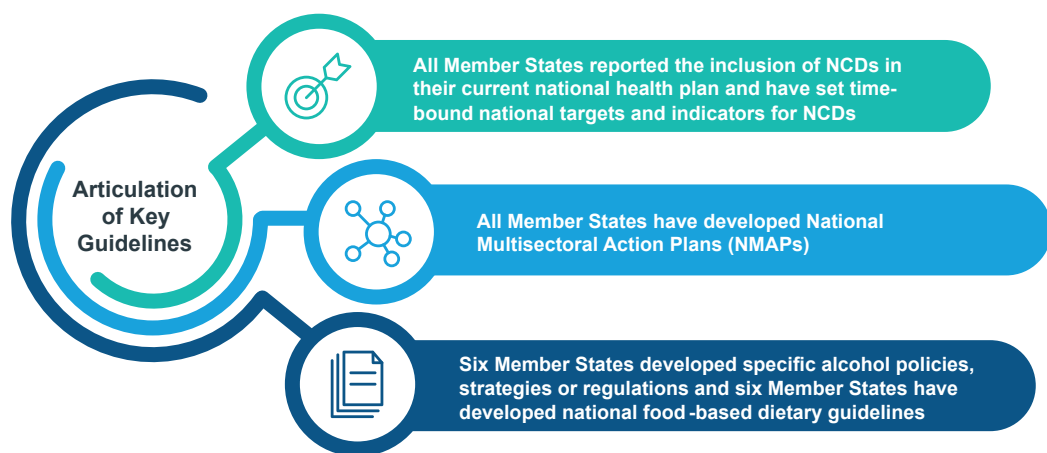
There has been a strategic shift in the way Member States responded to NCDs before and after 2014. Through WHO-led advocacy and technical support, Member States have strengthened their implementation of best buys. All Member States have developed national multisectoral NCD action plans and most of the Member States (nine out of 11) have endorsed these at their highest constitutional levels, exhibiting a positive uptake of these efforts by the Member States.

Articulation of policy documents, guidelines and directives: National Multisectoral Action Plans (NMAP) were developed as a blueprint and gave Member States a clear direction in which to implement policies and programs at the national level and to reduce the burden of NCDs. In 2018, all Member States in the SEA Region reported the inclusion of NCDs in their current national health plan, which is reflected in their national development agendas. All Member States have set time-bound national targets and indicators for NCDs, based on nine global targets from the WHO Global Monitoring Framework. Most SEA Region Member States implemented best buys, including strengthening smoke-free policies, graphic health warnings on tobacco packs, raising taxes on tobacco and implementing the Framework Convention on Tobacco Control (FCTC) 2030 Project. Additionally,

²⁵ World Health Organization. Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/259232>. License: CC BY-NC-SA 3.0 IGO

six Member States (Bhutan, India, Myanmar, Nepal, Sri Lanka and Thailand) have developed specific alcohol policies, strategies or regulations. Member States have also significantly contributed to the development of the Global Action Plan on Physical Activity (GAPPA). Six Member States have developed and are implementing national food-based dietary guidelines. This effort to sharpen the spotlight on NCDs as one of the greatest public health challenges of the Region is clearly appreciated. However, Member States are still facing challenges in the implementation of NCD policies and plans. Thus, the involvement of multisectoral coordination committees or groups in regular monitoring and evaluation of these policies and plans may result in progress.

Fig. 11: Key highlights: articulation of policy documents, guidelines and directives for Flagship 2



Technical assistance: Building an effective and sustainable response has meant creating systems and structures that support the efficient rollout of NCD best buy interventions. Working in close collaboration with the government in each Member State is a well-known strategy that WHO follows; the NCD flagship's activities were no different. It resulted in the establishment of an inter-ministry committee for the prevention of NCDs and the formulation of a TWG for each risk factor (tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity) to provide focused intervention across Member States (Table 2).

Technical and financial support has been provided to several Member States to introduce the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN) into the primary health care system. Screening, early detection and management services for four major NCDs (CVD, cancers, diabetes, chronic respiratory diseases) are being scaled up in all Member States as part of the adopted package of essential NCD (PEN) interventions in Bhutan, DPR Korea, Maldives, Myanmar, Nepal, Timor-Leste and Sri Lanka, and country-specific protocols are also in the packages for Bangladesh, India, Indonesia and Thailand. Also, Bhutan, India, Indonesia, Maldives, Sri Lanka, Thailand and Nepal have ensured the availability of basic diagnostics and essential medicines at primary healthcare (PHC) level.

Going forward, it will be critical to strengthen the implementation of regulatory and financial reform capacity and fiscal policies on tobacco and unhealthy foods including sugar-sweetened beverages. Further, there is a need to strengthen technical assistance to Member States to bring about policy reforms on the use of alcohol and foods high in salt and trans fats based on recommended best practices.

Table 2: Committees established by Member States for NCD prevention

Country	Name of the committee
Bhutan	National Steering Committee for NCDs; three implementation subcommittees: tobacco & alcohol; healthy settings; health services.
DPR Korea	Multisectoral coordination committee for NCDs
India	Standing Committee of Secretaries for prevention and control of NCDs Inter-ministerial Committee for prevention & control of NCDs Technical Advisory Groups (TAG) Health Promotion Board/Society of India
Indonesia	Healthy People Movement
Myanmar	Technical Strategy Group for NCDs National Road Safety Council (NRSC) Central Tobacco Control Committee
Nepal	National Steering Committee for NCDs National Committee for control and prevention of NCD Coordination committee for control and prevention of NCDs Ad hoc committees for control and prevention of NCDs Regional and district NCD prevention and control committees
Sri Lanka	National Health Council National NCD Steering Committee National Advisory Board for Noncommunicable Diseases Technical Working Group on NCDs
Thailand	Executive Committee of Thailand Healthy Lifestyle Strategic Plan (Phase 2) (also called National NCD Prevention and Control Plan (2017-21); can appoint subcommittees as appropriate

Capacity building: Efforts to strengthen the human resource base is key to building the sustainability of all programs. In 2014, a number of capacity-building initiatives were taken up at the Regional level, initiatives such as a regional training workshops to empower country teams to develop multisectoral policies and plans for NCD prevention and control; to support countries in data analyses of the data being collected from various surveys such as STEPS, the Global Adult Tobacco Survey (GATS), the Global School-Based Student Health Survey (GSHS), and the Global Youth Tobacco Survey (GYTS) etc.; and to increase the capacity of NCDs consultants in the OneHealth Tool (OHT) for costing. Countries learnt from each other, as a law enforcement official's team from Sri Lanka visited India to learn good practices in tobacco control at the national and subnational levels. The Regional Office carried out several capacity-building activities in this technical area, including the Regional workshop on

implementation of Health in All Policies (HiAP) in India in 2015. In 2016 and 2017, countries such as Maldives, Myanmar, Nepal and Timor-Leste conducted PEN trainings using the country-specific PEN training packages. Further, Bhutan, Sri Lanka, Myanmar, Thailand increased their capacity in alcohol-policy development, through a collaboration between the national governments and the SEA Region. WHO also assisted in capacity building and supported the discussions to include the NCD module in the Field Epidemiology Training Programme (FETP) in Thailand.

Monitoring and evaluation: Risk factor surveys were an important activity. Multiple surveys were conducted under the aegis of the flagship during the evaluation period. The interactions in India, Myanmar, Thailand, Maldives, Sri Lanka, Nepal and Timor-Leste highlighted that Member States were committed to conducting these essential surveys (such as the STEPs survey or the GYTS, on establishing and seeking NCDs risk factors). All countries except India and DPR Korea reported conducting integrated risk factor surveys among the youth (as part of GSHS) from 2016 to 2018. Five countries (Bangladesh, India, Indonesia, Nepal and Sri Lanka) conducted national adult NCD risk factor surveys (STEPS or STEP equivalents) to help track changes in the prevalence of key behavioural and physiological risk factors and to measure the health system's response in terms of coverage with screening and early treatment. A regional consultation and partners' forum on NCD surveillance and monitoring was organized to accelerate efforts to set up surveillance systems in Member States. In addition, the NCD unit of WHO-SEARO commissioned an evaluation of MPOWER, a tobacco-free initiative, to evaluate the implementation of tobacco-control policies in SEA Region Member States in 2018.²⁶



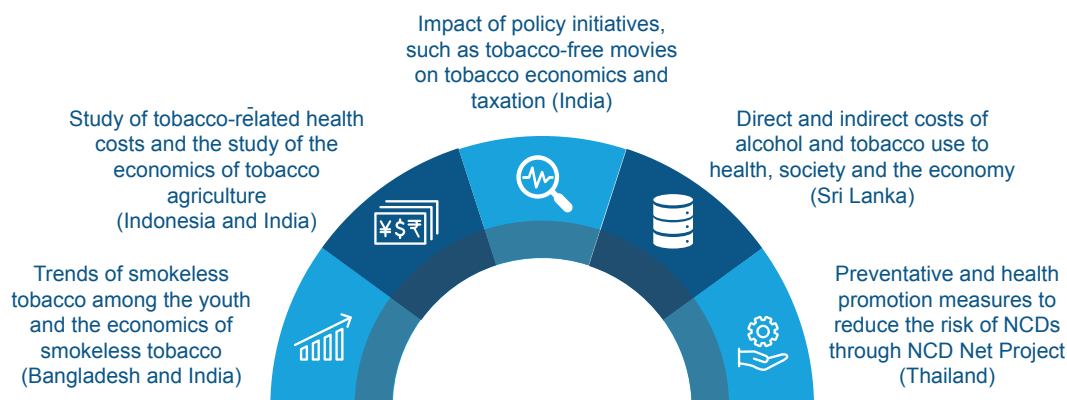
All countries except India and DPR Korea conducted an integrated risk factor survey among youth (as part of GSHS) between 2016 and 2018. Five countries conducted national adult NCD risk factor surveys (STEPS or STEPs equivalent) to help track changes in NCD prevalence.

Research and development, and evidence generation: During the evaluation period, WHO supported Member States in continuing to strive towards evidence-based policy-making to tackle NCDs and implementing cost-effective best buys with respect to key risk factors. This was in recognition of the need for robust scientific evidence to address national health priorities in the light of the epidemiological transition underway in the Member States of the Region. Key public health measures to battle NCDs, such as increased taxation and targeted legislation, are now backed by an increasing volume of evidence. A few key areas of research conducted across Member States are shown below (Fig. 12).^{3,14,16}

Despite efforts to prioritize research and evidence generation, a need to further scale up evidence-based interventions for NCD control, prevention and management was highlighted by respondents across the Member States. Also, it was observed that most of the research done on the NCD risk factors focus on tobacco usage, thus, necessitating focus on other areas.

26 World Health Organization. ACT for Performance and MDF. Evaluation of tobacco control policies and programmes including implementation of the WHO MPOWER technical package in SEAR Member States. Regional Office for South-East Asia World Health Organization Evaluation Report. World Health Organization. [Internet]. 2018 July 10.

Fig. 12: Key research conducted by Member States for Flagship 2

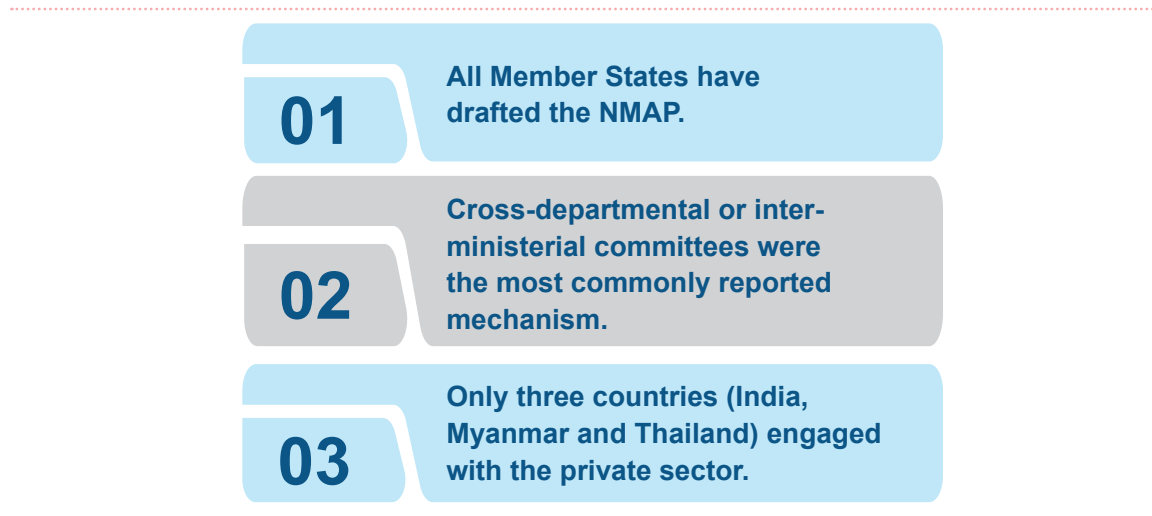


Advocacy: WHO recognizes that sustained advocacy is an important strategy to realize political will and implement the policy changes necessary to reduce the regional burden of NCDs. WHO has supported Member States in conducting numerous regional- and country-level meetings, forums, workshops and campaigns to aggressively advocate for the fight against NCD and the adoption of best buys (prevention and control of tobacco use, and salt reduction have been advocated as the most cost-effective interventions). WHO advocacy with political leaders in several Member States in the Region has helped increase the priority of NCD prevention and control in their development agendas and mobilized additional resources. Key areas of advocacy included legislative and taxation reforms for tobacco use, taxation reforms for sugar-sweetened beverages, the initiation and implementation of nutritional programmes, communicating the impact of childhood obesity, and the promotion of nutrition labelling to encourage healthy diets. Advocacy initiatives were not limited to political leaders and decision-makers, but also conducted with community members to raise awareness through campaigns and awareness drives. Furthermore, the advocacy efforts brought together multilateral stakeholders in the Member States and strengthened civil society networks for collaborative advocacy, action and accountability for NCD prevention and control. As the Region continues to forge ahead in managing NCDs and their risk factors, ongoing advocacy and engagement will be critical to sustain momentum.

Multisectoral and intersectoral collaboration: One of the primary focus areas of this flagship was to support Member States in developing multisectoral policies to combat NCDs. Encouragingly, all the Member States have drafted NMAPs in consultation with key stakeholders, and the entire activity was facilitated by ministries of health in synchronization with WHO country offices. In 2015, the Regional Office developed a regional guidance document titled *Approaches to Establishing Multisectoral Collaboration Mechanisms for Prevention and Control of NCDs*²⁷, to provide guidance to countries for strengthening the engagement and participation of key NCD stakeholders at the country level. Cross-departmental or inter-ministry committees were the most commonly reported mechanism for multisectoral coordination. In most instances, the mechanism was chaired by a health sector representative (minister, secretary or director-general).

27 World Health Organization. Approaches to establishing country-level multisectoral coordination mechanisms for the prevention and control of noncommunicable diseases. World Health Organization. Regional Office for South-East Asia. [Internet]. 2015. Available from: <https://apps.who.int/iris/handle/10665/312110>

Fig. 13: Key highlights: multisectoral collaboration for Flagship 2



Member States are cognizant of the fact that effective governance for NCDs at the national level requires the development of effective partnerships and coalitions to generate the demand for change and to catalyse political action. The range of actors and stakeholders for NCD control are complex and include food manufacturers and retailers, tobacco and alcohol industries, civil society organizations (such as NCD Alliances), disease/condition-specific advocacy groups (such as national diabetic associations), and professional associations. The multisectoral coordination mechanisms in some of the Member States (such as DPR Korea, India, Myanmar, Sri Lanka and Thailand) officially included the membership of NGOs; in others, it was confined to only government ministry representatives (Bhutan, Indonesia and Nepal); and only three countries (India, Myanmar and Thailand) engaged with the private sector. Although the role of WHO in convening and driving multisectoral and intersectoral collaboration was appreciated by the ministries of health of Member States, a further acceleration is required to strengthen and operationalize multisectoral mechanisms and to prioritize the full implementation of multisectoral policies, strategies and action plans. One of the major factors hindering collaborations was that across the Region, subnational NCD response is still largely limited to the health sector, partially due to ineffective functional NCD coordination mechanisms at the local levels. Divergent sectoral mandates, industry interference, political pressures and a lack of clarity of roles are among the other challenges to a multisectoral response in the Region.

“NCD prevention and control is not possible only with Ministry of Health alone, so that’s why there is encouragement for multisectoral collaborations but what I wish is, the WHO could also motivate to the other concerned ministry rather than talking every time with the health ministry” -- A Ministry of Health respondent from Myanmar

Equity: There is significant global evidence that the distribution and impact of NCDs and their risk factors is highly inequitable and imposes a disproportionately large burden on low- and middle-income countries. Member States across the Region have recognized the need to address issues associated with equity. Continued efforts are being made to include NCDs under primary health services package

so as to tackle socioeconomic and geographic barriers, and to ascertain that all populations are provided with universal access to NCD prevention, treatment and management at all health facilities. In addition, there was recognition and understanding in Member States that the working male population is least likely to access services for NCD management due to key socioeconomic concerns or the non-availability of services in non-working hours. To tackle this, some Member States took steps such as screening at workplaces and making functional health centres available on non-working days (Saturdays). However, most of the respondents acknowledged that equity was ensured while planning and policy-making but lost focus during implementation.

Efficiency

The allocation of financial and human resources towards NCDs has increased significantly after it was announced as a Regional Flagship Area. Additional sources were accessed for resource allocation, mobilization of funds and logistical support, through WHO's support and assistance.

NCDs have been a focus area since introduction of the flagships, and thereafter funding and human resources allocation towards NCDs have increased. Since no major global donor partners are supporting NCDs as a focus area, WHO is mobilizing funds with some help from governments, national and international donors in some countries, and funding agencies (such as Bloomberg Funds as part of Bloomberg Initiative²⁸ in Bangladesh, India, Indonesia and Thailand, HelpAge International in Myanmar), to reduce tobacco use. In Thailand, WHO launched a unique pooled-funding mechanism to fund country cooperation strategy priority programmes (NCDs being the target of one of the programmes), in which WHO contributed 30% of total estimated budget of THB 95 000 000 with the Ministry of Public Health and several quasi-government agencies contributing the rest.²⁹ There has been continuous financial support for activities on NCDs from WHO-SEARO to Member States. Progress has been made in setting national targets and developing national multisectoral NCDs action plans. The costing of the national action plans is underway in Bhutan, Nepal and Sri Lanka with technical and financial support from WHO.¹⁵



Taxes increased on alcohol and tobacco in Maldives are projected to add around 210 million MVR (≈US\$ 13.6 million) per year to government revenues, a portion of which will go to the Public Health Fund, set up by the health ministry to support health promotion programmes.

Some Member States increased internal resources to be allocated specifically to NCDs: India, Indonesia and Sri Lanka. Myanmar recently made significant increase in the number of sanctioned positions in underserved areas to meet the new targets for the minimum numbers of doctors, nurses and other health workers per population. However, the challenge of scaling-up human resources remains, particularly at primary healthcare levels. Maldives is witnessing a growing incidence of NCDs and the associated health-care cost is placing additional strain on the UHC programme, threatening financial

28 World Health Organization. Tobacco free initiative, Bloomberg Initiative to reduce Tobacco. World Health Organization. 9 November 2015 [Cited 17 July 2020], Available at <https://www.who.int/tobacco/about/partners/bloomberg/en/>

29 World Health Organization. Proposal Prevention and Control of Noncommunicable Diseases RTG-WHO Country Co-operation Strategy January 2017—December 2021. World Health Organization. Regional Office for South-East Asia Region. [Internet]. [cited 4 August 2020]. Available from: <http://origin.searo.who.int/thailand/areas/ccs-ncd-proposal-eng.pdf>

sustainability. To tackle this, taxes have been increased on alcohol and tobacco in Maldives and are projected to add around 210 million MVR (≈US\$ 13.6 million) per year to government revenues, of which a portion shall go to the Public Health Fund set up by the Ministry of Health to promote healthy lifestyles and support health promotion programmes.¹⁶ Medical insurance now covers essential medicines for NCDs in Indonesia, Maldives, Nepal and Thailand.¹⁶ With support of the Thailand Health Intervention and Technology Assessment Programme (HITAP), the Sri Lanka National Authority on Tobacco and Alcohol (NATA) and the Sri Lanka Medical Association (SLMA), a methodology for calculating the combined economic costs to society of tobacco and alcohol was developed in Sri Lanka. A regional pool of survey equipment (glucometer, survey tablet etc.) has also been created to facilitate NCD surveillance activities in Member States. Despite this support, underfunding, limited human resources and inadequate action-oriented collaboration across sectors remain key challenges for the NCD programme.¹⁴

According to a country capacity survey for NCDs conducted in 2017, all Member States of the SEA Region reported having an NCD unit, branch or department in their ministries of health and substantial improvement in NCD staffing capacity since 2010, especially in Bangladesh, Nepal and Timor-Leste. Although these results seem to show progress in the right direction, they do not reveal whether the financial or human resources are sufficient in quality or quantity to cope with the burden of NCDs and their risk factors in each country. In Bhutan, a multisectoral strategy that aims to reduce alcohol-related morbidity and mortality by 50% by the end of 2020 was developed with technical and financial support from WHO. However, it sees some challenges at the implementation level.

“As the outcome is truly driven to behavior change; changing the mindset of the population has been one of the major challenges for us” – A ministry official from Bhutan

Sustainability

The flagship has ensured sustainability with various actions such as adopting plans and policies, capacity building and accelerated delivery of NCDs services at the primary health care level.

Given the wide range of NCDs and their associated risk factors, a broad step to ensure sustainability in the priority area is to focus on best buys (cost-effective interventions). Moreover, these best buys help decrease behavioural risk factors, which are the major cause of NCDs, and in the long run facilitate the flagship’s sustainability. Political buy-in, multisectoral steering committees in the Member States and establishing high-level multisectoral coordination mechanisms under the guidance of the Regional Office have been catalysts. In addition, to accelerate implementation and build sustainability, the Member States have drafted NMAPs. The Region has identified innovative actions to accelerate the integration of NCD prevention and management within the primary health care level with the WHO PEN package, which has been of immense value in ensuring sustainability. Instituting and strengthening surveillance of NCD risk factors, monitoring and evaluation mechanisms to regularly assess progress, and sharing lessons for sustainable health systems to deliver NCD services will ensure sustainability. However, there is a lack of clarity of roles among stakeholders, which weakens the multisectoral

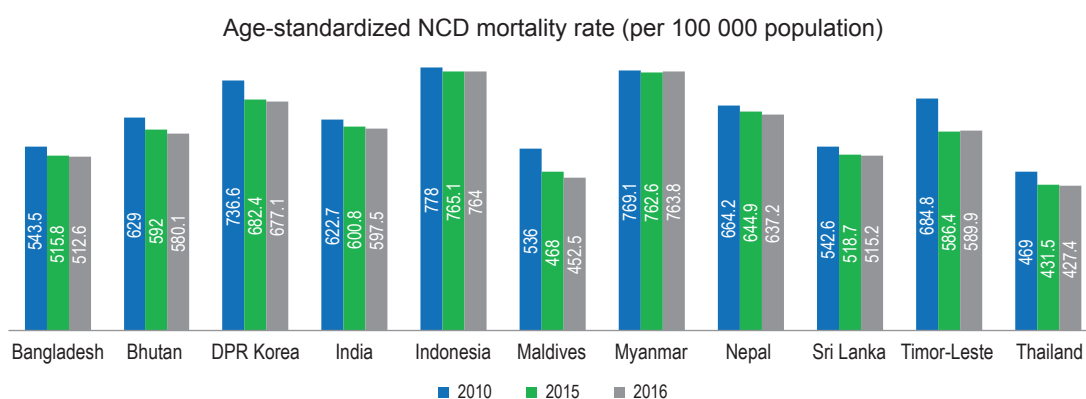
coordination, affecting the sustainability of progress made. With NCDs being the least-funded programme, the absence of funds from donor agencies is another threat. SEA Region countries, despite being lower- and middle-income countries, are still allocating funds to sustain their achievements. It indicates a need to advocate and coordinate with other sectors. Activities implemented by the countries are based on regulations, legislations and policies and are generally sustainable. But industries always interfere in government policy-making, leading to issues for sustainability. WHO should continue to emphasize technical assistance and funding for sustainability.

Impact

The flagship has given the required impetus to activities addressing NCDs, which, in turn, resulted in an improvement in NCDs indicators as all 11 Member States have developed NMAPs and implemented best buys at different levels.

The graph in Fig. 14 shows the trend analysis of NCD mortality per lakh population in the SEA Region. All of the Member States except Timor-Leste and Myanmar show a decreasing trend in NCD mortality at varying rates. Though most of the countries show a decrease in the prevalence of tobacco use (as shown in Table 3), only Thailand has been able to reduce per capita alcohol consumption, even if negligibly (Fig. 15).

Fig. 14: Age-standardized NCDs mortality rate in SEA Region

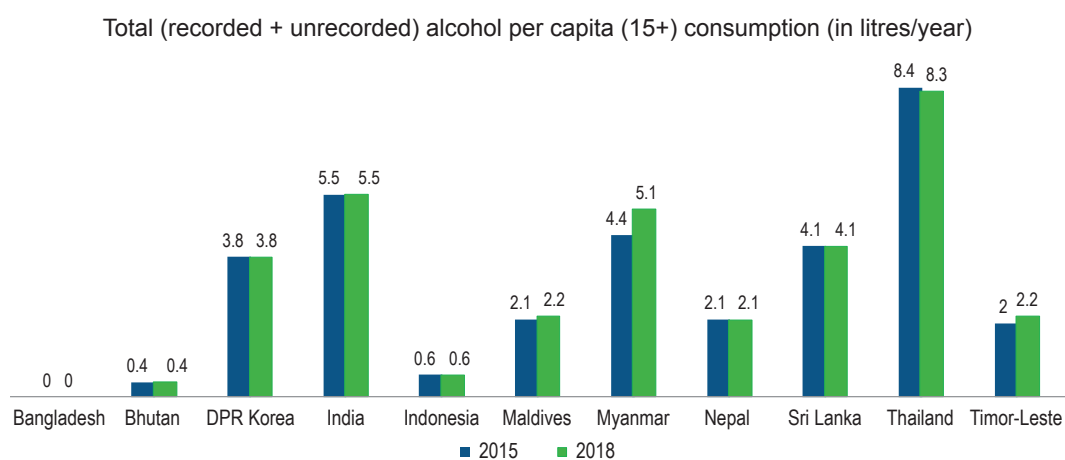


Source: Global Health Observatory, WHO

Table 3: Prevalence of current tobacco use in the SEA Region for adults and adolescents

Countries	Year of Latest Survey (Adult)	Adult (%)	Male (%)	Female*	Year of Latest Survey (Youth)	Youth (%)	Male (%)	Female (%)
Bangladesh	2017 (GATS)	35.3	46	25.2	2014 (GSBS)	9.2	13.2	2.1
Bhutan	2014 (STEPS)	24.8	33.6	13.6	2016 (GSBS)	24.2	36.5	13.9
DPR Korea	2017 (National)	22	46.1	0.0	N/A	N/A	N/A	N/A
India	2016-17 (GATS)	28.6	42.4	14.2	2009 (GYTS)	14.6	19	8.3
Indonesia	2018 (National)	33.8	62.9	4.8	2015 (GSBS)	12.7	23	2.4
Maldives	2009 (National)	N/A	53.5	N/A	2014 (GSBS)	11.2	15.8	6.8
Myanmar	2014 (STEPS)	54.4	79.8	29.1	2016 (GYTS)	13.6	26.3	3.7
Nepal	2016 (National)	N/A	N/A	N/A	2015 (GSBS)	7.2	9.5	4.8
Sri Lanka	2014 (STEPS)	25.8	45.7	5.3	2016 (GSBS)	8.1	13	3.1
Thailand	2017 (National)	20.7	38.3	4.3	2015 (GYTS)	15	21.8	8.1
Timor Leste	2016 (National)	48.6	53.7	4.1	2015 (GSBS)	23.4	31.8	14.1

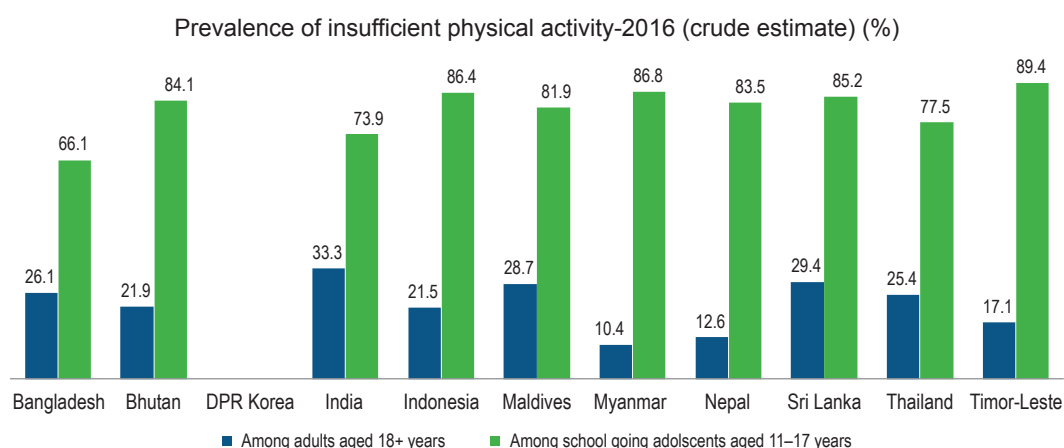
Source: Global Health Observatory, WHO

Fig. 15: Alcohol per capita consumption in the SEA Region

Source: Global Health Observatory, WHO

Member States (India, Sri Lanka and Thailand) that are implementing best buys and showing progress through core progress indicators are exhibiting a visible reduction in NCD mortality rate (Fig. 14), alcohol consumption (Fig. 15) and tobacco use. Countries such as Maldives, Myanmar and Timor-Leste are struggling to keep continuous decrease in alcohol consumption and the mortality rate. However, several other factors such as a country's overall health system and policies, economic status and political will are also responsible for its progress towards decreasing NCD mortality rates.

Fig. 16: Prevalence of insufficient physical inactivity in the SEA Region



Source: Global Health Observatory, WHO

Annually, an estimated 800 000 deaths in the Region are attributed to inadequate physical activity; there is a high burden of insufficient physical activity, especially among adolescents.³⁰ Though the Member States have demonstrated regional solidarity and leadership through the adoption of the GAPPA at the Seventy-first World Health Assembly in 2018, only six Member States have started to implement public campaigns on physical activity as of 2018.

All Member States have aligned the 2025 NCD national targets with the global voluntary targets and have agreed to the SDG target 3.4 on reducing premature mortality from NCDs. They have established governance and multisectoral coordination mechanisms to accelerate the implementation of plans because it is recognized and understood that effective NCD prevention and control require leadership, coordinated multi-stakeholder engagement and multisectoral action for health both in government and non-government organizations. NMAPs are developed with iterative consultations among these stakeholders. Overall, the efforts made by the Region and the Member States point towards significant progress in the prevention and control of NCD over the last few years.

All Members States have developed national multisectoral NCD action plans and nine Member States have endorsed them at their highest constitutional levels.³¹ There are some Member States that have also achieved the implementation of best buys at different levels. Some adopted measures to reduce

30 Physical inactivity & Harmful use of alcohol in South East Asian Region (SEAR) Countries. Medindia [Internet]. [cited 20 July 2020]. Available from: https://www.medindia.net/health_statistics/sear_countries/physical-inactivity-harmful.asp

31 World Health Organization. Prevention of noncommunicable diseases through multisectoral policies and plans with a focus on "best buys"; WHO flyer 2018. World Health Organization. Regional Office for South-East Asia. 2018

determinants and behavioural risk factors, while others have developed guidelines for the management of NCDs and made available basic diagnostics and medicines for them at the primary health care level.

Across all the Member States, Bhutan is the only country that has banned the production and sale of all the tobacco products. In DPR Korea and Indonesia, least progress has been achieved in tobacco control as compared to other countries in the areas of pictorial warnings and ban on advertisement of tobacco products. Some Member States have adopted 100% smoke-free policies and most of them have increased the excise taxes on tobacco products. Bhutan and Thailand have performed better than other Member States at curbing alcohol consumption due to the effective implementation of policies at the national level. Table 4 shows the status of progress indicators (including some best buys) in the SEA Region in 2018.

Table 4: Status of key progress indicators for NCD prevention in the SEA Region, 2018

	Governance				Tobacco				Alcohol			Diet			PA	Diseases			
	NCD Policy and Action Plans	Targets	Mortality data	Risk survey	Tax	Smoke-free	Warning/PP	TAPS ban	Campaign	Availability	Advertising	Tax	Salt reduction	Trans-fat Policies	Marketing Restrictions to Children	Marketing Restrictions-Breastmilk substitutes	Campaign	NCDs Management Guidelines	CVD Care
BAN	Green	Green	Blue	Green	Green	Green	Green	Blue	Green	Green	Green	Blue	Blue	Blue	Green	Green	Blue	Blue	Blue
BHU	Green	Green	Orange	Green	White	Green	White	Orange	Blue	Green	Blue	Blue	Blue	Orange	Green	Green	Orange	Green	Green
DPR Korea	Green	Green	Orange	Green	Blue	Orange	Orange	Green	White	White	White	Orange	Orange	Orange	White	White	Orange	Blue	Blue
IND	Green	Green	Green	Green	Blue	Blue	Green	Blue	Green	Blue	Blue	Blue	Blue	Blue	Blue	Green	Green	Green	Green
INO	Green	Green	Blue	Green	Blue	Orange	Orange	Green	Green	Green	Green	Blue	Orange	Blue	Green	Green	Green	Green	Green
MAV	Green	Green	Green	Orange	Blue	Blue	Orange	Orange	White	White	White	Orange	Orange	Blue	Green	Green	Orange	Green	Green
MMR	Green	Green	Orange	Green	Blue	Blue	Green	Orange	Blue	Blue	Blue	Orange	Orange	Orange	Green	Green	Green	Green	Blue
NEP	Green	Green	Orange	Green	Orange	Green	Green	Green	Blue	Blue	Blue	Orange	Orange	Orange	Green	Green	Green	Green	Green
SRL	Green	Green	Blue	Green	Green	Green	Green	Orange	Blue	Green	Blue	Blue	Blue	Blue	Green	Green	Orange	Green	Green
THA	Green	Green	Blue	Green	Green	Green	Green	Green	Green	Blue	Blue	Blue	Green	Orange	Green	Green	Green	Green	Green
TLS	Green	Green	Orange	Green	Orange	Green	Green	Blue	Orange	Orange	Blue	Orange	Orange	Orange	Blue	Blue	Green	Green	Blue

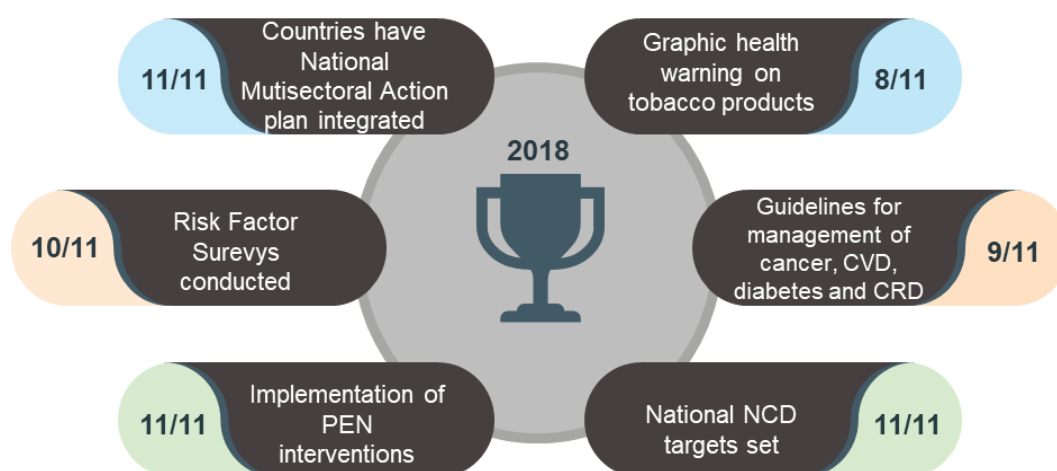
■ Achieved
 ■ Activities in progress
 ■ No progress
 Information not available / NA

Source: WHO SEARO flagship flyer 2018

It is clear from Table 4 that there is a disparity among the Member States in their achievement of the targets set as best buys. Bhutan, India, Sri Lanka and Thailand show promising prospects, whereas DPR Korea and Timor-Leste need extra effort to combat NCDs.

In conclusion, it can be established that this flagship has given needed impetus to activities that address NCDs, which in turn resulted in an improvement in NCDs indicators. However, the progress is attributable to the combined efforts of WHO, ministries of health and the technical partners of the respective Member States. Fig. 17 provides a snapshot of the achievements of the SEA Region in managing NCDs during the evaluation period.

Fig. 17: Key achievements of the SEA Region (2014–2018) for Flagship 2



Challenges

Suboptimal evidence-based interventions: Though all SEA Region countries reported having evidence-based guidelines, there is a need to further scale up evidence-based interventions for NCD control, prevention and management. Further, a significant focus of these studies has been on tobacco with limited research on other NCDs risk factors (alcohol consumption, unhealthy diet and physical activity), which will need more attention going forward.

Industry interference and weak multisectoral coordination: The range of actors and stakeholders for NCD control are complex and subject to interference, especially by industry, and this is one of the major challenges that hinders the implementation of best buys. Across the Region, the subnational NCD response is still largely limited to the health sector, partially because of ineffective functional NCD coordination mechanisms at local levels. The private sector often influences the decisions taken by the government. There is a predominance of OOPE on NCD management in most SEA Region countries, putting the population at risk of catastrophic health expenditures and consequently being driven into poverty, especially in the case of chronic illnesses. Divergent sectoral mandates, political pressure and a lack of clarity of roles are among the other challenges to a multisectoral response in the Region.

Implementation level challenges: Member States were seen to face challenges in the implementation of NCD policies and plans. Having only national structures may be highly inadequate, especially in larger countries such as India, Indonesia and Bangladesh, and more so in countries with a federal governance structure. Anecdotal and other published evidence from countries still suggests that building a sustainable infrastructure consistent with the magnitude of the NCDs continues to be a challenge.

Suboptimal technical expertise and resources: The challenge of scaling up human resources is still present, particularly at the primary healthcare level. Since no major global donor partners support NCDs as a focus area, WHO is mobilizing funds with some help from governments and local funding agencies. Despite this support, underfunding remains a challenge for the NCD programme in the Region.

Inadequate translation of high-level political commitments: Commitments made at the global, regional or national level are not adequately translated into improved and sustained investments or legislative and regulatory measures to address NCDs. Also, there is minimal commitment from senior officials, and convincing politicians from ministries other than the Ministry of Health poses a significant challenge to achieving targets.

Recommendations

Scale up evidence-based interventions: Member States look up to WHO for support in generating country-specific evidence, which can then be leveraged as a baseline for further progress, more advocacy, and to set targets for the future. Some of the domains within NCDs need more attention, such as alcohol consumption, unhealthy diet and physical activity.

Strengthen multisectoral coordination: In strengthening the multisectoral responses to health and reducing industry interference, WHO may need to explore reaching out to multiple stakeholders including government departments, ministries other than health, civil society, academia, the private sector and international organizations. Although the role of WHO in convening and driving multisectoral and intersectoral collaboration was appreciated by the health ministries of Member States, a further acceleration is required to strengthen and operationalize multisectoral mechanisms by involving the private sector and government, and to prioritize full implementation of multisectoral policies, strategies and action plans.

Enhanced technical support: There is a need to further increase the technical assistance to Member States to bring about policy reforms in the use of tobacco, alcohol and foods high in salt and trans fats, based on recommended best practices. The involvement of multisectoral coordination committees or groups in regular monitoring and evaluation of these policies and plans may result in progress.

Strengthen national capacity: It is evident from multiple responses in this study that strengthening systems, going beyond policy advocacy or capacity building, is becoming an urgent need. That said, capacity building is a great need across nations, and WHO must continue efforts in this direction to sustain existing gains. To attract funds from global donor agencies, it indicates a need for a higher-level advocacy to global partners and agencies.

Success Story: Thailand

In response to the growing threat of NCDs, Thailand has pioneered innovative policies and programs while facing and combating numerous challenges to achieving its NCD-related goals. The WHO country office Thailand has developed effective strategies and measures in line with the national policy and linked with different government sectors to work together on tackling NCDs and their risk factors. Several investments and implementation plans were put in place to promote health and beat NCDs, including implementing a tax on sugar-sweetened beverages, promoting physical activity, reducing the amount of salt in food products, and front-of-pack labelling on pre-packaged foods. In 2018, a milestone was achieved where Thailand became the first country in Asia and the first middle-income country to introduce plain packaging for tobacco products. The Regional Office also facilitated the UN Interagency Task Force on NCDs (UNIATF) missions to Thailand to strengthen the implementation of the country's national NCDs strategy. The Regional Office and the Thai Health Promotion Foundation (Thai Health) signed an MoU that aims to strengthen national capacity to address the commercial determinants of health as well as national food programmes to promote healthy diets. 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. Thailand charges a 2% cess (tax) on tobacco and alcohol, and Thai Health uses this money for activities related to health promotion.

WHO also strengthened multisectoral coordination for NCDs by establishing an UN-led forum for multisectoral engagement chaired by the UN Resident Coordinator. The health sector took coordinated action, augmented by the high-level participation of different government departments and ministries (finance, education, labor and civil society), with WHO as the secretariat. Diagnosing and treating NCDs is a core element of the primary care system in Thailand, and the country has a strong commitment to universal health coverage.

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

Relevance

This flagship reinforced focus on the unfinished MDG agenda and other emerging priorities by increasing resource allocation through fund mobilization and ensuring adequate infrastructure, a skilled workforce, strengthened surveillance and quality of care initiatives, and through collaborations such as the H6 working group (for harmonized support from UN agencies: WHO, UNICEF, UNFPA, World Bank, UNAIDS and UN WOMEN).

In 2014, several of the Region's Member States appeared unlikely to reach the targets for MDGs 4 and 5 on maternal and child mortality. The fact that neonatal mortality remained stubbornly high while progress to reduce it was slow was worrying. Even as the MDG era drew to a close, the annual death

toll remained unacceptably high globally: 289 000 maternal deaths, 2.6 million stillbirths, 5.9 million deaths in children under the age of five – including 2.7 million newborn deaths – and 1.3 million adolescent deaths.³² 94% of maternal deaths occur in low- and middle-income countries³³, and the SEA Region accounts for one third of global child deaths.³⁴ Neonatal deaths constitute a much higher percentage of the child mortality in the SEA Region than anywhere else, making up more than 60% of the infant mortality and about 40% of the under-five mortality rates in several countries in the Region.³⁵

Most of these deaths could have been prevented. To combat the unfinished MDG agenda, in 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development. To translate policy into action, the updated Global Strategy for Women's, Children's and Adolescent's Health 2016–2030³⁶ was launched to mobilize global, regional, national and community-level commitment to maternal, newborn and child survival. The SEA Region endorsed this strategy at the Sixty-ninth session of the WHO Regional Committee meeting (SEA/RC69/R3). Addressing the unfinished MDG agenda with a specific focus on neonatal mortality was a priority. The Region identified "ending preventable maternal, newborn and child deaths with a focus on neonatal deaths," as one of the seven Regional Flagship Areas for the Region to give it the attention and resources needed. It also put a spotlight on newborn mortality by generating research-based evidence, strategies for quality of care at birth, and an online database for the surveillance of newborns in a concerted manner that was not previously covered by the MDGs.

The flagship focus aligned with the priorities of health ministries and was reflected in the healthcare situation across Member States, thus reinforcing the focus of WHO country offices, health ministries and developmental partners. Progress was made towards realizing the vision to end preventable deaths through an emphasis on improving the quality of care, skilled care at births along with equitable coverage, the establishment of technical advisory groups, the endorsement of strategic frameworks for strengthening newborn and child healthcare, policy surveys, a refocusing on family planning initiatives, a strengthened surveillance system, the training of healthcare professionals and forging collaborations such as the H6 Working Group. Concerted advocacy efforts were made towards mobilizing domestic spending to ensure adequate health infrastructure, including a skilled workforce.

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- 32 World Health Organization, Every Women Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). World Health Organization. 2015. Available from: <https://www.who.int/life-course/publications/global-strategy-2016-2030/en/>
- 33 World Health Organization. Maternal Mortality; Global Health Observatory. World Health Organization. 2019. [cited 17 June 2020]. Available from: <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.
- 34 World Health Organization. Adolescent health in South East Asia Region. World Health Organization.2019 [cited 15 June 2020]. Available from: <https://www.who.int/southeastasia/health-topics/child-health>
- 35 World Health Organization. South-East Asia Regional Strategic Framework for Improving Neonatal & Child Health and Development. World Health Organization, 2012.
- 36 World Health Organization, Every Women Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). World Health Organization [Internet] 2015. Available from: <https://www.who.int/life-course/publications/global-strategy-2016-2030/en/>

Effectiveness

All Member States have adopted and developed guidelines and policies to accelerate progress with support from WHO. Member States found the support provided by technical advisory groups useful for tailoring their strategic approaches.

Articulation of policy documents, guidelines and directives: Most respondents across Member States acknowledged the contribution of WHO in the articulation of policies, guidelines, action plans and time-to-time guidance to Member States. WHO supported the strengthening of national plans for maternal, newborn and child health to accelerate the scaling up of the implementation of evidence-based reproductive maternal, newborn, child and adolescent health (RMNCAH) interventions. Further, the Regional Office developed and disseminated the Regional Framework for Improving Quality of Care for Maternal-Newborn-Child-Adolescent Health³⁷ and for scaling up of maternal death surveillance and response (MDSR). The regional proposal on safe abortion care (SAC) and post-abortion care (PAC) as an integral component of UHC for sexual and reproductive health and rights was developed in 2018. WHO also conducted orientations for Member States on the new guidelines for antenatal care³⁸ and intrapartum care³⁹ at the regional meeting in 2018 and encouraged Member States to update their national guidelines accordingly. A summary of the strategies and guidelines adopted by Member States on maternal and child health is shown in Table 5.

Technical assistance: The Regional Office has set up a Technical Advisory Group (TAG) of subject matter experts on maternal and child health. The TAG guided policies and strategies to improve maternal, child and adolescent health, and to reduce maternal, under-five and neonatal mortality in Member States. Between 2015 and 2018, there were four meetings to review the progress achieved by Member States and the TAG provided recommendations on the way forward accordingly. Technical Working Groups have been established across Member States, making WHO's presence for technical inputs evident.

37 World Health Organization. Improving the quality of care for reproductive, maternal, neonatal, child and adolescent health in South-East Asia: a regional framework. World Health Organization. Regional Office for South-East Asia. [internet]. 2015. Available from: <https://apps.who.int/iris/handle/10665/279775>

38 World health Organization. WHO Recommendations on Antenatal Care for a positive pregnancy experience. World Health Organization. [Internet]. 2016. Available from: <https://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf?sequence=1>

39 World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2018. Available from: <https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf>.

Table 5: Key strategies, policies, laws and guidelines for maternal and child health in the SEA Region

Indicators	Bangladesh	Bhutan	DPR Korea	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor Leste
Free access to health services newborn	★	★	★	★	★	★	★	★	★	★	★
Free access to health services pregnant women	★	★	★	★	★	★	★	★	★	★	●
Dedicated law newborn health	▲	★	★	★	★	▲	★	★	▲	▲	★
Dedicated law maternal health	▲	★	★	★	★	▲	★	★	▲	▲	●
National policies/ guidelines on antenatal care	★	★	★	★	★	★	★	★	★	★	★
National policies/ guidelines on childbirth	★	★	★	★	★	▲	★	★	★	★	★
National policies/ guidelines on postnatal care for mothers and newborns	★	★	★	★	★	★	★	★	★	★	★
National policies/ guidelines on management of low birth weight and preterm newborns	★	★	★	★	★	★	★	★	★	★	★
National standards for the management of newborn infants with severe illness	★	★	★	★	★	★	●	★	★	★	★
National policies/ guidelines competency framework for maternal and/or newborn health care	★	★	★	★	★	▲	★	★	★	★	★
National policies/ guidelines/ law requiring all maternal deaths to be reviewed	★	★	★	★	★	★	★	★	★	★	★
Facility stillbirth review process in place	▲	▲	★	★	▲	▲	★	★	★	▲	▲
Facility neonatal death review process in place	★	★	★	★	★	★	★	★	★	▲	▲

★ Yes ▲ No ● Uncertain

Source: WHO RMNCAH Policy Survey, 2018

WHO guidance on improving the quality of care through the development of standards, such as the Point of Care Quality Improvement (POCQI) model, guidelines and quality parameters has been significant. All Member States have been trained on POCQI, with a focus on building knowledge and skills for healthcare teams to improve the quality of care in health facilities at the national and subnational level. In 2018, the POCQI coaching guide⁴⁰ was prepared to support on-the-job supervision

40 World Health Organization. Coaching for quality improvement: coaching guide. World Health Organization. Regional Office for South-East Asia. [Internet]. 2018. Available from: <https://apps.who.int/iris/handle/10665/310421>

of healthcare teams and build their capacity for continuous quality improvement. The Regional Office also supported Member States in undertaking the assessment of the quality of maternal, child and newborn care services using WHO assessment tools (India, Sri Lanka, 2015). The technical assistance to India to strengthen its national Quality of Care Network on Maternal, Newborn and Child Health, which enabled teams of obstetricians, neonatologists and nurses across India to share experiences of improving the quality of care and learn from each other, and develop a district model of midwife-led care, has led to the success of the programme. In 2018, all Member States carried out the WHO RMNCAH Policy Survey with WHO support. The Regional Office enabled Member States to identify national total fertility targets and assisted Bhutan, Sri Lanka, Nepal, Indonesia and Maldives with revising their national guidelines on family planning.

Technical Assistance



- **Establishment of regional and national technical advisory groups**
- **Support in identifying national targets for MMR, NMR, U5MR and fertility rate**
- **Support in improving the quality of care by developing standards like the POCQI model**

Capacity building: Over the period evaluated (2014-2018), capacity-building initiatives were conducted across all the Member States; several training workshops were supported through technical and/or financial assistance from WHO. Respondents from almost all Member States confirmed their participation in regional trainings, which included ministry officials, and their replication at national and subnational levels. The Regional Office's support of institutional strengthening has been visible across Member States, who have established national networks of hospitals to improve maternal and newborn care and establish surveillance for birth defects, sick newborns and stillbirths along with emergency obstetric care (EmOC) centres. The Regional workshop on the use of computer-based tools, OneHealth, was conducted jointly by WHO-SEARO and UNICEF in 2015.

Evidence-based strategic planning and costing was facilitated to implement national reproductive maternal, newborn, child and adolescent health (RMNCAH) programmes. The Regional Office supported the training of hospital staff on birth defect surveillance in 2015 in Bangladesh, India and Myanmar. In 2016, the Regional Office disseminated a framework to improve facility-based quality of care for maternal and newborn health through a regional capacity-building workshop. To strengthen the capacity of family planning programmes in the Region, in 2017, the Regional Office organized a "Regional Meeting to Strengthen Capacity in the new WHO family planning guidelines: towards universal reproductive health coverage in the SDGs era" under the WHO family planning umbrella project to introduce Member States to new family planning guidelines, recommendations and tools.

Monitoring and evaluation: Support was leveraged to strengthen surveillance of birth defects to address neonatal mortality and still births. To address perinatal deaths, governments were supported for monitoring and the onsite coaching of tools at the community and facility level. Improving the quality of MDSR including community surveillance is critical because it not only provides information on maternal deaths but also helps to develop strategies to prevent more deaths. Maternal and perinatal death surveillance and response (MPDSR) was assessed across Member States to discover its cause and stimulate action, in Sri Lanka to seek the cause of stagnant maternal mortality ratio (MMR) and perinatal death from 2014-2017, and in 2015 in Timor-Leste, an EmOC assessment. A significant contribution to monitoring and evaluation was made through the strengthening and scaling up of

MDSR systems in Member States. Access to 24x7 EmOC should be improved with periodic EmOC assessment and an improvement plan (and its regular monitoring) including the adequate training of all the concerned healthcare professionals to provide basic and comprehensive EmOC, and the availability of essential equipment, drugs and supplies and a functional referral system. The Regional Office also supported a regional assessment of the nursing and midwifery workforce in 2017 to form the basis of activities to strengthen the size and quality of this workforce in India with the aim of improving maternal and child health care.

“Maldives has adopted MDSR. The maternal deaths are reported from all the health facilities to national wing, if any cases occur they will report within 24 hours and send all the reporting forms everything within seven days.” – A health ministry official from Maldives

Research and development, and evidence generation: During the evaluation period, limited scientific and operation research was conducted under this flagship. In 2016 and 2017, WHO headquarters and the US Center for Disease Control (CDC) conducted a joint experiment to demonstrate that the fortification of wheat flour with iron, B12 and folic acid would help prevent anaemia and neural tube defects in India, thereby testing the feasibility and sustainability of fortification.³ As part of evidence generation, the Regional Office developed progress reports towards MDG 5 in the Region in consultation with Member States, along with country factsheets on early pregnancy, the status of family planning and country reports on maternal death surveillance and response. In 2018, an intercountry meeting was held among the 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 the survival of preterm and low-birth-weight babies. SEA Regional TAG and Member States have strongly emphasized that more resources and efforts to strengthen research capacity are urgently required. Thus, in the pursuit of achieving targets, WHO and partners are urged to support research, especially implementation research, on stillbirth prevention and management, and maternal, neonatal and child health.

Advocacy: WHO has played a crucial role in advocacy for the prioritization of maternal and child health by national authorities. However, these efforts were varied and had several focuses, based on country-specific contexts and, as a result, the outcomes of advocacy efforts might not be as quick or tangible as expected in some cases. Member States used WHO-supported advocacy for multiple themes and subjects such as the adoption of guidelines (antenatal care, postnatal care, newborn care, midwifery operations), the adoption and implementation of MDSR, the expedited establishment of highly specialized centres for several maternal morbidities, and additional focus on mother and child health in the primary healthcare reforms. What is more, WHO and other stakeholders have also supported Member States in advocacy and awareness-building programs at the community level via community clinic groups and satellite clinics for family planning and newborn care. At the Regional level, efforts were made to better maternal and child health through a review meeting in 2014 on the



WHO-supported advocacy in Member States was on multiple themes and subjects, such as the adoption of guidelines, the adoption and implementation of MDSR, the expedited establishment of highly specialized centres and additional focus on MCH in the primary healthcare reforms.

Every Newborn Action Plan (ENAP) and post-natal care for mothers and newborns. In 2018, to increase the momentum and Member States' commitment to improving MCH, a regional parliamentarians' meeting was conducted to advocate for increased investment in and accountability for the reduction of maternal and newborn mortality. Despite concerted advocacy efforts, the need for WHO to continue to advocate at the highest level for investment in RMNCAH at different levels of implementation and focus on mother and child health in the primary healthcare services packages of Member States remains.

Multisectoral and intersectoral collaboration: The issues that need to be addressed to improve maternal and child health are multi-causal and, therefore, the response also needs to include intersectoral and multi-stakeholder efforts. As a result, WHO's collaboration with other UN agencies has markedly improved through regular teleconferences, joint meetings and joint country missions. In April 2014, a joint statement was issued by the Regional Director of WHO-SEARO, the UNICEF Regional Office for South Asia, and the Asia-Pacific Regional office of the United Nations Population Fund (UNFPA) through a regional meeting at Kathmandu. The key outcome was a raised commitment to strengthen regional partnerships and harmonize country support to end preventable maternal and child deaths. Furthermore, a joint statement titled *Ending preventable maternal, newborn and child mortality* (spearheaded by the Regional Director of the WHO SEA Region) was signed in 2015 by the regional heads of six UN agencies (WHO, UNICEF, UNFPA, UN Women, UNAIDS, World Bank). An H6 Regional Working Group was formalized in 2017, which has been responsible for coordinating harmonized support for RMNCAH activities in Member States of the Region. Throughout the evaluation period, WHO and its key partners (UNICEF and UNFPA) have conducted joint country missions in several Member States (Bangladesh, Indonesia, Nepal, Myanmar and Timor-Leste) to review and strengthen RMNCAH programmes and identify common areas for collaboration at the country level. Beyond the UN agencies, the WHO SEA Regional Office collaborated with the CDC and created an online database of newborn birth defects. Going forward, it will be critical to reinforce multisectoral and multi-stakeholder partnerships and commitments to address the underlying social determinants of women's and children's health to achieve the desired target for the Region.

Fig. 18: Key highlights: multisectoral collaboration for Flagship 3



“UNFPA works closely with WHO, not only as normative agency in MNCH and all other health topics. UNFPA focus on SRH, cervical cancer and midwifery (among other topics) has benefited from WHO technical guidance and advice, as well as advocacy support. WHO and UNFPA usually work together and coordinate closely our support to Ministries of Health.” – A technical partner respondent for DPR Korea

Equity: An equity-focused approach targeting the marginalized not only addressed the disparities among the population, but accelerated the progress towards the SDGs. Several Member States have conducted equity analyses based on training from the Regional Office and country offices to identify existing gaps and use the information to develop national and subnational resource allocation planning and access to services. Despite these efforts, there were bottlenecks with respect to equitable access to services for maternal and child health. Some examples of inequity were highlighted during the evaluation. There was inequitable access to services due to geographical disparity in DPR Korea, Myanmar and Nepal, inequity due to service delivery challenges in Bangladesh and social norms in Nepal led to low coverage of post-natal care. To counter inequity, Member States have taken initiatives such as health financing to increase institutional deliveries. Some of these are: universal health coverage schemes through the Thailand 30 Baht health scheme, universal health coverage with JKN in Indonesia (2014), institutional delivery care identified as an essential service delivery package in Myanmar and the Janani Shishu Suraksha Karyakaram conditional cash transfers in India.

Efficiency

There has been a significant increase in the allocation of resources (HR and funds) after RMNCAH was announced as a Regional Flagship Area.

The flagship accelerated ongoing efforts to mobilize financial and human resources across the Member States. The adoption of the SDGs and setting of ambitious targets for maternal and child health caught the attention of high-level authorities in the Region and RMNCAH gained the highest level of commitment. The WHO country offices and the Regional Office succeeded in securing funds from major donors (the Bill & Melinda Gates Foundation, UNICEF, the McArthur Foundation and the Buffett Foundation). Governments have become accountable for allocating funds to MPDSR (which now includes perinatal death). This success can be attributed to some countries having well-functioning health systems by adopting various national policies and strategies, micro-planning and including mother and child health in implementation plans at the community level. RMNCAH interventions and the coverage of services have increased overtime, but inequities with huge gaps in the financing and implementation of evidence-based interventions hindered the achievement of targets. Efforts and resources need to be scaled up to enhance the quality of care around birth at all health-care centres. Member States still need to expand health service delivery infrastructure and use innovative approaches in underserved areas to overcome geographical, financial and social barriers.

The outcomes are supported by various factors such as advocacy for high-level buy-in, resource allocation, well-functioning health systems and concurrent monitoring provided by WHO.

Maldives saw substantial progress in health-related MDGs: reducing child mortality (MDG 4), improving maternal health (MDG 5) and combating HIV/AIDS, malaria and other diseases (MDG 6). One of the primary drivers of this performance has been the strong and sustained allocation of the national budget and the spending of approximately 40% of the budget on the social sector (average over 2000–2010), more than any other South Asian country.⁴¹ The Government of Bhutan assumed most of the financing for the DPT-HepB-Hib (pentavalent) vaccine (previously supported mainly by Gavi) as well as 100% of the financing for all 481 essential medicines starting in 2016. These costs are now covered by BHTF, a unique mechanism that helped the country provide free medical care to its population with the aim of achieving universal health coverage.

Across Member States, there are health system constraints such as funding shortages, a dearth of skilled birth attendants (nurses, midwives, doctors), and the lack of access to essential infrastructure, medicines, equipment, and service delivery models. Bhutan has a critical shortage of qualified specialists, with only 12 local obstetricians/gynaecologists and five paediatricians in the entire country. There is also a shortage of qualified midwives, and the training programme for nurses-midwives and medical assistants needs to be extended and strengthened to meet international standards. Since evidence-based strategic planning and costing are essential to implement national RMNCAH programmes, Bangladesh, Myanmar and Indonesia received follow up support from WHO to use OneHealth to plan and cost their national newborn action plan.

Thailand extended health insurance to all documented and undocumented migrants, as part of the Government's commitment to the 'Global Plan towards the Elimination of New HIV Infections among Children by 2015 and to Keeping their Mothers Alive'. This allowed all pregnant women regardless of their legal status, to receive free antenatal care, delivery and PMTCT services. In Timor-Leste, to reduce maternal mortality and improve birth outcomes, WHO partnered with UNFPA to develop a costed improvement plan for emergency obstetric and neonatal care (EmONC), based on an assessment of available EmONC services and capabilities at community health centres and hospitals. Bangladesh piloted an orientation package in one district hospital and one *upazila* hospital where doctors, nurses and midwives were employed in the labour ward. In Myanmar, WHO country office forged partnerships through coordination meetings, small-scale funding and reallocation of responsibilities within state-level health clusters in Rakhine and Kachin states. Nepal collaborated with the Immunization and Vaccines Development (IVD) team in the WHO Regional Office, and forged new partnerships with Gavi, CDC and USAID (United States Agency for International Development) to negotiate funding for a surveillance network for rotavirus and for innovative projects on child mortality surveillance.

41 World Health Organization. The Work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January-31 December 2014. World Health Organization. Regional Office for South-East Asia. 2015.

Sustainability

Various initiatives, such as strategy formation, capacity building at the national level, strengthening surveillance system and making transition plans were undertaken to ensure sustainability.

The Region has adopted the updated Global Strategy for Women's, Children's and Adolescent's Health 2016–2030³⁶ and the strategic objectives outlined in the Every Newborn Action Plan (2014)⁴² as a step towards ensuring sustainability for maternal and child health services. This will sustain the progress made in terms of reduction of maternal, under-five and neonatal mortality in Member States.

WHO's initiatives (such as the formation of TAGs to guide policies and strategies and the formalization of the H6 working group) help improve health and reduce the mortality in the Region. The Regional Office supported training and capacity building on birth defect surveillance in Bangladesh, India and Myanmar. It also introduced the POCQI model to improve the quality of care in health facilities for mothers and newborns at the time of birth, and prepared a training package to aid national capacity building. To strengthen the capacity of family planning programmes, the WHO-SEARO organized a regional meeting in 2017 to introduce Member States to new family planning guidelines, recommendations and tools. WHO supported Member States in the implementation of MPDSR to document and review all maternal deaths and use the findings to improve and sustain the quality of maternal and perinatal care. The Regional Office has also helped develop exit strategies for taking ownership of services and programmes. For example, In Timor-Leste, the government has planned and agreed to gradually take over the funding for the procurement of commodities for family planning by 2023. In Bhutan, the Ministry of Health is undertaking pertinent assessments to devise appropriate transition plans to sustain free health care services.

The absence of innovative ways to provide a strong network of health services is a big challenge to the sustainability of the results, since the majority of the population lives in rural areas in most countries. Under-reporting and inadequate surveillance are added challenges to sustaining the gains achieved by the Member States. Thus, to sustain the gains and further accelerate mortality reduction, a rapid expansion of evidence-based life-saving interventions, especially ones delivered to 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.

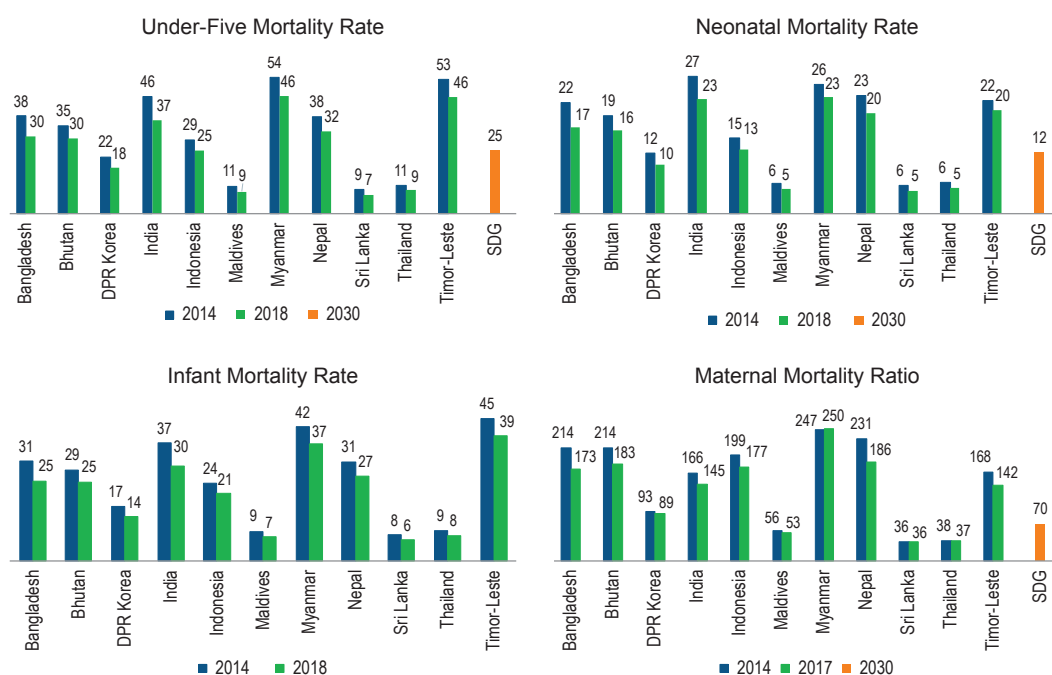
42 World Health Organization. UNICEF. Every Newborn: An Action Plan to end Preventable Deaths. World Health Organization. UNICEF. [Internet]. 2014. Available from: https://www.who.int/maternal_child_adolescent/documents/every-newborn-action-plan/en/

Impact

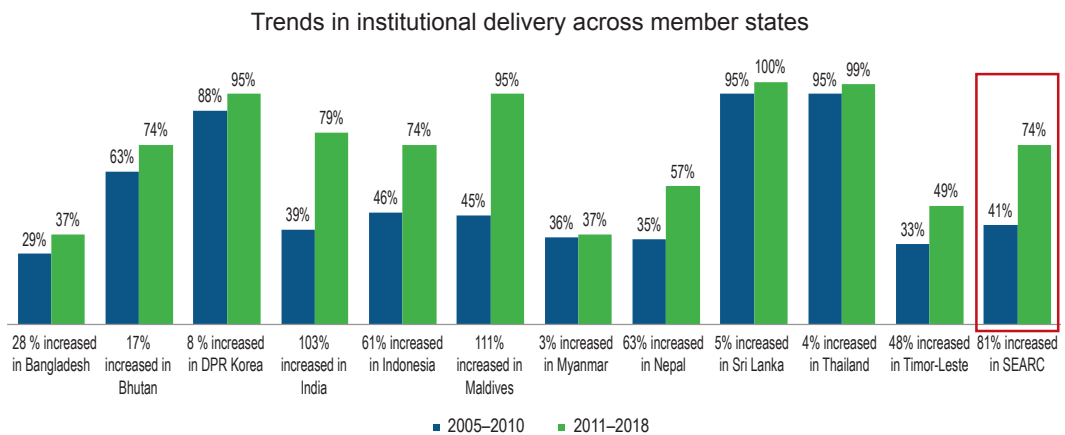
Five countries in the Region – DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand – have attained the SDG 3 target for 2030 for U5MR, and three of them – Maldives, Sri Lanka and Thailand – have reached MMR below the 2030 SDG target.

Fig. 19 shows that there was a decrease in mortality indicators from 2014 in 2018. Three countries – DPR Korea, Indonesia and Myanmar – need to expedite the annual rate of reduction to achieve SDG targets. India made remarkable progress in the MMR after 2015 with a reported MMR of 130 per 100 000 live births for the period 2014–2017. One of the key interventions contributing to a reduction in the MMR is the improvement in the number of institutional deliveries. The proportion of institutional deliveries has increased over the decade across all Member States with the maximum improvement shown by Maldives, followed by India (Fig. 20). The Region tracked the key indicators for measuring progress during the evaluation period; Fig. 21 exhibits the achievements made so far and the targets going forward.

Fig. 19: Key maternal and child mortality (U5MR, NMR, IMR and MMR) indicators in the SEA Region



Source: Global Health Observatory, WHO

Fig. 20: Institutional deliveries in the SEA Region

Source: Maternal & Reproductive Health in the WHO SEA Region –Situation Progress & Challenges (Update of 2019)

In conclusion, it can be ascertained that, despite persistent challenges, the Region has made some progress, showing commitments at WHO level as well as the health ministry level but, due to the low coverage of several interventions across the RMNCAH life course continuum with wide inequities, all SDG targets for maternal mortality and neonatal mortality are less likely to be achieved by 2030 by all the Member States. However, at the current rate of progress, the Region as a whole and all its Member States (except Myanmar and Timor-Leste) are likely to achieve the SDG target of under-five mortality rate by 2030.⁴³

Fig. 21: Key indicators measuring progress for Flagship 3

Source: WHO SEARO flagship flyer 2018

⁴³ World Health Organization. Progress report 2018: The unfinished MDG agenda: Ending preventable maternal, newborn and child deaths with focus on neonatal deaths; WHO flyer 2018. World Health Organization. Regional Office for South-East Asia. 2018.

Challenges

Equitable access to services: RMNCAH interventions and the coverage of services have increased over time, but inequities between and within countries are apparent with huge gaps in the financing and implementation of high-quality services, limiting the capacity of countries to address the larger social determinants of health such as poverty, illiteracy and gender imbalance. Barriers such as terrain, cost of institutional delivery (even in public facilities) and the attitudes of providers and beneficiaries were pointed out as leading to inequity.

Resource constraints: Resources are limited, whether human, financial, service delivery infrastructure, or essential commodities to improve the quality of maternal and newborn care, especially at the time of childbirth and during the newborn period.

Limited scientific and evidence-based research: There were limited efforts towards implementation research on stillbirth prevention and management, and maternal, neonatal and child health. This means Member States face challenges in addressing health system issues to support the implementation of the plans, policies and guidelines developed to prevent maternal and neonatal deaths. Countries need to scale up evidence-based interventions.

Inadequate surveillance and under reporting: Member States have adopted the MDSR and MPDSR but under-reporting and inadequate surveillance are added challenges to sustaining the gains achieved so far. Improving systems for reporting births and maternal and neonatal deaths is a matter of human rights and a prerequisite to reducing stillbirths and maternal and neonatal mortality.

Recommendations

Allocation of resources: More resources and efforts are needed to scale up initiatives that enhance the quality of care around birth in all hospitals and healthcare centres. Member States still need to expand health service delivery infrastructure and use innovative approaches in underserved areas to overcome geographical, financial and social barriers.

Focus on equity: Efforts have been made to advocate for and address the issue of inequity during operational planning, but their implementation needs to be scaled up to improve coverage, including that of remote areas. There is a further need to focus on reducing inequity by strengthening primary healthcare to improve antenatal care, institutional delivery and post-natal care and tackle demand-side interventions to improve coverage in ANC and institutional delivery.

Evidence generation: Countries need to progressively scale up the coverage of evidence-based interventions to a high level to end preventable mortality among women, newborns and children

Monitoring and surveillance: Strengthen and intensify MDSR programs and ensure that review findings are acted on, including the improvement of quality of care.

Success story: Sri Lanka

To sustain the low maternal, child and newborn mortality and to further reduce it to single digits, Sri Lanka invested in improving the quality of maternal and newborn care, particularly during labour, birth and the first day and first week of life (including care of complications). Initiatives to strengthen the health system to ensure UHC for essential and emergency care, addressing inequities in access to care, programme tracking and accountability were instrumental to this. WHO supported the Family Health Bureau in developing a quality assurance system. The system examines all the aspects involved in the provision of care: the availability of services, infrastructure, the availability and competencies of human resources, birth outcomes, service provider satisfaction and client satisfaction. This further helped identify gaps and improve quality of care standards for maternal and neonatal health to improve care around birth. The presence of quality of care assessment tools, the capacity building of healthcare providers on assessment techniques and implementation of quality improvement projects with WHO's support has further strengthened the quality of care.

To build further capacity in breastfeeding promotion and to sustain high rates, healthcare professionals have access to the WHO lactation management training course. Also, the government with WHO support converted the Sri Lanka Code for the Protection and Promotion of Breastfeeding into an Act of Parliament. WHO engaged with the Ministry of Education to promote a healthy diet and physical activity in schools, given the increasing prevalence undernutrition in children under five years of age.

Success story: Bhutan

WHO strengthened newborn health and improved statistics through the development of the Bhutan Newborn Action Plan⁴⁴ in collaboration with the Ministry of Health and other partners. To significantly reduce the preventable deaths of newborns, healthcare providers were trained in kangaroo mother care at the Tu Du Hospital in Ho Chi Minh City in Viet Nam, known as a centre of excellence. This helped them serve as trainers for other clinicians, in an effort to strengthen the country's care of preterm babies. A coaching programme for health workers of all levels in early essential newborn care was developed to increase the use of evidence-based best practices in newborn care. A digital tracking system for maternal and child health to enable the real-time tracking of pregnant women and their young children was developed by the Ministry of Health with support from WHO. In an effort to ensure that pregnant women receive antenatal care and that all children receive immunizations on time as well as other essential preventive health services, the system helped health workers to reach out to pregnant women when needed, thus increasing the number of deliveries aided by skilled birth attendants. In addition, the government developed a national Birth Defects Action Plan⁴⁵ to improve the ability of health workers to identify birth defects at an early stage, provide appropriate care, and prevent birth defects where possible.

44 Ministry of Health, UNICEF, World Health organization. Bhutan Every Newborn Action Plan (2016-2023). Ministry of Health, UNICEF, World Health Organization. [Internet]. 2017. Available from: <https://www.unicef.org/bhutan/reports/bhutan-every-newborn-action-plan-2016-2023>

45 World Health Organization, Country office for Bhutan. Road to SDGs: Encapsulating works of WHO, 2018. Thimphu: World Health Organization, Country Office for Bhutan. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2019. Available from: <http://origin.searo.who.int/bhutan/wco-bhu-report18.pdf>.

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

Relevance

This flagship reinforced the indispensable priorities of UHC, bringing focus to HRH and essential medicines across health systems by strengthening frontline services, the effective use of digital health to improve data, strengthening national regulatory authorities and forging collaborations.

The pursuit of UHC lies in meeting the healthcare needs of a population without financial hardships. The challenges of critical shortages, inadequate skill mix and uneven geographical distribution of the health workforce are seen globally as well in the SEA Region. In 2015, an estimated 130 million people in the Region did not have access to at least one of the seven essential health services, and 60 million people were impoverished as a result of healthcare costs.⁴¹ As per the latest estimates, 40% of WHO Member States globally report that they have less than 10 medical doctors per 10 000 population, and over 26% report having less than 3.15 medical doctors per 10 000 population.⁴⁶ WHO recommends a threshold of 4.45 physicians, nurses and midwives per 1000 population to meet the SDGs by 2030.⁴⁷ Catastrophic OOPe is of concern across low- and middle-income countries, with the lion's share being spent on medicines. Between 20% and 60% of the health budget in LMICs goes to expenditure on medicines, and up to 80-90% of medicines are purchased out-of-pocket instead of being paid for by health insurance schemes.⁴⁸

SEA Region reaffirmed and extended its commitment towards UHC and in 2014, The *Decade for Strengthening Human Resources for Health in the South-East Asia Region 2015–2024*⁴⁹ with a focus on transformative education and rural retention, thus translating global efforts to the Region was launched. Concerted efforts were made through a dedicated flagship on UHC, focusing on human resources for health and access to medicines – both being fundamental to an integrated and effective health system, which is indispensable to achieving UHC as part of the SDGs.

At the global level, WHO sets the agenda around access to medicines through releasing guidelines, convening meetings and panels and commissioning research. The Region extended its commitment by endorsing the Delhi Declaration in 2018⁵⁰, which goes beyond medicines to include vaccines, diagnostics and medical devices covering pricing, procurement, regulation and more. The Regional office's priorities are aligned with the new global roadmap on access to medicines and vaccines.

46 World Health Organization. World Health Data Platform, Global Health Observatory, Health Workforce. World Health Organization. 2018. [Internet]. [cited 17 June 2020]. Available from: [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-\(per-10-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-(per-10-000-population)).

47 World Health Organization. Health workforce requirements for universal health coverage and the Sustainable Development Goals. (Human Resources for Health Observer, 17). World Health Organization. 2016.

48 World Health Organization. Assessment of Medicine Pricing and Reimbursement Systems in Health Insurance Schemes Summary of Findings, Lessons and Recommendations. (ISBN: 978-929023314-5). World Health Organization. Regional Office for Africa. 2016.

49 World Health Organization. Decade for health workforce strengthening in the South-East Asia Region 2015–2024. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO [Internet]. 2018. Available from: <https://apps.who.int/iris/handle/10665/274310>.

50 World Health Organization. The Delhi Declaration; World Rural Health Conference, April 2018. World Health organization. [Internet]. 2018. [Cited 15 July 2020]. Available from: https://www.who.int/hrh/news/2018/delhi_declaration/en/

The fact that the UHC flagship – including both HRH and essential medicines – is aligned with well-established and long-standing national priorities within the Region highlights that the flagship has a high relevance. The existence of the flagship and the support from WHO helps accelerate and refine efforts towards UHC, even in mature health systems. The advent of this flagship has brought more political focus on these two challenges. The Regional Office supported several Member States in strengthening their national regulatory authorities (NRAs). There was an increase in the availability of information on the prices of medicines across Member States. Special attention was given to strengthening the health workforce for frontline services with a focus on transformative education and rural retention. The flagship is helping stimulate a more strategic policy with governments and with development partners to foster interdepartmental collaboration within WHO-SEARO and the Member States.

Effectiveness

Under the aegis of the flagship, WHO's major focus has been at the policy level, putting advocacy high on the agenda. WHO-assisted advocacy for UHC led to an increase in the health budgets of most of the Member States. In the case of Member States with relatively budding health systems, WHO's UHC agenda helped shape the country's health system with a focus on equity and accessibility. Even in mature health systems, WHO played an important role in sharpening the focus on UHC.

Articulation of policy documents, guidelines and directives: In 2014, the Regional Office provided strategic direction to Member States through the *Decade for Strengthening Human Resources for Health in the South-East Asia Region 2015–2024 guidelines*.⁴⁹ WHO country offices supported Member States in the inclusion of national mechanisms for health workforce planning. As a result, 10 Member States (India being the exception) have reported on HRH strategies, and five countries (Bangladesh, Myanmar, Nepal, Thailand and Timor-Leste) have updated their strategies since 2016 (Table 6). These strategies include interventions on education, retention, performance and data. Further, Member States highlighted WHO's support in the development of action plans and operational plans for strategies to make their goals achievable with measurable indicators. To better manage the international migration of health personnel, WHO-SEARO adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (The Code)⁵¹ by the Sixty-eighth World Health Assembly.

This flagship also has focused on improving access to essential medicines, along with strengthening the health workforce since 2014. The Delhi Declaration reinforcing regional collaboration in procurement, regulation and price transparency was adopted in 2018. National medicines policies provide the framework for how a country intends to organize, finance and regulate the pharmaceutical sector, to ensure equitable access to quality medicines and other health technologies to meet healthcare needs. National medicines policies have been updated in Bangladesh, Thailand, Timor-Leste and Myanmar in the last five years.

51 World Health Organization. WHO Global Code of Practice on the International Recruitment of Health Personnel; Report of the Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010). A68/32 Add.1. 68th World Health Assembly. Agenda Item 17.2 World Health Organization. [Internet]. 2015. [cited 16 July 2020]. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_32Add1-en.pdf

Table 6: Health workforce strategies in the SEA Region

Country	National Health Workforce Strategies
Bhutan	Health Human Resource Master Plan (2011-2023)
Bangladesh	Bangladesh Health Workforce Strategy (2016-2021)
DPR Korea	Strategic Plan for Development of HRH (2012-2015)
India	No dedicated HRH strategy; contained in National Health Policy (2017-2025)
Indonesia	Action Plan for Development of HRH (2015-2019)
Maldives	National Health Workforce Strategic Plan (2014-2018)
Myanmar	Myanmar HRH Strategy (2018-2021)
Nepal	HRH: Strategic Roadmap 2030
Sri Lanka	HRH Strategic Plan (2009-2018)
Thailand	Health Workforce Plan (2016-2026)
Timor-Leste	HRH Master Plan (2017-2021)

Technical assistance: Since 2016, there has been action in the four interrelated areas of health workforce governance, transformative education, rural retention and improving health workforce data. Transformative education aims to increase the quantity, quality and relevance of health professionals to strengthen their impact on population health. There is progress in the adoption of a range of approaches by all Member States that WHO recommended, such as interprofessional education, the accreditation of health professional training institutions, increased use of modern information technologies in pre-service education, continuing professional development, faculty development and curriculum development.

In terms of interventions leveraged to improve retention in rural areas, compulsory service and targeted admission policies are those most commonly reported. In Bangladesh and Thailand, mandatory clinical rotation in rural areas was instituted, and, in India and Myanmar, health professional training schools were developed in underserved areas.

Increased momentum in improving HRH data and HIS system building according to the new WHO guidance on National Health Workforce Accounts (NHWA) and information technologies was reported across eight Member States. This contributed to health workforce planning, national referral, training, reducing or eliminating misinformation and duplicate health worker records, improving the regulation of practice, and the tracking of appropriate licenses of health professionals. The adoption of standard indicators for the Region has enabled better monitoring. Five categories of health professionals (doctors, dentists, nurses, midwives and pharmacists) are now covered.

In 2016, SEARN was established, and it has since facilitated collaboration and reliance among the national regulatory authorities of all Member States in the Region. This network was established with



To improve rural retention, Bangladesh and Thailand adopted mandatory clinical rotation in rural areas. India and Myanmar developed health professional training schools in underserved areas.

the objectives of improving information sharing, strengthening the system by enhancing regulatory skills and competencies, and strengthening regulatory systems in the Region. SEARN also plays a major role in improving the technical capacity of national regulators, inspectors and medicine quality control laboratories to ensure the quality of medicines and other medical products.

WHO has supported EMLs since 1977. Since then, all countries in the Region have developed their own National EMLs. Criteria for the selection of medicines for national EMLs include common morbidities, evidence of cost-effectiveness, and affordability for government or health insurance schemes. WHO's support to countries in updating their EMLs occurred every two years during the period under evaluation. Since 2017, seven countries (Bangladesh, DPR Korea, Indonesia, Maldives, Thailand and Timor-Leste) have updated their national EMLs. EML updates in SEA Region countries also incorporated WHO's Access/Watch/Reserve (AWaRe) classification for antibiotics⁵² which was introduced in 2017. Antibiotics have been grouped into the three categories, with recommendations on when each category should be used. Bangladesh, Bhutan, Indonesia, Maldives and Nepal have already adopted or are in the process of adopting the AWaRe categorization into their national EMLs and/or national formulary, and other countries are also planning to use this strategy. In order to improve the affordability of medicines, India and Sri Lanka have set ceiling prices on selected essential medicines and devices, while Maldives has been successful in standardizing the price of essential medicines across the country.

Technical Assistance



- **Since 2017, seven Member States have updated their EML.**
- **Five Member States have included AWaRe classification of antibiotics to their EML.**
- **India and Sri Lanka have set ceiling prices on selected essential medicines and devices.**

Capacity building: To improve and assure the quality of training and thus the quality of health, WHO calls for adapting pre-service training curricula to better meet the needs of rural communities, offering online continuing professional development (e-CPD) for rural health workers, interprofessional training (in which professionals from different disciplines, such as nursing, medicine, laboratory science and pharmacy learn from each other), and continuous professional development of teaching staff of medical and nursing schools. WHO also focused on ways to improve a country's medical education and postgraduate training system for health professionals based on the country's needs. Distance education was focussed on via the telemedicine system, the engagement of private training institutions and providers in national strategy development, HRH governance and data sharing. Capacity development through the accreditation of health professional education is an increasingly popular strategy and contributes to creating a culture of quality in health professional education institutions and programmes when it is supplemented by other interventions including inter-professional education, faculty development and continuous professional development.

In Timor-Leste, WHO's support for Saúde na Família programme included providing technical and financial support (through the EU-WHO UHC partnership) to train health professionals in conducting

52 World Health Organization. Essential Medicines and Health products. WHO releases the 2019 AWaRe classification Antibiotics. World Health Organization. [Internet]. 2019. [Cited 16 July 2020]. Available from: https://www.who.int/medicines/news/2019/WHO_releases2019AWaRe_classification_antibiotics/en/

home visits, and financial support to procure basic PHC equipment for health centres and posts throughout the country.

Monitoring and evaluation: In 2015, WHO-SEARO developed a UHC monitoring dashboard to visualize data on health outcomes, health services, equity and financial protection for countries in the Region more easily. Nepal and Sri Lanka have the National Health Workforce Registry which captures data on HRH under their health ministries. Actions taken at the regional level included supporting the development and use of practical indicators, developing methods and tools for monitoring these different dimensions of access to medicines, and improving reporting on the medicine's indicator in the SDGs. Further, the Regional office published *Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region*⁵³ update annually to improve the monitoring of the progress achieved by Member States towards UHC.

In 2016, WHO successfully piloted a smartphone application as a data-collection tool for gathering information on the prices and availability of medicines in 19 LIMC countries. An initiative for Coordinated Antidotes Procurement in the South-East Asia Region (iCAPS) was launched in 2017.⁵⁴ It helped Member States procure antidotes for a range of common poisons. There is now an opportunity to develop tailored regional procurement models for medicines and vaccines. There has been significant progress in NRA capacity development in recent years in the Region. Currently, based on WHO's assessment, NRAs in three countries – India, Indonesia and Thailand – have been judged to have adequate regulatory capacity (functional NRA) for vaccines.⁵⁵ The Bangladesh National Regulatory Authority has completed the WHO interim assessment for both their medicines and vaccines regulatory capacity and is aiming to achieve Maturity Level 3 in the near future. Other regulatory agencies are at different stages of self-assessment using the WHO Global Benchmarking tool.

Research and development, and evidence generation: As a step towards evidence generation, in 2014, a special issue of the *WHO South-East Asia Journal of Public Health*⁵⁶ pulled together regional evidence on universal health coverage. This included articles on interventions to expand access to care, improve financing, and measure UHC. Throughout the evaluation period, WHO focused primarily on strengthening the evidence base to inform health financing policy for UHC. Most of the Member States in the Region now have estimates of catastrophic spending and impoverishment due to household health expenditures. Through WHO's assistance, Member States generated evidence for national health planning and enhanced their in-house capacity to produce national health accounts (through workshops at the regional and country levels), conducted health economic analyses, and developed policy actions to improve health equity in the Region.

In 2017, WHO undertook a survey, mapping existing HRH leadership courses and related capacity-building initiatives. Furthermore, the Regional Office facilitated a greater exchange of knowledge

53 World Health Organization. Monitoring progress on universal health coverage and the health-related sustainable development goals in the South-East Asia Region: 2019 update. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2019. Available from: <https://apps.who.int/iris/handle/10665/326828>.

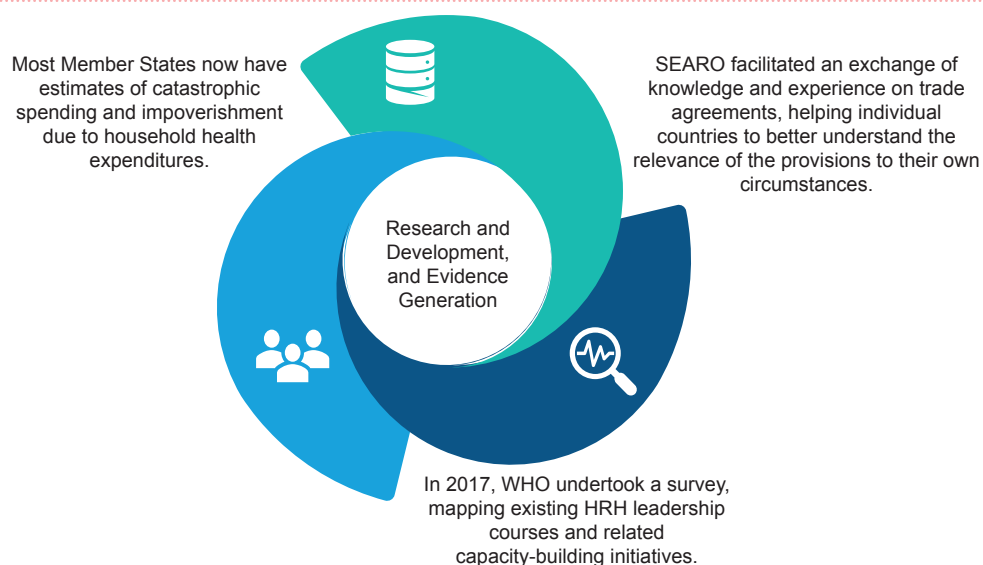
54 iCAPS: Initiative for Coordinated Antidotes Procurement in the South-East Asia Region. [Internet]. [Cited 20 July 2020]. Available from: <http://icaps.mystrikingly.com/>

55 World Health Organization. Access to medical products in the South-East Asia Region 2019: Review of progress. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO [Internet]. 2019. Available from: <https://apps.who.int/iris/handle/10665/326829>.

56 World Health Organization. WHO South-East Asia Journal of Public Health, Volume 3, Issue 3-4, July-December 2014. WHO Regional Office for South-East Asia. [Internet]. 2014. Available from: <https://apps.who.int/iris/handle/10665/206130>

and experience on trade agreements, helping individual countries to better understand the relevance of the provisions to their own circumstances and how to use trade related aspects of intellectual property rights (TRIPS) flexibilities where needed. However, most countries do not have a management information system and constant source of data for decision-making, thus, more operational research is required to identify which types of policies and strategies help improve equitable access to quality medicines at scale and can be sustained. Respondents across Member States identified that better data on access to medicines is the need of the hour. In addition, the WHO can further support the Member States in focusing on health service research to improve system efficiencies, the rational use of medicines, the retention of HRH and the development of cost-efficient packages of care.

Fig. 22: Key highlights: evidence generation for Flagship 4



Advocacy: In 2014, the 'Accelerating Universal Health Coverage in the South-East Asia Region' regional consultation meeting was convened to review evidence, share knowledge and stimulate and support country action. This consultation meeting was designed to increase awareness among policymakers and managers that progress towards UHC takes time but is possible from any starting point. Since then, a series of advocacy and educational activities were conducted with WHO's support across Member States to create awareness about UHC within the health sector and beyond. They sought to face health system challenges to meeting the UHC goal, including domestic resource allocation for health. They included UHC-orientation workshops for professionals in health and other sectors (including finance), educational visits to countries that are further advanced in achieving UHC, and conferences, brainstorming sessions, and training on UHC for high-ranking government officials. Respondents across Member States attributed several milestones that were achieved due to WHO-led advocacy for UHC. These milestones included the increase in domestic

WHO-led advocacy for UHC led to several milestones, such as an increase in domestic resource allocation for health by 120% in Bangladesh, parliamentarians taking a UHC pledge in Sri Lanka, the price standardization of drugs in Maldives and an increase in the fund allocation for HR under the national health plan in India.

resource allocation for health by 120% in Bangladesh, parliamentarians taking a UHC pledge in Sri Lanka, the price standardization of drugs in Maldives and an increase in the fund allocation for the HR component under the national health plan in India. To continue this progress and sustain the momentum, the Member States seek WHO's support for continuous advocacy which will be key to persuading governments to lay added emphasis on UHC and seek equitable and accessible health services for all.

Multisectoral and intersectoral collaboration: WHO played a catalytic role in the area of UHC by fostering partnerships and strategic collaborations, both within the country and at the Regional level. As per the diverse country context across Member States, WHO coordinated with a number of actors, including departments and ministries, such as ministries of finance for financial planning, ministries of education for the building of a workforce of quality medical professionals and the introduction of new courses and schools related to HRH, development partners (both bilateral and multilateral agencies), medical associations, allied health professionals' councils and academic institutions. In 2017, a regional workshop on health financing was conducted, which brought together combined country teams from the health and finance ministries to discuss opportunities for more strategic purchasing and found that there is much room for – and interest in – introducing more strategic purchasing across the Region. Further, in August 2017, the Regional Office held a regional consultation with 11 countries in the Region, United Nations agencies and international partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, to discuss options for inter-country and Regional collaboration on public procurement and pricing.

At the country level, respondents highlighted that several attempts were made to create a common vision among different stakeholders for UHC through multiple channels such as meetings, workshops, trainings, and symposia. However, a varied level of success has been achieved across Member States in bringing about this collaboration. According to the SEA Region 2018 HRH survey, only six SEA Region countries have the institutional mechanisms to coordinate an intersectoral health workforce agenda.⁴⁹ Further, there has been limited progress so far in engaging private training institutions and providers of national strategy development and governance for HRH and data sharing. Respondents also reflected that many of the issues around poor access to medicines stem from an incoherence between intellectual property laws, trade agreements and public health requirements. For this reason, it is essential to come up with solutions that require the involvement of multiple parties including national and subnational government bodies, national regulatory authorities, pharmaceutical manufacturers, health professional bodies, the research community and patient advocacy groups.

Equity: UHC by definition is concerned with equity, and, for health to be a human right, it must be accessible to all. Under the aegis of this flagship, WHO and the ministries of health in the SEA Region focussed on the equitable distribution of health services and their accessibility. WHO supported the Member States in numerous ways to make resource allocation for health more efficient and equitable. Some of the actions outlined by respondents included generating data for improved equity analysis in Member States, preparing the State of Health Inequality-Indonesia Report,



WHO assisted Bhutan in drafting national health plans for four towns using the Urban Health Equity Assessment and Response Tool (Urban HEART), WHO also supported Indonesia in preparing the State of health inequality report, and advocated for basic health service package in Nepal.

drafting national health plans for four towns in Bhutan using the Urban Health Equity Assessment and Response Tool (Urban HEART), advocating for a basic health service package in Nepal, analysing all the gender implications of all priority programs in Thailand, refining cause-of-death data in Nepal, and developing a prototype for a web-based real-time disease reporting system in India. Overall, WHO has tried to persuade governments to prepare national health plans and policies with an emphasis on equity, universal coverage and multisectoral collaboration. Despite these attempts, some respondents brought to the fore that equity has not been at the centre of the flagship focus, and this needs to be strengthened to make UHC a success in all the Member States. Although a significant amount of data is being collected, there is the need to analyse the data through an equity lens and then leverage it for advocacy and evidence-based policy making. Further, limited attempts have been made by countries (except Thailand and Sri Lanka) to ensure the equitable access to health services for migrant and refugee populations who are at great risk of being excluded from healthcare.

Efficiency

The flagship brought much-needed attention to UHC with the Member States realizing the need for an increased allocation of resources to strengthen health infrastructure.

At the Regional Committee meeting in 2014, many Member States identified the need to strengthen human resources for health and health infrastructure with adequate equipment to address the problems of providing emergency and essential health care services. It was noted that the country capacities must be further developed to address human resources issues and also provide adequate surgical and anaesthesia facilities along with primary healthcare in health centres.⁵⁷ This commitment from the individual countries with support from WHO led to a subsequent increase in funding and allocation in respective Member States. Apart from WHO's support in technical expertise, resource allocation, efficient resource mobilization and multisectoral coordination, certain factors at country level, like close collaboration between health ministries and WHO, enabled efficiency at Member State level. WHO was instrumental in seeking the highest levels of commitment, bringing together professional associations and helping to establish a strong cadre of health workforce at the primary care level. However, respondents indicated that there was still an opportunity for stronger collaboration, especially between flagships, driving examples from how the TB programme integrated with the UHC agenda. Another concern around the UHC flagship was that it does not have the appropriate focus: currently it only services HRH and access to medicines, but UHC also requires attention to service delivery. Ministries across Member States expected WHO to work with a systems-wide approach.

"I think WHO's role is critical, in guiding us how to use a health system approach to address programmatic issue and integrate UHC into the system thereby avoiding duplication of resource allocation" – A ministry official from Timor-Leste

The flagship attempted to strengthen existing health systems with more focus on fund mobilization and increased allocations.

⁵⁷ World Health Organization. SEA/RC67/35 - WHO Regional Committee for South-East Asia Report of the 67th session, Dhaka, Bangladesh, 9-12 Sep 2014. World Health Organization. Regional Office for South-East Asia. [Internet]. 2015. Available from: <https://apps.who.int/iris/handle/10665/148778>

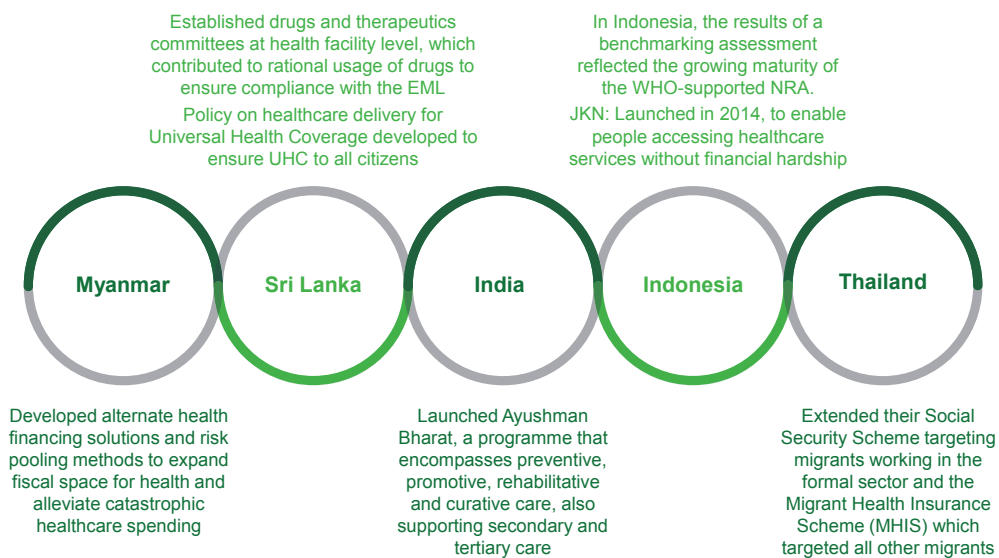
Beginning 2014, all but two Member States faced challenges in workforce distribution, retention and performance. Bangladesh had a shortage of nurses and midwives and retaining them posed a formidable challenge in attaining UHC. Issues such as strong procurement and supply chain systems, access to essential medicines, and the presence of regulatory bodies at the national level added to the constraint. Bhutan faced similar issues of insufficient HRH, limited health care financing and information management gaps. DPR Korea reported severe shortage of essential drugs. India was dealing with inadequate health financing and service provision modalities that slowed the advancement of UHC agenda. Indonesia faced challenges in adequately distributing physicians among its provinces. In Maldives, the health system faced serious human resource challenges which included the high turnover of expatriate staff who occupy most professional positions. There was also a shortage of medicines and basic medical supplies which constrained quality of care. Timor-Leste also suffered from weak health systems with inadequate human resources, improper procurement and forecasting systems and weak health information systems.

However, with the advent of the flagship, by 2018, most countries were able to address these issues (refer to Fig. 23). Additionally, Thailand extended their Social Security Scheme (SSS), targeting migrants working in the formal sector, and the Migrant Health Insurance Scheme (MHIS) which targeted all other migrants. For the first time, in 2018, 60% of the 3.3 million documented migrants were enrolled in these two schemes.¹⁴ Sri Lanka has policy on healthcare delivery for UHC to ensure UHC to all citizens, relevant to the disease burden experienced in the country through a well-integrated, comprehensive and efficient health service.⁵⁸ Indonesia's JKN to enable people to access healthcare without facing hardship was also launched in 2014. Eight of the 11 countries now exceed the original WHO HRH density threshold for the MDGs; nine are below the newer WHO HRH density threshold for achieving SDG-3. It was concluded in the 2018 review that countries need to focus more on frontline healthcare workers to accelerate progress on UHC. This will refocus attention on safe essential frontline healthcare services. In a WHO-facilitated cross-sectional analysis of public sector institutional capacity of HRH units where 10 out of 11 Member States responded to the survey, seven out of 10 reported having HRH units, though their scope, roles, capacity and size displayed considerable variability.⁵⁹ However, OOP expenditure on medicines continues to remain high, despite national policies to make medicines more available. This would need concerted efforts by governments through strategic prioritization and excellent implementation.

58 Policy on Healthcare delivery for Universal Health coverage [Internet]. Health.gov.lk. [cited 4 August 2020]. Available from: http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/2018/Policyonhealthcaredelivery.pdf

59 Cometto G, Nartey E, Zapata T, Kanda M, Md Y, Narayan K, Pritasari K, Irufa A, Lamichhane R, De Silva D, Noree T. Analyzing public sector institutional capacity for health workforce governance in the South-East Asia region of WHO. *Human resources for health*. 2019 December 1;17(1):43. [Internet]. 2019. [cited 30 June 2020]. Available from: <https://doi.org/10.1186/s12960-019-0385-1>

Fig. 23: Key highlights: steps taken by Member States for UHC



Sustainability

Action taken to ensure sustainability of the UHC includes capacity development, system strengthening and strategies such as health care financing and political support.

WHO collaborated with health ministries to strengthen systems through the design of relevant policies, strategies and models of community engagement, thus contributing to sustainability. A series of advocacy activities were conducted with WHO's support across Member States, to create awareness about UHC within the health sector and beyond. The Regional Office has provided strategic directions and has supported Member States in the inclusion of national mechanisms for health workforce planning. SEARN facilitated collaboration among NHAs and helped improved the national capacity to ensure sustainability. Further sustainability was ensured through situational analysis and continuous monitoring using a results measurement framework and a UHC monitoring dashboard to visualize the data. WHO has aided Member States in generating evidence for national health planning and enhancing their in-house capacities to produce national health accounts through workshops at regional and country level as a measure to sustain development. To achieve the pending or revised targets by 2023, respondents recommended drawing more focus towards strengthening primary healthcare and service delivery and having a multilateral approach. To further sustain the progress, establishing pooled procurement platforms was desirable, specifically for small countries like Bhutan. The Regional Office and country offices should give attention to updating designated WHO Collaborating Centres for medical education. But sustainability can still be a challenge as there is a lot of dependency on WHO and donor partners to move things forward, whether for human resources, technical expertise or funding support.

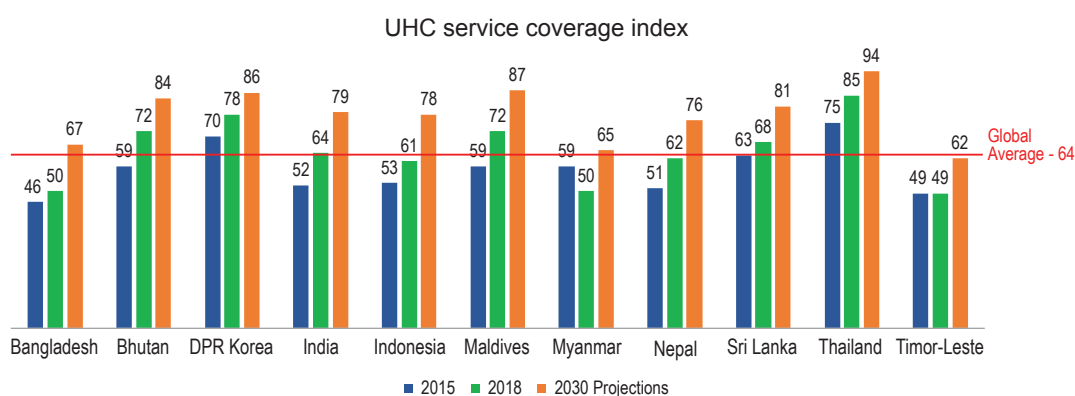
“Government will be able to work/sustain in HRH as it has been prioritized. The priority areas have been skill-building, retention of healthcare professionals, capacity building” – A ministry official from Bangladesh

Impact

As of 2018, there were seven countries with an up-to-date HRH strategy, while seven countries have updated essential medicine lists in the past three years.

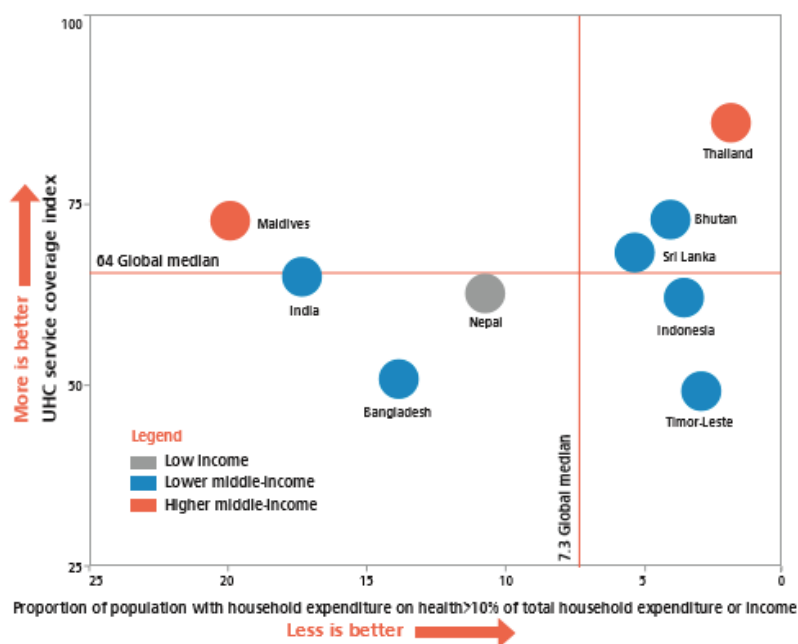
As depicted in Fig. 24, the UHC service coverage index has improved for almost all Member States during the period evaluated. However, based on the current trends, only five countries may reach more than 80% UHC essential health services coverage in PHCs by 2030.

Fig. 24: UHC service coverage index in the SEA Region



Source: WHO SEARO flagship flyer 2018

Fig. 25: Health services coverage and financial protection in nine Member States of the SEA Region, 2018

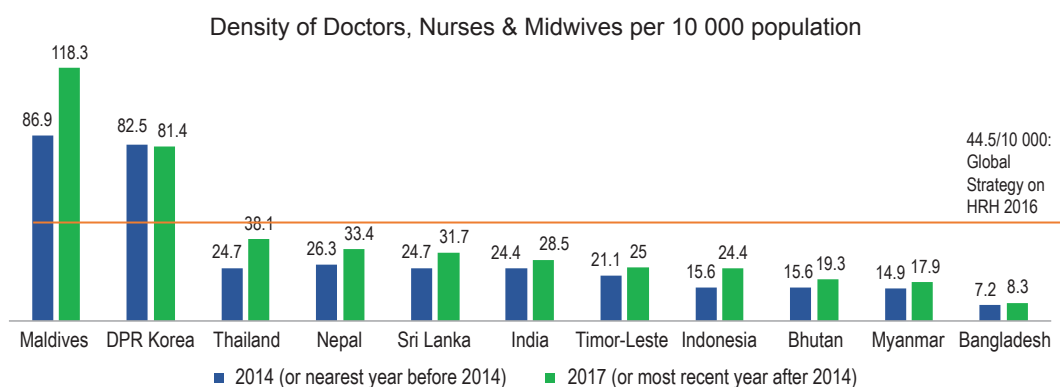


Source: WHO SEARO flagship flyer 2018

Upon correlating the UHC service coverage index and the proportion of population with greater than 10% of total household expenditure on health, the SEA Region showed varied results for various Member States (Fig. 25). There are countries like Thailand and Bhutan that have a better UHC coverage index and a smaller proportion of the population spending more than 10% of household expenditure on health. On the other hand, countries like India and Maldives have good UHC coverage, but a greater proportion of the population is spending more than 10% of household income on health. Bangladesh's OOPE is high, while its UHC coverage is on the low side when compared to the rest of the Region.

The figure below (Fig. 26) shows that, as of 2014-15, Maldives, DPR of Korea and Sri Lanka had the highest number of skilled health personnel per 10 000 population. As of 2017, DPR Korea, Maldives and Thailand had the highest number of doctors, nursing and midwifery personnel per 10 000 population. Ten of the 11 SEA Region countries have HRH strategies, with five updated in 2017 and 2018. These strategies include interventions on education, retention, performance and data. There appears to be growing attention to explicitly linking HRH strategies with service delivery strategies.⁶⁰

Fig. 26: Density of doctors, nurses & midwives in the SEA Region

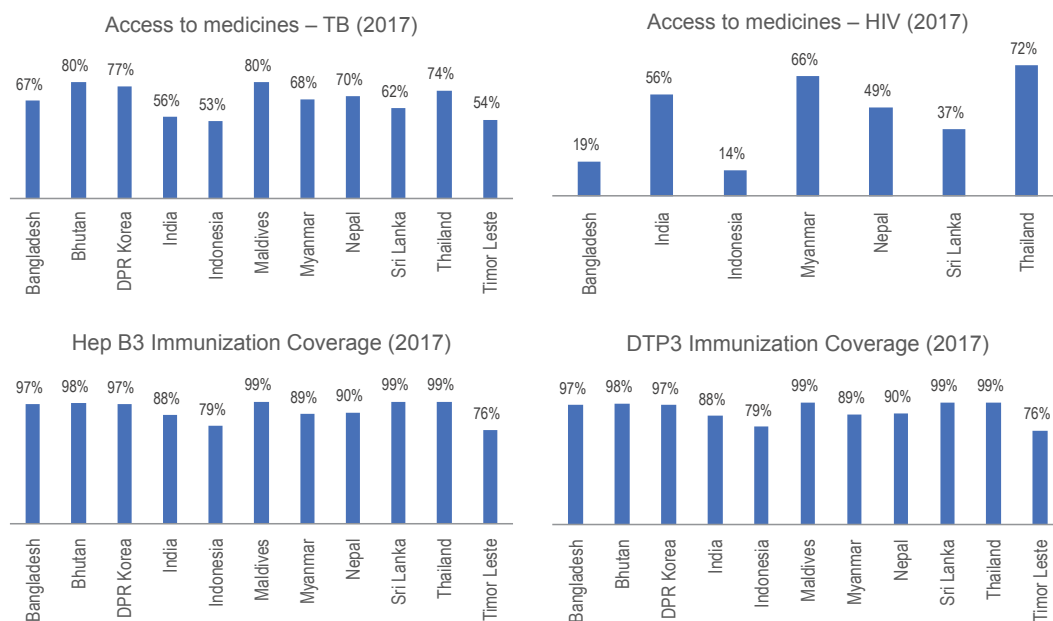


Source: WHO SEARO flagship flyer 2018

Coverage of third dose of diphtheria, tetanus and pertussis vaccine (DTP3) is an accepted global indicator for Routine Immunization Program performance, which is critical to achieve MDG4. As of 2017, Maldives, Sri Lanka and Thailand registered the highest DTP3 immunization coverage (Fig. 27). Recognizing the public health burden, hepatitis B control has gained momentum in the Region over the past few years. As of 2017, Maldives, Sri Lanka and Thailand have registered the highest HepB3 immunization coverage. The fig. 27 below shows the status of access to medicines in the Member States across the Region in 2017.

60 World Health Organization. Decade for health workforce strengthening in the South-East Asia Region 2015–2024; Second review of progress, 2018. New Delhi. World Health Organization. Regional Office for South-East Asia. 2018. License: CC BY-NC-SA 3.0 IGO.

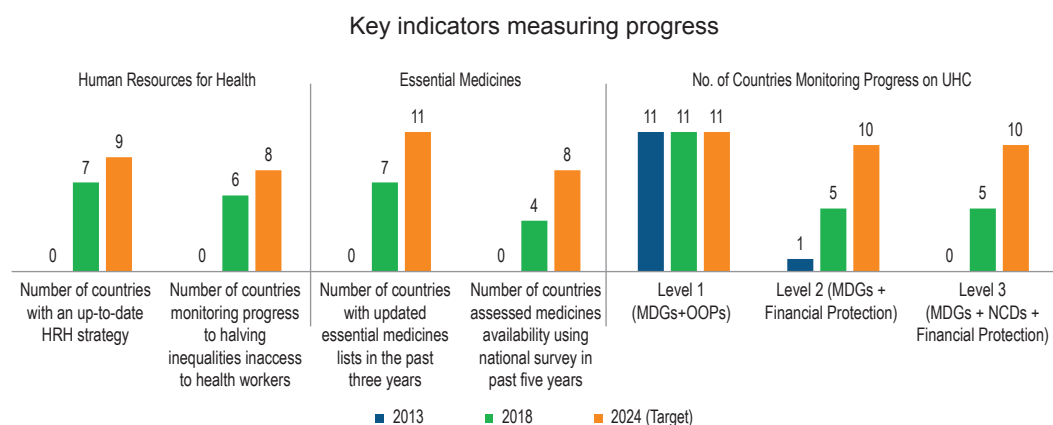
Fig. 27: Key indicators for access to essential medicines in the SEA Region



Source: Global Health Observatory, WHO

Fig. 28 shows the level of progress of key indicators against the targets set for 2024. As of 2018, there were seven countries with an up-to-date HRH strategy, while seven countries have updated essential medicine lists in the past three years. It is evident that there is a lot of improvement in the UHC in SEA Region, which can be attributed to the joint efforts of WHO, health ministries and technical partners.

Fig. 28: Key indicators measuring progress for Flagship 4



Source: WHO SEARO flagship flyer 2018

Challenges

Availability of data: Several Member States have limited data on the health workforce in the country. The data reported still mostly reflects the public sector health workforce. This matters most in those countries with a large private health sector like India and Bangladesh. Furthermore, there are limited data on the availability and performance of health workers, including physicians, nurses, midwives, auxiliaries and community workers, who are critical to achieving improvements in essential health service coverage.

Research and evidence generation: Medicines remain a major source of out-of-pocket payment and hence impoverishment and catastrophic health expenditure. As most countries do not have a management information system, more operational research is required to identify which types of policies and strategies help improve equitable access to quality medicines at scale, and can be sustained. Better data on access to medicines is the need of the hour.

Health of migrant population: Limited attempts have been made by countries to ensure equitable access of health services for the migrant and the refugee population who are greatly at risk of being excluded from healthcare.

Recommendations

Data Management: Improved data collection through digitized management information systems should be adopted by all Member States to ensure real-time and accurate availability of data for improved decision-making. Additionally, efforts to engage with the private sector need to be accelerated, with stronger collaborations with academic institutes and professional associations. Once a robust management information system is in place to map the availability of the health workforce, other key parameters such as performance management must also be incorporated.

Evidence and data generation: Improve access to essential medicines and include actions to improve their affordability; improve analysis and support for different procurement options, especially for smaller countries and efforts to strengthen country regulatory capacity. To ensure the availability of routine data, a simple hand-held application to monitor the availability and price of medicines has been piloted in 19 countries in Europe, the Americas and Africa.⁶¹ This application can be piloted in several Member States in the SEA Region and can then be further adopted with customization to Regional/country context.

Advocacy: Universal health coverage will not be a success until all sections of the population are catered to. WHO must advocate to Member States for the inclusion of migrant populations in the receipt of essential health services. Member States in the Region can learn from countries like Thailand, Sri Lanka on the ways to integrate the migrant population into UHC for better coverage and health outcomes.

61 Singh PK, Travis P. Accelerating access to essential medicines in the WHO South-East Asia Region: opportunities for greater engagement and better evidence. *WHO South-East Asia journal of public health*. 7(2):59. [Internet]. 2018 Jul 1. [cited 5 august 2020]. Available from: <http://www.who-seajph.org/text.asp?2018/7/2/59/239414>

Success Story: Indonesia

Indonesia aspires to focus on the quality of health services, in addition to emphasizing access to healthcare to provide comprehensive health amenities. In 2018, around 207 million Indonesians – more than 80% of the population – were enrolled in the Jaminan Kesehatan Nasional (JKN) programme. A key strategy to attain UHC is through the improvement of the recruitment and retention of health workers in rural areas by increasing the numbers of medical, nursing and midwifery students who come from rural areas, including instituting an affirmative action policy for applicants from rural areas. To further assure the quality of health services, the government, with WHO support, is instituting a series of accreditation processes for: (i) health professional training institutions (e.g., medical and nursing schools), in collaboration with the Ministry of Education; (ii) the hospital accreditation body itself (KAS) so that it is now accredited by the International Society for Quality in Health Care (ISQua); and (iii) non-physician healthcare workers, who will now have to be registered through professional councils. In 2017, with Global Fund HSS support and WHO technical assistance, the health ministry embarked on a national initiative to integrate an extremely fragmented health information system (HIS) into one that will meet the informational needs for planning UHC and measuring progress against the health SDGs. Through its advocacy, the Ministry of Health has been successful in mobilizing resources from the Central Government and subnational governments to expand the information system to 50 additional districts in 25 of the country's 37 provinces.

Success Story: DPR Korea

DPR Korea took significant steps towards strengthening its HRH, geared towards building the country's capacity to produce quality medical graduates and bolstering the clinical skills of frontline workers. The WHO country office processed a record 31 fellowship groups involving 115 fellows in 2014 and 2015. The estimated total cost of implementing these fellowships was a record US\$ 1.8 million, and, overall, with greater public health relevance than before. This led to the enhancement and upgradation of the skills of health professionals working in critical health programmes – including maternal and child health, TB and malaria control, immunization, and primary health care – through several training programmes. Further, to build national capacity in applied epidemiology, a national FETP, consisting of a six-week long course, launched with WHO support at the Pyongyang Medical College of Kim Il Sung University in 2016. WHO also supported in-service training provided in 2015 by the Ministry of Public Health (with added funding from the Republic of Korea and UN CERF) of more than 4200 health professionals and 160 health managers working in village, county and provincial hospitals. WHO also focused on ways to improve the country's medical education and postgraduate training system for health professionals based on the country needs, and provided distance education via the telemedicine system, to reach the extensive health workforce of over 200 000 scattered throughout the country. WHO supported the development of the essential health care service package, which package standardizes frontline services to be delivered at the primary healthcare level, including a standard list of equipment, medicines and diagnostics. It also includes a list of services to be provided, including the prevention and management of communicable diseases and NCDs, maternal and child health, and other general health services. A regional action plan for developing a set of indicators to monitor outcomes of traditional medical services, including improved adverse events reporting was strategized.

3.5 Building national capacity for preventing and combating antimicrobial resistance

Relevance

Assigning AMR as one of the Regional Flagship Areas helped Member States to make it a national priority.

A qualitative risk assessment showed that the SEA Region is possibly at the highest risk globally for the emergence and spread of AMR⁶², which could potentially result in approximately 10 million deaths globally every year by 2050 if the current situation continues unchecked.¹⁵ To address this increasing risk, the Region has been at the forefront of combating AMR since 2010 and has developed the Regional Strategy on Prevention and Containment of AMR, which was endorsed by the WHO Regional Committee for South-East Asia through Resolution SEA/RC/63/R4. To invoke greater political support, health ministers of the Region articulated their joint commitment through the Jaipur Declaration on AMR in 2011. To further consolidate efforts and collaborate with rest of the world on this critical aspect, in May 2015, the Sixty-eighth World Health Assembly endorsed the Global Action Plan to tackle Antimicrobial Resistance (GAP-AMR).⁶³

In 2014, AMR was included as a Regional Flagship Area by the Regional Director. The Region assisted Member States in supporting and mobilizing their governments to focus on AMR. The Member States were encouraged to develop NAPs for their respective countries and advised to advocate with their ministries to allocate budgets for activities such as appointing national focal points and to propel engagements with other stakeholders. The overall efforts helped sensitize most key stakeholders to the OneHealth approach, its importance, impact and the need for action. The flagship has provided the necessary impetus and momentum to bring the issue of AMR to national attention.

A multipronged strategic approach was adopted with a wide range of policy proclamations, advocacy meetings and statements. Multisectoral coordination mechanisms have been put in place and efforts have been made to raise awareness. Technical support has been provided to countries to improve regulatory capacity, generate policy-relevant evidence and monitor AMR containment efforts.

Effectiveness

The installation of a flagship focusing on building national capacity to combat and prevent AMR has led to some tangible gains for the Region, the most important being the development of NAPs by all the Member States.

Articulation of policy documents, guidelines and directives: The Regional Office developed a Regional roadmap in 2016⁶⁴ to guide Member States in developing their national AMR prevention and containment programmes and in implementing NAPs. In addition, a situational analysis tool was

62 World Health Organization. Antimicrobial Resistance - South East Asia Region. World Health Organization. 2019 [cited 18 June 2020]. Available from: <https://www.who.int/southeastasia/health-topics/antimicrobial-resistance>

63 World Health Organization. Global Action Plan on Antimicrobial Resistance. World Health Organization. [Internet]. 2015. Available from: <https://apps.who.int/iris/handle/10665/193736>

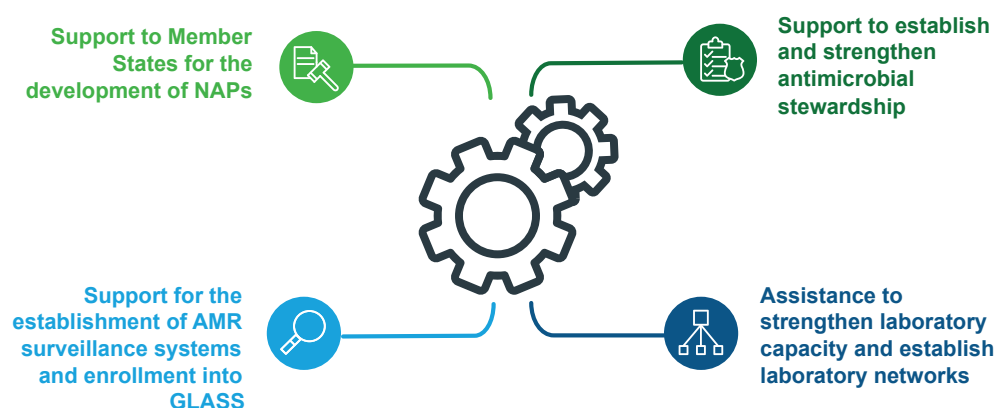
64 World Health Organization. Roadmap for Action on antimicrobial Resistance. World health Organization. Regional Office for South-East Asia. [Internet]. 2016. [cited 23 July 2020]. Available from: https://www.who.int/docs/default-source/searo/amr/roadmap-for-action-on-antimicrobial-resistance.pdf?sfvrsn=985b35ec_2

developed in 2016⁶⁵ to provide technical guidance to assess functionality and capacity in terms of the governance, policy and systems available to contain AMR across all Member States except DPR Korea.

All Member States have developed a NAP to address AMR, with each plan aligned with the Global Action Plan to tackle AMR. Respondents from Member States highlighted that other key policy documents, guidelines, directives in addition to the country-specific NAPs were prepared with technical guidance from WHO, such as guidelines for usage of antibiotics (Bangladesh, Bhutan, Indonesia), infection prevention and control guidelines (all Member States except Nepal), an AMR surveillance manual, a laboratory manual for AMR, the development of subnational plans (such as state level action plans in India), and an AMR stewardship policy (Bangladesh, Myanmar and Maldives).

Technical assistance: WHO's technical efforts to work with Member States to develop their National Action Plan on Antimicrobial Resistance (NAP-AMR) have culminated in seven countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar and Timor-Leste) having a government-approved plan along with operational and monitoring plans in place. Member States with strong health systems also appreciated WHO's support in identifying funding support and in involving the relevant sectors with a defined monitoring and evaluation process.

Fig. 29: Key highlights: technical assistance for Flagship 5



Most countries in the SEA Region (Bangladesh, India, Bhutan, Indonesia, Nepal, Thailand) have developed a national policy or plan to optimize the use of antimicrobials and reduce the risk of antimicrobial resistance, which includes actions to strengthen antimicrobial stewardship.

WHO-SEARO and country offices have been encouraging Member States to participate in GLASS; 10 countries have enrolled in GLASS and begun to prepare surveillance data for submission. The WHO country offices supported the establishment of the system of national human AMR surveillance to monitor AMR trends accurately and in a timely manner in Nepal and Sri Lanka. In Thailand, national AMR surveillance is regularly assessed and adjusted and contributes data meaningfully to GLASS. Standardized national surveillance is operational at a limited number of sites in Bangladesh and India.

65 World Health Organization. Situation analysis on antimicrobial resistance in the South-East Asia Region: Report 2016. World Health Organization. Regional Office for South-East Asia. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/272873>

As for the other six Member States (Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Timor-Leste), guidelines have been developed for human AMR surveillance, but implementation is limited due to various constraints on skilled human resources, access to funds and data management.

In Bangladesh, Bhutan and Nepal, the national AMR reference laboratory is functional, Clinical and Laboratory Standards Institute guidelines have been adopted as a reference standard, and a quality assured laboratory network is operational at selected sites that are participating in the external quality assurance system (EQAS). The laboratory network comprises laboratories both from the public and private sectors nationwide. Research is an integral component of laboratory surveillance, and there is an established infrastructure, equipment and human resources dedicated to research-related activities. These positive steps have helped Sri Lanka and Thailand attain a stage of sustainable operations. In India and Myanmar, a repository system and national EQAS have been set up at all surveillance sites. In Indonesia and Timor-Leste, no national laboratory network has been established for AMR surveillance in the human sector, and in DPR Korea, there is limited information on international standards and antimicrobial sensitivity testing. These three Member States continue to be in the stage of exploration and adoption.



In Bangladesh, Bhutan and Nepal, the national AMR reference laboratory is functional. In India and Myanmar, a repository system and national EQAS have been set up at all surveillance sites. The laboratory network comprises public and private sector laboratories nationwide.

Capacity building: Content for training on AMR and related issues has been included in continuous professional development courses for healthcare professionals and induction training organized by eight Member States (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Sri Lanka and Timor-Leste). These capacity-building initiatives were focused on a number of areas including hospital infection and prevention control through hand hygiene, AMR surveillance, training on data entry into GLASS, antibiotic awareness and laboratory quality assurance. Proposals to revise the medical curriculum to include AMR-related content are under consideration in Nepal. In DPR Korea, professional training proposals have been prepared to initiate annual training courses for health workers on AMR. Concepts related to AMR have been incorporated in Thailand in the pre-service training of all relevant cadres across sectors. Such training is regularly conducted as continuous professional development courses for all health-care professionals, and their performance is monitored and evaluated. The Regional Office also conducted meetings where stakeholders from different sectors came together from all Member States, leading to sensitization and cross-learning among countries.

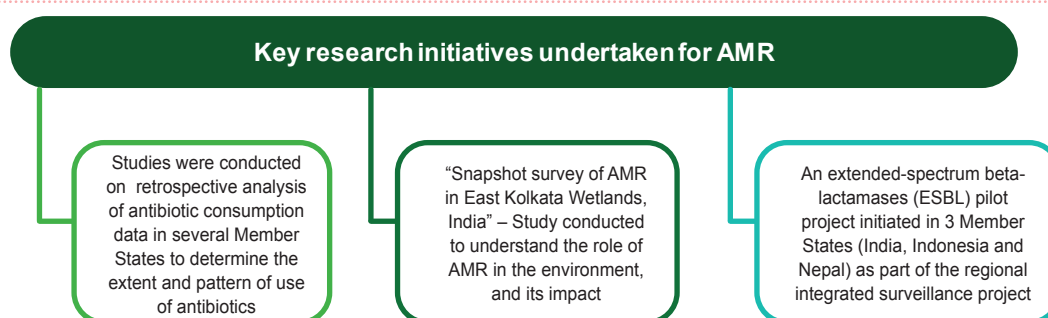
“Every year we have capacity building activities wherein we send our staff to SEARO as well as we get support from WHO to provide us with the reagents, so usually we don’t have stock out in the country.” – A ministry official from Timor-Leste

Monitoring and surveillance: Monitoring and surveillance were focused through cross-sectoral AMR surveillance, building surveillance networks, identifying and collaborating with sentinel sites to report GLASS data, antibiotics awareness surveys, and conducting situational analyses in 2016 and 2018 to review the progress made by Member States against the standards and targets laid down by the Region. Furthermore, a workshop was held in 2016 at the Regional level for all Member States to review the progress of planning and implementation of NAPs-AMR. Bangladesh and Thailand conducted data collection exercises to monitor antibiotic consumption in the country.

TrACSS is a tripartite (consisting of WHO, FAO and OIE) database that showed country progress in the implementation of the global action plan on antimicrobial resistance. Information captured in this database is a result of the country self-assessment questionnaires disseminated to countries by WHO, FAO and OIE in 2016, 2017 and 2018. The database currently contains data for the reporting years 2018 and 2019. All SEA Region countries participated in this self-assessment process and the data was updated until May 2019.

Research and development, and evidence generation: Some Member States are working towards collecting data on antibiotics consumption, prescription practices and behaviours to develop a baseline for AMR surveillance for improved decision-making. In 2017, a publication titled *Situation Analysis on AMR in SEAR*⁶⁵ was released during the 70th Regional Committee meeting in Maldives, serving as baseline data to measure the progress of national AMR control programmes. As a key step to expanding the areas of AMR-related research to be conducted or supported by WHO, the Regional Office published a document titled *Fostering research into antimicrobial resistance in India*⁶⁶, which discussed the research and development of new antimicrobials and rapid diagnostics. A few additional WHO-led key projects undertaken during 2017-2018 are laid out in Fig. 30.

Fig. 30: Key research conducted by Member States for Flagship 5



In addition, the data generated through GLASS helped build a picture of resistance patterns worldwide, detect new and emerging resistance at an early stage and guide local treatment protocols while also providing vital microbiological information for clinicians and their patients. Over time, the data is expected to show how levels of resistance might change in response to targeted interventions. Although substantial efforts have been taken at the Regional level to promote scientific research, it is non-existent in most of the Member States and it is important for all relevant key stakeholders to identify that critical research on the effects of AMR can have a high positive impact and play an instrumental role in evidence-based policy- and decision-making.

“Because the antibiotic consumptions data at present is not being analyzed, so there isn’t much for evidence for policy decisions.” – A ministry official from Nepal

Advocacy: All Member States in the Region were provided with advocacy support that has resulted in the strengthening of their respective governance of AMR, the designation of national focal points, the improvement of regulatory capacity, the enhancement of the capacity for laboratory surveillance,

66 Das B, Chaudhuri S, Srivastava R, Nair GB, Ramamurthy T. Fostering research into antimicrobial resistance in India. *BMJ*. 2017 Sep 6;358: j3535.

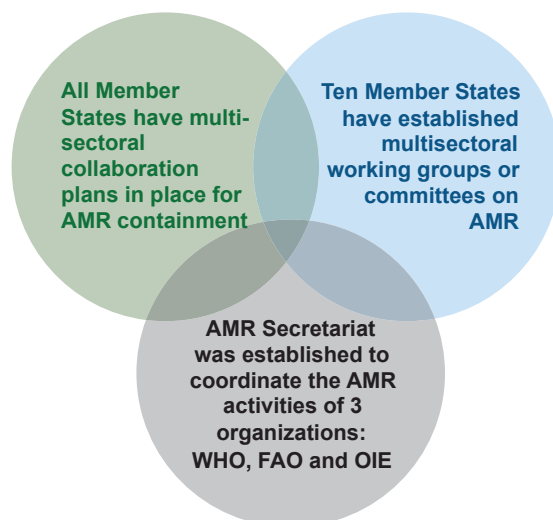
polices and regulations enforcing the rational use of quality antibiotics, and educating communities. During the period of evaluation, two high-level meetings were held in India and Japan to strengthen advocacy and secure the engagement of key sectors for the AMR agenda at the national, regional and global levels. Since 2015, the Region has been actively participating in World Antibiotic Awareness Week (WAAW) held every November to mark improved awareness and to spread the understanding of AMR through effective communication, education and training. Ten out of 11 Member States participated in WAAW in 2018. 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. WHO-led advocacy has resulted in political commitment in Member States such as in India, where AMR is now amongst the top 10 health priorities of the country; Indonesia, where AMR was included in the presidential instruction; and Sri Lanka and Thailand, where AMR is one of the key areas of country cooperation strategy.



In India, AMR is now among the top ten health priorities of the country; in Indonesia, AMR was included in the Presidential instruction, and in Sri Lanka and Thailand, AMR is one of the key areas of country cooperation strategy.

Multisectoral and intersectoral collaboration: AMR is a multi-dimensional problem involving different sectors, disciplines and stakeholders that requires a OneHealth comprehensive approach for containment. Hence, all Member States have multisectoral collaboration plans in place for AMR containment. However, all the countries are at varied levels of progress in bringing about this collaboration. WHO played a critical role in networking with non-health sectors and bringing them together on one platform to work towards addressing AMR concerns, but additional efforts are required for complete success. WHO is collaborating in Member States with the Food and Agriculture Organization of the United Nations (FAO), key ministries (agriculture and livestock, animal husbandry, fisheries, environment, external affairs, education), research institutes, local and international NGOs, foreign donors such as the Fleming Fund, Asian Development Bank, USAID, Department for International Development (DFID), Japan International Cooperation Agency (JICA) and bilateral engagements, such as with UK, Netherlands, etc. Collaborations with universities, medical colleges, academic institutes, and medical, pharmacists' and microbiologists' associations were also brought about to strengthen awareness and infection prevention and control practices. An example of WHO-assisted collaboration was when Myanmar's health ministry succeeded in releasing a joint statement with the Ministry of Agriculture Livestock and Irrigation as a symbol of their commitment to tackling AMR together going forward. To foster collaboration at the Regional level, a OneHealth/AMR Secretariat was established in October 2017 to serve as a regional multisectoral coordination mechanism for the AMR activities of three organizations – WHO, FAO and OIE. In 2018, the Global Tripartite for OneHealth (WHO, FAO and OIE) reaffirmed its commitment to working together on AMR through a revised MoU and also welcomed the inclusion of important new partners, such as the United Nations Environment Programme (UNEP), to strengthen the coordinated multisectoral response required to address AMR.

Fig. 31: Key highlights: multisectoral collaboration for Flagship 5



Equity: Member States are attempting to be all-inclusive from a geographical lens. They are selecting sentinel sites from across the country, including rural areas under the survey and for awareness campaigns. Some countries mentioned undertaking initiatives among gynaeco-obstetric patients to generate evidence on the inclusion of women and children access provided to antimicrobials. However, the activities being conducted to combat AMR are still in too nascent a stage to comment on equity in implementation.

Efficiency

The flagship has led to increased efforts from Member States to secure resources through governments as well as donor partners.

AMR is accorded a high priority by all Member States, each of which took several initiatives to mobilize and allocate resources towards combating it. Multisectoral steering committees to direct the process have been formed. In addition, WHO worked closely with health ministries and bilateral entities and donors such as the Bill & Melinda Gates Foundation, the Department of Foreign Affairs and Trade (DFAT) and the US President's Malaria Initiative through the Emergency Response to Artemisinin Resistance project on malaria control in the Greater Mekong subregion. Nepal, Bangladesh, Timor-Leste and Maldives received funds from the Fleming Fund to conduct activities under the umbrella of AMR, while other countries channelled funds through WHO or the health ministries. There have been some bilateral collaborations to generate funding, such as Australia in Nepal, Netherlands, UK and Sweden in India, and France in Myanmar. However, funding before and after the institution of a flagship for AMR at the Organization's level has not increased to the desired extent. Although the flexible funds WHO offered were limited, they play a catalytic role in propelling activities that may otherwise prove to be a roadblock in progress.

No separate human resource positions were created for AMR, but additional responsibility was allocated to existing staff for accountability. Indonesia had no AMR-specific team until a focal point/

team was created in late 2018. In Nepal, there has been a dedicated team for AMR since 2017. Dedicated resources were required to support the Member States for NAP activities and to provide technical guidance on data entry into GLASS. In terms of logistical support, WHO has been supporting national laboratories to provide funds for reagents and raw materials for sentinel sites. For example, in Maldives, WHO sponsored an high performance liquid chromatography (HPLC) machine to enhance institutional capacity for testing in antibiotics.

Several enabling factors like adequate sensitization and mobilization of multisectoral players helped contribute to the success and progress made by Member States in tackling AMR.

The Member States adopted a multipronged strategic approach to address AMR, and there has been a wide range of policy proclamations, advocacy meetings and statements. There has been a high level of political commitment and will in Bangladesh, India, Myanmar and Thailand with Union ministers steering national committees and attending key meetings.

***“There is high-level commitment from the Royal Thai Government to tackle AMR as it is part of CCS. The Deputy Prime Minister, himself chairs the National steering committee for AMR.”
– A ministry official from Thailand***

Global advocacy and technical support from WHO has helped in evidence generation. For example, in Thailand, the AMR burden estimation data was used to highlight the AMR problem and its impact. Effective drug regulatory mechanisms in Bhutan and Thailand have led to added benefits in controlling the sale of antibiotics without prescriptions.

WHO also funded some key activities such as awareness campaigns, meetings and workshops, and laboratory strengthening initiatives. In Maldives, most of the activities for AMR were funded by WHO. In India, WHO supported a few activities for which state governments did not have any budgetary allocations. Indonesia has a budget for AMR activities. In DPR Korea, a special budget was allocated to develop AMR-NAP. In Bangladesh, with the support of WHO’s flexible funds, institutional capacity was brought about by strengthening laboratories. In Bhutan, funding support from WHO was used to raise awareness.

Sustainability

Focus on AMR is fairly recent, and some governments have shown active participation and commitment.

The focus on AMR is a fairly recent occurrence, and thus the gains made so far should be sustainable. The Organization focused on promoting policy and technical dialogue on AMR across sectors in Member States, providing them with strategic support to scale comprehensive and sustainable action. In countries where the government has been more participative and been responsible for carrying out AMR-related activities, the gains are expected to be more sustainable. Surveillance systems were strengthened, plans were reviewed regularly, and were made according to the funds available from WHO, governments and donors. The Region also conducted situational assessments biannually during this period, which monitored Member States’ progress in mobilizing political commitment and advocacy around AMR that support effective and sustained management.

It is critical to sustain the programme strategy. But sustainability can still be a challenge as there is dependency on WHO and donor partners to move things forward, for manpower, technical expertise, funding or support. Also, countries that aren't receiving external financial support from partners may not be able to carry out new activities that require large amounts of funds. However, WHO continues to provide the technical support for capacity building, multisectoral collaboration, strengthening of institutional capacity and high-level advocacy among others.

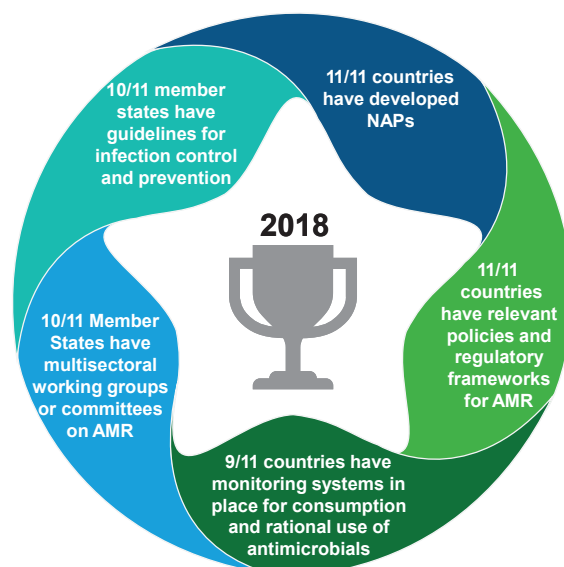
“We will be able to sustain maybe after 10 years as it is not easy to get HR in place in a year or two. Our country takes longer time, we have to plan and send it to the senior officials then send to the public service commission. Thus, human resources might be an issue but consumables and streamlining these things can still be managed. The data analysis part is still under technical assistance from WHO.” – A ministry official from Indonesia

Impact

All 11 Member States, supported by WHO, developed their NAPs and made significant progress in AMR prevention and containment activities.

By 2018, all 11 Member States had prepared their NAPs and initiated programmes based on these. Overall, the efforts made by the Region and the countries pointed towards significant progress in AMR prevention and containment initiatives in 2017 and 2018. However, all 11 Member States have achieved different levels of success in combating AMR, with a few countries achieving a higher level of implementation during the evaluation period than others.

Fig. 32: Key achievements of the SEA Region (2014–2018) for Flagship 5



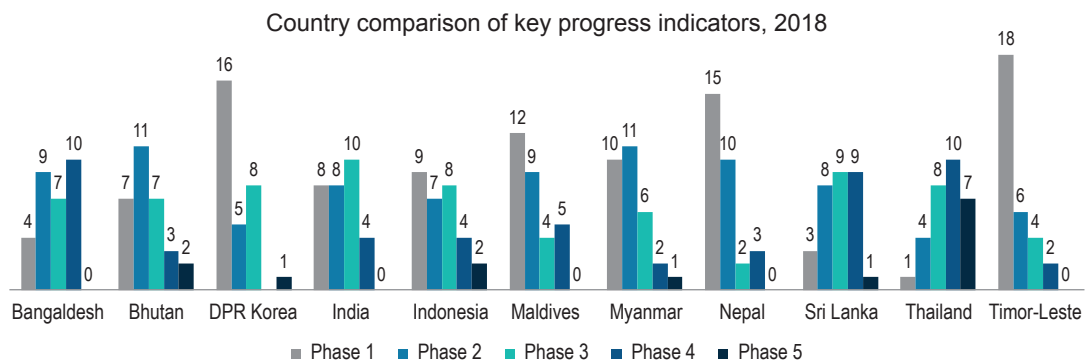
A situational analysis was first conducted in 2016 and was followed by another in 2018. The tool assessed the progress of NAP-AMR implementation based on 30 indicators as a proxy for strategic interventions and programmes across eight focus areas. All indicators reflect progress based on the activities and actions implemented as part of the NAP as per the five phases of development proposed in the roadmap developed by the Regional Office.⁶⁷

Fig. 33: Five phases of development as per the Regional roadmap



As per the 2018 situational analysis, Thailand achieved 17 indicators in Phase 4 and above, followed by Sri Lanka (10) and Bangladesh (10). DPR Korea (1) and Timor-Leste (2) had the least number of indicators in full operation. Inadequate infrastructure, the absence of skilled manpower, gaps in operational guidelines and laboratory standard operation procedures have contributed to varying levels of AMR-containment activities in most of the Member States in the Region.⁶⁷

Fig. 34: Key progress indicators in the SEA Region for Flagship 5



Source: Situational Analysis of AMR in the South-East Asia Region 2018

As shown in Table 7, 10 out of 11 countries have participated in GLASS, while seven countries are performing antimicrobial susceptibility testing for lab integration. Four countries are implementing infection prevention and control guidelines, and six other countries have also developed them, though they are not implementing them yet. It is evident that there is a lot of improvement in this area in the SEA Region, which can be attributed to the joint efforts of WHO, health ministries, and technical and donor partners.

⁶⁷ World Health Organization. Situational analysis of antimicrobial resistance in the South-East Asia Region, 2018. New Delhi. World Health Organization. Regional Office for South-East Asia; 2019. License: CC BY-NC-SA 3.0 IGO

Table 7: Status of AMR control in the SEA Region

	Multisector Collaboration	National Action Plan (NAP)	Infection Prevention and Control (IPC)	Participation in GLASS	National Human AMR Surveillance	Lab Integration
Bangladesh	Established	Government approved	Plan developed not fully implemented	Yes	Phase of initial implementation	Performing AST and integrated
Bhutan	Established	Government approved	Plan developed not fully implemented	Yes	Phase of programme installation	Performing AST and integrated
DPR Korea	Established	Plan developed	Implementing	Yes	Phase of programme installation	Information NA
India	Functional working group	Government approved	Plan developed not fully implemented	Yes	Phase of initial implementation	Performing AST and integrated
Indonesia	Not formally	Government approved	Implementing	Yes	Phase of programme installation	Performing AST and integrated
Maldives	Functional working group	Government approved	Plan developed not fully implemented	Yes	Phase of programme installation	Information NA
Myanmar	Joint working	Government approved	Implementing	Yes	Phase of programme installation	Information NA
Nepal	Functional working group	Plan developed	Plan NA	Yes	Phase of full operation	Performing AST and integrated
Sri Lanka	Integrated	Funding, M&E	Implementing	Yes	Phase of full operation	Performing AST and integrated
Thailand	Integrated	Funding, M&E	Plan developed not fully implemented	Yes	Phase of sustainable operation	Performing AST and integrated
Timor-Leste	Established	Government approved	Plan developed not fully implemented	Not Yet	Phase of programme installation	Information NA

Source: WHO SEARO flagship flyer 2019

AST: Antimicrobial Susceptibility Testing; M&E: Monitoring and Evaluation; NA: Not Available

Challenges

Research and development: Most Member States were not conducting evidence generation for advocating the concerns of AMR as they have limited funding or capacity to conduct this type of critical research. Most countries in the Region are yet to put together a strategic research agenda that is relevant to current policies and programmes. In addition, there is a need to conduct policy research to strengthen tripartite lab system surveillance.

Awareness among stakeholders: Respondents highlighted issues such as limited awareness among all stakeholders, especially manifesting as irrational prescription practices amongst pharmacists and prescribers. Similarly, mid-level management was found to be active, but there was limited awareness at the higher level (ministers and policymakers). Community awareness on the ill effects of irrational use of antibiotics needs further strengthening.

Multisectoral collaboration: Bringing everyone to a consensus was an ongoing challenge, and indistinct multisectoral coordination between different sectors was identified. Most ministries weren't aware that their sector contributed to the AMR problem and there was minimal inclusion of the private sector. Though multisectoral steering committees had been formed in most of the Member States, they were not necessarily functioning optimally.

Data quality and AMR surveillance: Most countries indicated a lack of baseline data on antibiotic consumption, surveillance, the use of antimicrobials, the health and economic impact of AMR, and burden estimation at the national and subnational level. Furthermore, even if data were available, it was scattered for most of the countries and not being analysed and, therefore, it was not usable for decision-making or evidence generation. This further hinders effective advocacy with key policymakers as the Member States were unable to highlight the significance, impact and frequency of AMR.

Implementation of NAPs: Even though all SEA Region Member States have developed national multisectoral action plans, the implementation was weak. Also, the Member States have a dependency on WHO and donor partners to move things forward, whether for manpower, technical expertise, or funding support.

Recommendations

Strengthen governance and multisectoral collaboration: Policy frameworks must be strengthened to make AMR a priority public health issue in the Member States with a special focus on non-human sectors. Active engagement with international and national partners will be another step towards containing the risk of AMR at the global as well as country levels. The OneHealth concept captures the full scope by recognizing the interdependence between various sectors including human health, animal health and environmental aspects.

Expand awareness of AMR and related issues: Awareness and understanding of AMR through effective communication, education and training to ensure high-level political buy-in and commitment (both in human health and other key sectors contributing to the issue of AMR) must be improved. A comprehensive strategy to raise awareness and strategies to optimize the rational use of antimicrobial medicines in human and animal health must be developed and implemented.

Support implementation with standard guidelines: In addition to strengthening regulatory capacity and frameworks, special focus is required to strengthen capacity for the implementation of various interventions and programmes. Implementation needs the commitment of high-level policymakers, annual allocation of funds and technical expertise.

Strengthen the data and evidence base through surveillance and research: There is a need to have proper coordination between clinicians and laboratories to obtain not only baseline data but also achieve the targets. Member States must be supported to share AMR data to GLASS and participate in a standardized approach to the collection and analysis of AMR data at a global level. Critical research on the effects of irrational antibiotic use can have a high positive impact.

Success Story: Myanmar

WHO has played a catalytic role as it has driven most of Myanmar's AMR-related activities. The National Action Plan for Containment of Antimicrobial Resistance Myanmar (2017–2022)⁶⁸ was developed through a OneHealth approach with WHO's technical support. In the process of its development in 2017, WHO bolstered the preparation of NAPs-AMR, arranged stakeholder meetings, and conducted WHONET training with the help of WHO. A National Multisectoral Steering Committee (NMSC) for AMR was established in early 2018, comprising 19 members from multisectoral departments and ministries, including the Union Minister of Health and Sports as chair, which showcased the country's political commitment to tackling AMR. In 2018, WHO convened the first meeting of the NMSC, followed by the National Antimicrobial Coordination Committee (NCC) meeting which helmed five technical working groups (awareness, surveillance, infection prevention, control and hygiene, optimizing antimicrobial use, and research and innovation).

WHO's efforts to facilitate multisectoral engagement in the country resulted in the release of joint statement in 2018 by the Ministry of Health and Sports and the Ministry of Agriculture, Livestock and Irrigation as an exhibition of their joint commitment to combat AMR. WAAW was also celebrated in Myanmar in both 2017 and 2018. A research prioritization workshop on AMR was conducted (though in 2019) in which stakeholders discussed research priorities for AMR and 10 out of a total 30 research agendas were prioritized. Myanmar has also enrolled in the programme to enter data in GLASS. In addition, support was provided for national capacity building and the strengthening of the national health laboratory by providing it with logistical support and opportunities to cross-learn.

68 Ministry of Health and Sports, and World Health Organization. Myanmar National Action Plan for Containment of Antimicrobial resistance. World Health Organization. Regional Office for South-East Asia. [Internet]. 2017. Available from: <https://www.who.int/antimicrobial-resistance/national-action-plans/library/en/>

3.6 Scaling up capacity development in emergency risk management in countries

Relevance

The flagship provided strategic support for the improved management of emergencies through advocacy, information management, and technical, operational, financial support and partnerships.

On an average, natural disasters kill 60 000 people per year globally.⁶⁹ The World Disasters Report 2015 indicates that the Region contributed 24.6% to global mortality due to disasters and health emergencies over the past decade.⁷⁰ The SEA Region is vulnerable to different types of emergencies and disasters from natural hazards from floods, cyclones, earthquakes, tsunamis, landslides, volcanic eruptions, heat waves and droughts to outbreaks and epidemics of common infectious diseases, and emerging and re-emerging diseases including zoonotic infections. To tackle the global burden, updated International Health Regulations (IHR) (2005) were endorsed by the Fifty-eighth World Health Assembly on 23 May 2005 and came into effect in 2007. The global momentum has been mirrored at the Regional level and, since 2010, the IHR (2005) have been executed in all Member States to assess the implementation status of 13 core capacities. In 2014, the strengthening of emergency risk management was declared as a Regional Flagship Area to improve coordination mechanisms for emergency response through effective partnerships. In 2016, the Global WHO Health Emergencies Programme (WHE) was created and rolled out in 2017. Both these developments have accelerated the capacity development across Member States. Further, to improve public health preparedness and response at the global level, the Global Strategic Plan 2018–2023⁷¹ was launched at the Seventy-first World Health Assembly in 2018.

Since the advent of the flagship, many milestones have been achieved in capacity development in emergency risk management, and the focus is to maintain and scale them up further. The flagship has been a priority and is relevant to the Region both at the national and subnational levels, and WHO has a unique role to play in the implementation of the agenda. The flagship provided strategic support for improved management of emergencies through advocacy, preparedness and response, information management, technical and operational support and partnership. WHO works with Member States and partners to strengthen implementation of the IHR (2005) at the Regional level. This is done by enhancing laboratory capacity, ensuring surveillance at ports, airports and ground crossings, building response capacity by linking the health sector with other health-related sectors (animal health, water and sanitation, nutrition), developing and maintaining a knowledge network of IHR national focal points (NFPs), and facilitating the implementation of disaster risk reduction approaches and the SDGs. The flagship aimed to deliver the expected results and capacities for improved management in emergencies in the Region with five objectives: advocacy, information management, technical and operational support, preparedness and response, and partnership.

69 Culver, A., Rochat, R. & Cookson, S.T. Public health implications of complex emergencies and natural disasters. *Confl Health* 11, 32. BMC. [Internet]. 2017. [cited 30 June 2020]. Available from: <https://doi.org/10.1186/s13031-017-0135-8>

70 International Federation of Red Cross and Red Crescent Societies. *World- Disaster Report- Focus on local actors, the key to humanitarian effectiveness*. IFRC. 2015

71 World Health Assembly, 71. *Public health preparedness and response: implementation of the International Health Regulations (2005): Report by the Director-General*. World Health Organization. [Internet]. 2018. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_8-en.pdf

Effectiveness

Emergency response is an area where the WHO has a unique, visible and acknowledged role to play. The WHO country offices have pursued a variety of different strategies to help countries be more prepared for emergencies at both the national and subnational levels. Thus, Member States have made notable progress with respect to emergency risk management with a sharp focus on various indicators of IHR leading to improvement in overall preparedness.

Articulation of policy documents, guidelines and directives: The IHR (2005) require all WHO Member States to develop and maintain capabilities to respond rapidly and effectively to public health threats and risks. WHO has also continued to support countries to enable them to meet the provisions of the legally binding agreement to prevent, protect against, control and provide a public health response to health and non-health emergencies. WHO-SEARO provided all Member States with updated WHO guidance on the development of various plans and frameworks such as the ones listed in Fig. 35.

Fig. 35: List of key regional plans and frameworks

-
- Sendai Framework for Disaster Risk Reduction
 - National Pandemic Influenza Preparedness Plans (NPIPP)
 - Framework for action in building health systems resilience to climate change 2017
 - Regional framework on operational partnership for emergency response 2017
 - Third Asia Pacific strategy for emerging disease and public health emergencies (APSED III) 2017
 - Guidelines on integration of care of people with NCDs into emergency response
 - Development of a brief guide to emerging infectious diseases and zoonoses 2017
 - Development of a regional roadmap for high threat pathogens
-

The development of National Action Plan for Health Security (NAPHS) was proposed, which aimed to accelerate the implementation of IHR (2005) core capacities, capture national priorities for health security, bring sectors together, identify partners and allocate resources for capacity development in health security. Following the identification of gaps and priorities during assessments, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have developed their NAPHS for the implementation of IHR in 2018. Several countries are in different stages of preparing and costing of NAPHS. Regional training for the development and costing of a NAPHS was conducted in July 2018 in Dhaka, Bangladesh, to increase the prospects of resource mobilization and external support for implementation. By 2018, The Regional Office was in the process of finalizing an emergency response operations manual with clear roles and standard operating procedures (SOPs).

Technical assistance: Prone to natural disasters and at risk of climate change related and other health hazards, WHO-SEARO has been investing in strengthening emergency response capacities as a priority since 2014. In the Sixty-ninth World Health Assembly (SEA/RC 69/2016), the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) was expanded with the start of a preparedness stream focused on strengthening disease surveillance, the health emergency workforce and emergency medical teams (EMTs). EMTs are an important part of the global health workforce. Arriving where needed in the shortest time and delivering quality care appropriate to the context, EMTs can help substantially reduce loss of lives during public health emergencies. Before 2018, EMTs typically comprised of foreign nationals and their deployment involved language barriers, systems misalignment and high costs. In 2018, the Regional Committee decided to strengthen national-level EMTs for greater cost effectiveness and responsiveness. Technical support to Member States was also provided through organizing a regional meeting on strengthening of HEOCs in July 2017. Thereafter, Member States in the SEA Region have improved their existing HEOCs and/or established dedicated HEOCs to strengthen communication and coordination. Thailand's contribution to the preparedness stream is being utilized to strengthen HEOCs in smaller countries. A number of respondents highlighted that the WHO's support does not only extend to the national level, but the subnational level as well. The HEOC network model has been replicated in all countries in the Region and covers both the national and subnational levels (from 2016). This included building emergency infrastructure for hospitals and emergency response centres.

WHO supported affected and at-risk countries with technical guidance on how to manage outbreaks and on how to prevent their occurrence. WHO-SEARO, along with WHO country offices, provided technical and financial support to Member States during emergencies as shown in Fig. 36.

Fig. 36: Key highlights: technical assistance for Flagship 6



Technical Assistance



- **SEARHEF scope expanded for focus on strengthening disease surveillance, the health emergency workforce and EMTs**
- **Regional Committee decided to strengthen national level EMTs for greater cost effectiveness and responsiveness**
- **Established or updated dedicated HEOCs to strengthen communication and coordination**

Capacity building: To augment the response capacities of WHO country offices, the Regional Office conducted three modules of WHO Operational Readiness Training in 2017 and 2018, focusing on the Emergency Response Framework, Incident Management System, HEOCs, the virtual Strategic Health Operations Centre (vSHOC) platform, business continuity plans, operational readiness training, contingency plans and administration- and finance-related functions in emergency response. In addition, WHO also conducted training workshops, simulation exercises and mock drills to improve local capacity for preparedness and response in case of an emergency.

As a response to the Zika virus outbreak, WHO assisted Bhutan, Maldives and Timor-Leste in conducting various actions including risk assessments. WHO supported a series of trainings in emergency response for government staff of Member States and WHO staff. Member States received training on conducting risk assessments for acute public health events with a focus on emerging infectious diseases.

A regional training on conducting risk assessment and establishing early warning and response systems (EWARs) was also conducted in 2017. Regional training for the development and costing of a NAPHS was conducted in 2018 in Dhaka, Bangladesh.

Monitoring and evaluation: The IHR (2005), a self-evaluation monitoring process for countries to assess the implementation status of 13 core capacities, has been executed in all Member States. Since 2010, the monitoring process involved the use of a self-assessment monitoring questionnaire to assess the implementation status of 13 core capacities across Member States, and it was followed until 2017. In 2018, WHO provided a new State Parties Self-Assessment Annual Reporting Tool (SPAR)⁷² with a revised interpretation of national IHR capacities (13) on a scale scoring system. As of 2018, the new IHR M&E framework is being used to review progress in implementing IHR core capacities in States Parties. The Regional Office has initiated support to Member States to conduct a comprehensive assessment of these core capacities for emergencies with a specific focus on JEE and SPAR followed by an after-action review and simulation exercise. These efforts have culminated in 100% compliance to SPAR since 2016, and in 2018, all 11 Member States of the Region reported on their IHR capacities through the SPAR mechanism. Eight Member States completed the JEE by the end of 2018 (Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste) and two more were to follow in 2019. Some countries have also done after-action reviews and simulations.



All 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.

“The JEE Score as compared to SPAR is not so good but we are now finding the gaps and developing it. We scored very low but we are now planning, to get to the next level we had big discussions...now its already in place for a long time” – A ministry official, Sri Lanka

Research and development, and evidence generation: Since the introduction of this flagship, several disaster mitigation studies were commissioned and research undertaken on disaster risk and vulnerability, seismic microzonation, building codes and methodologies for early warning and damage/

72 World Health Organization. E-SPAR. State Party Annual Report. World Health Organization. [Internet]. Available from: <https://extranet.who.int/e-spar>

loss to gather evidence. One of the key achievements of WHO was the publication of the report *Roots for Resilience: A health Emergency Risk Profile of the South-East Asia Region* in 2017s.⁷³ This scientific risk profiling was the first effort to quantify the risk to health and health systems posed by natural disasters (such as earthquakes, cyclones, floods and droughts) and epidemics in the Region. The findings of this report served as a tool for policymakers to prioritize risk management in vulnerable areas and clearly showed that existing capacities in the SEA Region did not match the prevailing and ever-increasing threats. This risk assessment exercise included two studies carried out by independent groups of researchers and epidemiologists. One was a vulnerability profile of communicable disease threats in the Region while the other looked at multi-hazard vulnerability and capacity and risk analysis for the Region. Research priorities that emerged from this assessment include infection control practices, vaccine development, understanding disease epidemiology, surveillance and risk communication.



*To enable evidence-informed planning, a comprehensive analysis was undertaken, resulting in the publication of *Roots for Resilience: a health emergency regional risk profile of SEA Region*. This report clearly demonstrated that existing capacities in the Region did not match the prevailing and ever-increasing threats.*

Advocacy: Advocacy and generating awareness on health issues during emergencies was one of the key objectives of this flagship. Through this flagship, WHO advocated for Member States to continue efforts and investments in planning for and responding to emergencies and making risk management capacities pervasive with the objective of saving human lives. One of the respondents from Nepal indicated that the establishment of the health emergency and disaster management unit in the health ministry of Nepal was a result of WHO's continued advocacy for a dedicated wing to manage emergencies in the Member State. Some of the steps taken during the evaluation period for raising awareness included the following.

- In 2015, a situation analysis on the implementation of the Asia Pacific Strategy for Emerging Diseases (APSED) 2010 was conducted⁷⁴, and each Member State in the Region was briefed on its status towards fulfilling the IHR (2005) core capacity requirements.
- The Regional Office convened a number of meetings attended by Member States and partners to strengthen regional capacity in emergency risk management to strengthen operational partnerships and EMTs.
- The SEA Region participated in national awareness and advocacy meetings for EMTs and the Global Outbreak Alert and Response Network (GOARN) held in India, Indonesia and Thailand and contributed to the development of the UN Global Health Clusters' Strategy for 2017–2019. The Region successfully advocated for quality standards and quality assurance processes for EMTs at the 42nd World Congress on Military Medicine held at New Delhi in November 2017.

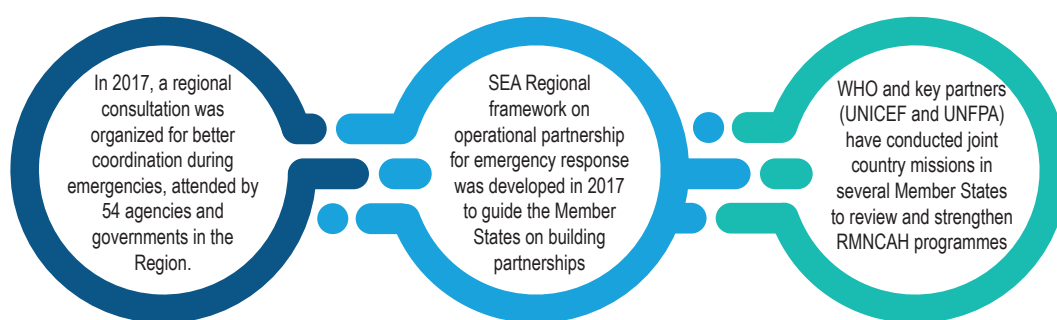
Multisectoral and intersectoral collaboration: Building partnerships across sectors was one of the five objectives of this flagship. The Organization supported Member States in taking necessary action to build intersectoral partnerships and coordination mechanisms by establishing multisectoral steering committees and convening advocacy meetings and workshops for awareness and funds

73 World Health Organization. *Roots for Resilience: A health Emergency Risk Profile of the South-East Asia Region*. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO. [internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/258766>.

74 World Health Organization. *Asia Pacific strategy for emerging diseases (APSED): evaluation report 2005-2015*. World Health Organization. 2018. License: CC BY-NC-SA 3.0 IGO.

mobilization. To strengthen intersectoral synergies and partnerships and collaboration among public and private stakeholders and operational partners for emergency preparedness and response, the Regional framework on operational partnership for emergency response (South-East Asia Region)⁷⁵ was developed in 2017. It guided Member States, WHO country offices and partners on building operational partnerships the in pre-emergency, emergency and post-emergency phases. The Region actively contributed to the dialogue around and the development of guidelines and strategic plans for the Global Health Cluster, arrangements with the Inter-Agency Standing Committee of Humanitarian Partners (IASC) and the strengthening of GOARN. In 2017 and 2018, it also participated in the meeting of the Global Health Cluster for its multiple-year strategy for 2017-2019.

Fig. 37: Key Highlights: multisectoral collaboration for Flagship 6



In addition, a two-day regional consultation entitled "Networking and Coordination of Health Partners for Emergency Response" was organized in 2017 in Thailand. The meeting, attended by 86 delegates from 54 agencies and governments in the Region, was held in recognition of the need to strengthen the existing partnership networks set up to respond to health emergencies and the coordination between them in order to ensure effective, seamless and coordinated responses to emergencies. These networks included the Global Health Cluster of the UN, EMTs, GOARN, WHO Standby Partners as well as multilateral and bilateral aid agencies. Respondents across Member States underlined the need for WHO to continue its efforts to bring about these partnerships to raise awareness, mobilize funds and develop a coordinated response during emergency response.

Equity: WHO contributed several approaches to address equity. The Health Cluster strategy in Nepal and Myanmar supported pregnant women, children, and the old and disabled. In Sri Lanka, the marginalized were supported through financial incentivization. Other approaches included the capacity building of Member States to address specific needs on gender equality during emergencies and monitoring of the data related to equity through a rapid response questionnaire, such as in Timor-Leste. However, going forward, as per the respondents, it will be crucial to sharpen focus on equity in policy planning as well as in the implementation of plans and policies during emergency preparedness, response and recovery.

⁷⁵ World Health Organization. Regional Framework on Operational Partnerships for Emergency Response (South- East Asia Region). World Health Organization. Regional Office for South-East Asia. [Internet]. 2017 November.

Efficiency

The flagship has led to increased efforts from Member States to secure resources through government as well as donor partners.

One of the key strengths of WHO in terms of emergency response is its ability to mobilize resources from across the Region and sometimes globally. The SEARHEF was established in 2008 and was used to provide immediate financial support to nine out of 11 Member States in 37 emergency operations, with disbursements from the fund totalling US\$ 5.95 million as of July 2018. The establishment of the SEARHEF ensured the improved availability and mobilization of funds, which helped the Member States to manage emergencies and has helped the readiness and preparedness stream in smaller countries such as Timor-Leste, Sri Lanka, Maldives and partially Bhutan. In addition, the response capacity of Member States was enhanced by the establishment of HEOCs to coordinate the response during emergencies. In developing its emergency risk management activities and plans, the Regional Office has engaged in discussions with potential technical partners and donors, including the CDC, the Australia Department of Foreign Affairs and Trade (DFAT), and the European Commission. Through this engagement, SEARO has been able to obtain funding commitments to support some of its emergency risk management activities. Apart from these factors, training health professionals through simulation exercises, convening health clusters (in Nepal and Myanmar) including multisectoral collaboration, monitoring emergency reports, and policy resolutions and the formulation of directives were instrumental in preparing Member States for any type of health emergencies.

“The Health Emergency Operation Center has been tested to see how the emergency response can be coordinated which was realized in the 2014 earthquake – it is the main driver.” – A ministry official from Nepal

The achievements were supported by various factors such as high-level political commitment, improved resource allocation, the strengthening of health systems and enhanced monitoring.

The Regional Office upgraded its vSHOC to equip it with the most up-to-date hardware and software. In response to the 2015 earthquake in Nepal, the health cluster immediately activated and deployed nearly 100 staff from WHO-SEARO and other WHO offices to provide medical supplies and equipment for earthquake relief operations. The Maldives WHO country office procured and pre-positioned the country's first Inter-Agency Emergency Health Kit (IEHK) to cater to 10 000 people for three months during an emergency in 2015. Myanmar established the National Emergency Operation Center within the health ministry in 2014 to orchestrate and redeploy staff in disaster situations. The Bhutan WHO country office was able to acquire funding from the European Commission Civil Protection and Humanitarian Operations Disaster Preparedness programme (DIPECHO) to conduct seismic assessments of health facilities and develop SOPs for emergency response. The DPR Korea WHO country office participated in joint field assessments with other UN partners and contributed to the UN Central Emergency Response Fund for financial support. During the 2016 flood in Sri Lanka, the WHO country office was able to mobilize funds within 24 hours and deployed mobile medical teams in disaster-affected areas.

However, despite the availability of additional funding sources, SEARHEF stands apart as an exclusive regional fund for the 11 Member States and is more easily accessible than other global funds with similar objectives.

“In the country if any emergency happens, every cluster convenes immediately. They come in the meeting. So, this cluster is one enabling factor.” – A technical partner from Nepal

Sustainability

Action is needed to ensure the sustainability of the progress and achievements in the Region, including improved political commitment, allocation of resources, evidence-based interventions, monitoring and evaluation guidelines and surveillance activities and implementing the regional plan for emergency preparedness and response capacity building.

Despite its vulnerabilities, the Region has implemented good practices and innovations for managing risks better, but it must sustain efforts to strengthen emergency preparedness and response capabilities in health and related sectors. The Region invested and built capacity in emergency risk management to tackle the emergency situations both at the WHO and Member State level. Sustainability has been ensured by reviewing the progress of the implementation of IHR Core Capacities in States Parties, the enhancement of laboratory capacity, ensuring surveillance, building response capacity by linking the health sector with other health-related sectors (animal health, water and sanitation, nutrition), the development and maintenance of a knowledge network of IHR NFPs, and the facilitation of implementation of disaster risk reduction approaches. The Region has also helped to build the capacity of Member States with numerous trainings, established HEOCs in the countries, and developed EWARS and internationally classified and/or nationally accredited EMTs in the Region. Regular risk assessment exercises and reviews ensured the sustainability of efforts on emergency risk management. In addition to this, Member States provided support and political will for emergency preparedness. The 2016 Regional Office decision to expand the SEARHEF to invest in emergency preparedness, not just in response, was a crucial step towards sustaining the gains and preparing countries in advance.

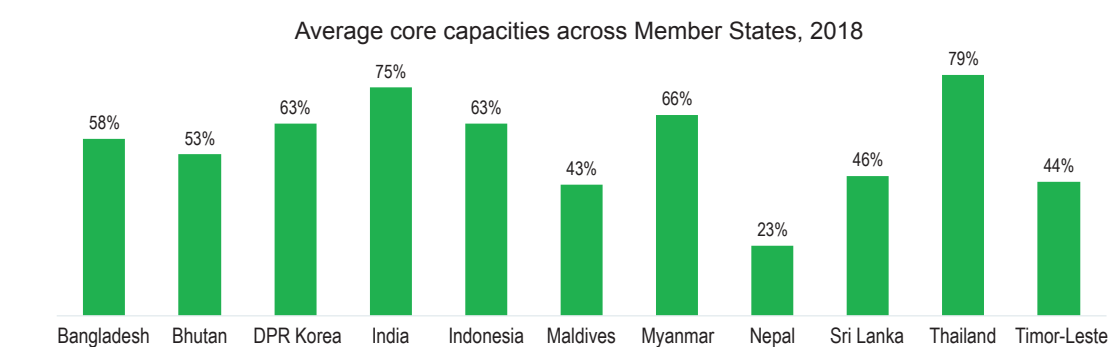
“The importance of health emergency management has been reflected in the national legislations and policies such as Disaster Management Act, National Health Bill and National Health Policy. Further, it has been also included in the 12th Five Year Plan and the Annual Performance Agreement. This would ensure the sustainability of the program and activities related to health emergency management. In addition, there is also commitment from high-level authority.” – A ministry official from Bhutan

Some of the challenges they face in the Region include the limited capacity of the IHR NFPs across the Region, the paucity of trained personnel, the difficulties of intersectoral coordination, the adaptation of technical guidelines, limited contingency funds for response and for funding for preparedness activities, supply chain management, and information and communications technologies for emergencies and risk communication capacity. Combating them necessitates more training and implementing the regional plan for emergency preparedness and response. The renewed focus of this flagship is on sustaining these capacities by various means, including by accelerating progress and innovation.

Impact

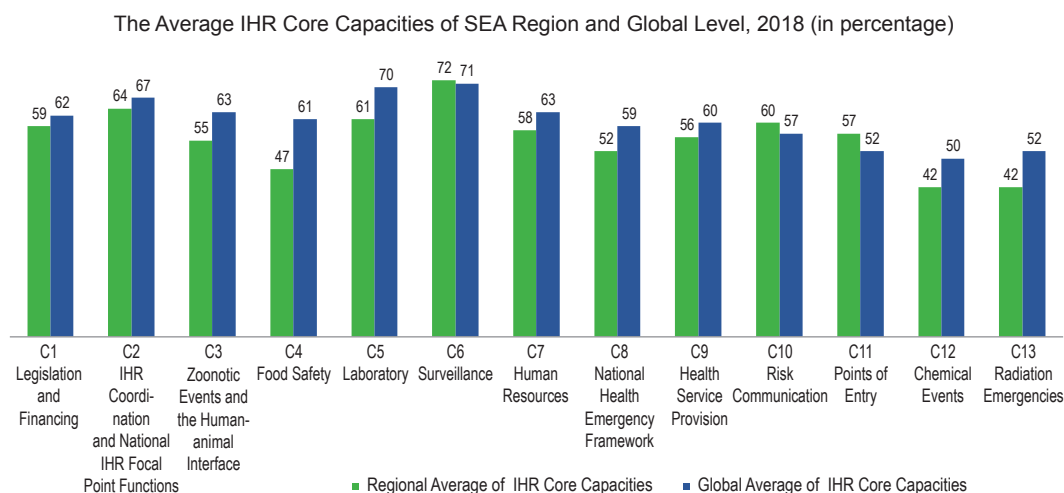
The average core capacity score of the SEA Region in 2018 was 56%. All 11 Member States of the Region reported on their IHR capacities through the SPAR mechanism.

Fig. 38: Average IHR core capacities score for Member States of the SEA Region, 2018



Source: Global Health Observatory, WHO

In 2018, WHO provided a new SPAR tool with a revised interpretation of 13 national IHR core capacities on a scale scoring system. In 2018, the average core capacity score of all reporting countries at the global level was 61% whereas it was 56% for the SEA Region. Fig. 38 shows the Member States' average capacity score for these core capacities, and Table 8 showcases the IHR score for the 13 core capacities in 2018.⁷² Eight Member States completed the JEE by the end of 2018 (Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand, and Timor-Leste) and two more followed in 2019. After the identification of gaps and priorities during the assessments, five Member States (Indonesia, Maldives, Myanmar, Sri Lanka, and Thailand) have developed their National Action Plan for Health Security (NAPHS) to implement IHR. Bangladesh, Bhutan and Timor-Leste proposed the development of their NAPHS in 2019. Fig. 39 represents the comparison between the average IHR core capacities of the SEA Region and the global average in 2018. It is interesting to note that the score of only three capacities (surveillance, risk communication and points of entry) in SEA Region is above global average.

Fig. 39: Regional average of IHR core capacities (in percentage), 2018

Source: Global Health Observatory, WHO

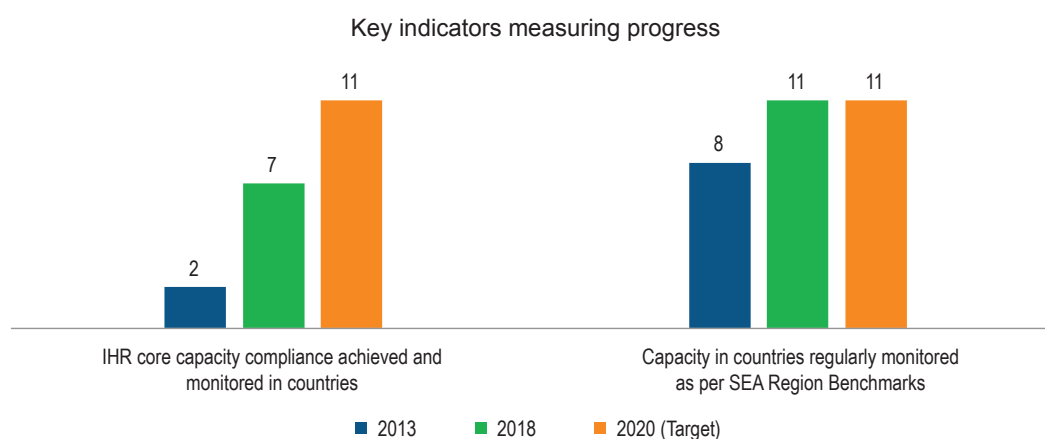
Table 8: IHR core capacities score for 13 core capacities across Member States (in percentage)

	Legislation and Financing	IHR Coordination & National Focal Point Functions	Zoonotic Events & the Human-animal Interface	Food Safety	Laboratory	Surveillance	Human Resources	National Health Emergency Framework	Health Service Provision	Risk Communication	Points of Entry	Chemical Events	Radiation Emergencies
Bangladesh	60	80	80	40	73	80	40	47	60	60	60	40	40
Bhutan	53	70	80	40	60	80	60	47	67	60	50	20	0
DPR Korea	60	40	60	40	80	70	80	80	67	80	60	60	40
India	80	90	60	60	47	100	100	67	33	80	80	80	100
Indonesia	73	60	60	60	67	70	80	53	53	60	80	40	60
Maldives	67	70	20	80	73	70	20	53	60	20	40	0	0
Myanmar	53	70	80	40	67	80	60	60	67	60	60	80	80
Nepal	27	20	20	20	33	40	40	40	20	20	20	0	0
Sri Lanka	60	40	20	20	53	70	60	33	47	60	50	40	40
Thailand	53	90	100	80	73	80	80	60	87	100	70	80	80
Timor-Leste	60	70	20	40	47	50	20	27	53	60	80	20	20

Source: Global Health Observatory, WHO

WHO's role in building country capacity for an emergency response is unique and is acknowledged by the major actors of the health system. Respondents from Sri Lanka, Timor-Leste, Nepal and Myanmar emphasized the importance of WHO's role in advocacy, convening, capacity building, and coordination for both emergency preparedness and response. Several respondents mentioned that the resources and the level of communication and responsiveness have improved since the advent of the flagship. Fig. 40 shows the trends in the progress of key indicators as of 2018.

Fig. 40: Key indicators measuring progress for Flagship 6



Source: WHO SEARO flagship flyer 2018

Challenges

Limited resources: Despite the establishment of the SEARHEF, Member States faced challenges from limited funds, both for emergency preparedness and during emergencies. Although 41% of the SEARHEF requests were approved within 24 hours,⁷⁶ a few Member States witnessed a slower turnaround time for release of funds.

Research and development, and evidence generation: Respondents across Member States highlighted that areas like knowledge sharing by building communities of practice and operational research are weaker than required. There is a need to promote the development and application of evidence-based practices and targeted operational research for all-hazards emergency and disaster risk management.

Partnerships: The network of operational partners needs to be mapped and strengthened. In addition, there aren't any formal mechanisms available to Member States to establish intersectoral coordination. Respondents expressed the need to strengthen cross-border and intersectoral partnerships to assess and manage risks and strike meaningful partnerships to enhance the efforts of disaster mitigation.

⁷⁶ World Health Organization. PWC. Evaluation of South East Asia Regional Health Emergency Fund (SEARHEF)-a 10 year milestone. World Health organization. Regional Office for South East Asia. [Internet]. 2019 May 17. [cited 5 August 2020]. Available from: <http://origin.searo.who.int/evaluation-of-searhef-10year-milestone.pdf>

Limited capacity: Various gaps have been observed in the preparedness and capacity for risk management in terms of resources, NFPs, trained personnel, the adaptation of technical guidelines, supply chain management, information and communication technologies and risk communication for emergencies. The capacity of the staff at the subnational level was not optimal and, in some Member States, the capacity of the rapid response teams required strengthening.

Limited availability of data: Most countries indicated the unavailability of quality data on emergencies. If data is at all available, it is not being analysed and is not usable for decision-making or evidence generation. In addition, pandemic plans, operational plans and contingency plans were unavailable.

Recommendations

Additional funds: The success of any programme lies in the right mix and quantity of resource allocation. Proactive resource mobilization and greater investment are required to sustain and consolidate the preparedness-stream related fund through stewardship and inclusion of donors, private sector stakeholders.

Capacity Building: The capacity of Member States must be strengthened by appointing national program officers with technical expertise. There is a need for more training, strengthening of operational partnerships such as EMTs, technical assistance for the development and costing of NAPHS, and the strengthening the operational readiness of WHO country offices.

Strengthen policies and plans: There is a need to strengthen existing national policies, frameworks and regulatory mechanisms. The development and implementation of policies and plans that are most suited to the Region for emergency preparedness, response and recovery must be prioritized.

Advocacy: There is an immense need to advocate to key partners for improved awareness on health issues in emergencies and promote the development and application of evidence-based practices and targeted operational research for all-hazards emergency and disaster risk management.

Success story: Nepal

In response to the 2015 earthquake in Nepal, WHO-SEARO and Nepal WHO country office led the response operations. The Regional Director WHO-SEARO held emergency meeting with the Ministry of Health, immediately activated the health cluster and deployed nearly 100 staff from WHO-SEARO and other WHO offices. Medical supplies and equipment such as Interagency Emergency Health Kits were provided for earthquake relief operations and to set up operational rooms. WHO provided support for coordinating with medical teams and in the assessment and surveillance of activities. Within six hours of the earthquake, WHO-SEARO had also transferred US\$ 175 000 from SEARHEF to Nepal for response and recovery and established a TAG to the Regional Director on post-earthquake recovery in Nepal. The WHO country office continued its technical support in the 14 most affected districts through the work of 10 WHO emergency district support (WEDS) officers.

A year after the earthquake, WHO and the Ministry of Health organized a two-day technical conference in Kathmandu on the lessons learned from the health sector response to the disaster and updated the response capacity in line with the Sendai Framework for Disaster Risk Reduction. In 2016, the primary focus had been on strengthening the capacity of the HEOC established on the Ministry of Health premises and three regional operational centres in Pokhara, Surkhet and Doti. Other actions to increase the health sector's disaster readiness were completed in 2016 and included pre-positioning emergency medicines, supplies and equipment in six designated hub hospitals in Kathmandu, training 1665 health staff at these hubs, 70 satellite hospitals in the Kathmandu Valley in different aspects of emergency care (such as primary trauma care, hospital preparedness for emergencies, basic first aid), and the development of health sector contingency plans in six additional districts, bringing the total to 70 out of 75 districts with these plans in place.

Success story: Bangladesh

In addition to several small-scale emergencies in the Region, the Regional Office provided technical and financial support to the highest-graded emergency caused by the new influx of almost 700 000 Rohingyas in Cox's Bazar, Bangladesh, since late August 2017. The Regional Office mobilized funding support through the SEARHEF mechanism twice to address the various health needs of the population. In addition, more than 100 international experts were mobilized through different mechanisms to provide technical assistance. The Technical Emergency Reference Network (TERN) established by the Regional Director to harness WHO expertise across different programmes was also activated. The Independent Oversight and Advisory Committee (IOAC) of the WHO Health Emergencies Programme (WHE) visited Cox's Bazar to evaluate the response on the ground and met with senior officials at the country office (Dhaka) and Regional Office (New Delhi) to discuss the findings and make recommendations.

3.7 Finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis and yaws)

Relevance

Making NTDs a Regional Flagship Area provided much-needed acceleration through advocacy, political commitment, resource allocation, collaboration and the implementation of treatment regimens.

Globally, NTDs affect more than one billion people and cost developing economies billions of dollars every year.⁷⁷ The SEA Region is disproportionately affected by NTDs with 67% of all new leprosy cases and 60% of all new cases of visceral leishmaniasis (kala-azar) worldwide occurring in the Region, and as many as 850 million inhabitants at risk of contracting lymphatic filariasis.⁷⁸ Efforts to combat NTDs reached a turning point in 2007 when the Global Plan to combat neglected tropical diseases 2008–2015⁷⁹ was laid down to translate the political commitment and strategies into reality. The Organization's 2011 report titled *Accelerating work to overcome the global impact of NTDs: A roadmap for implementation*⁸⁰ proposed the way forward for combating NTDs along with cross-cutting goals, disease-specific targets and key milestones. Leading pharmaceutical companies agreed to donate billions of dollars' of drugs until 2020 guided by a technical strategy devised and managed by WHO, in the London Declaration of 2012.⁸¹ The international community was committed to rooting out these diseases, resulting in the World Health Assembly resolution WHA66.121, which was adopted by the Sixty-sixth World Health Assembly in May 2013.

The Regional Strategic Plan for integrated neglected tropical diseases control in South-East Asia Region 2012–2016⁸² was developed in line with the Global Plan to combat neglected tropical diseases 2008–2015. Considering the massive contribution of the Region to the global burden of NTDs, the WHO–SEARO introduced Regional Flagship Areas in 2014, with finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis, trachoma and yaws) as one of the focus areas.

Declaring NTDs as one the Regional Flagship Areas encouraged the WHO country offices to advocate for prioritizing them in the agendas of health ministries and technical partners. The respondents described the flagships as a complementary tool to enhance the inflow of resources, expressing the thought that donors could see the emphasis that the flagship status brought to NTDs, which helped generate funding for this focus area. The Region benefited with high level political engagement

77 World Health Organization. Neglected tropical diseases. World Health Organization. 2019. Available from: https://www.who.int/neglected_diseases/diseases/en/

78 Narain JP, Dash AP, Parnell B, Bhattacharya SK, Barua S, Bhatia R, Savioli L. Elimination of neglected tropical diseases in the South-East Asia Region of the World Health Organization. *Bulletin of the World Health Organization*. 2010;88:206–10.

79 World Health Organization. Global plan to combat neglected tropical diseases 2008–2015. World Health Organization. 2007 April.

80 World Health Organization. *Accelerating work to overcome the global impact of neglected tropical diseases : a roadmap for implementation : executive summary*. World Health Organization. [Internet]. 2012. Available from: <https://apps.who.int/iris/handle/10665/70809>

81 World Health organization. London Declaration on Neglected Tropical Diseases. World Health Organization. [Internet]. 2012 [Cited 20 July 2020]. Available from: https://www.who.int/neglected_diseases/London_Declaration_NTDs.pdf?ua=1

82 World Health Organization. Regional strategic plan for integrated neglected tropical diseases control in South-East Asia Region, 2012–2016. WHO Regional Office for South-East Asia. [Internet]. 2012. Available from: <https://apps.who.int/iris/handle/10665/205832>

and strong leadership commitment, and the availability of new resources and tools to fast-track implementation and speed up the process of elimination. The intervention of the Organization, specifically in introducing and supporting Member States in the implementation of new treatment regimens, has helped increase the efficiency of the NTD elimination programme. The flagship focus and implementation at the country level have significantly helped improve health outcomes, equity and intersectoral collaboration.

“NTDs was not a national priority. We did not really have commitment at that time to achieve elimination, so because of this flagship, WHO advocated the country and put some resources at the beginning, stimulate and assist country in achieving elimination.” – A ministry official from Indonesia

Effectiveness

Member States have highlighted the effectiveness of WHO's role in providing clear policies, integrated strategies and capacity building for surveillance activities towards the elimination goal.

Articulation of policy documents, guidelines and directives: WHO supported the Member States in achieving the elimination of targeted diseases through the development of a number of frameworks, guidelines and policy narratives. The Regional Strategic Framework for the elimination of kala-azar from the SEA Region (2011–2015)⁸³ provided direction to Bangladesh, India, Nepal, Bhutan, Sri Lanka and Thailand on the attack phase, which focused on actively finding cases and performing rapid point-of-care diagnosis and treatment with a single dose of liposomal amphotericin B at a primary healthcare unit.

The *Global Leprosy Strategy 2016-2020, Accelerating towards a leprosy-free world manual*⁸⁴ was developed through a series of consultations with various stakeholders during 2014 and 2015. Inputs were provided by national leprosy programmes, technical agencies, independent leprosy experts, public health experts, funding agencies and representatives of affected patients and communities.

The strategy was endorsed by the WHO TAG on leprosy. To meet the challenge of containing the disease and being able to respond to an increase in the circulation of drug-resistant strains, it is essential to assess drug-sensitivity patterns globally, as well as to monitor resistance among both new and retreatment cases. WHO released an update to the guide for the surveillance of antimicrobial resistance in leprosy in 2017, and this helped countries to deal with the challenge of drug resistance among patients.

Strategic plans for 2007–2010 for lymphatic filariasis elimination had been developed in line with global targets and strategies that were successfully implemented in the Region. Taking into consideration

Frameworks, Guidelines and Strategic Plans



- LF Regional Strategic Plan (2010–2015)
- Regional Strategic Framework for Elimination of Kala-Azar (2011–2015)
- Regional Strategic Plan for elimination of Yaws (2012–2020)
- The Global Leprosy Strategy 2016-2020 endorsed by the Region

83 World Health Organization. Regional strategic framework for elimination of kala azar from the South-East Asia Region (2005-2015). World Health Organization. Regional Office for South-East Asia. [Internet]. 2005. Available from: <https://apps.who.int/iris/handle/10665/205825>

84 World Health Organization. Global Leprosy Strategy 2016–2020: Accelerating towards a leprosy-free world. World Health Organization. Regional office for South East Asia. [Internet]. 2016 August. Available from: <https://www.who.int/lep/resources/9789290225096/en/>

further progress and the new knowledge and tools available, this strategic plan was revised and updated with the goal of eliminating lymphatic filariasis from the Region by 2020 (the Regional Strategic Plan for elimination of lymphatic filariasis⁸⁵). The key strategies included were a roll-out of mass drug administration (MDA) with diethyl carbamazepine citrate and albendazole, prevention and alleviation of disability, community awareness and mobilization, etc.

The Regional Strategic Plan for the elimination of Yaws from South-East Asia Region (2012–2020)⁸⁶ was developed to eliminate (complete interruption of transmission) yaws in endemic countries by 2016 and thereafter at the SEA Regional level by 2020. The participants recommended that yaws-endemic countries and WHO move forward with a revised regional strategic plan for 2012–2020.

Further, the WHO country offices supported the formulation of various directives for NTDs at the country level across the Member States. The formulation of a national strategic plan in Bangladesh, a lymphatic filariasis elimination plan in Myanmar, a dossier for yaws eradication in India, and a national integrated NTDs control programme in Timor-Leste are some examples.

Technical assistance: WHO provided technical assistance and played a critical role in the planning, supply chain management, training and monitoring of the programme. Similarly, WHO oversaw the NTD programme's progress through the NTD regional programme review groups and approved applications and managed the NTD medicines donated by pharma companies. Management involved planning and forecasting with the help of international partners. WHO's role in engaging with other implementing partners and guiding them towards a common goal was appreciated.

TAGs and a regional task force were established in 2014 to guide and advise the Regional Director on further accelerating progress in the Region and overcoming the challenges identified. In 2014, India adopted single-dose liposomal amphotericin B as first-line treatment, and this has advanced the elimination of kala-azar. Bangladesh and Nepal have also adopted single-dose liposomal amphotericin B as first-line treatment. This culminated in a significant increase in the number of sub-districts that have achieved the elimination target in Bangladesh and India from 2014 to 2015.

"It (WHO) is not only giving technical assistance but also provides support in operational activities like initial activities for Mass Drug Administration at the district level." – A ministry official from Indonesia

"WHO played a critical role in planning, implementation and monitoring of various flagship by recruiting NTD coordinators and Zonal coordinators for the elimination of LF & VL across the 8 highly endemic states of India." – A technical partner from India

WHO-SEARO and country offices provide technical support to Member States in achieving and sustaining national-level elimination and further reducing the burden of leprosy. WHO's assistance to the countries included advocacy at policy levels, assisting countries in mobilizing the required resources

85 World Health Organization. The Regional Strategic Plan for Elimination of Lymphatic Filariasis 2010–2015. New Delhi; World Health Organization. Regional Office for South East Asia. [Internet]. 2010. Available from : http://origin.searo.who.int/entity/vector_borne_tropical_diseases/documents/SEA-CD-203/en/

86 World Health Organization. Regional strategic plan for elimination of yaws from South-East Asia Region 2012–2020. World Health Organization. Regional Office for South-East Asia. [Internet]. 2013. Available from: <https://apps.who.int/iris/handle/10665/205830>

and strengthening partnerships and technical support for activities aimed at reducing the burden of leprosy in the Region further.

WHO's strategy to eradicate yaws using azithromycin for the treatment of cases and contacts (2012) was incorporated in the revised regional strategic plan to hasten the process of elimination of yaws from the SEA Region. A team from WHO visited several areas of Indonesia to assess eradication efforts and review implementation of the national elimination plan.

Thailand and Bangladesh have completed MDA, a key initiative for lymphatic filariasis elimination in all endemic areas with technical support from WHO.

Capacity building: WHO continued to train national programme staff to strengthen their capacity in programme management and address programmatic issues and challenges at the country level. Fig. 41 shows some key examples of capacity building initiatives through the flagship.

Fig. 41: Key capacity building initiatives for Flagship 7



In 2016, WHO supported the training of more than 4200 health-care workers at different levels from 100 upazilas to strengthen surveillance, early diagnosis and prompt treatment of kala-azar cases in Bangladesh.



In Sri Lanka, WHO conducted training for health-care workers on early case detection and morbidity management, and supporting transmission assessment surveys and programmatic reviews.



In India, a pharmacovigilance system for kala-azar therapies was introduced in the accelerated plan and WHO provided training to medical officers and data entry personnel to operationalize the system.



In Maldives, WHO facilitated a training of local doctors and other health-care providers on the management of leprosy. The three-day training with experts focused on the key strategic pillars of the Global Leprosy Strategy.

Monitoring and evaluation: The Regional Office works closely with the WHO country offices and health ministries to build capacity and strengthen surveillance systems for NTDs across Member States to achieve the elimination of yaws, lymphatic filariasis, kala-azar and leprosy in 2020.

In 2016, Thailand conducted the final lymphatic filariasis transmission assessment survey (TAS) required for a formal validation of the elimination of lymphatic filariasis as a public health problem with support from WHO. Also in 2016, a software programme was developed for India to enable it to implement a real-time leprosy surveillance and monitoring system and improve programme performance. The surveillance and monitoring experience gained from India may be useful, with adaptation, in other high-burden countries in the future. WHO also supported a study of post-kala-azar dermal leishmaniasis to identify risk factors and assess the quality of services for patients with this condition in India.

Research and development, and evidence generation: Operational research on NTDs and strengthening the research capacity of Member States were two areas where internal collaboration within the Regional Office was crucial. The extent to which the implementation and monitoring of NTD

control interventions has been facilitated by evidence-based technical guidelines and support varies by country and disease. Some guidelines have helped Member States remain current on changes or advancements made. For example, in 2017, WHO recommended an alternative triple drug treatment, which known as IDA and is a combination of ivermectin, diethylcarbamazine citrate and albendazole, to accelerate the global elimination of LF. Owing to this recommendation, India adopted and scaled up the triple drug treatment in 2018–2019. Further, Timor-Leste and Indonesia will soon be implementing the triple drug therapy. Respondents across several Member States mentioned that through this flagship, WHO played a key role in generating evidence and conducting operational research for policy guidance and the development and implementation of national strategies related to management of NTDs during the evaluation period.



WHO recommended an alternative three triple drug treatment to accelerate the elimination of LF. India adopted and scaled up the triple drug treatment in 2019. Additionally, Timor-Leste and Indonesia will soon implement the therapy.

Advocacy: Through this flagship, there was strong advocacy from WHO for the allocation of more resources for national programmes, to expand them and accelerate interventions to achieve targets. In this regard, there was an increase in resource allocation from both the global and the Regional Office that was channelled to the national programmes, resulting in a significant improvement of the programme coverage. In addition, respondents in some Member States highlighted that WHO-assisted advocacy led to an increase in domestic investment and the national budgets earmarked for NTDs in the Member States. Some key actions related to advocacy during the evaluation period were:

- WHO-SEARO spearheaded and facilitated the signing of the MoU on the elimination of kala-azar from the Region, which reflected the strong political commitment from the top health leadership of endemic countries in the Region to strengthen efforts towards the elimination of the disease. The Dhaka Declaration on Vector-borne Diseases in 2014⁸⁷ was an important regional commitment that includes several of the diseases targeted for elimination.
- A high-level regional ministerial meeting titled “Keeping the Promise: ending NTDs on time in the SEA Region” was held in Indonesia in 2017. The meeting was attended by ministers and high-level delegates from the Region as well as partners supporting NTD programmes in the Region. The meeting concluded with the “Jakarta Call for Action” on accelerating progress towards eliminating neglected tropical diseases endemic in the SEA Region.
- Two important advocacy books were published in 2017. The first, titled *From neglecting to defeating NTDs*⁸⁸, described the status of NTDs in the Region, showed progress, explained the challenges and proposed a way forward with a roadmap. The second publication is a coffee-table book titled *Care over Neglect*.⁸⁹

87 World Health Organization. Dhaka Declaration on vector-borne Diseases. World Health Organization. Regional Office for South-East Asia. [internet]. 2014 September 14. Available from: <http://origin.searo.who.int/mediacentre/events/governance/rc/67/dhaka-declaration-rc67.pdf>

88 World Health Organization. From neglecting to defeating NTDs. World Health Organization. Regional Office for South-East Asia. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/258727>

89 World Health Organization. Care Over Neglect: Neglected Tropical Diseases in South-East Asia Region. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/258909>.

Multisectoral and intersectoral collaboration: During the evaluation period, WHO was successful in bringing about collaboration to tackle NTDs with non-governmental organizations, donors and pharmaceutical companies. WHO collaborated with various stakeholders such as ministries, national and international technical partners (the Bill & Melinda Gates Foundation, the Nippon Foundation, the World Bank etc.) and local NGOs to work towards achieving the common goals set for NTDs in the Member States. In most Member States, each partner's area of work was clearly defined and delineated. WHO was also instrumental in facilitating and arriving at partnerships and agreements with industry, in providing a framework facilitating contributions from donors, administering those agreements, and coordinating the supply chain. Of the approximate 17 different medicine donations, 15 were donated through WHO.⁹⁰

At the SEA Regional level, several attempts were made to strengthen multisectoral and intersectoral partnerships:

- The Bangkok Declaration in 2013 set a global leprosy elimination target of less than one case per million by 2020. WHO is working with the Nippon Foundation, the Novartis Foundation for Sustainable Development and the International Federation of Anti-Leprosy Associations and networks of persons treated for leprosy to create a roadmap for the last mile in leprosy elimination.
- The NTD medicine donation programme delivered 1.762 billion treatments to 1 billion people in 2017 across five preventive chemotherapy diseases (lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis and trachoma).⁹⁰ In April 2017, at the WHO Global Partners Meeting on NTDs, the Brazilian pharmaceutical company EMS pledged to donate azithromycin to support the yaws eradication effort in Indonesia.

Respondents across Member States highlighted that partnerships and collaborations were crucial to work on NTDs. There are a number of players who have played critical roles in leading NTD strategy development, conducting research, donating medicines, implementing NTD activities and generally supporting work on NTDs at the subnational, national and regional levels.

Equity: NTDs are essentially diseases of the people that are left behind. The elimination of NTDs is one more step towards a more equitable world. There are certain activities undertaken by health ministries and WHO country offices to ascertain the equity of health services, addressing gender, socioeconomic and geographical barriers. The distribution of free medication for NTDs across Member States has been a crucial step in addressing equity. Further, WHO supported the ministry in setting up satellite clinics in Sri Lanka, organizing camps at the community level in Bangladesh, conducting a coverage survey in Timor-Leste and engaging with ethnic health organizations in Myanmar. However, the challenges to the equitable availability of NTD-related services included high OoPE in Bangladesh and inadequate monitoring data in Indonesia. Timor-Leste has difficult



WHO supported the ministry in setting up satellite clinics in Sri Lanka, organizing camps at community level in Bangladesh, conducting coverage survey in Timor-Leste and engaging with the ethnic health organizations in Myanmar as an attempt to ensure equitable services are available to all for NTDs.

⁹⁰ World Health Organization. Evaluation of the WHO Neglected Tropical Diseases Programme Volume 1: Report. Pg. 9-15. World Health Organization. [Internet]. 2019. Available from: https://www.who.int/docs/default-source/documents/evaluation/evaluation-ntd-report.pdf?sfvrsn=351a363f_2

geographical terrain, and Myanmar was struggling with ongoing conflict in some parts of the country, making it difficult to universally provide services to treat NTDs.

Efficiency

The allocation of resources for NTDs in terms of funding and human resources improved in the period of evaluation.

The diagnostic large-scale surveys and treatment costs needed to accelerate elimination efforts required additional resources. The initiatives were funded through cooperation with bilateral and multilateral agencies (USAID, Bill & Melinda Gates Foundation, DFAT) supporting national integrated NTD action plans for lymphatic filariasis and soil-transmitted helminthiasis elimination. To sustain these efforts, the capacity of national programme managers had to be strengthened. Despite good donor support in general, there was less interest, especially in smaller Member States, in elimination programmes that would require meaningful and timely assistance.

There were strong advocacy efforts at the regional level to allocate more resources to the ministries of health to help expand the programme and accelerate interventions to achieve targets. A regional task force was established to guide the Regional Director to overcome identified challenges. Free drugs were being provided for lymphatic filariasis, kala-azar, leprosy and schistosomiasis in all endemic countries. Some support on diagnostics for lymphatic filariasis and kala-azar programmes was being provided.

The achievements were supported by various factors such as high-level political commitment, improved resource allocation, strengthening of health systems, and enhanced monitoring.

Factors like the formulation of pertinent directives, good governance, high-level political priorities, adequate resource allocation and well-functioning health systems have contributed to the successful implementation of activities at the Member State level. To achieve the desired goals for NTDs, a strong political commitment and will were present in Member States like India, Timor-Leste, Maldives, Bhutan and Bangladesh. Technical support and expertise, along with the national-level advocacy that WHO brings, also supported the countries in working better in the concerned areas.

Most countries saw an overall increase in funding and human resource allocation. In India, WHO served as the lead agency harnessing partner support and coordinating the procurement and donation of drugs, while a huge component of human resources was mobilized through donor support. Timor-Leste, with WHO's support, started MDA, which was discontinued earlier due to a lack of funding. They were also supported by the Korea International Cooperation Agency (KOICA) to support the implementation of the NTD elimination programme targeting lymphatic filariasis, yaws and soil-transmitted helminthiasis.

“Resource allocation in terms of Kala-Azar has improved drastically. In 2015 there was around 2.8 million for this elimination program. By 2018 it reached to 5.8 million and right now it is 8.4 million.” – A technical partner from India

Sustainability

WHO helped Member States to ensure the sustainability of the flagship by providing various strategic directives; the Regional Office must continue high-level advocacy and sustain the plan of action on post-validation surveillance.

To ensure the sustainability of the NTD programme, the SEA Region supported the formulation of strategic directives and plans for the elimination of targeted NTDs at the country level across Member States. WHO provided technical support to Member States to reduce the burden of NTDs and achieve and sustain national level eliminations. However, for countries that have achieved the elimination targets for any NTDs, there is a need to sustain the plan of action on post-validation surveillance. WHO made efforts to sustain these gains, assisting the countries with advocacy at policy levels, mobilizing the required resources, and strengthening partnerships. The ministries were also encouraged and technically supported by WHO in the process of drafting integrated NTD plans, which included budgetary costing for the necessary interventions. Technical advisory groups and a regional task force were established to guide and advise on accelerating the progress in the Region further and overcoming identified challenges. As a measure of sustainability, the Regional Office worked closely with WHO country offices and health ministries to build the capacity of national programme staff and strengthen surveillance system for NTDs across Member States. WHO also conducted training for and monitoring of the programmes, strengthened the research capacity of Member States and brought in collaborations with implementing partners, NGOs, donors, and pharmaceutical companies. Consistent advocacy from WHO was directed towards allocating more resources for national programmes to expand the programme and accelerating interventions to achieve targets to sustain the progress.

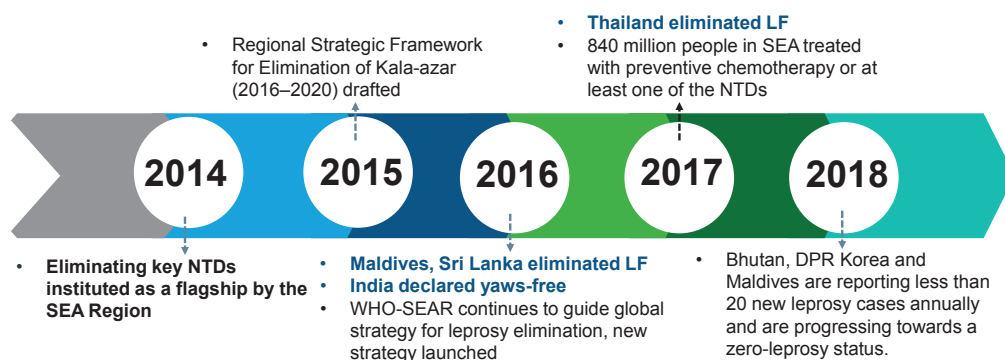
The Member States exhibited political commitment to strengthening the efforts towards the elimination of these diseases. However, deeper commitment is needed to achieve targets. Also, there were some gaps in political commitment once elimination targets were reached. There were other challenges associated with sustainability, such as the low priority of NTDs, limited resource allocation in decentralized settings, a delay in reporting, poor data management, lacunae in regional programme management, and sustaining post-validation surveillance. The Regional Office must continue high-level advocacy through multiple partner channels to ensure political commitment in countries in the post-elimination phase, and adequate resource mobilization in endemic countries for disease elimination.

“Government is interested in sustaining the progress so far, they are trying to recruit people, allocate money, and making both TB and NTDs as the priority areas.” – A ministry official from Bangladesh

Impact

All the 11 Member States have eliminated leprosy as a national health problem while 3 Member States have eliminated lymphatic filariasis.

Despite bearing the second-highest NTD burden globally, the Region’s progress in eliminating NTDs has been significant. Fig. 42 lists the Region’s achievements from 2014 to 2019:

Fig. 42: Key achievements of the SEA Region (2014–2018) for Flagship 7

Source: Global Health Observatory, WHO

In 2016, Maldives and Sri Lanka eliminated lymphatic filariasis, while Thailand did so in 2017. India was declared yaws-free in 2016. By 2018, Bhutan, DPR Korea and Maldives reported less than 20 new leprosy cases annually and have progressed towards a zero-leprosy status. This progress is due to the combined efforts of WHO, ministries of health and technical and donor partners. Table 9 highlights the status of the flagship NTDs elimination as of 2018.

Table 9: Status of NTDs across Member States, 2018

Countries	Kala-Azar	Leprosy	Lymphatic Filariasis	Yaws
Bangladesh	●	★	●	●
Bhutan	●	★	●	●
Democratic People's Republic of Korea	●	★	●	●
India	●	★	●	★
Indonesia	●	★	●	●
Maldives	●	★	★	●
Myanmar	●	★	●	●
Nepal	●	★	●	●
Sri Lanka	●	★	★	●
Thailand	●	★	★	●
Timor-Leste	●	★	●	●

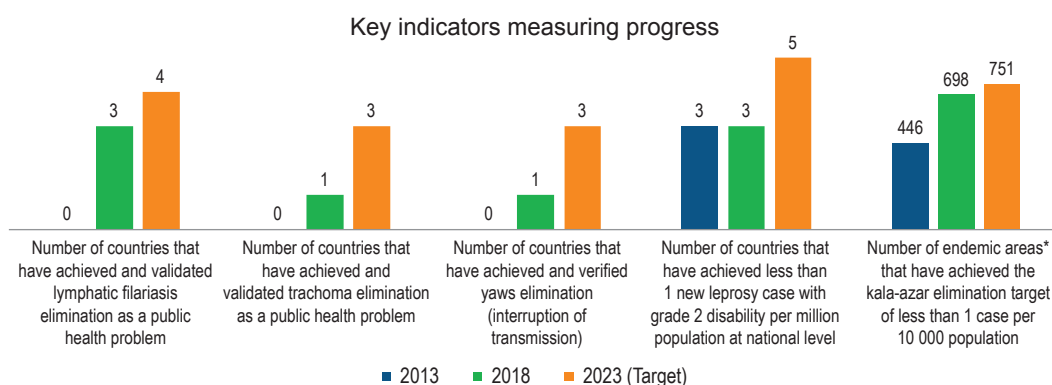
Legend:

- Endemic
- Not endemic
- No autochthonous cases reported
- Previously reported cases
- No previous history
- Previously endemic (current status unknown)
- ★ Eliminated as a public health problem

Source: Global Health Observatory, WHO

Myanmar, Sri Lanka and Thailand have eliminated LF as a public health problem while Bangladesh is expected to achieve the same by the end of 2020. India achieved the yaws free status in 2016 and it is expected that Indonesia and Timor-Leste will be declared yaws free by 2023. Fig. 43 shows key indicators tracked by the Region for this flagship along with the progress achieved.

Fig. 43: Key indicators measuring progress for Flagship 7



Source: WHO SEARO flagship flyer 2019

Challenges

Limited resources and inadequate political commitment during post-elimination surveillance:

Once the elimination target is achieved, there is a decline in the funds available to conduct post-elimination surveillance as countries lose momentum and commitment. Also, it has been observed that WHO's support (technical as well as financial) for surveillance diminishes during the post-elimination stage.

Resource scarcity for efficient procurement and service delivery: WHO provided drugs to cure NTDs to national programs, but the health ministry procurement systems were not sufficient to cater to the country's drug needs, for reasons such as a longer lead time and limited suppliers for NTDs drugs.

Data management: Delays in reporting, poor data quality, and the inability to take timely corrective measures based on local data were some of the other challenges faced by Member States. Cross-border surveillance and information-sharing can be improved.

Recommendations

Advocacy: WHO must continue high-level advocacy through multiple partner channels to ensure political commitment in countries in the post-elimination phase and adequate resource mobilization in endemic countries to eliminate the disease. Enhanced advocacy is required for effective compliance with existing treatment combinations and the early uptake of new recommended treatment strategies such as the triple drug therapy for lymphatic filariasis.

Partnerships: WHO needs to accelerate its quest to collaborate with key partners to tackle NTDs. It has been observed that there has been minimal engagement of the private sector in this flagship at country level. In addition, WHO should encourage donors to adopt an integrated approach to NTDs and ensure intersectoral collaboration within WHO and externally.

Improved quality of data management: WHO can support Member States in designing and implementing web-based surveillance and monitoring platforms with trackers for diseases to have real-time data that will further facilitate evidence-based decision-making and lead to focused interventions as per the gaps identified. In addition, to improve the quality of data being collected, training workshops and refresher training can be provided to field and program officers with a focus on data collection, analysis and interpretation.

Success Story: Maldives (lymphatic filariasis)

Maldives was the first country in the SEA Region to be certified to have eliminated lymphatic filariasis in 2016, demonstrating how far it had come both in addressing the disease's biosocial components and enhancing its technical capacity to defeat the parasites that cause it. While attempts were made to tackle the disease, progress was slow. In recent years, however, political commitment has been strong, allowing health authorities to sustain MDA campaigns that provided at-risk communities with several rounds of preventive drugs annually. This occurred alongside mosquito control efforts and a greater emphasis on case identification and treatment. Robust and sensitive surveillance proved crucial to overcome last-mile challenges. It gave health authorities the ability to better target interventions and overcome hurdles in the campaign's final stages. Importantly, the infrastructure in place will help sustain the elimination status. For Maldives's health authorities, the psychological power of success is likely to hasten momentum in the battle against NTDs specifically, and in forging other public health gains broadly.

Success story: India (yaws)

WHO has partnered with the Government of India and provided technical inputs and modest financial support for some critical activities. WHO's assistance included technical advice, advocacy, vehicles for use in endemic areas, the sensitization of key stakeholders at community level, the establishment of surveillance systems, capacity building of health personnel, and monitoring and evaluation. The strategy was kept simple yet effective with a biannual pre-and-post-monsoon active house-to-house search followed by the treatment of cases and contacts. This was supplemented by strengthening the capacity of health personnel in the identification and management of the disease, strong surveillance, advocacy and community awareness, and intersectoral coordination with other concerned departments, such as the department of tribal welfare. To promote self-reporting and referrals, the programme also introduced cash incentives for patients as well as informers.

3.8 Accelerating efforts to end TB by 2030

Relevance

Identifying TB as one the flagships accelerated the ongoing work in TB and boosted activities for a strategic shift in approach from controlling to ending TB.

The WHO SEA Region bears a disproportionate burden of TB. In 2015, the 11 countries of this Region accounted for 25% of the world's population but 40% of global TB deaths, the highest of any of the WHO regions.⁹¹ The Region includes India and Indonesia, two countries with high absolute numbers of TB cases that together account for an estimated 37% of global TB incidence.⁹² With respect to the global initiative (to end the global TB epidemic, 2014), a key ministerial meeting in 2017 led to a unified commitment from the Member States of the Region and the adoption of the Delhi Call for Action⁹³, a pledge to fast-track efforts to end TB. This shaped the eighth Regional Flagship Area, accelerating efforts to end TB by 2030. While there has been a steady decline in incidence, the targets can only be achieved realistically with a fast-track approach to completely control and stop TB.

Declaration of TB as a flagship helped the Member States to strengthen their ongoing response to TB, since it already was a high-priority area for the Region. The countries were already developing strategies and policy guidelines, but the advent of the flagship resulted in focussed action and directives to develop fast-action plans. There has been a strategic shift in the approach, with the goalpost shifting from controlling the disease to ending it. Across all Member States, it was clearly evident that TB was being accorded more weight and priority than before, whether through leadership, on-ground action or collaboration and partnership. To this end, multi-dimensional efforts and initiatives have been rolled out. Strategies, operational plans and guidelines were designed and are currently in use in most of the Member States.

Effectiveness

With the institution of this flagship, ending TB gained attention at the highest political level and almost all heads of state issued political statements underpinning the importance of their TB programmes, due to WHO-led advocacy. Additionally, WHO's technical support for developing strategic plans, adopting diagnostic tools and setting treatment guidelines has proved instrumental in achieving progress in battling TB.

Articulation of policy documents, guidelines and directives: The Regional Strategic Plan for TB (2016–2020)⁹⁴ provided guidance to Member States in updating their national strategic plans.

91 World Health Organization. Global tuberculosis report 2018. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO [Internet]. [cited 30 June 2020]. Available from: 2018. https://www.who.int/tb/publications/global_report/gtbr2018

92 Pai M, Memish ZA. New tuberculosis estimates must motivate countries to act. *Journal of epidemiology and global health*. 2017 Feb 14;7(2):97-8.

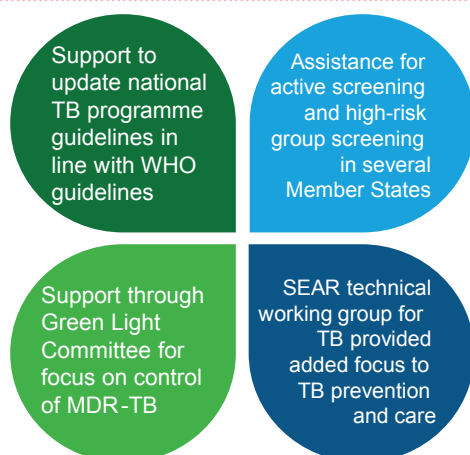
93 World Health Organization. Call for action: ministerial meeting towards ending TB in the South-East Asia, 15-16 March 2017, New Delhi. World Health Organization. Regional Office for South-East Asia. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/255553>

94 World Health Organization. Ending TB in the South-East Asia Region: Regional Strategic Plan 2016-2020. World Health Organization. Regional office for South -East Asia. [Internet]. 2016. Available from: <https://apps.who.int/iris/handle/10665/205065>

The South-East Asia Regional Response Framework for DR-TB 2017–2021⁹⁵ complemented the Regional Strategic Plan and outlined key strategies for reducing the morbidity, mortality and transmission of drug-resistant TB (DR-TB). By fully implementing this Response Framework, the Region will be on track to achieve the overall goal of ending TB. The Plan anticipated that, by 2021, all Member States will have fully implemented the WHO guidelines on multi-drug-resistant TB (MDR-TB) management and there will be universal access to quality-assured services for all those who need them. Also, the Regional Office worked on modelling exercises for the management of latent TB infection. The model quantified the resource gap and supported Member States in understanding the prevention coverage targets that need to be met when implementing the new WHO guidance on latent TB infection treatment. A regional workshop on the transition plan for implementing recent WHO guidance on DR-TB and latent TB infection was organized in late 2018, in which 10 out of 11 Member States participated. Based on technical presentations and extensive deliberations, Member States drafted plans for implementation of recommended diagnostics and treatment protocols for DR-TB and latent TB infection.

Technical assistance: WHO continued to coordinate with partners to provide technical and financial support for national TB control programmes. All 11 countries addressed the following priorities: increased case finding and notification, improved treatment outcomes and improved diagnosis and management of MDR-TB. Bangladesh, Bhutan, DPR Korea, Nepal, Sri Lanka and Timor-Leste were supported in revising their TB programme guidelines and bringing them in line with WHO guidelines. All countries in the Region adopted accelerated case finding using active screening. Bangladesh, Bhutan, India, Indonesia, Sri Lanka, Thailand and Timor-Leste conducted high-risk group screenings.

Fig. 44: Key highlights: technical assistance for Flagship 8



Efforts by Member States to control MDR-TB received special support through the regional Green Light Committee (GLC) (MDR-TB advisory committee) Secretariat, housed in the Regional Office. WHO assisted Member States in adopting recent WHO recommendations regarding diagnostics, newer drugs and shorter treatment regimens for MDR-TB cases that should help improve the performance

⁹⁵ World Health Organization. South-East Asia Regional response framework for DR-TB, 2017-2021. World Health Organization. Regional Office for South-East Asia. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/259812>.

of national TB programmes. MDR-TB support missions were held in nine Member States of the Region through the regional Green Light Committee mechanism. The SEA regional technical working group on TB care and prevention (SEAR TWG-TB) for South-East Asia provided a forum for technical discussion and advice in the field of TB care and prevention throughout the WHO SEA Region in line with the End TB Strategy.

Capacity building: WHO supported the training of national programme staff to strengthen their capacity in programme management and address programmatic issues and challenges at the country level. The Regional Office also worked with countries on modelling exercises to determine the resources needed to fast-track interventions to achieve the End TB targets by 2030. Several Member States participated in the workshop and were sensitized on modelling processes and the real-time monitoring of data. The Regional Office organized workshops for Member States to build capacity on molecular tests for the diagnosis of DR-TB as well as active drug safety monitoring and management. In addition, national consultations on ending TB were facilitated in Sri Lanka, while country support missions were organized in all 11 Member States in 2018. With WHO's support, the capacity of health workers to use improved methods for TB diagnosis and treatment was strengthened. Health workers were trained in clinical management, case detection, data collection and analysis, and epidemiology in Timor-Leste. Also, WHO conducted training for medical officers on the guidelines for patient care and treating drug-susceptible TB in Bhutan.

Monitoring and evaluation: In the global effort to end TB in the next few years, stringent reviewing and monitoring of programs and initiatives is absolutely essential. In each of the Member States, several activities are ongoing, including joint monitoring missions, external reviews and evaluations.

WHO also assisted several Member States with TB surveillance studies. These include TB prevalence surveys conducted in Bangladesh, DPR Korea, Myanmar and Nepal, and planned in India and Thailand. With MDR-TB being such a huge challenge, the WHO drug resistance surveys were seen as significant across Member States. The Regional Office, with the country offices, assisted the Member States in finalizing protocols for drug resistance surveillance in Bangladesh, Sri Lanka, Timor-Leste and Thailand.

Research and development, and evidence generation: Reflecting the aspirations of the Region with respect to TB, the Regional Office commissioned research in 2018 to suggest options for ending TB on time. This research study, *Ending TB: Invest Now or Pay Later*⁹⁶, provided an analysis of the resources needed and gaps identified in the Region, which further guided the Member States on additional investments needed. Before this research, in 2017, WHO published a report on fast-tracking TB control in the Region, a technical companion piece to the Bending the TB Curve acceleration plan for the Region.⁹⁷ This report provided technical justification for the strategic shifts needed to end TB and the corresponding resources needed to implement the strategies. In Indonesia, a TB inventory study was conducted with WHO support, the purpose of which was to directly measure the level of underreporting of detected TB cases in

Research and Development



- **Thailand, with WHO assistance, became one of the first Asian countries to develop a TB research agenda.**
- **Operational research found a significant place in the NSPs of six countries.**
- **Two countries have plans to address development of new tools for diagnosis of TB and DR-TB.**

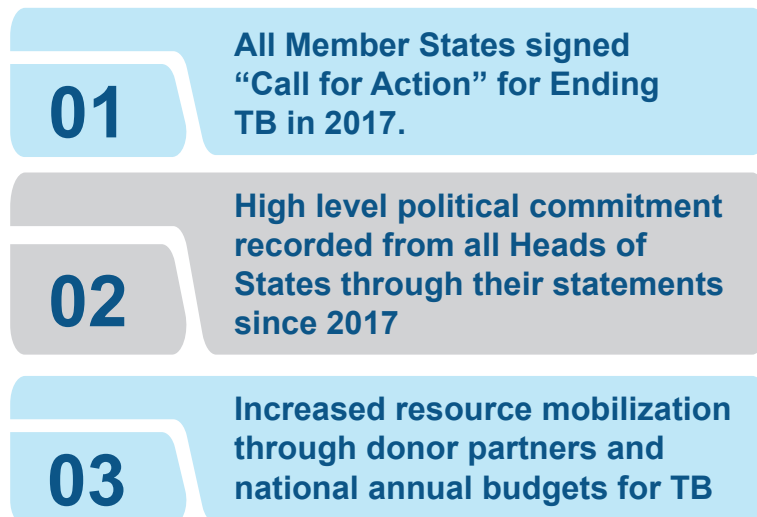
96 World Health Organization. *Ending TB: Invest Now or Pay Later*. World Health Organization. Regional Office for South-East Asia. [Internet]. 2018. Available from: <https://apps.who.int/iris/handle/10665/272489>

97 World Health Organization. *Bending the curve: ending TB in the WHO South-East Asia Region, 2*. World Health Organization. Regional Office for South-East Asia. [Internet]. 2017. Available from: <https://apps.who.int/iris/handle/10665/258693>

the national TB surveillance system. Furthermore, Thailand, with WHO's assistance, became one of the first Asian countries to develop a TB research agenda using a participatory and intellectually rigorous process that involved top academicians, health ministry officials and civil society representatives. However, the capacity of Member States to undertake research, specifically product research, varied significantly. Operational research found a significant place in the national strategic plans (NSPs) of six countries, while four others have included elements of operations research to some extent. Two countries out of 11 have plans to address the development of new tools for diagnosis of TB and DR-TB. Thus, having a funding mechanism for research is essential to expediting the introduction and expansion of new tools of diagnosis, treatment and prevention as they become available, and thus to fast-track ending TB.

Advocacy: The Region has demonstrated leadership in galvanizing political commitment to ending TB in the Region by 2030. The momentum began to build in 2017, in the first ministerial meeting in Asia on TB, with the specific objective of generating political commitment to the 'End TB' goals. All Member States of the Region signed the Delhi Call for Action for Ending TB in the WHO SEA Region. Since the issue of the Call for Action, Bhutan started formulating the terms of reference for a multisectoral committee, Bangladesh committed to developing and adopting the shorter regimen for MDR-TB, India's TB programme was reviewed by the Prime Minister himself, and the President of Maldives himself gave a call to fast-track the ending of TB. India and Sri Lanka expressed a bold vision of ending TB by 2025.

Fig. 45: Key highlights: advocacy for Flagship 8



In 2018, the momentum continued to build, with another high-level meeting in Delhi, where Member States discussed progress since the Delhi Call for Action and adopted a statement of action to operationalize the elements of the Delhi Call for Action in all Member States. Since the institution of this eighth flagship focusing on TB, high-level political commitment has been recorded from all heads of state through public statements. WHO supported the advocacy initiatives of the Member States by conducting ministerial meetings, workshops and awareness generation activities on World TB Day. In Indonesia, the Ministry of Health issued, for the first time, a decree making TB a mandatory notifiable

disease. In Myanmar, following WHO's advocacy, TB was made a mandatory notifiable disease and the health ministry secured additional investment from The Global Fund and the Access to Health Fund for TB activities. The Royal Thai Government increased its commitment and funding to fast-track effective strategies to end TB. In India, the control of TB became a top government priority with the approval of a new NSP for TB elimination by the Ministry of Health and there was a four-fold increase in the annual TB budget. Overall, the respondents across Member States accredited WHO's role in gaining attention at the highest level for the ending TB initiative in the Region.

“WHO's advocacy plays a very important role in progress as they bring the policy makers together, at least once a year and provide advocacy messages. They highlight that how the funding or contributions made to the National TB programme will be crucial and lead to greater returns and how it's going to minimize the TB burden in the long term, thus, emphasizing on the need to invest now and especially for Ending TB in Maldives and in the Region” – A ministry official from Maldives

Multisectoral and intersectoral collaboration: To accelerate the efforts to end TB in the Region, WHO coordinated technical collaboration and strong partnerships with a number of international and national organizations, donors and other partners. These include BRAC, Global Drug Facility, The Global Fund, Médecins Sans Frontières, Stop TB Partnership, the TB Alliance, the Union, UNITAID, USAID, World Bank and others. Member States made a commitment to end TB using a multisectoral approach at the Global Ministerial Meeting on TB in Moscow in November 2017, during which the Moscow Declaration on TB was adopted.⁹⁸ Additionally, WHO worked closely with the health ministries of several Member States to collaborate with other relevant ministries, such as the education, human rights, law, labour and finance ministries.

Across Member States, several efforts have been made to bring about this collaboration for resource mobilization and the better adoption and implementation of NSPs. Additionally, Member States and WHO intended to supplement medical care for TB with patient-centred, community-empowering, necessary social and financial protection in a holistic manner through collaborations across and beyond the health sector in every country of the Region. For example, Sri Lanka and India have started providing nutritional support to all TB patients while several other countries have project-based nutrition support (mostly funded by the Global Fund, the World Food Programme in DPR Korea). In 10 of 11 countries, there are plans to engage with civil society organizations for community engagement, though the nature of engagement is highly variable and very few actually aim to build the capacity of civil society organizations and community-based organizations.



Ten of eleven Member States have plans to engage with civil society organizations (CSOs) for community engagement, though the nature of engagement is highly variable. Five countries in the Region have well laid out plans to engage sectors outside the NTPs, while three more address it partially.

Furthermore, several TB patients seek care in sectors outside the national TB programme (NTP). It is important that all such patients get quality care and that those outcomes are reported to the NTP. Five countries in the Region have well laid-out plans to engage sectors outside the NTPs, while three

98 World Health Organization. Ministry of Health of Russian Federation. Moscow Declaration to End TB. First WHO Global Ministerial Conference; Ending TB in the Sustainable Development Era: A Multisectoral Response – Policy Briefs. Geneva: World Health Organization. Ministry of Health of Russian Federation. License: CC BY-NC-SA 3.0 IGO. [Internet]. 2017. Available from: https://www.who.int/tb/features_archive/Moscow_Declaration_to_End_TB_final_ENGLISH.pdf?ua=1

more address it partially. However, sectors outside the NTPs often fail to notify the public health authorities of TB cases. In its efforts to end TB through a multisectoral approach, India 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.

Equity: As the Region continues to battle TB, all countries in the Region have adopted the principles of a patient-centred approach in their plans. However, actual action on the ground in support of this has been varied. According to a snapshot assessment conducted in 2018 to evaluate the progress of the Region after the Delhi Call to Action, only 2 out of 11 countries may meet the targets of zero catastrophic costs by 2020.¹⁴ Member States have also identified that the national programmes need to reach out to those who have limited access to any kind of formal service. Thus, accelerated case finding using active screening activities is being adopted by all countries of the Region. High-risk group screenings were being done in Bangladesh, Bhutan, India, Indonesia, Myanmar, Sri Lanka, Thailand and Timor-Leste.

Several steps have been taken by Member States to ensure equity during programme planning and implementation. Direct benefit transfer schemes for TB patients, such as the one in India, were another positive step towards ensuring equity. Other countries were also providing small disability pensions (in Thailand for MDR patients), or patient transport support. However, this is rarely systematic, and in some cases this support is totally donor-dependent. In India, a committee was set up to address issues related to TB and women, which looked into the barriers to women accessing care. Nepal, Myanmar, Maldives and Thailand provided increased access of services to priority populations (mostly migrants) and better insurance coverage. Timor-Leste emphasized how they integrated TB into the Mother and Child Nutrition programme by screening malnourished mothers and children for TB.

Efficiency

The allocation of resources in terms of additional funding was significantly increased after the advent of the flagship.

TB services became part of the essential package of health services due to the relatively high returns on TB control, with the economic case being that TB treatment is low-cost and highly effective and gives an individual roughly 20 additional years of life. Reducing deaths from TB would generate a benefit of US\$ 43 per dollar spent.⁹⁹ Likewise, the costs of inaction are huge. The Stop TB Partnership warned that a five-year delay in funding TB research and development could result in additional 8.4 million TB cases and 1.4 million TB deaths by 2030, which equates to over US\$ 5 billion in excess of treatment costs.¹⁰⁰ Although TB-related costs are expected to decline in the Region with TB interventions increasing markedly, more resources are still needed to meet the public health expenditure.

In India, WHO is very closely aligned with the government in running the TB programme, including capacity building, health systems strengthening, treatment, diagnostics, supply chain management, developing policies, guidelines, the national strategic plan, and the implementation of these plans

99 World Health Organization. Global Tuberculosis Report. World Health Organization. 2019.[Internet]. Available from: <http://www.who.int/tb/data/en/>

100 World Health Organization. Stop TB Partnership. The Paradigm Shift 2016–2020: Global Plan to End TB. World Health Organization: Geneva, Switzerland. 2015

through a large network of consultants. With the approval of a new NSP for TB Elimination by the Ministry of Health and Family Welfare, there was a four-fold increase in the annual TB budget. In Indonesia, too, the health ministry received the full support of WHO on its TB programme. These working relationships also include bringing together additional departments and ministries. In Indonesia, for instance, WHO hosted a meeting with the Ministry of Law and Human Rights, Ministry of Education, Ministry of Home Affairs. This helped them to address the role of other departments and ministries in the NSP.

The overall changes in funding and HR allocation have been noted in the area of TB mainly in India, Bangladesh and Indonesia, which bear a majority of the burden. Indonesia mentioned receiving additional funding to address communicable diseases, particularly TB. Nepal also optimized its portfolio by securing active donor funding once TB was declared a Regional Flagship Area. The human resources, however, did not see a similar raise in terms of allocation. Timor-Leste, Myanmar and Nepal mentioned that, despite the increased focus on TB, there was not much increase in the human resources allocated to the flagship.

The Ministry of Health in Bhutan had a clear set of priorities to focus on in terms of TB, some of them being improving access to quality diagnostic services, intensifying the diagnosis of childhood TB cases, identifying TB among marginalized and vulnerable populations, improving active case finding and referral of TB symptomatic patients, providing standardized treatment for all forms of TB and ensuring an uninterrupted supply of TB drugs, increasing awareness, advocacy and screening programmes, and strengthening supervision and monitoring.

Sustainability

The main factors ensuring sustainability included advocacy, political will and resource allocation, encompassing an overall commitment to strengthening health systems and major progress towards universal health coverage, though the funding gap is a threat.

This flagship was established after witnessing the tremendous commitment of Member States and partners in 2017, which improved sustainability from the beginning. The Region has supported review and revision of NSPs for TB, improved outreach through universal access to recommended diagnostic and treatment services, and allocated greater financial and human resources, commensurate with the need for ending TB. There was also an increased political will and commitment, including key regional initiatives like the Delhi Call for Action, that underscored steps to accelerate progress against TB. To sustain progress, the technical support needs of Member States are assessed on an annual basis by the Regional Green Light Committee, and most countries have strengthened their field-based surveillance, developed tools and integrated data into their health management information systems. It has also been observed from the evaluation data that Nepal, India and Indonesia significantly increased their funding and political support, while others received strong support from donor partners like the Global Fund.

“So last year we started to design all the data field what is required for actual surveillance for the TB, and integrate with the HMIS, this is going to be a good activity if you could sustain it. So as soon as this becomes as part of HMIS, even TB program doesn't have to fund it in the long run.” – A ministry official from Nepal

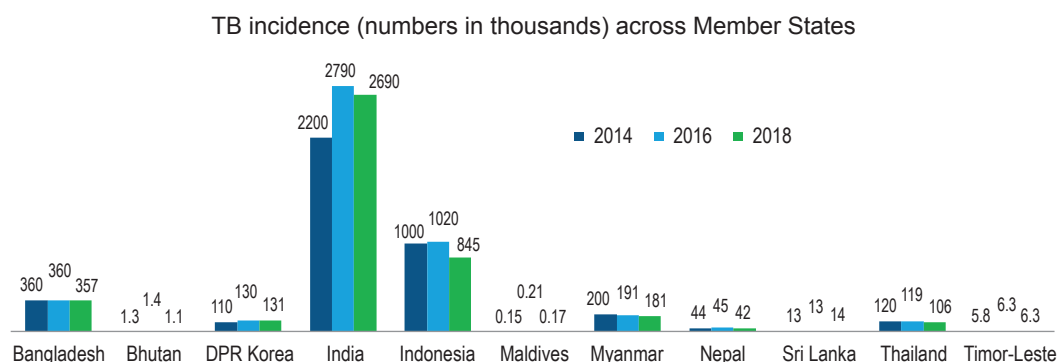
Although the six high-burden countries have substantially increased their budgets since 2017, some of the programmes in the Region remain severely under-funded, with a gap of more than US\$ 1 billion across the Region³, affecting the sustainability of the progress. WHO is advised to continue their support to the Member States and keep TB high on their political agenda by mobilizing additional resources to end the epidemic. Furthermore, Member States should be encouraged to accelerate and innovate the creation of new diagnostics available to large population, rolling out drugs to combat MDR-TB, intensify active case finding, and address latent TB infections among other interventions.

Impact

This flagship was instituted in 2016 (hence, data included in this section is for 2014, 2016 and 2018). Since then, TB incidence has declined in 8 out of 11 Member States. However, all the efforts made under the aegis of the flagship will require time to show their results in the coming years.

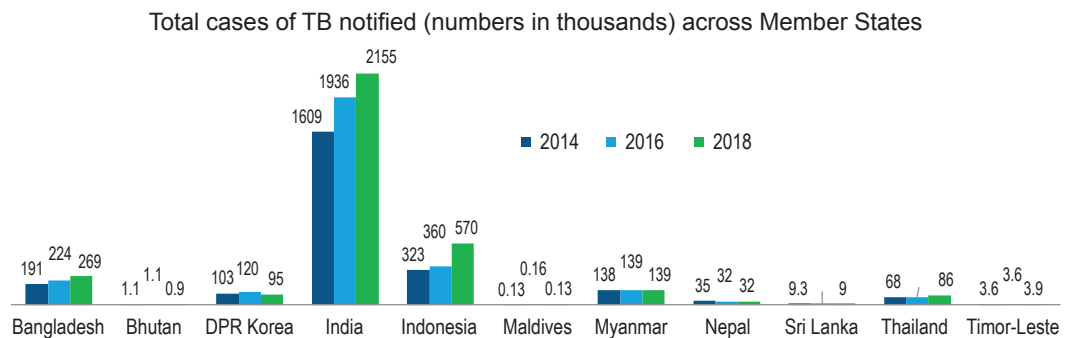
Despite bearing the highest TB burden globally, the Region's progress in addressing TB has been significant, as a result of the combined efforts of WHO, health ministries, and technical partners. The SEA Region has 6 out of 30 high TB burden countries in the world: Bangladesh, DPR Korea, India, Indonesia, Myanmar and Thailand. From 2016 to 2018, the incidence of TB declined in 8 out of 11 Member States, (Fig. 46). Also, multidrug-/rifampicin-resistant TB (MDR/RR-TB) incidence declined in all Member States except Timor-Leste, where a rise of 14% MDR/RR-TB cases was observed. Bangladesh and Indonesia showcased a decline of 33% and 25% respectively for MDR/RR-TB cases, the most marked decline across all Member States.

Fig. 46: TB incidence in the SEA Region

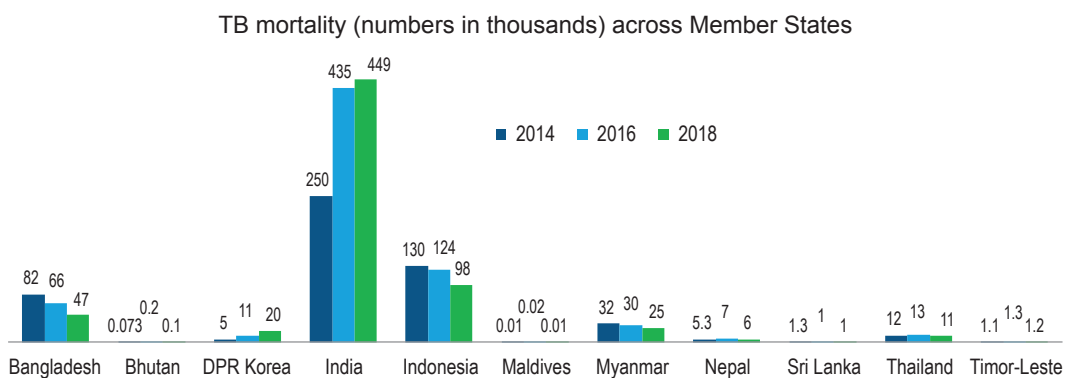


Source: Global TB Report – 2015, 2017, 2019

The notification of TB increased in 6 out of 11 Member States of the Region (Fig. 47). India and Indonesia have exhibited a marked increase in the number of notifications due to a strong political commitment, with the introduction of a national policy of mandatory notification (in India since 2012 and in Indonesia since 2015).

Fig. 47: TB cases notified in the SEA Region

Source: Global TB Report – 2015, 2017, 2019

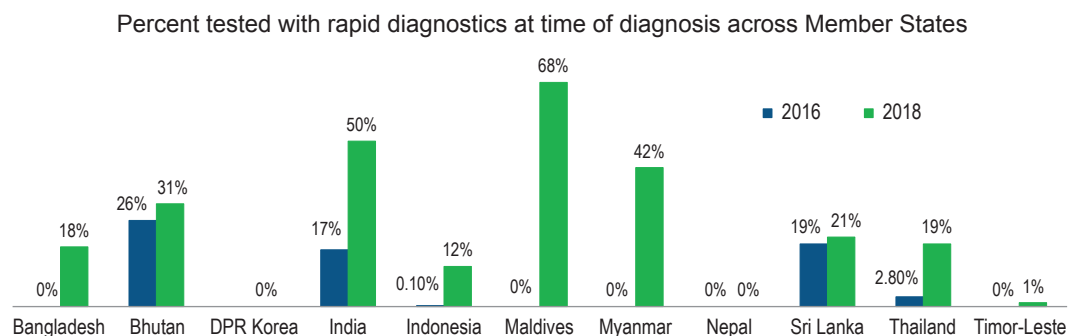
Fig. 48: TB mortality in the SEA Region

Source: Global TB Report – 2015, 2017, 2019

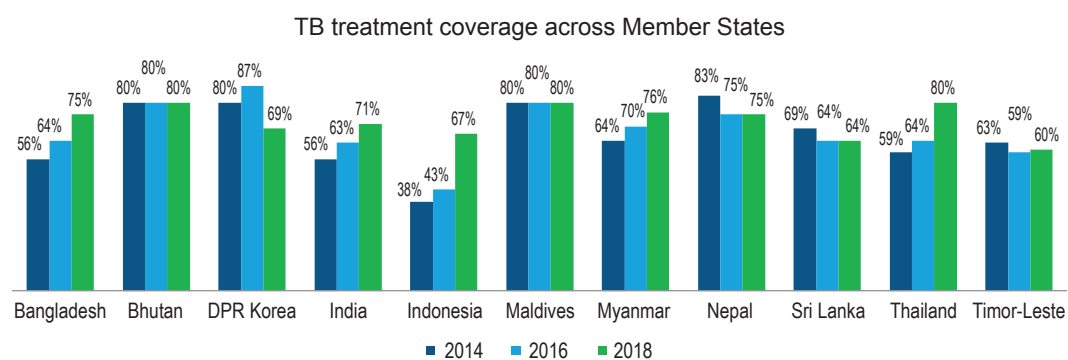
The WHO SEA Region accounts for 44% of the global TB incidence and more than half of the global TB mortality.¹⁰¹ The Region has enhanced investments in innovation, improved the outreach through community and allocated greater financial and human resources commensurate with the need for ending TB. From 2016 to 2018, all Member States showcased a decline in TB mortality except India (Fig. 48). In 2018, India accounted for 35% of global TB deaths among HIV-negative people and 30% of the combined total number of TB deaths in HIV-negative and HIV-positive people.

In 2016, the uptake of rapid diagnostics was very low across the Region. In 2018, India, Maldives and Myanmar showcased a pronounced rise in the utilization of rapid diagnostics at the time of diagnosis of TB. This is largely due to the deployment of GeneXpert machines across major testing sites in these countries.

¹⁰¹ World Health Organization. Tuberculosis in South-East Asia Region. World Health Organization. Regional Office for South-East Asia. [Internet]. [Cited 20 July 2020]. Available from: <https://www.who.int/southeastasia/health-topics/tuberculosis>

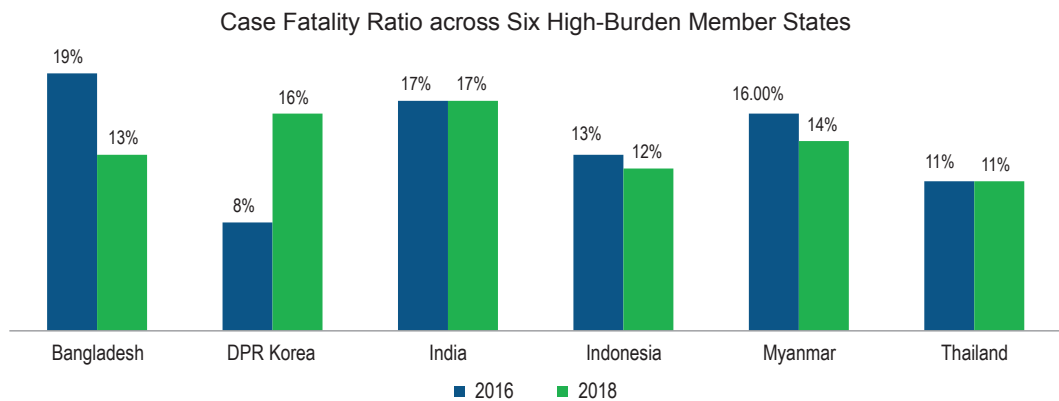
Fig. 49: Uptake of rapid diagnostics in the SEA Region

Source: Global TB Report – 2017, 2019

Fig. 50: TB treatment coverage in the SEA Region

Source: Global TB Report – 2015, 2017, 2019

Two key indicators for measuring the progress of UHC and social protection for TB are TB treatment coverage and case fatality ratio (CFR). In 2018, five out of six high-burden Member States displayed an increase in treatment coverage, with Indonesia showcasing the largest increase of 24%, from 43% in 2016 to 67% in 2018. DPR Korea is the only country to experience a decline in treatment coverage. Bhutan, Maldives and Sri Lanka maintained the status quo. For the Region overall, the case fatality ratio was constant at 15% from 2016 to 2018. However, a variation was observed in four out of the six high-burden Member States of the Region.

Fig. 51: Case fatality ratio in the SEA Region

Source: Global TB Report – 2017, 2019

Challenges

Research and evidence generation: Increased attention is being given to both implementation and clinical research. This, however, is not at par with the speed and investment needed to meet the fast-track targets as demanded by some Member States.

Multisectoral collaboration: Multisectoral collaboration appeared to be an ongoing challenge for NTPs in all countries as it needs the engagement of partners beyond the Ministry of Health. Member States do not have a formal structure or mechanism for multisectoral collaboration with clearly laid-down roles and responsibilities for all partners, thus leading to delays. For instance, private providers often fail to notify the public health authorities of TB cases and roadblocks in progress. Additionally, collaboration with the private sector has been limited in most Member States.

Limited resources and capacity: Most countries still struggle with inadequate quantities of testing machines, or face challenges in operationalizing the existing ones. The low technical capacity of the existing human resources and service delivery challenges were identified in some Member States.

Funding gaps of more than US\$1 billion: Although the six high-burden countries have substantially increased their budgets since 2017, with India almost doubling the levels from 2016, some of the programmes in the Region remain severely under-funded. An additional investment of US\$ 1.3 billion per year is needed in the Region.³

Recommendations

Sustained advocacy: WHO is advised to continue advocacy activities to ensure high-level political commitment from key stakeholders (inside and outside the health ministries) which will be instrumental to ensuring the implementation and monitoring of NSPs that are crucial to ending TB.

Additional focus on research and development: WHO may lay additional focus on research to address the development of new tools for the diagnosis of TB and DR-TB, and innovative approaches for the adherence to treatment and prevention to expedite ending TB. This would require funding for research and innovation in most countries.

Accelerated efforts for capacity building: The capacity of the health workforce when new/revised guidelines are implemented should be built, and user-friendly, readily-available training content should be made available to them to refer to or update their skills while they perform their duties in the field.

Innovate to garner additional funding: WHO-SEARO should commit to finding innovative ways of seeking additional donors to support the diagnostic requirements for countries based on the results of evaluation gaps.

Success Story: India

India has the largest number of TB cases in the world – over a quarter of the global TB and MDR-TB burden.¹⁰² Thus, in recognition of these alarming statistics and to consolidate the achievements of the previous NSP, the NSP 2017–2025¹⁰³ was developed with technical support from WHO. It was aligned with the Global End TB Strategy. Additionally, in 2017, India demonstrated stronger political commitment to end TB as the Government of India announced a plan to eliminate TB by 2025 during the annual budget. This commitment was further consolidated by the special attention the Prime Minister gave to ending TB. In addition to announcing TB elimination as a national priority, he requested all the heads of state governments to make it a priority and have a clear coordination plan for the quarterly review of the programme. Some states saw their chief ministers or health ministers take up the cause and develop their own action plans in line with the NSP.

India took up a number of initiatives to achieve the ambitious target of ending TB by 2025. To accelerate the diagnosis of TB in India, WHO partnered with Foundation for Innovative New Diagnostics (FIND), India and USAID to expand the network of GeneXpert machines. The Government of India designed a financial intensive packet with a four-fold increase in the annual TB budget. A Direct Benefit Transfer (DBT) scheme was introduced, which aimed to provide financial incentives to both patients and healthcare providers to have infected people tested and undergo effective treatment. A switch in the National Programme was made from the drug regimen of three days a week to a daily regimen of a four-drug combination, and the use of bedaquiline in the public sector was approved under strict criteria to treat pre-XDR and XDR-TB cases.

102 World Health Organization. Tuberculosis. World Health Organization [Internet]. 2020 March 24. [Cited 15 July 2020]. Available from: <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>

103 Central TB Division, DGHS, Ministry of Health and Family Welfare. Revised national Tuberculosis Control Programme; National Strategic Plan for Tuberculosis Elimination 2017-2025. Central TB Division, DGHS, Ministry of Health and Family Welfare, New Delhi. [Internet]. 2017 March. Available from: <https://tbcindia.gov.in/WriteReadData/NSP%20Draft%2002.2017%201.pdf>

Section 4: Enabling factors and challenges

4.1 Enabling factors

There are multiple factors that have driven advancements in Member States, and the flagships played a catalytic role in accelerating these achievements. Broadly, the enabling factors that led to progress were:

- (1) **The capitalization of advocacy efforts to generate buy-in from partners:** WHO-led advocacy across all Regional Flagship Areas has successfully garnered political commitment and high-level buy-in, which has been instrumental in pursuing the agenda of key public health concerns such as tax reforms for tobacco, the elimination of NTDs in select Member States, the development of NAPs to tackle AMR, the adoption of ambitious goals to end TB and the reduction of maternal and neonatal mortality. WHO was not only recognized for placing the eight flagships on the agenda of national priorities, but also for the advocacy efforts carried out with many publications and participation in key scientific events.
- (2) **The elevation in commitment from Member States:** The political will exhibited by Member States in certain focus areas proved to be crucial (for example, UHC and a commensurate increase in the funding for some disease areas such as TB). The understanding between WHO and the ministries of health of Member States was very important, and their commitment and harmonious functioning was one of the key enabling factors that drove progress.
- (3) **The development of policy guidance and strategic plans:** WHO's technical support to Member States for policy guidance and the development of strategic plans and directives at the national level provided the necessary impetus to the countries' health systems to perform better and work towards achieving their targets.
- (4) **The provision of catalytic financial support:** WHO-led financial support and mobilization of funds for several Regional Flagship Areas (such as the establishment of SEARHEF, WHO-supported activities to tackle AMR and the availability of free medicines to eliminate NTDs) were other factors to which progress during the evaluation period can be attributed.
- (5) **The existing level of healthcare systems and institutional capacity:** The pre-existing institutional capacities of several Member States, such as polio eradication mechanisms and

machinery being leveraged for measles elimination, existing health systems with great institutional capacity, strong academia and a strong civil society in upper middle-income countries have led to the achievement of improved health outcomes.

4.2 Challenges

The challenges have been classified as technical challenges and operational challenges.

Technical challenges

- (1) **Nature and scope of Regional Flagship Areas:**
 - While most of the flagships were focused and targeted with clearly defined outcomes, some of them (such as UHC and NCDs) were purposely left broad, which led to ambiguity amongst Member States, thereby losing a sense of direction required to work on them and make progress.
 - Some key areas, such as migrant health, climate change, malnutrition leading to stunting (for children under the age of five years), and dengue in which the WHO country offices support the governments, were not part of the Regional Flagship Areas, which led to limited resources for them. These areas are critical health priorities for countries and should be worthy of more focused attention, like other Regional Flagship Areas.
- (2) **Focus on equity:** Although equity has been an inherent feature of all flagships and Member States have attempted to look through the equity lens (gender, geographic and economic), most of the flagships were unable to incorporate or undertake specific activities promoting equity.
- (3) **Monitoring and evaluation:** Despite efforts to monitor Regional Flagship Areas and the progress made through implementation of the flagships, there are still limited key performance indicators that provided little opportunity for course correction during the term of the flagships.
- (4) **Advocacy:** The evaluation highlighted that WHO made limited advocacy efforts to engage with stakeholders other than policymakers at the country level, stakeholders such as civil society organizations, disease-specific advocacy groups and the private sector.
- (5) **Multisectoral collaboration:** Multisectoral collaboration and coordination have been achieved for a few Regional Flagship Areas such as AMR and NCDs, but was still weak for the others. WHO has convening power like no other agency and needs to further strengthen its role.
- (6) **Evidence-based research:** Although attempts have been made to boost research culture within the Region, they have not been in line with the pace and investment needed to meet the fast-track targets demanded by some Member States. Most of the Member States reported that efforts to carry out research in MCH, TB and AMR needed evidence to support the cause, and that tailored operational research for all-hazard emergency and disaster risk management was required across the countries.
- (7) **Support to Member States at the subnational level:** WHO, as mandated by its constitution, usually supports governments at the national level to provide normative standards and catalytic support in areas of health. However, most Member States found it challenging to implement the

plans, guidelines and directives at the subnational and provincial levels with limited WHO support. As the global scenarios are changing, WHO's role is also evolving, and it should continue to do so with an increased focus on the provincial and subnational level.

Operational challenges

- (1) **Funding and resource mobilization:** As the flagships were instituted, an attempt was made to ensure that they were sufficiently backed by resources, both technical and financial. Therefore, the Member States were supported in the preparation of biennium plans such that 80% of the funds and resources were allocated to the flagships. However, these funds at a country level have only a catalytic effect, and, at times, the WHO country offices were not able to carry out all their planned activities because of limited funds. Further, some Regional Flagship Areas didn't receive enough donor funding, which laid added responsibility on WHO and governments to work towards them both technically and financially, which limited progress.
- (2) **Human resources:** Staffing was a challenge for WHO country offices and officials in their respective ministries. In addition to vacant positions, the technical capacities of the human resources, high turnover rates and multiple vacant positions posed significant challenges at times. As the Member States continue to develop and build their own human capital, there are strong expectations from the health ministries in terms of receipt of innovative solutions and highly-skilled and politically astute support from WHO country offices. Sufficient manpower at the ministry level is also critical to move things forward. This challenge has been identified in the MCH, TB, emergency and NCD Regional Flagship Areas.
- (3) **Political environment:** For certain Member States, an unstable political environment posed a challenge to pursuing key health agendas.
- (4) **Sustainability:** Sustaining the progress achieved so far can be a challenge if the Member States do not proactively think beyond donor funding or look to develop institutional and HR capacity within the country with the aid of WHO support. At the same time, Member States need to commit to invest more in the health sector, as the SEA Region is one the Regions where government expenditure on health is lower than other regions in the world.

Section 5: Conclusion

The concept of flagships provided direction to the Member States and contributed successfully to additionally accelerate the regional health priorities. In conclusion, the evaluation attempted to address the four overarching questions (as indicated in the methodology) to assess the impact these flagship priorities brought between 2014 and 2018 in advancing the WHO-SEARO's health agenda at the regional and country levels.

I. To what extent has the flagship focus and implementation at country level helped to improve the health outcomes, equity, inter-sectoral collaboration, effectiveness and efficiency of WHO's interventions?

The eight Regional Flagship Areas were selected based on regional priority issues, echoing the health priorities of the Member States. The regional and country level targets to measure the progress of each flagship were in alignment with the SDGs and GPW13. These flagships did not contradict global health targets and goals. It was noted that the flagships provided an accelerated and galvanized focus on key priority areas of health. These areas were important since they enabled the Member States to make a real difference in peoples' lives. The majority of Member States stated that flagships at the regional level (flagship focus) created an active environment, propelling actions at the country level. Additionally, they made it easier to negotiate for improved human resources, additional funding resources and increased commitments with the highest authorities. It was observed that the advocacy efforts for the focus areas were boosted as information spread across all the Member States of the Region. The achievements were strategically used and managed to bring about a sense of urgency among Member States, calling attention to key priority areas. However, it must be noted that the SEA Region is a region of diversities, with varying health priorities, which meant that some flagships were not relevant to all Member States.

- With the support of collaborative centres, technical experts and regional leadership, national program officers have undergone continuous capacity-building workshops, which have helped them to translate gains to country-level implementation.
- The Member States appreciated the results that were measurable because of clearly laid-out objectives and monitoring plans. For instance, measles elimination and rubella control had the clear objective of elimination, and Member States felt that they were associated with the country's pride.

- It was important to have achievable plans, because dividing small financial allocations between an unrealistic number of objectives was pointless. Therefore, the Regional Office ensured that country plans and budgets focused on agreed priorities through high-level advocacy.

Fig. 52: Perception comparison amongst the different sets of respondents about the significance of flagships to address the concerned health priority

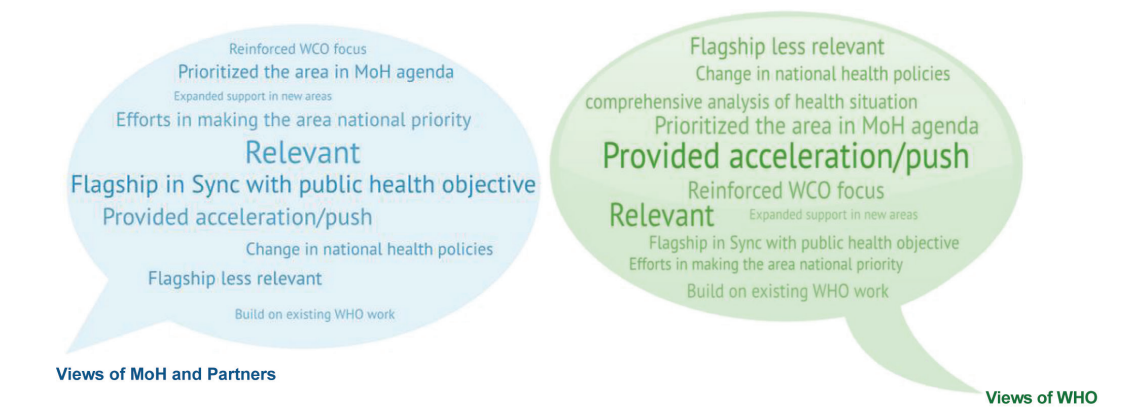
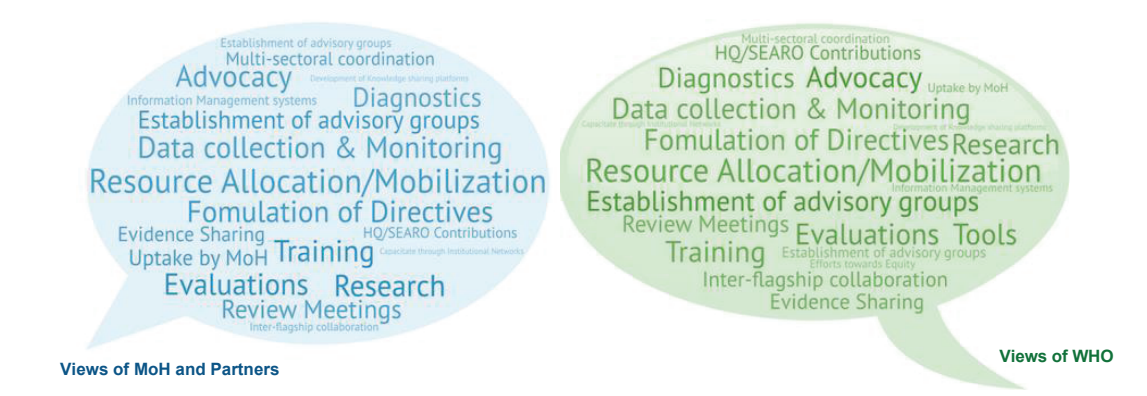


Fig. 52 shows a word cloud comparing the perceptions of respondents from WHO (internal) and health ministries and technical partners (external) regarding the significance of the flagships in addressing a concerned health priority. Both sets considered flagships relevant and felt that the declaration of flagships provided additional impetus to public health programs. WHO respondents also said that the advent of Regional Flagship Areas helped to undertake comprehensive analyses of the health situation in relevant areas. However, some respondents also implied that some of the flagships were less relevant to their respective countries and health priorities.

Fig. 53: Perception comparison amongst the different sets of respondents about the role/contribution of WHO in addressing the concerned Regional Flagship Area



Additionally, there is an opportunity for WHO to re-focus its efforts in areas such as equity, inter-flagship collaboration and multisectoral coordination. Comparing perceptions about the contribution of WHO to addressing the concerned Regional Flagship Area revealed that, while WHO saw its role in

the areas like equity, inter-flagship collaboration and multisectoral coordination as satisfactory, health ministry officials and development partners expressed their need for an increased focus there (see Fig. 53 for details).

II. What are the significant achievements and success stories at the country level due to implementation of the flagships? (What successes are attributable to the priority-setting exercise of establishing flagship focus areas?)

Rapid, inclusive and sustainable achievements have followed the advent of the Regional Flagship Areas. To reduce the immunity gaps in measles and rubella, all 11 Member States administered two doses of MCV and 10 Member States administered RCV through routine immunization programs. WHO PEN Disease Interventions have been implemented in almost all the Member States, and all are now Parties to the WHO Framework Convention on Tobacco Control (except Indonesia). Under-five mortality in the Region has declined by nearly 70%, neonatal mortality by 60%, and the maternal mortality ratio by 69% from the baseline of 1990. As of 2017, there were 9 countries with an up-to-date HRH strategy, while all 11 countries have updated essential medicine lists in the past three years. All 11 Member States had prepared their NAPs and started AMR programmes based on them. Five Member States (Indonesia, Maldives, Myanmar, Sri Lanka, and Thailand) have developed their NAPHS to implement IHR. Bangladesh, Bhutan, and Timor-Leste proposed developing their NAPHS in 2019.

In the year 2016, Maldives and Sri Lanka eliminated LF, while Thailand did so in 2017. India was declared yaws-free in 2016. By 2018, Bhutan, DPR Korea and Maldives reported less than 20 new leprosy cases annually and have progressed towards a zero-leprosy status.

TB became a top government priority with the approval of the NSP for Tuberculosis Elimination by the Ministry of Health and Family Welfare in India and a four-fold increase in the annual TB budget. Tuberculosis incidence declined from 2016 to 2018 in eight out of 11 Member States, except for DPR Korea, Sri Lanka and Timor-Leste. In 2018, five out of six high-burden Member States displayed an increase in treatment coverage (with Indonesia showcasing the largest increase of 24%) from 43% in 2016 to 67% in 2018. From 2016 to 2018, all Member States except India showcased a decline in TB mortality.

III. What have been the key enabling factors and challenges in developing and implementing SEA Regional Flagship Areas at a country level during the period 2014–18?

A clear and strong consensus was observed among health ministry officials and development partners on WHO's contributions from 2014 to 2018. WHO made a significant contribution to health policy and programmes in the Member States, covering a wide range of issues. In turn, WHO received unwavering support from the ministries of health to propel them to progress and success across national health priorities (which in most cases were in sync with the flagships). However, the progress achieved couldn't be exclusively attributed to the existence of flagships. There were multiple other factors that drove the advancements, with the flagships playing a catalytic role in accelerating the achievements.

- Broadly, the enabling factors leading to progress involved political will and commitment towards certain focus areas. For instance, improved health outcomes were observed in existing health systems, particularly in upper middle-income countries (e.g. Thailand). Moreover, measures such as an implementation of UHC, an increase in funding for few diseases (e.g. TB), and a strengthened institutional capacity contributed to better health outcomes.
- Despite the achievements, some key challenges persisted in the implementation of flagships. These challenges should be addressed to ensure smooth progress towards larger health goals (e.g. SDGs and GPW13). As discussed in the report, challenges include: limited monitoring and evaluation (M&E) mechanisms; scant focus on equity in most flagship-related activities; a need for WHO to further strengthen their role in multisectoral and intersectoral coordination; some key health priorities for the Region such as malaria, dengue and malnutrition were not addressed under these flagships; inadequate funds, infrastructure and human resources; lower expenditure on health from governments in the SEA Region; and changing political environments in countries, all of which need to be taken into consideration by WHO while designing the future interventions.

IV. What are the lessons and best practices from different countries and regional technical programmes that can be adapted to sustain the gains, accelerate action and innovate where needed at the country and regional level to achieve the impact targets of GPW 13 and the Sustainable Development Goals?

The Region and other countries can adapt or develop and implement strategies under the flagships from the best practices of various countries during the period evaluated, which are discussed here, as observed through our primary findings. For measles and rubella, in Bangladesh, after the last influx of international migrants in 2017, three rounds of the MR campaign have been conducted from 2017 to 2020 in the camps in Cox's Bazar. Thailand implemented a sugar-sweetened beverage tax to control NCDs. Thailand also charges a 2% cess (tax) on tobacco and alcohol, which Thai Health uses in tobacco and alcohol control. In India, the introduction of midwifery into the health system and the launch of the programme LaQshya to improve the quality of care in labour rooms and maternity OTs aimed to improve the quality of care for mothers and newborns during the intrapartum and immediate post-partum period. DPR Korea developed a roadmap to uncover major issues in HRH in the country. As a recommendation, a medical education unit was established in Pyongyang Medical University. Longhorn University, which is a collaborative centre, was also involved in this exercise. In Myanmar, multisectoral collaboration is a critical component of managing AMR, something most Member States are currently struggling with. However, the Ministry of Health, Myanmar succeeded in releasing a joint statement with the Ministry of Agriculture, Livestock and Irrigation as a symbol of their commitment to tackling AMR together going forward. For emergency preparedness, Nepal is building the capacity of its academic institutions such as medical colleges, which was previously never seen as a resource hub for public health-related activities. Training of trainers is now a process being followed to ensure in-country capacity-building of academicians. In the area of NTDs, the surveillance of Kala-Azar accelerated in Nepal due to the WHO country office's efforts. WHO's efforts helped to strengthen the internal monitoring and evaluation mechanism. Now the programme is able to track patients at all levels through an online reporting system. To address the TB problem, Timor-Leste prioritized incentivization through newer policy guidelines. Their drug resistance survey was successful despite the challenges of

access to collect samples and transport them for testing, because the country incentivized the sputum collection and transport system. Bhutan developed Newborn Action Plan in collaboration with WHO and other partners. Also, a digital tracking system for maternal and child health to enable the real-time tracking of pregnant women and their young children was developed by the Ministry of Health with support from WHO. To sustain the low maternal, child and newborn mortality and to further reduce it to single digits, Sri Lanka invested in improving the quality of maternal and newborn care, particularly during labour, birth and the first day and first week of life (including care of complications). In 2018, around 207 million Indonesians – more than 80% of the population – were enrolled in the Jaminan Kesehatan Nasional (JKN) programme which is a national health insurance. Maldives was the first country in the SEA Region to be certified to have eliminated lymphatic filariasis in 2016.

There will always be more demand than the Regional Flagship Areas are able to meet. However, current WHO resource levels are seldom adequate to face such demand, and there may be questions about whether all the activities and support fall within WHO's mandate (versus the Member State's mandate). Nevertheless, there are important components across multiple domain areas that need continued WHO support. Through the flagships and even beyond, WHO should continue to support the Member States in improving the health of the Region.

Section 6: The way forward

Significant progress has been made since the Regional Flagship Areas were launched in 2014. Five countries have now eliminated measles and six have controlled rubella. All 11 Member States are implementing NAPs to tackle NCDs as well as AMR. Region-wide, the coverage and quality of health services is stronger than ever before, while the unfinished MDG agenda has now been finished. Emergency risk management proceeds apace while the battle to eliminate diseases on the verge of elimination is being won. The drive to end TB has gathered unprecedented momentum. However, with the evolving scenario of global commitments (GPW 13 and SDGs) and the transformation of Regional and country priorities and contexts, it's necessary to call for a revision of the flagships. Thus, to carry forward the success achieved and to improve further based on the lessons learnt, the Region's Member States have now launched version 2.0 of the Regional Flagship Areas at the 2019 Regional Committee meeting in New Delhi. These flagships will continue to provide directional focus for the Member States to work on and will improve the health outcomes of the countries in a concerted manner. The changes recognize the progress made thus far and orient towards a continued focus on regional priorities till 2024. The Region must ensure that each Regional Flagship Area is pursued with vigour as per the Region's quest to sustain its achievements, accelerate progress and harness the full power of innovation. Table 10 exhibits the revised flagships alongside the key goals and activities based on the pillars of Sustain, Accelerate and Innovate.¹⁰⁴

Table 10: Flagship-wise way forward

Flagships 2.0	Sustain	Accelerate	Innovate
Eliminate measles and rubella by 2023	Sustain measles elimination in Bhutan, Maldives, DPR Korea, Sri Lanka and Timor-Leste, and rubella control in Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste	Accelerate efforts to strengthen surveillance and bridge the immunity gaps against measles and rubella MCV and RCV coverage at subnational level, specifically in area/provinces with below 90% coverage	Innovative approaches in achieving highest vaccine coverage, strategies to reach unimmunized/left out children (including migrants) and integration with other primary healthcare services

¹⁰⁴ World Health Organization. Sustain. Accelerate. Innovate. – For Health for Billions in WHO South-East Asia Region. World Health Organization. Regional Office for South East-Asia.2019. [cited 29 May 2020]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/328135/health-billions-eng.pdf?sequence=1&isAllowed=y>

Flagships 2.0	Sustain	Accelerate	Innovate
Prevent and control noncommunicable diseases through multisectoral policies and plans, with a focus on best buys	High-level political commitment to beat NCDs	Implement multisectoral NCDs plans addressing health impact of the environment, climate change, tobacco, lifestyle and diet	Explore effective strategy for the implementation of NCDs programmes and strengthen advocacy for commitment, resource allocation and regulatory enforcement
Accelerate reduction of maternal, neonatal and under-five mortality	Polio-free status and elimination of maternal and neonatal tetanus	Efforts to further reduce maternal mortality rates that declined by 69%, child mortality rates that fell by 70% and neonatal mortality that reduced by 60% between 1990 and 2017	Further advances on maternal, newborn, child and adolescent health
Continue progressing towards universal health coverage with a focus on human resources for health and essential medicines	Track progress towards UHC with a focus on reaching the poorest and most vulnerable	Strengthen the health workforce and improve access to essential medicines	Support innovations to improve access to quality primary care services without financial hardship Innovate digital solutions to measure the progress
Further strengthen national capacity for preventing and combating antimicrobial resistance	The commitment to control AMR in the SEA Region Development of NAPs and their review	Implementation of multisectoral actions to combat AMR.	For comprehensive implementation of NAPs Innovate strategies for collecting baseline data for AMR
Scale-up capacity development in emergency risk management in countries	Efforts to strengthen emergency preparedness and response capabilities in health and related sectors Capacity building by sharing best practices across the Region for preparedness	Investment to address critical gaps at the national and subnational levels Decentralized/centralized strengthening of the health system for emergency preparedness and response	Continuously improve preparedness and response systems. Mapping of institutions that are part of GOARN, having different specialties (like zoonosis, etc) within the Region, to strengthen collaboration with other agencies
Finish the task of eliminating neglected tropical diseases (NTDs) and other diseases on the verge of elimination*	Elimination of lymphatic filariasis as a public health problem in Maldives, Sri Lanka and Thailand; yaws-free India; and trachoma elimination in Nepal	Efforts to further reduce leprosy, eliminate kala-azar, lymphatic filariasis and trachoma as public health problems, and achieve yaws-free status in the remaining endemic areas	For newer guidelines, treatment regimens and strategies to end NTDs at the earliest
Accelerate efforts to end TB by 2030	Highest-level of political commitment	Implementation of TB elimination plans with a focus on treating the unreachable	Newer drugs, treatment regimens and diagnostics to rapidly reduce TB Innovate strategies for prevention of TB and identification of latent TB infections

*NTDs: kala-azar, leprosy, lymphatic filariasis, trachoma and yaws. Other diseases on the verge of elimination: malaria and MTCT of HIV and congenital syphilis.

Section 7: Recommendations

Based on the evaluation findings and the key challenges identified, following recommendations are proposed:

7.1 Recommendations for the WHO Secretariat

- (1) **Revisit the scope of Regional Flagship Areas:** In addition to the revision of Regional Flagship Areas for 2019-23 (which were launched as Flagships 2.0), the following points may be considered:
 - Including additional areas under the umbrella of certain flagships to provide the necessary attention and impetus to these diseases/issues. These are areas where WHO is already supporting the ministries of health across several Member States and additional focus and resources would be beneficial. Some key areas are:
 - Dengue can be considered as a focus area since Asia bears 70% of the global burden of dengue. This can be achieved through inclusion of dengue under existing Flagship 7 addressing NTDs. The scope of Flagship 7 could also be further broadened for incorporating other prevalent vector borne diseases in the Region.
 - Malnutrition and child stunting need additional focus under the maternal and child health flagship, which can be integrated with the Strategic Action Plan (2016–2025) to reduce the double burden of malnutrition.
 - A strategic plan to address migrant health should be developed and integrated within relevant flagships (UHC, emergency preparedness) so as to ensure equitable services.
 - The flagships need to formally set the conditions and provisions for equity, to increase access and barriers of care (catering to hard-to-reach populations, geographical access, gender, etc.) and integrate into the Regional Flagship Areas. This action will help the Region to achieve SDG Goal 3 of ensuring healthy lives and promote well-being for all at all ages.
- (2) **Develop a standardized monitoring and evaluation framework:** The flagships should have a standardized monitoring and evaluation framework using existing programme reviews and programme monitoring indicators for each flagship. This will ensure that stakeholders have performance data for decision-making and tracking progress across Member States for each of the flagships. To that end, it is recommended:
 - Regular reviews and independent evaluations for each of the flagships can be conducted periodically until the end of the flagship term to that ensure course corrections vis-à-vis regional objectives and reporting are regularly tracked and managed.

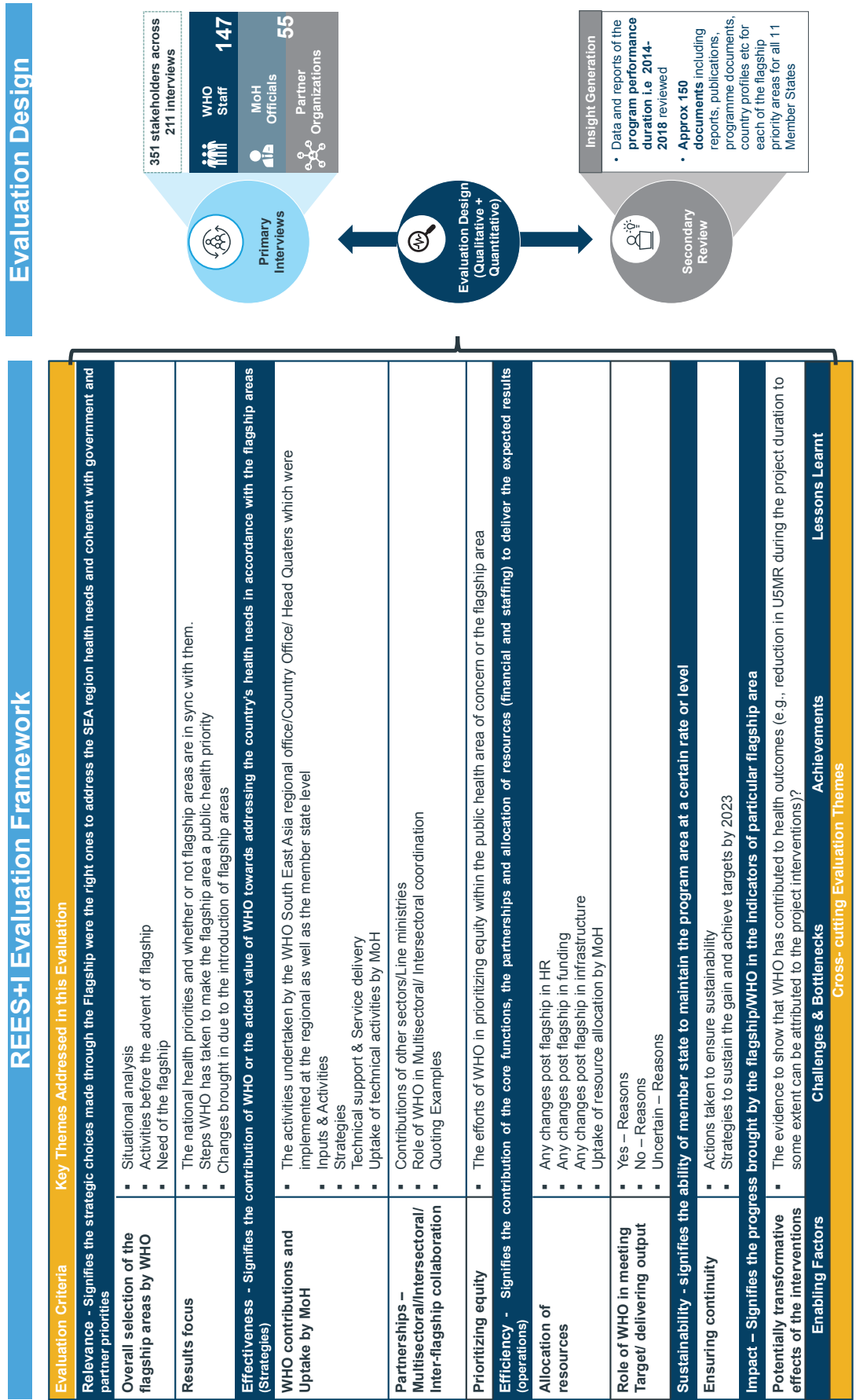
- Standard templates for monitoring and reporting across all countries can be implemented.
 - Periodic (annual) sensitization workshops for WHO country offices and Ministry of Health officials to introduce the monitoring and evaluation process and templates for reporting data can be conducted.
 - The targets defined as per the monitoring and evaluation framework should be relevant and customized to country context.
- (3) **Accelerate efforts for advocacy initiatives:** WHO may consider accelerating their efforts towards the political advocacy for and awareness of flagships that are still a lower priority for some Member States. This will garner political commitment, which will lead to improved ownership and increased investment from Member States to ensure sustainable progress in achieving better health outcomes. To that end:
- Consider establishing a regional flagship caucus with representation from parliamentarians, civil society organizations and community representatives
 - Accelerate efforts to engage with the private sector and encourage integration with the public sector
- (4) **Establish a funds mobilization strategy:** WHO could establish a funds mobilization strategy (customized to country context) that assesses future funding needs and identifies specific actions to address any potential shortfalls and improve donor management relationships.
- (5) **Develop a multisectoral accountability framework:** WHO could leverage its convening power to support Member States in effective multisectoral collaboration with key actors both within and outside the health sector. The Organization could:
- conduct a comprehensive partner and donor landscaping to bring about intersectoral collaboration, and map and engage with key ministries, other than the ministries of health, to achieve progress and ensure multisectoral engagement
 - develop a multisectoral accountability framework for each of the flagships at country level that will clearly lay down the roles and responsibilities of each of the partners.
- (6) **Strengthen Member States' capacity for evidence-based research:** Research will not only promote the development of guidelines and plans relevant to country context, but also build the country's capacity to invest in research and innovation. To that end:
- WHO could form a research network across the Region involving academia and institutions from all Member States. Through this network, Member States will be able to share knowledge and conduct synchronized research activities across domain areas. This can be further supplemented by WHO's technical expertise at the regional and country levels. This will strengthen the voice of the Regional Office in shaping the health agenda at the global level.
- (7) **Strengthen human resource capacity in WHO country offices:** It is suggested that the Regional Office assess the current staffing and skills mix in WHO country offices in the light of the new flagship priorities, addressing gaps in relevant areas and providing capacity building opportunities to existing staff in order to be better prepared and respond more effectively to the needs of the Member States.

7.2 Recommendations for ministries of health/Member States

- (1) **Enhance efforts to ensure sustainability:** For programmes and projects that are donor funded, ministries of health are encouraged to develop country-specific implementation plans with a feasible exit plan to ensure that the progress achieved is long term and is not impeded in the absence of donor support. The exit plan should delineate clear roles and responsibilities for each stakeholder in for the respective flagship.
 - Increase efforts to build the capacity of the health workforce using digital platforms and module-based learning on a regular basis.
- (2) **Encourage programme specific external evaluations:** Member States should plan programme-specific external evaluations and reviews such as JEEs and joint monitoring missions (JMMS) which will guide them through improved policy planning, customized strategic plans and focused implementation of activities.
- (3) **Lead multisectoral collaboration:** Ministries of health should lead multisectoral collaboration efforts by developing a multisectoral accountability framework with support from WHO, and actively engage with other ministries and non-health actors in critical areas such as NCDs, AMR, UHC and migrant health.
- (4) **Increase funding for the health sector:** Overall, Member States are encouraged to invest more in the health sector. This will lead to sustainable progress and achievements. The expenditure should focus on the treatment and prevention of diseases, for example, addressing latent TB infections, airborne infection control measures, early diagnosis and screening. These funds will also be essential to enhancing the capacity of human resources and strengthening health systems.

Evaluation framework

Figure 1: Evaluation framework



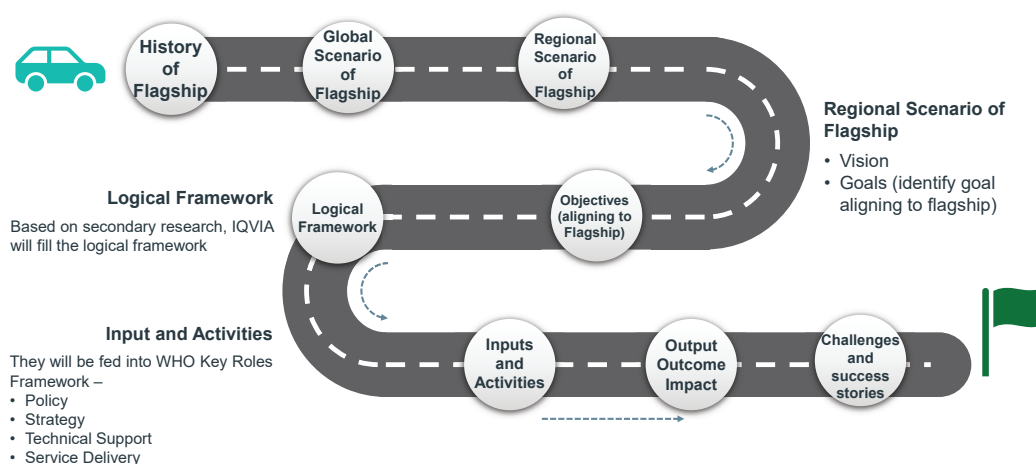
Annex II

Secondary review methodology

The chronological steps of the detailed secondary review wherein the ultimate goal was to formulate a logical framework *for each of the flagship priority areas* is depicted in Figure 2, below. The team ensured robustness of the associated data as well as of the monitoring mechanisms referred. All relevant documents were reviewed to develop an understanding of global, regional and country level scenario of the flagship priority areas. Specifically, these documents were reviewed to identify; inputs and activities by WHO SEA Region for each of the flagships; and outputs and outcomes indicators (key progress indicators) identified for each of the flagship priority areas for all 11 Member States.

Figure 2: Methodology for secondary review

Approach for Desk Review



Annex III

Quality assurance measures

Several quality assurance measures were taken at various stages of the evaluation. These have been summarized in table below.

Table 1: Quality assurance measures taken during evaluation

Evaluation Aspect	Resource
Objectives	Evaluation domain was reviewed at the outset of the study problem and research question were defined prior to study initiation
a. Problem definition	Relevance of the evaluation was recognized and documented
Design	
a. Research groups	The groups chosen represented the stakeholders; selection criteria was set and defined pre-hoc
b. Research methods	A detailed research protocol of the study, using appropriate methods was developed. Appropriate methods for conducting this evaluation were delineated in main study proposal.
c. Research instruments	Tools used for in-depth interviews were validated through pilot studies before data collection
Data	
a. Data collection	Pre-tested tools were used for data collection; ideal procedures for obtaining informed oral consent were used; field notes were taken and recording equipment was used during interviews; supervisory visits were arranged to observe the interview procedure with attention to details and approach of the interviewers towards objectivity and impartiality of the procedure
b. Training of Data collectors	The investigators were trained about the research subject prior to data collection. The training included hands on experience in using different data collection tools and orientation on the subject matter. Moreover, the selected investigators were public health professionals who had prior experience of conducting research in public health.
c. Data entry	Transcriptions were done inhouse as well as via a professional transcription agency; After initial quality check of transcripts by the investigators only, the data was used for further analysis
d. Data cleaning	All the qualitative data were maintained as field files, mundane files and analytic files; clean-up files were renamed and numbered appropriately; all transcripts were maintained in an organized manner; entered data were checked for errors.
e. Data storage	Cleaned data files were developed with separation of identifiable details from the research data; only the study team had access to the raw and 'ready-to-analyze' data; all the clean-up files were stored and protected as back-up files
f. Data analysis	Analysis plan was outlined prior to the data collection; analysis of data was done with the help of Atlas. ti software; a codebook was developed; analyses procedures were monitored and checked for errors from time to time

Annex IV

Rigor

Separate, semi-structured interview guides were prepared for the various stakeholder groups. Data collection and analysis took place concurrently; hence, quality assurance was integrated directly into the approach through course corrections. The team took great caution to transcribe audio recordings, including all words, phrases and pauses in conversation, as accurately as possible. The final data was *triangulated* through transcripts from the secondary research findings. To ascertain inter-coder reliability, initially few of the transcripts were coded individually by three members of the research team. To make the coding process transparent and replicable, a “coding & categorising protocol” was developed in which the rules for coding were described. After coding the interviews, the coding of the coders was compared and discussed with the entire team to assess the inter coder reliability. “Percentage agreement” was used for calculating inter coder reliability. The formula in Miles & Huberman¹ was used.

Reliability = Number of agreements / (number of agreements + number of disagreements)

Out of total 140 codes, there was agreement on 125 codes which gives us reliability of 89.28 %. Since, Miles and Huberman (1994) suggest that an inter coder reliability of 80% agreement between coders on 95% of the codes is sufficient agreement among multiple coders, the reliability of the evaluation findings was ascertained¹.

For substantiating **validity**, *constant comparison* of data was done which enabled the researchers to treat the data as a whole instead of fragmenting it. It also enabled us to identify the emerging/unanticipated themes.

¹ Miles M and Huberman A; Qualitative Data Analysis; 2nd ed; Sage Publications; 1994

Annex V

Evaluation management group

S. No.	Evaluation Management Group	
01	Elil Renganathan	Co-chair and DG Representative for Evaluation and Organisational Learning, WHO-HQ
02	Pem Namgyal	Co-chair and Director, Programme Management, WHO-SEARO
03	Rajesh Pandav	WHO Representative to Timor-Leste
04	Rony Maza	Coordinator, Programme Planning, Monitoring and Evaluation , WHO-SEARO
05	Anuruddhe Thushara Ranasinghe	Programme Management Officer, WHO-SEARO
06	Rahul Srivastava	Technical Officer-Regional Director's Office, WHO-SEARO
07	Robert J McCouch	Chief Evaluation Officer, WHO-HQ
08	Tasnim Azim	Regional Adviser, Research and Policy Coordination, Department of Communicable Diseases(CDS), WHO-SEARO
09	Rakesh Mani Rastogi	Technical Officer-Health Situation and Trend Assessment, Department of Health Systems and Life-Course, WHO-SEARO

Annex VI

Stakeholders interviewed

S. No.	Regional	
	World Health Organization	
01	Poonam Khetrpal Singh	Regional Director, South East Asia Region
02	Pem Namgyal	Director, Programme Management
03	Roderico Ofrin	Director, Health Security and Emergency Response
04	Thaksaphon Thamarangsi	Director, Non-Communicable Diseases & Environmental Health
05	Neena Raina	Director, Family Health Gender and Life Course
06	Tjandra Yoga Aditama	Director, Communicable Diseases
07	Manoj Jhalani	Director, Health Systems Development
08	Sunil Kumar Bahl	Team Leader Immunization and Vaccine Development Family Health, Gender and Life Course
09	Jagdish Kaur	Regional Adviser, Tobacco
10	Manju Rani	Regional Adviser, NCD, Policy
11	Nazneen Anwar	Regional Adviser, Mental Health/ Alcohol
12	Padmini Angela De Silva	Regional Adviser, Nutrition
13	Lesley Onyon	Regional Adviser, Air Pollution
14	Rajesh Mehta	Regional Adviser, Child and Adolescent Health
15	Tomas Zapata	Regional Adviser, Human Resources for Health
16	Klara Tisucki	Regional Adviser, Essential Drugs and Medicines (UHC and AMR)
17	Ahmed Jamsheed Mohamed	Regional Adviser, Neglected Tropical Diseases Control
18	Mukta Sharma	Regional Adviser, TB/HIV/STI/HEP
19	Gyanendra Gongal	Medical Officer, Food Safety
20	Anoma Jayathilaka	Medical Officer, Maternal and Reproductive Health
21	Sudhir Khanal	Medical Officer, Measles Immunization and Vaccine Development
22	Maung Than Htike	Technical Officer, Capacity Development
23	Supriya Bezbaruah	Technical Officer, Risk Communications
24	Arti Garg	Technical Officer, Emergency

S. No.	Regional	
25	Vineet Bhatia	Technical Officer, Tuberculosis
26	Anil Bhola	Consultant, Operational Partnerships
27	U Zaw Lin	Entomologist, Member of NTD program
Technical/Donor Partners		
28	Ashok Deorari	MD, Dip NB FAMS FNNF, Professor & Head- All India Institute of Medical Sciences

S. No.	Bangladesh	
Ministry Officials		
29	Sabina Alam	Joint Secretary (HR), Health Service Division, Ministry of Health
30	Md. Habibur Rahman	Line Director, NCDC, Directorate General of Health Services (DGHS), Ministry of Health
31	Salah Uddin	Deputy Director, Directorate general of Drug Authority (DGDA), Ministry of Health
32	Alim Prodhan	Assistant Director and Deputy Programme Manager, NCDC, Directorate General of Health Services (DGHS), Ministry of Health
33	Md Humayun Kabir Talukder	Professor of Curriculum and Evaluation, Centre of Medical Education, Directorate General of Medical Education, Ministry of Health
World Health Organization		
34	Bardan Jung Rana	Country WHO Representative
35	Rajendra Bohra	Team Lead, Immunization and Vaccine Development
36	Nuruzzaman	National Professional Officer, Human Resource for Health
37	Syed Mahfuzul Huq	National Professional Officer, Non-Communicable Diseases
38	Md Touhidul Islam	National Professional Officer, Health Financing
39	Mahbuba Khan	National Professional Officer, Making Pregnancy Safer
40	Sangay Wangmo	Technical Officer, Integrated Service Delivery and acting Team lead of Health Systems
41	Mohd. A. Ramzy Ismail	Technical Officer- Essential Drugs and Medicines- World Health Organization
42	Farzana Akter	National Consultant, Planning, Monitoring and reporting on Health-related SDGs
43	Mya Sapal Ngön	Medical Officer, Communicable Diseases

S. No.	Bangladesh	
	Technical/Donor Partners	
44	Maya Vandenant	Chief of health, UNICEF
45	Robert D. Simpson	Representative, FAO
46	Eric Brum	Country Team Leader, FAO - ECTAD

S. No.	Bhutan	
	Ministry Officials	
47	Wangdi Gyeltshen	Chief Programme Officer, Ministry of Health
48	Laigden Dzed	Deputy Chief Program officer, Nutrition, Ministry of Health
49	Pemba Yangchen	Deputy Chief programme Officer, Ministry of Health
50	Tshewang Tamang	Deputy Chief programme Officer, Ministry of Health
51	Rada Dukpa	Sr. programme Officer, Ministry of Health
52	Sonam Phuntsho	Sr. Planning Officer, Ministry of Health
53	Pema Yangzom	Programme Officer, Ministry of Health
54	Pema Lethro	Programme Officer, Ministry of Health
55	Sangay Phuntsho	Program Officer, Ministry of Health
56	Ugyen Tshering	Programme Officer, Ministry of Health
57	Tashi Chozom	Planning officer, Ministry of Health
58	Mindu Dorji	Program Analyst, Ministry of Health
59	Tobgyel	Program Analyst, Ministry of Health
	World Health Organization	
60	Rui Paulo de Jesus	Country WHO Representative
61	Kencho Wangdi	National Professional Officer, NCD and ERM
62	Lobzang Dorji	National Professional Officer, RMNCH
63	Sonam Wangdi	National Professional Officer, Communicable Diseases
64	Sonam Yangchen	National Professional Officer, Health Systems and UHC
	Technical/Donor Partners	
65	Chandralal Mongar	Health and Nutrition Officer, UNICEF
66	Tashi Tobgay	Former Registrar and Technical Advisor, Khesar Gyalpo University of Medical Sciences of Bhutan

S. No.	DPR Korea	
	World Health Organization	
67	Edwin Salvador	Country WHO Representative
68	Thushara Fernando	Ex-Country WHO Representative, DPR Korea
69	Pushpa Ranjan Wijesinghe	Ex-Technical Officer at DPR Korea
70	Atul Dahal	Ex-Technical Officer at DPR Korea
	Technical/Donor Partners	
71	Hassan Mohtashami	UNFPA Representative
72	Bir Mandal	FAO Deputy Representative

S. No.	India	
	Ministry Officials	
73	Ajay Khera	Deputy Commissioner, Child health and Immunization, Ministry of Health
74	Pradeep Halder	Deputy Commissioner, Immunization Division, Ministry of Health
	World Health Organization	
75	Henk Bekedam	Country WHO Representative
76	Pankaj Bhatnagar	Team lead, NPSP
77	Sandra Vokaty	Team lead, Communicable Diseases
78	Pushpa Choudhary	Team lead, National Programme Officer, maternal and child health
79	Ranjani Ramachandran	Technical Lead, Tuberculosis
80	Hilde De Graeve	Technical lead, Health System
81	Deepti Agarwal	National Professional Officer, Child Health
82	Ram Chahar	National Professional Officer, Maternal Health
83	Dhruv Pandey	National Professional Officer, Visceral leishmaniasis
84	Rashmi Shukla	National Professional Officer, Leprosy
85	Malik Parmar	National Professional Officer, Tuberculosis
86	Chandrakant Lahariya	National Professional Officer, Healthcare, Access and Protection
87	Dileep Singh Mairembam	National Programme Officer, Health Workforce
88	Anuj Sharma	Technical Officer, Antimicrobial Resistance
89	Madhur Gupta	Technical Officer- Pharmaceuticals
90	Pradeep Joshi	Technical Officer, Non-Communicable Diseases

S. No.	India	
	Technical/Donor Partners	
91	NK Arora	Chairperson, National Verification Committee for Measles and Rubella
92	Umesh Alavadi	Project Management Specialist, Division of Tuberculosis & Infectious Diseases, USAID/INDIA
93	Amit Khurana	Programme Manager, Food Safety and Toxins-Centre for Science and Environment
94	Bhupendra Tripathi	Country Lead, Routine Immunization & Neglected Tropical Diseases, BMGF
95	Kayla Laserson	Deputy Director, Infectious diseases, India Country Office, BMGF
96	Reuben Swamickan	Division Chief, Tuberculosis and Infectious Diseases, USAID

S. No.	Indonesia	
	Ministry Officials	
97	Oscar Primadi	MPH, Secretary General, Ministry of Health, Republic of Indonesia
98	Bambang Wibowo	SpOG (K), Mars Directorate General of Health Service, Ministry of Health
99	Bayu Teja Mulyawan	MM, Apt Director, Bureau of Planning and Budgeting Ministry of Health
100	Acep Somantri	Director, Bureau of International Cooperation
101	Wiendra Waworuntu	Director, (ERM, NTD), Communicable Diseases Prevention and Control- Ministry of Health
102	Saraswati	MPH, Director, Primary Health Care, Ministry of Health
103	I.B. Arom	Director, Referral Health Services, Ministry of Health
104	Nellor Puspansari	Director, Research and Development Center for Biomedical and Basic Health Technology, Ministry of Health
105	Refiandes	Director, Pharmaceutical Services, Ministry of Health
106	Siti Nadia Tarmizi	Director, Directorate of Vector Borne and Zoonotic Diseases Prevention and Control, Ministry of Health
107	Aina Fatry	PHC Director, Ministry of Health
108	Acus Hendroyono	Head, Prevention, Mitigation and Preparedness Division, Ministry of Health
109	Ina Augustina	Head, Sub-Directorate, Prevention, Mitigation and Preparedness Division, Ministry of Health

S. No.	Indonesia	
110	Wara Pertiwi	Head of Subdit school age and adolescent, Ministry of Health
111	Lily Banonah	Head, Sub-Directorate, Direct Transmission Tropical Diseases (Leprosy and Yaws), Ministry of Health
112	Lita Sianipar	Head, Sub-Directorate of Filariasis and STH, Ministry of Health
113	Triya Novita Dinihari	Sub Directorate, Surveillance, Ministry of Health
114	Irna Qusmi	Sub Directorate, Surveillance, SPFF, Ministry of Health
115	Muhammad Yusuf	Sub Directorate, Maternal Health, Ministry of Health
116	Arman Syah	Deputy Head, Pusat Pembiayaan dan Jaminan Kesehatan (PPJK), Ministry of Health
117	Gerttrudis Tandy (Yudith)	EPI, Ministry of Health
118	Ackhmad Afflazir	Pusat Pembiayaan dan Jaminan Kesehatan (PPJK) Ministry of Health
119	Lusiana S.	Pusat Pembiayaan dan Jaminan Kesehatan (PPJK) Ministry of Health
120	Ranti Dewi	Pusat Pembiayaan dan Jaminan Kesehatan (PPJK) Ministry of Health
121	Eva Herlinawaty	Pusat Pembiayaan dan Jaminan Kesehatan (PPJK) Ministry of Health
122	Imroatul Aflah	Representative, Reproductive Health, Ministry of Health
123	Milwi Yandle	Representative, Under Five, Ministry of Health
124	Noor	ISPA (Upper Respiratory Tract Infection), Ministry of Health
125	Syswanda	Kasi Filariasis, Ministry of Health
126	Solihah W	Kasi Filariasis, Ministry of Health
127	Inong	TB Programme, Ministry of Health
128	Cansa Lesmana	Pharmaceutical Services, Ministry of Health
World Health Organization		
129	N. Paranietharan	Country WHO Representative
130	Alaka Singh	Team Leader, Health System Strengthening
131	Shalala	Medical Officer, CDS
132	Farrukh Qureshi	Medical Officer, Tobacco Control and NCDs
133	Serene Joseph	Technical Officer, NTDs
134	Sharad Adhikary	Technical Professional Officer, RMNCAH
135	Kwang IL Rim	Technical Professional Officer, WHE

S. No.	Indonesia	
136	Olivi O.P. Silalohi	EPI Consultant
137	Dina Kania	National Professional Officer, Tobacco control
138	Alfrida Silitonga	National Professional Officer, RMNCAH
139	Setiawan Jati Laksono	National Professional Officer, Tuberculosis
140	Fina Tama	National Professional Officer, IVD Unit
141	Gde Yogadhita	National Professional Officer, Emergency
142	Herfina Nababan	National Professional Officer, UHC
143	Naufal Achmed Azhari	National Professional Officer, NTDs
144	Sugens Eteol	National Professional Officer, Nutrition
145	Benyamin Sihombing	AMR Focal Point
146	Listy Handayani	Data Manager, NTDs
147	Endang Srilitami	Immunization Data Assistant, IVD Unit
148	Manz Meo	WHE
149	Yoana Anaudin	Member, TB Programme
150	Mikyal Faralina	Member, TB Programme
151	Jonashan Marbun	Member, TB Programme
152	Maria Regina	Member, TB Programme
Technical/Donor Partners		
153	Christine	Australian Embassy
154	Ramout	Australian Embassy
155	Pamela Foster	Acting Health Officer, Office of Health, USAID
156	Tim Meinko	Director, Office of Health, USAID
157	Laksono Trisnantoro	Professor in Health Policy and Administration, University of Gajah Mada
158	Ascobat Gani	University of Indonesia

S. No.	Maldives	
Ministry Officials		
159	Aishath Mohamed	Deputy Director General, Maldives Food and Drug Authority, Ministry of Health
160	Ibrahim Nishan	Deputy Director General, Emergency and NTDs, Health Protection Agency, Ministry of Health
161	Aishath Jaleela	Director, Maldives Food and Drug Authority, Ministry of Health
162	Mohamed Fazeen	Director, Maldives Food and Drug Authority, Ministry of Health
163	Hassan Mohammad	Deputy Director, NCDs-Health Protection Agency, Ministry of Health

S. No.	Maldives	
164	Rahmath	Assistant Director, HRH- Ministry of Health
165	Ali Ahmed Manik	Assistant Director, Policy and International Health Division, Ministry of Health
166	Aishath Rishmee	Assistant Director, Policy and International Health Division, Ministry of Health
167	Abdulla Muaaz Adam	Senior Public Health Program Officer, Child Health, Health Protection Agency, Ministry of Health
168	Aminath Moomina	Senior Public Health Program Officer, Director, Maldives Food and Drug Authority, Ministry of Health
169	Saina Ali	Public Health Program Manager, Maternal Health, Health Protection Agency, Ministry of Health
170	Abdul Hameed	Program Manager, TB/HIV/Hepatitis/Migrant Health, Health Protection Agency, Ministry of Health
171	Mizna Abdul Kareem	Program Officer, NCDs-Health Protection Agency, Ministry of Health
172	Aishath Lubana	Assistant Program Officer, NCDs-Health Protection Agency, Ministry of Health
173	Sadha Hassan	Assistant Program Officer, NCDs-Health Protection Agency, Ministry of Health
174	Shifza Mohamed	Senior Administrative Officer, Policy and International Health Division, Ministry of Health
175	Dr. Ibrahim Afzal	Epidemiologist Health Protection Agency, Ministry of Health
World Health Organization		
176	Arvind Mathur	Country WHO Representative
177	Aishath Thimna Latheef	National Professional Officer, Immunization and NTDs
178	Aminath Fariha Mohammad	National Professional Officer, Health System
179	Faiha Ibrahim	National Program Officer, AMR, ERM and Tuberculosis
180	Fathimath Hudha	National Professional Officer, NCDs and RMNCHA
Technical/Donor Partners		
181	Nazla Musthafa	Ex-chair, NTAGI and Pediatrician at Indira Gandhi Memorial Hospital
182	Zeena Abdul Qayyoom	Vice-President, Maldives Nursing Association
183	Aminath Shafia	Treasurer, Maldives Nursing Association

S. No.	Myanmar	
	Ministry Officials	
184	Myint Than	Deputy Director General, Maternal and Child Health, School Health and Nutrition (MCHSHN), Ministry of Health
185	Si Thu Aung	Director, National TB Program, Ministry of Health
186	Htun Tin	Director, Epidemiology and Public Health Emergency, Ministry of Health
187	Kyaw Kan Kaung	Director, NCD Unit- Ministry of Health
188	Win Thein	Director (National Health Laboratory), Ministry of Health
189	Cho San	Deputy Director, National TB Program, Ministry of Health
190	Eh Htoo Pe	Deputy Director (National Health Laboratory), Ministry of Health
191	Hrin Twin	Deputy Director (Reproductive and Maternal Health), Ministry of Health
192	Maung Maung Myo Wynn	Deputy Director, Trachoma Control, Ministry of Health
193	Nay Yi Yi Linn	Deputy Director (LF), Ministry of Health
194	Nyen Nin Myint	Deputy Director, Epidemiology and Public Health Emergency, Ministry of Health
195	Theingi Aug	Deputy Director (Child Health), Ministry of Health
196	Ye Min Htwe	Deputy Director, NIMU, Ministry of Health
197	Aung Naing Oo	Assistant Director, EPI, Ministry of Health
198	Aye Mya Chantha	Assistant Director, EPI, Ministry of Health
199	Kyaw Khine San	Assistant Director, Epidemiology and Public Health Emergency, Ministry of Health
200	Myo Ko Ko Zaw	Assistant Director (Leprosy), Ministry of Health
201	New Ni Linn	Assistant Director(vector borne disease control)- Ministry of Health
202	Phyu Win Thant	Assistant Director, NIMU, Ministry of Health
203	Ye Win	Assistant Director, Trachoma Control, Ministry of Health
204	Aung Khant Thu	Central Project Coordinator (Vector Borne Disease Control), Ministry of Health
205	Thet Htar Sme	Medical Officer (Vector Borne Disease Control), Ministry of Health
206	Thi Htoon	Senior Consultant Microbiologist (National Health Laboratory), Ministry of Health
207	Pan Ei Soe	Junior Consultant Microbiologist (National Health Laboratory), Ministry of Health

S. No.	Myanmar	
	World Health Organization	
208	Stephan Paul Jost	Country WHO Representative
209	Nilesh Buddha	Country Deputy WHO Representative
210	Allison Gocotano	Technical Officer, ERM
211	Badri Thapa	Technical Officer, NTDs
212	Stephen Chacko	Technical Officer, EPI
213	Shahjahan Mohammad	Technical Officer, RMNCHA
214	Rahman	Technical Officer, NTDs
215	Lluis Vinals Torres	Health Policy Advisor, Health Systems
216	Aung Thu	National Professional Officer, TB
217	Aye Myat Soe	National Professional Officer, NCD
218	Khine Thet Su	National Professional Officer, TB
219	May Myat Thu	National Professional Officer, RMNCHA
220	Myo Paing	National Professional Officer, NCD
221	San Win	National Professional Officer, NTDs
222	Tin Aye	National Professional Officer, EPI
223	Win Bo	National Professional Officer, ERM
224	Zar Naing	National Professional Officer, AMR
	Technical/Donor Partners	
225	Yin Yin Htun Ngwe	Deputy representative, UNFPA
226	Satish Gupta	Immunization manager- UNICEF

S. No.	Nepal	
	Ministry Officials	
227	Bikash Devkota	Chief, Policy, Planning and Monitoring Division, Ministry of Health
228	Sagar Dahal	Chief, Health Emergency and Disaster Management Unit, Ministry of Health
229	Yeshoda Aryal	Chief, Health Coordination Division, Ministry of Health
230	Sharad Sharma	Section Chief, National Tuberculosis Control Center, Ministry of Health
231	Prakash Shah	Section Chief, NTDs & VBD section, Epidemiology and Disease Control Division, Ministry of Health
232	Chuda Mani Bhandari	Former Chief, Health Emergency and Disaster Management Unit, Ministry of Health
233	Sagar Rajbhandari	Director, National Tuberculosis Control Center, Ministry of Health

S. No.	Nepal	
234	Bibek Kumar Lal	Director, (NCDs and AMR) Epidemiology and Disease Control Division, Ministry of Health
235	Runa Jha	Director, National Public Health Laboratory, Ministry of Health
236	Bhim Singh Tinkari	Director, Family Welfare Division, Ministry of Health
237	Poma Thapa	Basic Health Section Curative Service Division, Ministry of Health
238	Jyoti Acharya	Joint Chief Medical Technologist, National Public Health Laboratory, Ministry of Health
239	Bimalesh Kumar Jha	Co-chief Medical Technologist, National Public Health Laboratory, Ministry of Health
240	Bal Kishan Awal	Microbiologist, National Public Health Laboratory, Ministry of Health
World Health Organization		
241	Jos Vandelaer	Country WHO Representative
242	Anindya Sekhar Bose	Team Lead, IPD Team
243	Lungten Wangchuk	Team lead, CDS
244	Md Khurshid Alam Hyder	Team Lead, PHA, HSS Unit
245	Reuben Samuel	Team Lead, WHE
246	Sadhana Bhagwat	Medical Officer, NCDs
247	Khin Pa Naing	Technical Officer, HSS
248	Damodar Adhikari	National Professional Officer, WHE
249	Lonim Prasai Dixit	National Professional Officer, NCDs
250	Pooja Pradhan	National Professional Officer, RMNCAH & HSS
251	Rajan	National Professional Officer, WHE
252	Roshan Karn	National Professional Officer, Health Financing
253	Usha Kiran	National Professional Officer, NTDs
254	Kimat Adhikari	National Professional Officer, HSS
Technical/Donor Partners		
255	Valerie Julliand	United Nations Resident Coordinator (UNRC), Nepal
256	Birendra Pradhan	HIV Specialist (PMTCT and Pediatric HIV), Health Section, UNICEF
257	Latika Maskey Pradhan	Assistant Representative, UNFPA
258	Hari Karki	National Humanitarian Response Officer, UNFPA
259	Neera	Reproductive Health Officer, UNFPA
260	Rajendra Basnet	Save the Children

S. No.		Sri Lanka	
		Ministry Officials	
261	Kanti Gunawardhana	Additional Secretary, Administration, Ministry of Health	
262	Sunil De Alwis	Additional Secretary, Ministry of Health	
263	Vindhya Kumarapelli	Director, NCDs (Tobacco and Alcohol), Ministry of Health	
264	Eshani A. Fernando	Director, Planning, Ministry of Health	
265	Chitramalee de Silva	Director MCH, Family Health Bureau, Ministry of Health	
266	P. Samarakshya	Director (Acting), Anti-Filariasis Campaign, Ministry of Health	
267	Chaupa Aluthweera	Director, Anti-Leprosy Campaign, Ministry of Health	
268	A.G. Ludowyke	Director, International Health- Ministry of Health	
269	S. Sridharana	Deputy Director General, Planning, Ministry of Health	
270	Susie Periera De Silva	Deputy Director General, Public Health, Ministry of Health	
271	Rohan Ratnayake	Deputy Director, NCD Mental Health, Ministry of Health	
272	B.U.S.H Baneregama	Deputy Director General, Laboratory Services, Ministry of Health	
273	Kapila Piyarene	Consultant, Community Physician, Ministry of Health	
274	Deepa Kamagh	Consultant, Epidemiologist, Ministry of Health	
275	M. Pathiraja	Consultant, DDG, Laboratory Services Office, Ministry of Health	
276	Lushan	Consultant, Planning Team, Ministry of health	
277	Asanden Wedamulla	Medical Officer, Disaster, Ministry of Health	
278	Maza Cader,	Community Physician- Ministry of Health	
279	Muditha Hapendeniya	SR, Health Information, Ministry of Health	
280	D.M.T Dassanayakta	Entomologist, Anti-Filariasis Campaign, Ministry of Health	
		World Health Organization	
281	Razia Narayan Pendse	Country WHO Representative	
282	Virginie Mallowaarodchhi	National Professional Officer, Non communicable diseases	
283	Thirupathy Suveendran	National Professional Officer, Mental Health and Substance Abuse	
284	Sadhani Rajapaksha	National Professional Officer, Psychosocial Wellbeing	

S. No.	Sri Lanka	
285	Nalika Gunawardena	National Professional Officer, Non-Communicable diseases
286	PC Samaraweera	National Professional Officer, Non-Communicable diseases
287	Janahan Navratna Sen	National Professional Officer, Non-Communicable diseases
288	Sapumala Dhanapala	National Professional Officer, Emergency Risk Management
289	Manjula Danasuriyam	National Professional Officer, RMNCH+A-Global Fund
290	Padmal De Silva	National Professional Officer, Human Resource for Health
291	Preshila Samaraweera	Acting National Professional Officer - RMNCH+A
292	Nalinda Wellapuli	National Consultant, Human Resource for Health
293	Achala Jayatiikele	National Consultant
294	Olivia Corazon Nieveras	Public Health Administrator
Technical/Donor Partners		
295	Safina Abdulleena	Child Survival and Development Program Manager, UNICEF
296	Dhammia Rowel	Health & Nutrition Officer, UNICEF
297	Palitha Abeykoon	Former Chairman, National Authority on Tobacco & Alcohol (NATA)
298	S.W. Rajapaksha	Chairman, NATA
299	Sajeewa Panaweera	Former Technical Consultant, NATA
300	Sampadh De Seran	Director, NGO ADIC
301	Asita De Silva	Chairman, National Medicines Regulatory Authority (NMRA)
302	Muradha Mohideen	Team Leader, United Nations Resident Coordinator (UNRC) Office
303	Indika Karunathilake	Faculty of Medicine, University of Colombo
304	J. Vidhpariya	Immediate Past Present, College of Community Physicians
305	Deepika Attygake	Senior Health Specialist, World Bank
306	M.R.Hanifa	Ex-President, SLMA

S. No.	Thailand	
	Ministry Officials	
307	Viroj Tangcharoensathien	Advisor, International Health Policy Program, Ministry of Health
308	Suwit Wibulpolprasert	Vice-Chair, International Health Policy Program, Ministry of Health
	World Health Organization	
309	Renu Garg	Team Lead, NCDs
310	Liviu	Team Lead, UHC
311	Richard Brown	Team Lead, AMR & ERM

S. No.	Timor Leste	
	Ministry Officials	
312	Odete Viegas	Directorate General of Health Services, Ministry of Health
313	Narciso Fernandes	Director of Cabinet Policy, Planning and Cooperation, Ministry of Health
314	Manuel Mausiry	National Director, Department of Immunization, Ministry of Health
315	Marcelo A.	National Director, Budget and Financing Management, Ministry of Health
316	Josefina C. Jao	National Director, Disease Control Program, Ministry of Health
317	Isabel Maria Gomes	Former National Director, Department of Maternal and Child Health, DNSP, Ministry of Health
318	Endang Soares da Silva	Executive Director, National Health Laboratory, Ministry of Health
319	Maris Dolores J.	Director, National Health Laboratory, Ministry of Health
320	Custodia Florindo	National Directorate, Emergency Management, Ministry of Health
321	Delfim Ferreira	Former Director, DNFM, Ministry of Health
322	Horacio Sarmiento	Former Director, Emergency Management, Ministry of Health
323	Frederico Bosco A	Health Officer, NCDs Department, Ministry of Health
324	Nunu Vital	Head, Medical Emergency and Ambulance, Ministry of Health
325	Constantino Lopes	TB programme Manager, Ministry of Health
326	Suzana Henriques	Pharmacist, Ministry of Health

S. No.	Timor Leste	
327	Jose G. Moniz	Staff, National Health Laboratory, Ministry of Health
328	Agostinha Amaral	Staff, Emergency Management, Ministry of Health
329	Joanico P.A. Vieras	Biomedical Engineer, Ministry of Health
World Health Organization		
330	Rajesh Pandav	Country WHO Representative
331	Sudath Peiris	Technical Officer, EPI
332	Debashish Kundu	Medical Officer, TB/HIV
333	Jayendra Sharma	Technical Consultant, HSS
334	Vinay Bothra	Technical Consultant, HSS
335	Young Hee Jung	Technical Consultant, NTDs
336	Dongbao Yu	National Professional Officer, AMR
337	Leoneto Pinto	National Professional Officer, NCDs
338	Luis Dos Reis	National Professional Officer, WHE
339	Jermiaz Da Cruz	National Professional Officer, RMNCHA
Technical/Donor Partners		
340	Roy Trivedi	United Nations Resident Coordinator (UNRC), Timor-Leste
341	Domingas Bernardo	Assistant Country Representative, UNFPA
342	Paolo barduagni	Assistant Country Representative, Health and Nutrition, European Union
343	Dara Doldo	First Secretary (Development) for Health, Australian Embassy (DFAT)
344	Carli Shillito	Counsellor, Human Development, Australian Embassy (DFAT)
345	Julia Magno	Senior Health Officer, Australian Embassy (DFAT)
346	Sikhyon Kim	Country Director, KOICA, Timor Leste
347	Sohoe Chum	Programme Coordinator, KOICA, Timor Leste
348	Gaurav Sharma	Health Manager, UNICEF
349	Aderito do Carmo	Health Officer, UNICEF
350	Faraja Chiwile	Nutrition Specialist, UNICEF
351	Teresa Miller	Director, Office of General Development, USAID

Annex 7

Discussion guides

Annex VII.A – Discussion Guide for WHO stakeholders

Name of the respondent:

Designation:

- Q1. Can you tell me how long have you been in your current role?
- Q2. Prior to 2014, how was this area of public health concern addressed?

Questions concerning the WHO Activities for the Flagship Priority Area

- Q3. Can you tell us about any change in the resource allocation for this flagship at the WHO?
 - Funding
 - Manpower
- Q4. What activities has the WHO undertaken to produce results within the flagship area? How were they monitored?
- Q5. How is this Flagship priority area still relevant for your country?
- Q6. What role has the WHO played in multi-sectoral coordination for the flagship area? Can you share some examples?
- Q7. Does this flagship collaborate with other flagship programs?
- Q8. How did you ensure that equity was prioritized under this flagship? What can be done to improve equity?

Questions concerning the Ministry of Health for the Flagship Priority Area

- Q9. What significant changes have occurred at the country level since the introduction of this flagship?
- Q10. How has the uptake been for the above-mentioned activities by the Ministry of Health?
- Q11. Which were the factors that a) facilitated b) hampered the progress of this flagship at the country level?
- Q12. What are the lessons and successes for this flagship within your country?
- Q13. How do you ensure sustainability of achievements made by the flagship?
- Q14. Going forward, what can be done differently for the flagship to achieve its targets (pending/ revised) by 2023? (For WHO and for MoH)

Annex VII.B – Discussion Guide for MoH stakeholders

Name of the respondent:

Designation:

Organization:

- Q1. Can you tell me how long have you been in your current role?
- Q2. In 2014, WHO launched flagship areas in the SEA region to prioritize key public health concerns. Have you heard about them?
- Q3. Can you please tell us about the national health priorities of the country from 2014-2018? Do the WHO flagships areas align with the national health priorities of your country?
- What was the role of the WHO flagship in making the public health concern a national priority?*
- Q4. How effective has WHO's contribution been in delivering results in the flagship area at the country level? To what extent has the flagship focus and implementation at country level helped to improve health outcomes?
- Q5. How could WHO contribute better in supporting the Ministry's objectives?
- Q6. What are the significant achievements at country level due to implementation of this WHO flagship?
- Q7. What have been the enabling factors that facilitated the achievement of the results?
- Q8. What have been the challenges that hampered the achievement of the results?
- Q9. In case the funding and support from donor agencies reduces, how do you plan to sustain the achievements made so far?
- Q10. Going forward, what can be done differently for the flagship to achieve national targets (pending/ revised) by 2023?

Annex VII.C – Discussion Guide for Technical Partners/ Donors

Name of the respondent:

Designation:

Organization:

Role of Organization (in general):

- Q1. Can you tell me how long have you been in your current role?
- Q2. In 2014, WHO launched flagship areas in the SEA region to prioritize key public health concerns. Have you heard about them?
- Q3. How was the WHO flagship successful in advocating for this public health concern to become a national priority?
- Q4. To what extent has the flagship focus and implementation at country level helped to improve results?
- Q5. Can you tell me about collaborative efforts between your organization, the WHO and the Ministry of Health within the flagship area in the period 2014-2018?
- Q6. What has been WHO's contribution in the progress of the flagship? Any examples?
- Q7. What have been the enabling factors that facilitated the achievement of the results?
- Q8. What have been the challenges that hampered the achievement of the results?
- Q9. In case the funding and support from donor agencies reduces, how do you think the government will be able to sustain the achievements made so far?
- Q10. Going forward, what can be done differently for the flagship to achieve national targets (pending/ revised) by 2023?

Annex VII.D – Likert scale questionnaire for MoH stakeholders and Technical Partners/Donors

	Does not perform the function at all (1)	Less than expected (2)	Meets expectations (3)	A little more than expected (4)	Exceeds the expectations (5)
How do you think WHO performs in terms of articulating country specific policy options and guidelines for the flagship priority areas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How do you think WHO performs in terms of providing technical assistance for the flagship priority areas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How do you think WHO has enabled your country for evidence-based research for informed decision making?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In your opinion, how strongly has the WHO supported in monitoring and evaluation of this flagship priority area?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How do you think WHO supports in mobilizing political advocacy for this flagship priority area in your country?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How do you rank WHO's support in mobilizing funding for this flagship priority area?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Annex VIII

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