

Family health and research

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Primary and community health care

1. In response to the regional consensus to revitalize primary health care, the Primary and Community Health Care Unit was created in the Regional Office in June 2009. The Regional Conference on Revitalizing Primary Health Care held in Jakarta, Indonesia in August 2008 had called for adopting a “development approach” to strengthening health systems. The Regional Office for South-East Asia subsequently supported the development of a Strategic

Route Map (SRM) in Thailand. The SRM is a management tool to empower the community in health development. The WHO Regional Office for the Eastern Mediterranean (EMRO) has shown interest in applying SRM and has planned to visit Thailand for this purpose. Senior officials from Bangladesh, India, Indonesia, Sri Lanka and Thailand were oriented to SRM through a multicountry activity organized in Bangkok in May 2009.

2. To strengthen intercountry collaboration, a team from Thailand visited Sri Lanka to observe PHC innovations/initiatives in that country.

3. Community-based initiatives (CBI) are an important element of primary health care. Several countries in the Eastern Mediterranean Region have established effective models of CBI. To promote similar initiatives in the South-East Asia Region, a knowledge exchange programme of high-level officials from Bangladesh, India, Indonesia, Sri Lanka and Thailand was organized in Morocco in November 2009. Participants interacted not only with Moroccan policy-makers and programme managers, but also with community-based workers and volunteers and community members as well. This visit will be followed by a reciprocal visit by EMRO to Thailand to observe SRM.

4. Bangladesh embarked upon an ambitious countrywide project to strengthen and expand community-based health services through Community Health Clinics. In support of this initiative the Regional



Community-based initiatives are an important element of PHC.

Office arranged an observational field visit of a team of senior officials from Bangladesh led by the Adviser to the Prime Minister to study similar initiatives in India and Myanmar. The Regional Office is providing technical support for the project and also provided ambulances to three districts to strengthen referral transport under the project.

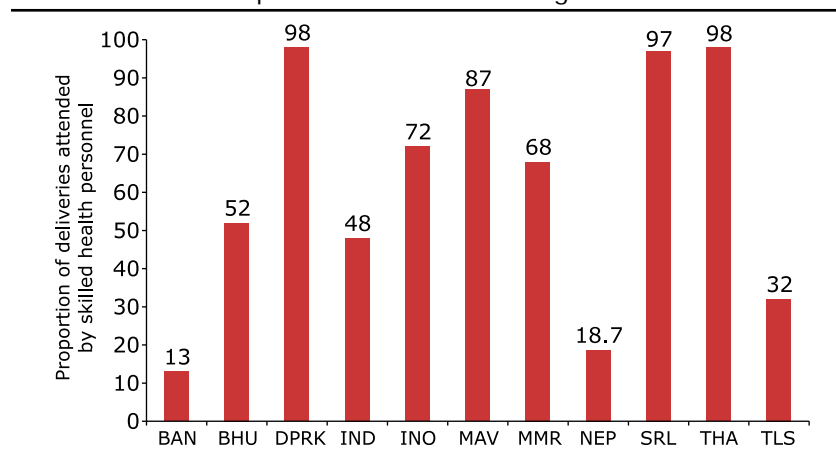
5. To provide a regional platform for ideas exchange on PHC, the Regional Office, in consultation with Member States, established the PHC Innovations Network. This network will draw its membership from grassroots institutions active in PHC and will serve as a think-tank for revitalizing primary health care in the Region. To promote interregional cooperation, the Regional Office has entered into a collaborative agreement with the Regional Office for the Eastern Mediterranean (EMRO) to facilitate exchange of experiences and build capacity for PHC implementation.

6. Recognizing that PHC is an intersectoral effort, an interdepartmental working group was created in the Regional Office to guide PHC-related activities. The focus of activities is on health policy analysis, promoting self-care by individuals and communities, urban primary health, strengthening referral care and knowledge, family medicine and dissemination regarding regional and global innovations in primary health care.

Making pregnancy safer and reproductive health

7. All pregnant women and their newborns have the right to get the best possible health care, especially during childbirth and immediately after, when most complications and deaths occur. One of the indicators for Millenium Development Goal (MDG) 5 is the proportion of births attended by skilled health personnel, with the targets for high MMR countries set at 50% and 60%, by 2010 and 2015 respectively and 85% and 90% globally. Although 4 out of 11 Member States have achieved universal coverage for skilled care at birth, four others have not achieved the 50% target. This lack of access to key maternal and newborn health (MNH) care continues to be the main issue in the Region, besides the issue of overall quality of care.

Figure 3.1: Proportion of deliveries attended by skilled health personnel in the SEA Region



Source: 11 health questions about the 11 SEAR countries, SEARO

8. To promote the achievement of “skilled care at every birth”, the Sixty-first Session of the Regional Committee urged Member States to strengthen the database and national plan for human resources for maternal and newborn health, as well as to improve MNH human resource management at entry, performance and exit levels. During the period under review, Member States were supported in strengthening pre-service midwifery training; improving neonatal health through promoting essential newborn care; improving quality of pre-service and in-service midwifery training; and improving quality of MNH services, including adaptation and utilization of evidence-based guidelines and tools. Evidence-based guidelines for MNH were translated and utilized widely. Member States are accepting family planning, skilled care at birth, emergency obstetric care and essential newborn care as the main interventions for reducing maternal and neonatal mortality.

9. Multi-year projects on MNH are being implemented in Bangladesh and DPR Korea with external resources. A multi-year project on newborn health is ongoing in Myanmar. Neonatal health was promoted in nine countries.

10. Various activities to strengthen management of MNH programmes were carried out in Bangladesh, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste. Bangladesh and Timor-Leste worked on strengthening district programme management through the District Team Problem-Solving approach and Local Area Monitoring for MNH, respectively. Indonesia worked on the development of maternity waiting homes for remote areas; Maldives on disseminating Maternal Mortality Reports and initiating maternal and perinatal near-miss

reviews; Myanmar and Nepal on strengthening community involvement in MNH; and Sri Lanka developed a strategic plan for MNH.

11. Several important meetings were organized in 2008-2009. Issues addressed included: (i) continuum of care and partnerships in accelerating the achievement of MDGs 4 and 5 in the context of primary health care by strengthening the health system and involvement of relevant sectors; (ii) the need to review and develop country strategies for improving postnatal care and prevention and treatment of postpartum haemorrhage; and (iii) analysing sociocultural dimensions of MNH, and the way they are incorporated in programmes for improving MNH. As a follow-up to these meetings, countries disseminated the information nationally and took necessary actions to improve the quality of care for mothers and their newborns.

12. A major challenge faces the Region in relation to MNH human resources, especially in the four Member States that have a low proportion of deliveries assisted by a skilled attendant, where the number of health providers at community level with midwifery skills is usually inadequate and the quality of their services needs improvement. At the national level, databases on human resources for MNH are not

well established and national plans are unclear, or available but not well implemented. Quality of MNH services is another challenge in most countries of the Region. While evidence-based guidelines have been adapted in most Member States, their utilization in daily practice at all levels remains an issue. Resource mobilization at the regional and country level, with a few exceptions (in Bangladesh and DPR Korea) remains a major challenge.



Maternal and newborn health (MNH) is a key issue regionally.

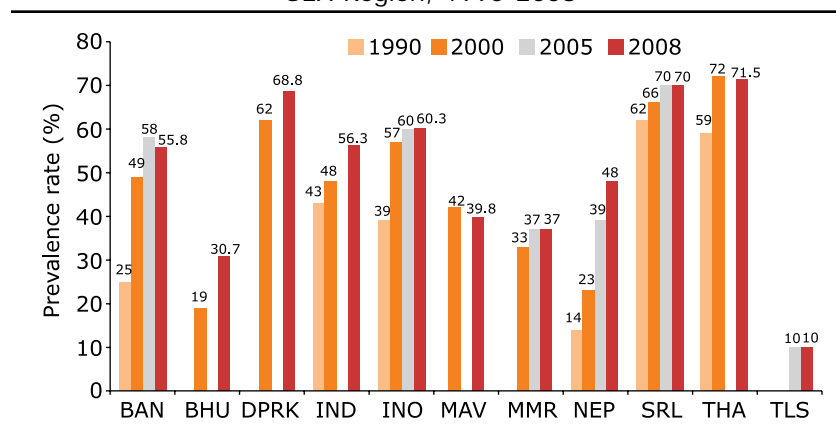
Reproductive health

13. Among the many elements of reproductive health, maternal and neonatal health continued to be a major issue in most SEA countries. The other key elements, such as family planning, prevention of unsafe abortion and sexually transmitted infections (STIs), contribute to the improvement of maternal and neonatal health. Countries with a high maternal and neonatal mortality usually also have a high fertility rate, low age at marriage and a high burden of teenage pregnancy. Many reproductive health problems are interrelated and therefore need an integrated approach to address them.

14. A framework for implementing the WHO-recommended Reproductive Health Strategy was published in 2008. Many Member States have adapted the framework or use it as a reference for the development of their reproductive health strategy. Technical support was provided to Myanmar to develop its Reproductive Health Strategic Plan 2009-2013.

15. The contraceptive prevalence rate varies among Member States. Figure 3.2 indicates that progress in many countries of the Region has been promising; however, Bhutan, Maldives, Myanmar, Nepal and Timor-Leste still have rates of less than 50%. The issues of expanding contraceptive choice, quality of family planning services, and unmet needs are being addressed. In this context, Timor-Leste was assisted in conducting a study tour for programme managers and partners to Indonesia to strengthen maternal and newborn health, as well as family planning programmes. India, Indonesia, Sri Lanka and Thailand were assisted in producing the Family Planning Wheel, which is a practical job aid for family planning service.

Figure 3.2: Trends in contraceptive prevalence rate, SEA Region, 1990-2008



Source: World Population Policies 2005; World Population Data Sheet 2006; Family Planning Worldwide 2008 Data Sheet.

16. Unsafe abortion is responsible for about 13% of all pregnancy-related deaths,² while about half of the unsafe abortions in the world occur in Asia. Bangladesh managed to mobilize resources from the Royal Netherlands Embassy for a four-year programme on improving quality of menstrual regulation (MR) services in the country. The “Strengthening of National Menstrual Regulation Programme in Bangladesh” was then launched in 2008. NGOs working in this area are supported for improving access and quality of the service, especially in rural areas, as well as research on sociocultural aspects of non-use of MR services. DPR Korea was also supported in improving the capacity of health facilities to provide safe abortion care, while Thailand organized national and international meetings in prevention of unsafe abortion.

17. The integration of prevention and management of STIs/HIV infection into reproductive, maternal and newborn health services continues to be a priority. An intercountry workshop on the elimination of congenital syphilis was carried out in collaboration with the WHO HIV/AIDS programme with the participation of India, Indonesia, Sri Lanka and Thailand. A biregional workshop attended by participants from selected countries from the WHO Western Pacific and South-East Asia regions was organized to build capacity for writing proposals related to maternal and newborn health and other reproductive health issues for submission to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

18. As a follow-up of the Global Survey on Maternal and Perinatal Health, an intercountry meeting involving India, Nepal, Sri Lanka and Thailand was organized. It facilitated the discussion on how best to use the results of the Global Survey and identification of further research and interventions for improving maternal and perinatal health. Thailand followed this up with a national meeting among relevant stakeholders.

19. There are other reproductive health issues of interest to Member States, such as the review and development of national policies and guidelines on prevention and control of cervical cancer. Technical assistance was provided to Bhutan, DPR Korea, Maldives and Nepal for this purpose. The WHO guideline on essential practice on the subject was adapted. DPR Korea was also supported in improving health providers’ capacity in early detection and management of breast cancer, as well as in development of educational material on

²Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000, WHO, 2004.

management of menopause syndrome. Sri Lanka was supported in producing an information book for newly married couples.

20. The achievement of universal access to reproductive health, as stated in Millennium Development Goal 5B, remains a challenge. Integrated services of various elements of reproductive health, especially at primary care level, need further strengthening. Monitoring of progress in achieving universal access to reproductive health at national and subnational levels is necessary, especially in the effort to achieve MDG 5.

Nursing and midwifery

21. The focus of work in nursing and midwifery during the biennium 2008-2009 was mainly on education, maternal and newborn health, nursing and midwifery workforce planning and management, nursing and midwifery services and regulation.

22. Efforts were made to improve the quality of nursing and midwifery education through advocacy, providing technical assistance to Member States and organizing the meeting of the South-East Asia Nursing and Midwifery Educational Institution Network (SEANMEIN). A case study to demonstrate the commitment and investment of the Government of India to nursing and midwifery education was developed. In the national eleventh Five-Year Plan, the government has included the policy and plan on nursing and midwifery education for the first time and has allocated substantial budget to build nursing schools and for the recruitment and development of teachers.

23. With support provided by the Regional Office, sets of models and mannequins along with textbooks were procured for nursing and midwifery schools in Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste for self-learning and skill practice.

24. The second meeting of SEANMEIN in April 2009 provided opportunities to share experiences on the global and regional initiatives in nursing and midwifery. Discussions included the role of educational institutions in nursing and midwifery workforce planning, quality assurance (especially in setting the standards of education), and the need for institutions to adapt curriculum to address the issues and trends facing the health systems and national health problems. A framework for public health/community health nursing education was also introduced.



Education and training have improved the quality of nursing and midwifery in the Region.

25. While technical assistance is aimed to strengthen a three-year Diploma in Nursing and Midwifery in Bangladesh and Democratic People Republic of Korea, technical support is also extended to Member States that are implementing or planning to implement a degree programme for professional development. In this context, assistance was provided to the National University of Timor-Leste to implement two Bachelor's degree programmes in nursing and midwifery, and the development of the Bachelor's degree curriculum in nursing and midwifery for Bhutan.

26. With WHO support, the Faculty of Nursing, Khon Kaen University, Thailand, organized a regional training on community nursing and a study tour on the role of community-based health workforce in line with revitalization of primary health care. Support was provided to Bhutan to develop an information kit, with an emphasis on health promotion and disease prevention for community-based health workforce, including auxiliary nurse-midwives, and to organize national trainings on the information kit.

27. The work of the unit focused on advocacy for utilization of nurse-midwives or midwives at the community level, the strengthening of pre-service nursing and midwifery education and the training of existing nurse-midwives or midwives.

28. In collaboration with the Making Pregnancy Safer (MPS) and Reproductive Health and Research (RHR) units, an advocacy document on *Effective management of health workforce in accelerating the*

reduction of maternal and newborn mortality was produced and disseminated. Other activities included a regional meeting on sociocultural factors and MDGs 4 and 5; a review of the midwifery section in pre-service nursing and midwifery curriculum in Bhutan; national training of midwifery teachers in Nepal; and development of strategic directions for enhancing contribution of nurse-midwives for midwifery services in Bangladesh.

29. In collaboration with other units in both SEARO and WPRO, support was provided to the Asia-Pacific Emergency and Disaster Nursing Network (APEDNN). The network meeting in Cairns, Australia in 2009 demonstrated progress made with regard to the network website; core competencies of nurses and midwives in disaster preparedness and response; training courses; and a research framework.

30. Challenges remain. Strong professional leadership and unity and commitment by the government for strengthening nursing and midwifery is important in order for nurses–midwives be able to respond to the health needs of the people more effectively.

Child and adolescent health and development

Adolescent health and development

31. Adolescence (10-19 years) is a period of rapid growth and development. Adolescents constitute about 25% of the total population in countries of the SEA Region. Early marriage, early childbearing, undernutrition, sexually transmitted infections (STIs) and HIV/AIDS are major public health priorities in selected Member States of the Region. In order to achieve the Millennium Development Goals (MDGs) 5 (maternal health) and 6 (HIV/AIDS), it is important to focus on sexual and reproductive health of adolescents. Lack of access to information and health services hinders improvement in adolescent health. WHO has articulated a 4 "S" strategic framework to strengthen health sector response to adolescent health: strategic information; supportive policy environment; services and supplies; and strengthening collaboration with other sectors. Member States have adopted this strategy and WHO has provided assistance in the following areas:

32. Strategic information: WHO provided technical assistance to Member States to strengthen their epidemiological database on

adolescent health and HIV/AIDS in young people. Country factsheets for all Member States and national profiles in five countries (Bangladesh, Bhutan, Nepal, Sri Lanka and Thailand) were developed and disseminated. Sub-set analyses of existing national surveys (DHS, behaviour surveys and HIV surveillance, etc.) were supported in Bangladesh, India, Indonesia, Nepal and Sri Lanka, the reports of which are being finalized. All efforts mentioned above were found to be useful in advocating for increased investments in adolescent health and for provision of information and services to adolescents.

33. Supportive policy environment: With continued technical support from WHO, four countries (Bangladesh, India, Myanmar and Nepal) have developed national strategy on adolescent health. Youth policy in Sri Lanka is in the process of approval. Laws and policies affect access to information and health services for adolescents. Within the Human Rights framework and Convention of the Rights of Child (CRC), an assessment tool on laws and policies was adapted from the general tool of WHO in Sri Lanka. To share the tool and findings of Sri Lanka assessment, an intercountry meeting was organized in March 2009 in Colombo, Sri Lanka. In addition to adolescent health programme managers, legal officers/lawyers from Member States participated in the meeting; plans to conduct similar assessments and to develop guidelines for health providers were discussed. Subsequently Bangladesh completed assessment of laws and policies related to adolescent health.

34. Services and supplies: Tremendous progress has been made by Member States in implementation of adolescent/youth-friendly health services (AFHS/YFHS). Technical assistance was provided to develop a systematic approach to development, implementation and scaling-up of these services. Activities involving setting of national standards on quality of health services, implementation of guidelines to operationalize standards and adaptation of the training package for health providers, were completed in Bangladesh, Bhutan, India and Sri Lanka. Capacity building at national and subnational levels is being supported to implement AFHS/YFHS. Job-Aid (clinical algorithms for health providers developed by WHO) were field-tested in India.

35. Assessment of quality and coverage of AFHS/YFHS has been initiated in Bhutan, Bangladesh, India, Sri Lanka and Thailand. Technical assistance was provided for adaptation of quality and coverage tools, based on national standards. Results of the quality and coverage assessment conducted in selected sites have been obtained from India, Sri Lanka and Thailand. It is proposed to organize a regional meeting

to share the findings of assessment in selected countries and build capacity of remaining countries to adapt and use the tools according to the existing monitoring and supervisory mechanisms.

36. Technical assistance was provided for a national consultation to include adolescent health in the undergraduate curriculum of medical education in India. Job-Aid (clinical algorithms) have been adapted and printed for inclusion in the course for Postgraduate Diploma in Maternal and Child Health (PGDMCH) by the Indira Gandhi National Open University (IGNOU), New Delhi, India.

37. Strengthening collaboration with other sectors: Efforts have been initiated to build linkages between school health programmes and AFHS in Member States. An intercountry workshop on national nutritional surveillance was organized in July 2009 in Kathmandu, Nepal, to introduce the adolescent growth reference. Participants from both education and health sectors were invited. Selected countries were supported to implement the peer education programme to enhance demand-generation for services. In Bhutan, development and field-testing of modules on adolescent health for school health coordinators was supported. The modules have since been printed and released by her majesty the Queen of Bhutan.

Child health and development

38. WHO has extended technical assistance to Member States in the Region to contribute to achievement of MDG 4. A High-Level Consultation to Accelerate Progress towards Achieving Millennium Development Goals 4 and 5 in South-East Asia was organized in October 2008, one of the major recommendations of which was to strengthen maternal, newborn and child health through initiatives to strengthen health systems while addressing the contextually relevant social determinants.

39. Integrated Management of Childhood Illness (IMCI) continues to be the main vehicle to promote child health. Scaling-up of implementation to cover additional geographic areas has been achieved in seven Member States.

40. In-service training of health-care providers has been further strengthened in the countries implementing IMCI. Alternate methodology of training through computer applications (ICATT) has been expanded in Indonesia. Pre-service education of medical and nursing cadres has also been scaled up in Bangladesh, India and



IMCI is the main vehicle for promoting child health.

Indonesia and review meetings were held to document progress and plan future actions.

41. Implementation of IMCI is likely to increase referral of sick newborns and children to hospitals for inpatient care. To strengthen inpatient care, initiatives to provide standard case management to sick children and newborns have been supported in Bangladesh, India and Indonesia. India has developed a training package for doctors and nurses to improve their competence to manage sick newborns and children in first-level referral hospitals. During the "Regional Workshop to Improve Inpatient Hospital Care of Children in South-East Asia", a framework for improving quality of hospital care for children was developed. Subsequently, adaptation and initial application of tools for assessment of quality of care of sick newborns and children in hospitals has been strengthened in Indonesia and introduced in Bangladesh.

42. Periodic review of child health programmes at national and sub-national levels contributes to its effective planning and implementation. WHO has developed guidelines for conducting Short Programme Reviews (SPR) of child health to enable assessment of progress towards programme goals, objectives and implementation, to identify bottlenecks and develop recommendations for improving planning and implementation. The findings of SPRs were used in the development of a five-year national child health strategic plan in Myanmar, and in Bangladesh and Nepal, child health plans were strengthened as a part of the national health plans.

43. Fact sheets on child health have been developed to provide key information related to epidemiology, demographic indicators and coverage of the key child health interventions in all Member States. The fact sheets would be useful for high-level advocacy for informed planning to accelerate implementation of child health interventions to achieve MDG 4.

44. WHO has advocated with Member States to invest in the early childhood development (ECD) strategy, which focuses on the age group 0-3 years and ensures that children are exposed to age-appropriate psychosocial stimulation through communication and play activities, along with necessary health and nutrition interventions. A joint WHO-UNICEF "Regional Meeting on Promoting Early Childhood Development" was organized in Colombo, Sri Lanka in July 2009, where the global ECD package and a draft regional strategy on early childhood development were shared with representatives from SEA Region countries. The Regional ECD strategy is being finalized.

Immunization and vaccine development

45. At the end of 2009, India remained the only polio-endemic country in the Region. Recently re-infected countries remained polio-free: Bangladesh, Indonesia and Myanmar for more than two years, and Nepal for more than one year. India had 740 cases of polio, of which 79 cases were of type 1 poliovirus and 661 cases were of type 3 poliovirus mainly due to an outbreak in western Uttar Pradesh in the middle of



Immunization practices and policies have been strengthened by Member States.

2009. However, the number of infected districts was reduced by a third from 2008 to 2009. An independent evaluation reaffirmed the high quality of polio surveillance and supplementary immunization activities that were being implemented in the endemic areas of western Uttar Pradesh and Bihar. The evaluation acknowledged the unique challenges of migratory populations, poor routine immunization coverage, high population density and poor sanitation.

46. The evaluation and discussions at global and regional level led to the development of a three-year (2010-2012) programme of work (PoW) to interrupt wild poliovirus circulation in India, with a focus on 107 high-risk blocks in the endemic areas. With support from WHO and partners, the Government of India in late 2009 intensified its efforts in these blocks through high-quality supplementary immunization using existing oral polio vaccines (tOPV, mOPV1 and mOPV3), routine immunization, and intensification of short-term sanitation activities.

47. The polio laboratory network, which consists of 16 accredited laboratories, continued to play a vital role in polio surveillance. In 2009, the regional network processed an incredible 110 000 AFP (acute flaccid paralysis) specimens within the global standard of 14 days for reporting results. The experience of the polio laboratory network was used to further strengthen the regional laboratory surveillance for measles/rubella, Japanese encephalitis/acute encephalitis syndrome, and sentinel laboratory surveillance for invasive bacterial disease and rotavirus.

48. In polio-free countries in the Region, the challenge remains to maintain high levels of OPV immunization through routine immunization and sustain high-quality AFP surveillance. WHO periodically conducted risk assessments for all Member States, which guided decisions for conducting national surveillance reviews. EPI and VPD surveillance programme reviews (with a focus on AFP surveillance) were conducted in Myanmar and Indonesia in 2008 and 2009, respectively.

Measles

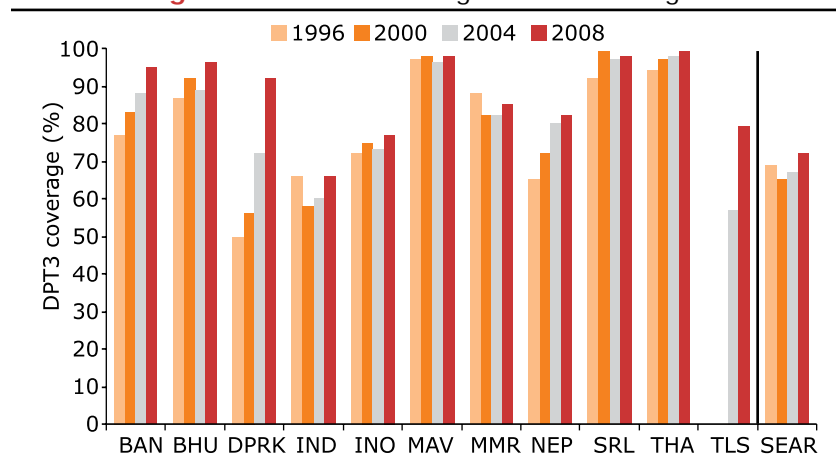
49. The Regional measles consultation in August 2009 in New Delhi confirmed that all countries in the Region except India had achieved or exceeded the 90% measles mortality reduction goal. It recommended a goal of eliminating measles from the Region by 2020. All Member States conducted measles surveillance with the support of a regional network of 20 measles/rubella laboratories, of which 18 were accredited. In

2009, the national surveillance systems in Bhutan, DPR Korea, Maldives and Timor-Leste did not detect any suspected measles outbreaks. Seven states in India began case-based surveillance with laboratory confirmation for suspected measles outbreaks.

50. Although the Region achieved measles routine immunization coverage of about 75% and completed catch-up campaigns in all countries except India and Thailand, approximately 9.9 million children born each year in 2008 and 2009 were not vaccinated against measles.

51. In 2008, according to WHO/UNICEF estimates Bangladesh, Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand achieved greater than 90% DPT3 coverage nationally. Myanmar and Nepal achieved greater than 80% DPT3 coverage. Indonesia and Timor-Leste achieved greater than 70% DPT3 coverage while India achieved greater than 60% coverage.

Figure 3.3: DPT3 coverage in the SEA Region



Source: WHO/UNICEF Estimates

Note: Timor-Leste was part of Indonesia prior to 2002

52. In an effort to further strengthen immunization practices and systems, WHO assisted ten countries in the Region to form national advisory committees for immunization practices and developed an orientation package for the committees. The committees will advise the government in immunization policy development and introduction of new vaccines and strategies. By the end of 2009, countries had either developed a comprehensive multi-year immunization plan or were updating existing plans during the biennium. Member States developed national curriculum for mid-level managers and basic health workers, updated existing training materials and conducted courses.

These training activities were linked with measles supplementary immunization activities. In India, technical assistance was provided to conduct a survey to assess the performance of health workers who received immunization training in seven low-performing states. Four Member States (Bangladesh, Bhutan, Nepal and Sri Lanka) introduced *Haemophilus influenzae* type b vaccine in their national immunization schedule. In order to better understand the disease burden for recently developed vaccines, laboratory surveillance sites comprising four rotavirus and six invasive bacterial diseases (IBD) laboratories were established in Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka.

53. Despite these achievements, over 10 million children in the Region do not receive DPT3 vaccination during their first year of life. The trend for DPT3 coverage appears to be stagnant at 72% since 2006. In India, 11 states account for 90% of the unimmunized for DPT3.

54. Many factors contribute to this situation including difficult terrain, inadequate human resources, suboptimal use of resources, poor transport facilities, extreme weather conditions, and the knowledge, attitudes and behaviours of clients and immunization service providers, as well as the occurrence of adverse events following immunization (AEFI). In the past two years, as a result of WHO assistance, nine Member States established a national AEFI committee. The committees in India, Indonesia, Nepal and Sri Lanka received training on causality assessment of AEFI.



Despite constraints Member States are taking steps to expand immunization coverage.

55. Three of 11 Member States have a functional National Regulatory Authority (NRA). Twenty workshops and meetings were conducted for training 68 NRA/National Control Laboratory (NCL) staff in regulatory functions. The Regional Working Reference Standards (RWRS) for pertussis were developed. Studies on RWRS for JE and mOPV1 have been initiated. Four countries conducted injection safety assessment and developed policies to strengthen injection safety in immunization settings. One country conducted a study on risks associated with the needle pullers device for sharps management.

56. A regional strategic framework for improving and sustaining immunization coverage was drafted and circulated among all stakeholders. In the area of vaccine supply and quality, the focus was on strengthening national regulatory authority capacity and preparing the RWRS. Efforts were also made to establish and harmonize injection safety policies. Systems and tools were developed for Effective Vaccine Stores Management (EVSM).

Nutrition and food safety

57. The ninth South-East Asia nutrition research-cum-action network (SEA-RCA) meeting was organized in 2008 where the emerging issues of increasing food prices and their impact on nutrition and food security and the persistence of iodine deficiency disorders (IDD) were



National IDD capacity has been strengthened through training programmes.

discussed. A key recommendation was to strengthen the capacity of Member States to gather accurate, representative and frequent data on nutrition and food security and support the national IDD monitoring and quality control mechanisms. Technical assistance in understanding and formulating nutrition, food safety and security interventions in response to climate change and its impact on food production, availability and consumption was provided to six Member States: Bhutan, India, Maldives, Nepal, Sri Lanka and Thailand.

Box 3.1: Strategic Focus in Nutrition & Food Safety:

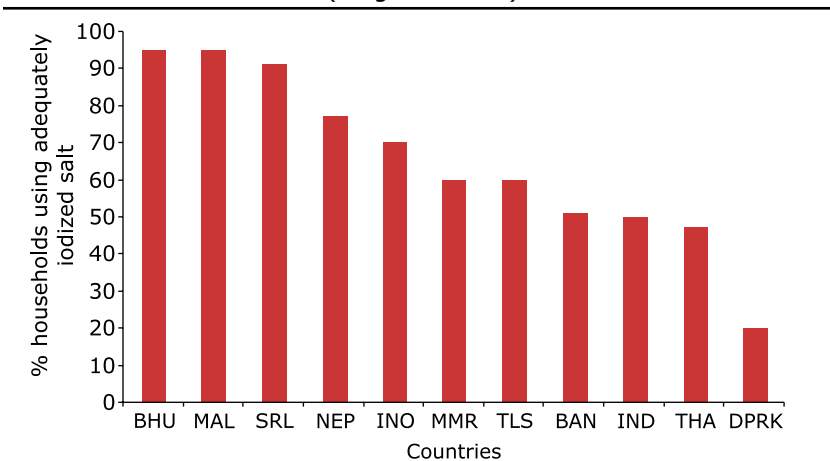
1. Policy formulation and operationalization of integrated nutrition, food safety and food security;
2. Surveillance and intelligence for effective management and monitoring;
3. Programme guidance on evidence-based interventions.

58. The national food safety programme and the iodine deficiency disorders (IDD) control programme of Thailand and the national IDD control programme of Sri Lanka were reviewed in terms of their policy and implementation content; the recommendations emanating from these assessments were shared and discussed with the highest-level health policy and programme personnel in these countries.

59. Participants from the Region were trained in the newer concepts of monitoring of urinary iodine and quality control of salt iodization at a regional workshop. The national IDD control and prevention programmes in Myanmar and the Democratic People's Republic of Korea received support in the form of training of laboratory staff, standardization of laboratory techniques and provision of necessary equipment. Additional technical assistance was provided in designing the national IDD survey in the Democratic People's Republic of Korea.

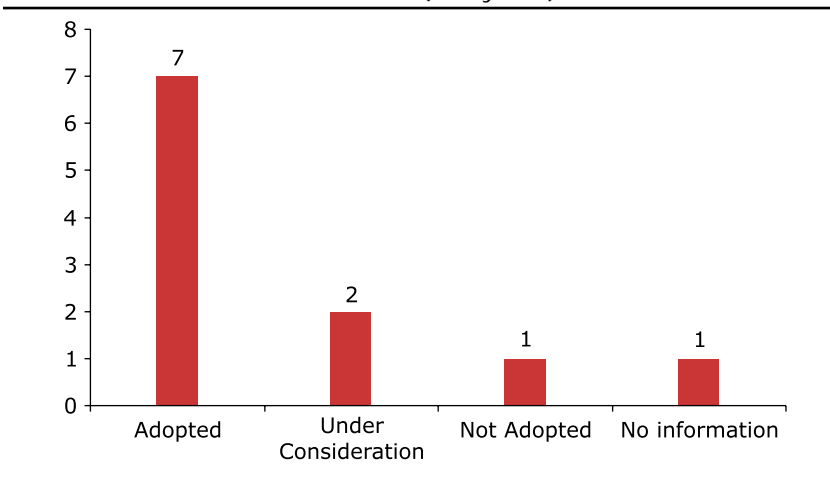
60. A new initiative known as "Landscape Analysis" to assess the capacity of Member States to respond to high levels of chronic malnutrition—stunting—in young children was piloted in Timor-Leste. The Regional Office and Member States also participated in the global review of food and nutrition policy survey.

Figure 3.4: Proportion of households using adequately iodized salt (Target $\geq 90\%$)



Sources: DHS surveys of various years / UNICEF MICS / ICCIDD SEA Regional Office / Annual Report

Figure 3.5: Status of adoption of the WHO new Child Growth Standards (0-5 years)



Sources: WHO-SEARO Questionnaire Survey (2009)

61. A nutrition programme relies on accurate nutrition intelligence and a surveillance system for effective monitoring and assessment of programme interventions. This strategic focus was achieved through a series of activities, starting with training in the use and interpretation of WHO growth standards for young children in India, Myanmar and Nepal. A regional workshop on the nutrition surveillance system was organized with the participation of representatives from Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste. Nine Member States in the Region have thus far adopted the WHO growth references for children under five years; the new WHO

growth references for children and adolescents are yet to be adopted by any Member State. The existing nutrition surveillance systems in the countries of the Region remain limited in scope, range, frequency and accuracy.

62. Technical capacity to conduct food analysis and monitor food contamination was enhanced through training and procurement of laboratory equipment for the Food and Drugs Authority in the Maldives (MFDA).

63. With regard to programme guidance based on evidence-based interventions, the Regional Office was the first to introduce a training module developed by WHO Geneva, on preparing national food-based dietary guidelines, in three member states (Maldives, Nepal and Sri Lanka). An integrated breastfeeding and complementary feeding counseling course for health staff was introduced in Indonesia, Myanmar and Sri Lanka, also using a WHO module. Training for food inspectors was organized in the Maldives; an approach to healthy market places along a standard operating procedure was introduced in Indonesia; and food contamination/total diet studies were supported in India.

64. Several challenges lie ahead. Collaboration with partner organizations and stakeholders at the regional and country levels needs to be enhanced for effective dissemination and use of resources. Development of a regional strategy on nutrition with an integrated approach to food safety and security, preparation of a model nutrition surveillance system and regional food-based dietary guidelines are



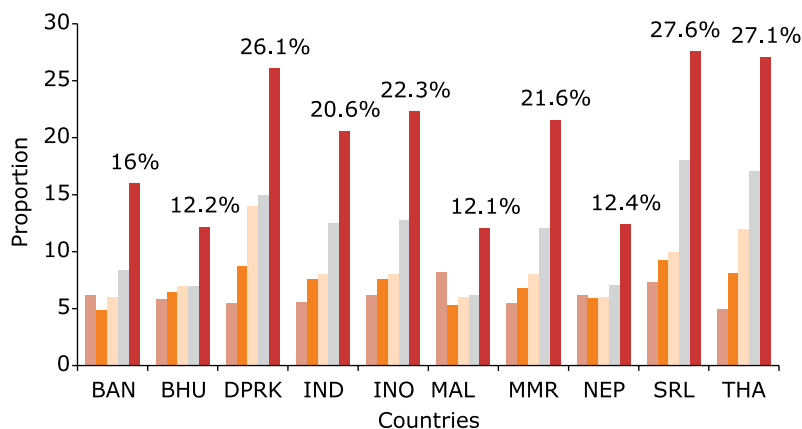
National capacities to develop food-based dietary guidelines have been strengthened in many Member States.

needed to assist Member States to develop their own nutrition policy, nutrition surveillance systems and food-based dietary guidelines. Appropriate nutrition education of policy- and decision-makers, as well as the general population, are a priority issue.

Active healthy ageing

65. Population ageing, defined as an increase in the proportion of persons aged 60 years and over, has emerged as a dominant demographic trend. The proportion of population 60 years and over is increasing in all 11 SEAR Member States and it is estimated that by 2050, in over half (55%) of the Member States, 20% or more of the population will be 60 years old or more. Also by 2050, it is estimated that average life expectancy at birth in the Region will be 75 years. These trends imply that the national social and health services will face demands in catering to an increasingly aged population.

Figure 3.6: Trend in the increase of proportion of population aged 60 years and more in Member States of the South-East Asia Region



66. Following several regional activities, SEARO organized a regional consultation on a strategic framework for active healthy ageing in 2009 to share relevant experiences on policies and programme interventions for strengthening active healthy ageing. The principal objective of the regional strategic framework was to provide technical support to the Member States in developing and implementing policies and programmes for active healthy ageing and old age care. Follow-up workshops to assist Member States in adapting the regional strategic framework and work on the national policy on ageing were planned.

67. Also, limited technical and financial support was provided to a NGO-based in New Delhi, India to promote age-friendly primary health care in selected communities with the involvement of family physicians.

Research policy and cooperation

68. To ensure WHO streamlining and effective implementing of research activities and harmonizing of the Regional Strategy on Research for Health and the Global Strategy, a SEARO Staff Dialogue Workshop on WHO Strategy on Research for Health was held in collaboration with WHO headquarters on 10-11 January 2008 at the Regional Office, New Delhi, India. The Asia-Pacific Preparatory Meeting for the 2008 Bamako Global Ministerial Forum on Research for Health, "Strengthening national health research systems", was jointly organized by Health Systems Research Institute (HSRI) in collaboration and supported by SEARO, WPRO and WHO headquarters on 10-12 June 2008 in Bangkok, Thailand. This resulted in the "Bangkok statement on research for health" that was endorsed as the recommendations of the biregional preparatory meeting for the 2008 Bamako meeting.

69. The Thirty-first Session of the WHO South-East Asia Advisory Committee on Health Research (SEA-ACHR) was held in Kathmandu, Nepal on 21-23 July 2009. A draft regional and national strategy on research for health was developed. A SEA-ACHR sub-committee on vaccines and drugs development was established in September 2009. National research capacity for health and development in Maldives and



The Thirty-first Session of the ACHR was held in 2009.

Timor-Leste were assessed by consultants teams in December 2009 and an assessment in Bhutan was planned.

70. The Regional Task Force on Avian Influenza (AI) was established to formulate policy, strategy and priority areas for AI research. It held its first meeting in March 2008 in Bali, Indonesia. The Regional Task Force on Health Research Management and Capacity Building held its first Meeting in 2008. Ten health research management modules as a self-learning package were endorsed at the intercountry workshop on research management, in Bali, Indonesia on June 2008. Small grants were provided for country priorities meeting through WHO country offices for applications of those modules. Health Research Management workshops were conducted in Bhutan, India, Myanmar, and Nepal in 2008, and Bangladesh and Thailand conducted country workshops in 2009.

71. The Regional Office promoted international research ethics standards in collaboration with national medical research councils, national research institutions and the Forum for Ethical Review Committees in Asia and the Pacific (FERCAP). WHO supported the research ethics and ethics review committee (ERC) capacity of Member States through a series of international training courses on human research subjects protection, developing standard operating procedures (SOPs), and the Surveying and Evaluating Ethics Committees for International Standard Recognition programme. Various ERCs of academic and MoH institutions in eight countries in the Region joined the accelerated training workshops for worldwide recognition programme of the Strategic Initiative for Developing Capacity in Ethical Review (SIDCER/WHO TDR).

72. Out of fourteen ERCs, 11 new ERCs were recognized in 2008-2009. This resulted in a total of 14 ERCs, in Thailand (10), India (2), Indonesia (1) and Sri Lanka (1) that were recognized for international standard review systems by external evaluator's teams from FERCAP/SIDCER. The national ERCs in Bangladesh, Bhutan, and Nepal have made great progress in series training, developing SOPs and preparing for international evaluation and accreditation.

73. A regional workshop on "Capacity Building for the Ethical Review Committee of Health Sciences Research" was jointly organized by the multi-faculty ethical committees of Chulalongkorn University (ECCU), College of Public Health Sciences (CPHS) in collaboration with and supported by SEARO and WHO headquarters for sharing and harmonizing research ethics review systems and regulation, including training and networking in SEA Region countries (Bangkok,

19-20 October 2009). To promote and enhance countries' research ethics capacity and knowledge sharing, WHO SEARO supported annual meetings of FERCAP in 2008-2009.

Collaboration in research

74. During 2008-2009, 15 meetings of the Regional Research Review Committee (RRC) were held. A total of 54 research proposals were reviewed; 45 proposals for small grant Tropical Disease Research (TDR) and 9 proposals for other sources. Of 54 proposals, 12 were approved for small grant TDR with a total budget of US\$ 82 321. Twenty proposals were subject to modification and 22 proposals were rejected.

75. An important function of the Research Development Committee (RDC) is to conduct meetings to review the institution proposals for designation or redesignation as WHO collaborating centres (WHO CCs). During 2008-2009, 49 proposals for designation and redesignation of WHO CCs were reviewed, of which 23 proposals were approved; 2 centres were newly designated, 23 centres were redesignated and 1 centre was discontinued.

76. As of 15 January 2010, there were 86 active WHO CCs in the Region. The numbers of WHO CCs are highest in India (40) and Thailand (35) as shown in the table 3.1.

Table 3.1: Distribution of WHO CCs by country
(as of 15 January 2010)

S. No	Country	2008	2009
1	Bangladesh	0	3
2	Bhutan	0	0
3	DPR Korea	1	1
4	India	42	40
5	Indonesia	4	4
6	Maldives	0	0
7	Myanmar	2	2
8	Nepal	2	1
9	Sri Lanka	2	0
10	Thailand	35	35
11	Timor-Leste	0	0
	Total	91	86

77. Table 3.2 shows the distribution of WHO CCs in the Region by country and area-wise as follows: communicable diseases (30 CCs), family health research (22), noncommunicable diseases and mental health (18), health systems development (11), and sustainable development and environmental health (5). However, there are no WHO CCs in four countries in the SEA Region.

Table 3.2: Distribution of WHO CCs by country and area of work (as of 15 January 2010)

Area of work / Country	BAN	BHU	DPRK	IND	INO	MAL	MMR	NEP	SRL	THA	TLS	Total
Communicable diseases	0	0	0	13	1	0	1	1	0	14	0	30
Noncommunicable diseases and social determinants of health	1	0	0	11	1	0	0	0	0	5	0	18
Family health and research	1	0	0	11	2	0	1	0	0	7	0	22
Health systems development	1	0	1	3	0	0	0	0	0	6	0	11
Sustainable development and environmental health	0	0	0	2	0	0	0	0	0	3	0	05
Total	3	0	1	40	4	0	2	1	0	35	0	86

78. SEARO continued supporting, promoting, expanding and strengthening capacity of the network of WHO CCs and National Centres of Expertise as follows:

- The annual meeting of the General Assembly of Network for World Health Organization Collaborating Centres and Centres of Expertise in Thailand (NEW-CCET), was held on 20 June 2008 and 25-26 February 2009.
- A country workshop on information and technological communication for WHOCC designation and re-designation was held by the Network for WHO-CCs and National Centres of Expertise in Thailand (NEW-CCET), 4-5 November 2008.
- The Meeting of WHO Collaborating Centres of India was held on 12-13 November 2009. This resulted in recommending the establishment of a network of WHO CCs in India to promote research, training and updating of expert's database.

WHO expert advisory panels

79. At present, Member States in the SEA Region contributing to the global EAPs are India (40), Thailand (17), Sri Lanka (7), Indonesia (5), Bangladesh (4), Nepal (2) and Myanmar (1). There are no experts in the EAPs from Bhutan, DPR Korea, Maldives and Timor-Leste.

80. Out of 796 EAP experts worldwide, 76 experts are from the SEA Region and represent 31 areas of expertise.

81. In terms of challenges and areas of work for future emphasis in the Region, WHO will focus on:

- country research capacity-building,
- strengthening health research management and governance,
- enhancing research ethical review,
- supporting research infrastructure to enhance the quality of health research,
- and strength health research networking and partnerships.