South-East Asia Regional Parliamentarians’ Meeting: A Renewed Commitment to Women’s, Children’s and Adolescents’ Health

26–27 July 2018 | New Delhi, India
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Executive Summary

The regional meeting of parliamentarians was organized to enhance political commitment and engagement of Parliamentarians for operationalizing Global Strategy for Women’s, Children’s and Adolescents’ health (2016-2030) with a focus on ending preventable maternal, newborn and child mortality in the Region.

The meeting was inaugurated by Honorable Minister of State, Ministry of Health and Family Welfare, Government of India, Smt. Anupriya Patel. In her inaugural speech she stressed that addressing the health and wellbeing of women, children and adolescents is not only crucial for India but also for our neighboring countries in the South-East Asia Region. She acknowledged the role of WHO and partners for providing support and working together with national governments towards their pursuit of improving health of mothers, children and adolescents.

Dr Poonam Khetrapal Singh, Regional Director of the WHO South-East Asia Region in her address stated that “The health of women, children and adolescents is critical to sustainable development – economic as well as social development. This population should be at the center of our efforts to achieve universal health coverage – with quality health care provided to everyone, everywhere,” (see annex for full address). The Regional Director also said that the parliamentarians, who represent all sections of the society and cut across all political formations, have the much-needed influence in countries to make this happen.

Over 30 parliamentarians from Member States in WHO South-East Asia Region (SEAR) attended the meeting (see annex for full list of participants). Other participants included senior officials from Ministries of Health, representatives of partner organization such as UNICEF, UNFPA, World Bank, and representatives of Asian Forum and Indian Association of Parliamentarians on Population and Development.

Through discussions in the two-day meeting; it was expressed that “health is a political issue, but health should be kept free of politics.” Parliamentarians are best positioned to address and promote women’s’, children’s and adolescents’ health including increased financing for RMNCAH, strengthening human resource for health including midwifery care for the mothers and newborns, making obstetric and neonatal services and family planning services available, and addressing inequalities in healthcare.

At the end of the parliamentary meeting the delegates adopted a ‘Call to Action’ expressing commitment to contribute towards increasing national budgets for health services for this key population; ensuring access to and financial protection for quality reproductive, maternal, newborn, child and adolescent health services within the provision of universal health coverage; and deploying skilled workforce, especially in rural areas and ensure national accountability for the health of women, children and adolescents.
Objectives of the meeting

The overall purpose of the meeting was to enhance political commitment and engagement of Parliamentarians for operationalizing Global Strategy for Women’s, Children’s and Adolescents’ health with a focus on ending preventable maternal, newborn and child mortality in the Region.

The specific objectives of the meeting were:

- Advocate that RMNCAH remains at the core of UHC discussions; and for provision of appropriate human and material resources as well as adequate financing by governments
- Strengthened National accountability so that each maternal, newborn and child death and stillbirth is counted, and services improved to end preventable mortality
- Bring attention to emerging priorities like early childhood development and adolescent health and development
- Ensure inter-sectoral actions for RMNCAH within government and outside

Source: Standees developed by WHO SEARO 2018 for the meeting
Background

The meeting was organized to enhance political commitment and engagement of Parliamentarians for operationalizing Global Strategy for Women’s, Children’s and Adolescents’ health (2016-2030) with a focus on ending preventable maternal, newborn and child mortality in the Region. Reaching the targets set under the SDGs of 70 or fewer maternal deaths per 100,000 live births, 25 or fewer under-5 deaths per 1000 live births, 12 or fewer neonatal deaths per 1000 live births and 12 or fewer stillbirths per 1000 total births will require substantial investment, commitment and action. It is very reassuring that all Member States in the WHO South-East Asia Region have committed to the Sustainable Development Goals (SDGs) and to the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

Both initiatives SDGs & GS provided new impetus for -- and increased attention to -- the health needs of women, children and adolescents. The WHO Regional Director launched a Flagship action1 with the goal of accelerating reduction in maternal, newborn, and child mortality in the Region and established SEAR Technical Advisory Group to provide additional technical guidance to Member States and partners for effective implementation of prioritized interventions. Yet challenges abound. Maternal and child mortality rates decreased significantly in the WHO South-East Asia Region between 1990 and 2015, but still fell short of the Millennium Development Goals.2

Between 1990 and 2015, maternal mortality rates declined by 69%, deaths in children less than five years of age reduced by 67% and newborn deaths rates declined by 57%. The momentum picked up in recent years with WHO declaring ‘reducing preventable maternal, child and neonatal deaths’ as a flagship programme in South-East Asia Region in 2014. However, despite progress, nearly 170 women and nearly 4000 children die every day in the Region that accounts for one fourth of the world’s population and more than one third of its total births.

SEA region also has more than 360 million adolescents, more than 20% of the total population3, the largest number in the history of mankind. It is increasingly recognized that the window to adulthood opens in adolescence, and that many adult health issues have their origins during this period, creating an unprecedented opportunity for the demographic dividend.

Access to quality health services is critical to achieve reduction in morbidity and mortality and to improve health status. The intended outcomes are universal health coverage (UHC), with equitable access to and coverage of services, while the anticipated impact is the reduction in mortality and morbidity, and the attainment of a healthier life. Actions by parliamentarians are essential for ensuring that a legislative framework is fit for purpose, for monitoring the implementation of legislation adopted and of services provided (for example checking the coverage of and increased investments for services within a constituency) and ultimately for achieving impact.

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12015 and beyond: the unfinished agenda of MDGs 4&5 in South East Asia. Report of a regional meeting May 2014, Kathmandu, Nepal
2Regional average MMR 164/100,000 in 2015. In 2016 1,407,052 children under 5 years died (31.5/1000 live births), that is 25% of the global under 5 deaths. 58% were newborns under 28 days (22.6/1000 live births). Source: UN Inter agency Estimates: Trends in maternal mortality: 1990 to 2015 and UN Inter agency Estimates: Levels and Trends in Child Mortality: 2017 Report
Role of Parliamentarians

Parliamentarians were identified as having a vital role to play in achieving universal health coverage, particularly in upholding existing standards for quality of care, and ensuring their adequate, sustained implementation. The health of women, children and adolescents is both a human right and a national development necessity. A great proportion of lives can be saved, suffering avoided, and health improved with concerted and sustained action.

✓ **Represent women and children**: Parliamentarians can demonstrate that the health of women, children and adolescents is at the core of a nation’s development and the well-being of constituents by acting on the current situation in their constituencies and carrying the voices of their constituencies to the national level.

✓ **Budget**: Budget appropriation is an important way of ensuring that funds are allocated where there is greatest need and in the most effective way. All parliamentarians should ensure that reproductive, maternal, newborn; child and adolescent health receives (RMNCAH) adequate funding for cost-effective interventions towards UHC. This may also include mobilizing resources locally in their constituent areas.

✓ **Mobilize the population and generate demand for services**: As a conduit for information, parliamentarians can help the population understand their rights and mobilize them to seek timely services, and to demand that quality services be affordable, accessible and available.

✓ **Legislate**: As lawmakers, parliamentarians can design, adopt and oversee the implementation of legislation that promotes health rights for all women, newborns, children and adolescents, including sexual and reproductive rights, and rights that promote equity in health-care provision.

✓ **Ensure oversight**: Parliamentarians hold national governments accountable through their oversight functions. As such, they have a crucial role in monitoring the laws, policies and strategies that are in place with a view to ensuring their effective implementation and improving reproductive, maternal, newborn, child and adolescent health (RMNCAH).

The standards on which parliamentarians can have the greatest impact concern human resources for health, systems for water and sanitation, essential medicines and supplies and demand for services. The parliamentary voice was stressed upon as being very important in supporting and contributing to regional and global processes, as well as to ensuring positive changes at local levels—*linking global commitments with local action*. 


Call to Action

South-East Asia Parliamentarians’ Call to Action on Women’s, Children’s and Adolescents’ Health - 2018

South-East Asia Regional Parliamentarians’ Meeting: A renewed commitment to women’s, children’s and adolescents’ health
26–27 July 2018, New Delhi

We, the Parliamentarians of countries of South-East Asia

Recognising our Constitutional mandate to initiate, adopt and implement legislation; ensure policy coherence; exercise robust oversight, hold the Executive to account; prioritize and appropriate resources through the budgetary process; and represent our constituents;

Upholding the importance of governance and effective, accountable and inclusive institutions at all levels;

Conscious that this Region accounts for one fourth of the world’s population and an even greater proportion of global health burden; with more than one third of the world’s total births; and the largest adolescent population ever in the history of mankind – 360 million; realise that global achievements will depend on the success of national and regional progress;

Mindful of the Flagship launched by the WHO Regional Office for South-East Asia and endorsed by the Ministers of Health of all Member States in 2014, towards ending preventable maternal, newborn, and child mortality in the Region;

Cognizant that the Sustainable Development Goals (SDGs) and the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 have provided new impetus to the health and well-being of women, children and adolescents;

Recognising that reaching the ambitious 2030 targets for women, children and adolescents depends on national ownership, commitment, multisectoral investment and urgent action;

Acknowledging that access to affordable and quality health services for everyone is critical to further reduce morbidity, mortality and potential causes of disability, promote health and well-being, and transform societies towards sustainable development;

Commit ourselves to:

1. Putting women, children and adolescents at the centre of all our actions towards attaining the Sustainable Development Goals (SDGs);
2. Ending preventable maternal, newborn and child deaths and stillbirths by ensuring equitable access and financial risk protection for good-quality reproductive, maternal, newborn, child and adolescent health (RMNCAH) services within the national provisions for universal health coverage (UHC);
3. Ensuring enhanced budget allocation and timely disbursement to health with an appropriate proportion allocated to women, children and adolescents to ensure that reproductive, maternal, newborn, child and adolescent health services are effective, of high quality, and equitably distributed;
4. Initiating and supporting policies for the availability of competent human resources for health (HRH), especially midwifery personnel, including investing in ongoing education and training linked to supervision; strengthening regulatory/accreditation frameworks; and recruitment, appropriate deployment and retention of skilled health workers, especially in rural areas;
5. Promoting nurturing care, good-quality and holistic approach to early childhood development, and adolescent health and development including life-skills, and prevention of common risk factors (such as tobacco, alcohol and substance use) and the linkages thereof, to address inter alia, new priority areas beyond ‘Survive’, under the ‘Thrive’ and ‘Transform’ objectives of the Global Strategy;
6. Introducing or amending laws that protect women’s, children’s, adolescents’ health including sexual reproductive health and rights (SRHR), laws to prevent early marriage; harmful traditional practices; comprehensive sexuality education; gender-based violence (GBV) and violence against children;
7. Strengthening partnerships and undertaking multisectoral actions within health, and across finance, education, social and child protection, environment and other sectors, to ensure realization of the rights to health for women, children and adolescents, including the prevention and management of cervical and other reproductive cancers and infections; strengthen community services; and also ensure that improved drinking water and sanitation, and adequate medicines and supplies, are available in all health facilities;
8. Ensuring regulation and oversight in the planning, implementation and monitoring of health services for women, newborns, children and adolescents in both the public and private sector, to ensure collective actions towards equitable, resilient and sustainable health systems so that no one is left behind;
9. Monitoring progress towards the SDGs and ensuring accountability by tracking expenditure, conducting periodic reviews, monitoring quality and coverage of services; strengthening birth and death registration (CRVS), maternal and perinatal deaths surveillance and response (MPDSR); promoting social accountability through mobilizing communities, leveraging technology, and using existing platforms and tools such as RMNCAH scorecards;
10. Striving constantly to enhance the capacity of the institution of Parliament and that of individual Parliamentarians to perform our tasks effectively, and sharing good practices amongst Parliamentarians of the Region; and

Pledge to work in collaboration with a range of partners and stakeholders including but not limited to the local government, civil society organizations, cooperatives, nongovernmental organizations, private sector and academia to deliver on the Global Strategy for Women’s, Children’s and Adolescents’ Health critical to achieving the Sustainable Development Goals.
Proceedings of the meeting

Inauguration

Smt. Anupriya Patel, Honorable Minister of State, Ministry of Health and Family Welfare, Government of India (GoI), inaugurated the WHO South-East Asia Regional Parliamentarians’ Meeting to renew their commitment to women’s, children’s and adolescents’ health was inaugurated. In her speech, she stressed that addressing the health and wellbeing of women, children and adolescents is not only crucial for India but also for our neighboring countries in the South-East Asia Region. She highlighted India’s achievement in reducing maternal and child mortality and that the proportion of institutional deliveries had doubled to nearly 80% over last decade.

She emphasized the need to strengthen health system to ensure increased access to good quality healthcare for those who need it most without financial hardship and to focus on the needs of adolescents and young people. She acknowledged that the WHO has been a long standing technical partner to ministries of health towards improving health of mothers, children and adolescents and appreciated the concerted efforts of WHO in the direction of setting an accountability framework in RMNCHA.

Dignitaries on the dais included - Honorable Mr Eran Wickramaratne, State Minister of Finance and Mass Media, Democratic Socialist Republic of Sri Lanka; Professor Dr Vinod K Paul, Chair SEAR Technical Advisory Group (SEAR TAG) and Member NITI Aayog, Government of India; Dr Pem Namgyal, (Director Programme Management, WHO-SEARO), Dr Henk Bekedam, WHO Representative to India and Dr Neena Raina, Director a.i. Family health, Gender and Life Course (FGL), WHO-SEARO.
1. Global Vision to Regional relevance: Women’s, children’s and adolescents’ health at the center of SDGs

Purpose: The session set the stage for the meeting and provided global perspective of health of women, children and adolescents in the era of SDGs and regional progress and situation of maternal, newborn and child mortality. The strategies and priority actions for reducing maternal, neonatal and child mortality needed going forward in the Region were also presented. Role of Parliamentarians in implementing the Global Strategy for Women’s, Children’s and Adolescents’ Health was also discussed.

Discussions: The delegates expressed that the health and well-being of women, children and adolescents is the key to sustainable development and a prosperous future for all in the SDGs era. For this renewed mission, UN Secretary General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, endorsed by the Member States, provides the vision and framework, and a new paradigm highlighting three main objectives – “Survive”, “Thrive” and “Transform”.

It was discussed that “MDG targets were relative while SDGs are absolute; thus, business as usual is not an option.” This further enhances the role of parliaments in achieving development goals. It was pointed out that the Parliaments themselves are the subject of targets under SDG 16 (16.6 and 16.7) recognize the need for effective, accountable and transparent institutions to ensure responsive, inclusive, participatory and representative decisions) on strong institutions, which provides an opportunity to review and strengthen parliament’s own performance. At the same time, Parliament’s oversight function for the monitoring of national progress toward SDG targets could ensure more transparent and accountable implementation.

The delegates acknowledged Parliament as the only institution with a political mandate from the people to monitor the management of the State; hold Governments to account for their actions and decisions and also link the Government with its people. Parliamentary oversight was reiterated as being key in promoting people’s freedoms and well-being, and to ensure transparency in government.

2. Unfinished business: Reaching the unreached - Saving lives of mothers and children through Universal Health Coverage

Purpose: To highlight the need to ensure universal health coverage for women, children and adolescents for addressing the survival objectives of the Global Strategy.

During MDG phase significant reduction in maternal mortality (69%) and child mortality (67%) was achieved since 1990 in the Region owing to progressively improving the coverage of life-saving interventions for mothers, newborns and children. For example, a 78% increase in institutional deliveries has been achieved over the last decade in SEA Region. However, the situation analysis reveals that coverage has been uneven (still low for some interventions) with wide socio-economic disparities in the Region.

As countries plan to move forward towards universal health coverage the interventions for women, newborns and children will have to be made accessible to all sections of populations so that no one is
left behind and reach coverage levels of 95% or higher. At the same time, good quality of care will have to be ensured so that the healthcare outcomes improve with higher efficiency of resources. Such high coverage with good quality must be made available without financial burden on the women, children and adolescents.

It was agreed that the present paradigm in the SDG phase extends beyond the unfinished work of maternal, newborn, and child survival to the aspirational holistic goals of 2030. The bar has been raised significantly for equitable coverage so that no one is left behind. A more inclusive and dynamic action for women’s, children’s and adolescents’ health and development was identified as the way forward for all stakeholders including national governments, WHO and Partners.

Ensuring that every woman, child and adolescent has access to health care is fundamental to achieving (UHC), building robust national economies and ending poverty. This requires sustained commitment from National Governments and support from Partners for the reproductive, maternal, newborn, child and adolescent health (RMNCAH) agenda.

Adequate financing for RMNCAH and more competent skilled health workers was unequivocally recognized as the two pillars of health systems that need our urgent attention moving towards Universal Health Coverage (UHC) in the region.
- **Financing** that is predictable, sustained and more focused on local evidence while reducing reliance on Out of Pocket expenditure. There is a need for progressively scaled financing from domestic resources – both public and private and reducing dependence on external sources.
- Adequate provision of health workforce with an appropriate skill-mix for RMNCAH within a supportive health system, especially availability of *Midwifery workforce*, was recognized as an important necessity.

**Panel discussion:** Members of Parliament from selected countries were invited to a Panel discussion to share the highlights of what has been done in specific areas and what is the plan in future towards improving health of women, children and adolescents.

**Bangladesh: Increasing domestic funding for health and midwifery led services**
Since 2010 rapid developments have taken place to establish the midwifery profession in Bangladesh. A commitment was made by the Prime Minister in 2010 to create posts for 3000 midwives across the country. Following this, a 6-month post-basic training was offered to existing nurses to qualify them as midwives. Concurrently a three-year direct entry diploma course was established to educate professional midwives. 597 midwives graduated from the three-year diploma course in 2015 and were officially licensed in February 2016. Meanwhile, 600 certified midwives, nurse-midwives who completed a six-month post-basic training, have already been posted to sub-district level health facilities.

Beyond providing skilled service where it is needed most, the introduction of midwives into the health care workforce will improve the efficiency of maternal-newborn services. With their specialized training, midwives will be authorized to act decisively and without direct oversight for routine management of cases. Nationally accredited midwives have been educated to a global standard as recommended by the
International Confederation of Midwives and 1200 nurses have been deployed in Upazila and Union level facilities to initiate a recent Government-driven midwife-led model of care.

**DPR Korea: Household doctors for primary health care**
Free health care, along with free public education, is an important pillar of DPR Korea’s social structure. DPRK Representatives stated that the healthcare delivery model was based on a two-way system - One medical doctor for 100 families conducts home-visits in the first half of the day and sets up an OPD for the community in the afternoon. All the steps of health care from prevention, diagnosis, treatment with medicines, to hospitalization are provided free of cost. There is no private sector in healthcare. All citizens receive free health care, leaving no village without doctors. Special programs have also introduced for maternal care and for the protection of workers’ safety.

**India: Health protection scheme, addressing health inequity**
Indian delegation presented on the *Ayushman Bharat - National Health Protection Mission*, the world’s largest single scheme that will have a defined benefit cover of Rs. 5 lakh (Half a million Indian Rupees) per family per year.

Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country. It is going to be an entitlement-based scheme for the poorest of poor.

- The beneficiaries will be able to avail benefits in both public and empanelled private facilities.
- To control costs, the payments for treatment will be done on a pre-decided basis.
- For giving policy directions and fostering coordination between Centre and States, it is proposed to set up a National Council at apex level chaired by the Health Minister.
- States would establish State Health Agency (SHA) to implement the scheme.

**Indonesia: Insurance coverage and Quality Improvement**
Effective 1 January 2014, Indonesia has launched a Mandatory Health Insurance Scheme (JKN) that ensures universal health coverage (UHC). It is managed by Indonesia’s Social Security Organising Body. JKN covers medical and non-medical benefits but excludes treatments for aesthetics, orthodontics, infertility, drug de-addiction and rehabilitation programmes and services performed overseas. This scheme is mandatory for all Indonesian citizens and residents, including those who are covered by other health insurance programmes.

Currently, the MoH is working to also prevent risk selection and under provision, as these can rapidly deteriorate access and quality, and withdraw people’s support for the program. In order to do that, the MOH need to maintain its status as a third-party agency that regulates enrolment (to prevent risk selection) and manage internal competition (to improve quality).

**Thailand: UHC for women, children and adolescents**
In 2000, about one-quarter of people in Thailand were uninsured and many other people had policies that granted incomplete protection. In 2001, Thailand introduced the Universal Coverage Scheme (UCS).
It is described as “one of the most ambitious and successful healthcare reforms ever undertaken in a developing country”.

Several things worked in favour of Thailand’s UCS, including a sustained support system and a broad reach. The scheme has proven that a well-researched system with a dedicated leadership can improve health in an affordable way. As of 2011, the country’s health scheme cost just $80 per person annually, primarily funded by general income tax. It has effectively reduced infant mortality, decreased worker sick days and reduced families’ financial burden for healthcare.

3. Accountability for Global Strategy

**Purpose:** To discuss the accountability mechanisms for the health of women, children and adolescents

Member States in the Region have committed to implementation of the Global Strategy for women’s, children’s and adolescents’ health (2016-2030) and Sustainable Development Goals. National leadership played a very important role during the MDG phase to achieve significant results and this leadership role needs to be further augmented in SDG phase as the agenda is broad and target much more ambitious.

Concurrent with responding to the needs of the populations it will be equally important to ensure accountability for health and wellbeing of all, especially the key populations of women, children and adolescents. Accountability in the country applies to the highest level as well as to the level of individuals so that the rights to health and wellbeing of everyone are upheld.

The global processes on establishing mechanism for accountability for health and wellbeing of women, children and adolescents were described. The Independent Accountability Panel for the Global Strategy has submitted reports every year and the 2017 report had a focus on adolescent health and describes a rights-based approach that countries will benefit from. The governments and parliaments could play an important role for improving health and wellbeing of this population that is central to what we want to achieve under SDGs.

Monitoring the Global Strategy will need better investments in data collection, compilation, and most importantly analysis, communication and use in countries. Towards this, action is needed for:

- Advocacy for and invest in strengthening and vital statistics (CRVS) systems
- Regular programme review, supplemented by international survey programmes
- Improvements in facility-based information systems, including web-based systems of routine reporting and feedback and regular facility surveys;
- Focus on disaggregated data to address equity and human rights considerations so that no one is left behind, including in humanitarian and fragile settings;
- Strengthening country capacities for analysis, communication and use of monitoring data;
- Improved monitoring of health system resources such as financing, health workforce and access to medicines, with a focus on RMNCAH

Community-led oversight and monitoring of health services will lead to better alignment with users’ perspectives and aspirations. This will require constant and progressive efforts in ensuring close engagement with and building capacity of community groups and individuals.
Panel discussion: Members of Parliament from selected countries shared the highlights of what has been done to uphold the national commitment for the health of women, children and adolescents and how is the accountability articulated and practiced at different levels.

Bangladesh delegates described how the commitment from the highest level of the Prime Minister and consequent close monitoring has led to observation of accountability that has ensured implementation of actions, like, establishing of special care newborn units to provide quality treatment for sick and small babies in health facilities, establishment of midwifery cadre that is contributing to better outcomes for mothers and newborns as well as scaling up of adolescent-friendly health services. Currently 59 hospitals have special newborn care units, which include lifesaving equipment for newborns, such as radiant warmers and resuscitation sets.

Myanmar: Commitment to Universal Health Coverage (UHC)
In 2017, the government of Myanmar endorsed the National Health Plan (NHP) of 2017–2021, which aimed to increase equity and financial protection and extend access to the Essential Package of Health Services for the entire population by 2021. It is the first of the three phases envisioned to reach UHC by 2030, a goal which has the highest level of political commitment in Myanmar.

The Plan sets forth many service delivery reforms. The basic package of services is explicitly covers a wide range of interventions for reproductive, maternal, newborn, child, and adolescent health (RMNCAH); nutrition; communicable and noncommunicable diseases; and emergency conditions. Though the package is broader than RMNCAH, the NHP prioritizes to improve health and nutrition for women and children taking forward the earlier Reproductive Health Strategic Plan of 2014–2018 and the National Strategic Plan for Newborn and Child Health Development of 2015–2018.

The NHP also recognizes the important role of the private sector in expanding access to services. The involvement of ethnic health organizations will be able to improve access to services in conflict-affected areas. Certifying providers in border areas in basic emergency obstetric care and other human resource reforms are being initiated including redefining the role of Voluntary Health Workers and revising the job descriptions of Basic Health Staff in the context of delivering the basic package of services for UHC.

Nepal: Commitment for ending early marriage and safe pregnancies
Nepal has made important steps over the past few years to promote gender equality, but the country still has one of the highest rates of child marriage in the world despite the legal age of marriage being 20 for both men and women. The law states that punishment for child marriage is imprisonment for up to three years and a fine of up to 10,000 rupees ($100 or £102). An action plan is required to implement the strategy as well as the investments along with broader partnerships. The programme addresses several key areas including life skills education for girls, policy research and advocacy.

Thanks to the programme and support from the key donors, a National Strategy on Ending Child Marriage was developed and endorsed by the Cabinet in 2016 – more than 15,000 girls have received social and financial skills training and 2,000 girls have gone back to school; more than 10,000 parents have also
received an orientation on the social and financial skills; and 100 health posts in programme areas are implementing guidelines for adolescent-friendly health services.

The new federal structure in Nepal consisting of three tiers of government provides a unique opportunity to give girls and boys, including those from the marginalized communities, a greater voice in decisions that directly affect their lives. It offers better prospects for tailored policies and programmes that put children and girls’ rights at the centre.

**IAPPD: Advocacy and actions for Health**

Advocacy and communications are critical to prioritizing policy and financial attention to women’s, children’s and adolescents’ health; ensuring that all stakeholders have access to the latest evidence; and encouraging stakeholders to play their role in improving health outcomes.

Advocacy focused on accountability could ensure that commitments are fulfilled, and that progress is sustained. IAPPD shared its experiences in advocacy and communications around women’s, children’s and adolescents’ health over the past 10 years which have resulted in great successes, particularly at the national level. We now need to build on this solid foundation and maintain the global community’s focus on health while, at the same time, continue to support countries to make and implement global and regional commitments.

### 4. Nurturing the next generation: Thriving for prosperity

The purpose of the session was to highlight the key actions under the Thrive objective of the Global Strategy for women’s, children’s and adolescents’ health.

The Global Strategy highlights the need for moving beyond survival to also focus on the **Thrive** objective that ensures that children and adolescents receive critical inputs for realizing maximum human potential including nutrition, interventions for early childhood development (from conception to first three years of age) and education that continue during adolescences. The session focused on Nurturing Care for Early Childhood Development and Adolescent Health.

**Investing in early childhood development** is one of the best investments a country can make to boost economic growth, promote peaceful and sustainable societies, and eliminate extreme poverty and inequality. Equally important, investing in early childhood development is necessary to uphold the right of every child to survive and thrive.

Global institutions have prioritized early childhood development in their programmes of work. Now we need to work together in a unified way towards shared goals, and to inspire governments and other stakeholder groups in the Region to invest in early childhood development. Through mutually accountable partnerships between relevant sectors – health, nutrition, education, social welfare, child protection, and environmental health, the Nurturing Care Framework inspires common action. Parliamentarians could ensure collaborative work across several ministries for early child development through country leadership.
Prioritizing adolescent health and development: With over 360 million adolescents in the South-East Asia Region (SEAR), our Member States have the largest adolescent population in the history of mankind. Bearing the changing global health agenda in mind, holistic and effective interventions during adolescence can protect long-term public health investments- both by rectifying gaps from the first decade of life and optimizing potential future gains in health and welfare.

In the Region, at 33.9%, although the adolescent birth rate is less than the global average, it remains to be alarmingly high. It is disconcerting to know that in some countries in the Region, a large proportion of girls are married before 18 years of age (59% in Bangladesh, 47% in India, and nearly 41% in Nepal). About six million girls between 15 and 19 years of age give birth each year in SEAR mostly within marriage. Early pregnancy has higher adverse reproductive health outcomes like high maternal mortality and high infant mortality.

The focus on adolescent health is rapidly moving beyond the traditional sexual and reproductive health agenda in the region. For a healthy transition from childhood to adulthood other parameters like nutrition and physical activity, mental health and well-being, risk-taking, violence and injuries, and habits that form the basis of life-style diseases must be addressed. WHO-SEAR reiterated their commitment to provide technical assistance to Member States in the Region and support country adaptation of tools for planning, capacity-building, monitoring and supervision of adolescent health.

Panel discussion: Members of Parliament from related countries presented national actions towards thriving for prosperity

Bhutan: Adolescent Health Programme: focus on School Health
The goal of the national adolescent health program is to improve the physical and mental health of adolescents and youths by appropriately addressing all risk factors and health concerns of this age group in order to ensure their overall growth and development.

Under this initiative the government has developed and delivered a comprehensive life skill-based information package and curriculum that focuses on improving health and well-being of adolescent and youth. It also provides a safe and supportive environment to adolescents and youths through evidence-based, cost-effective policy and program interventions targeting adolescents and youth in all settings.

- The government has set up Youth Friendly Health Services and taken actions to increase their availability, access and utilization of such clinics. They provide adolescents with support, opportunities and resources they require to actively engage in implementation and decision-making processes. To enhance communication and coordination, international partners and stakeholders were brought in to strengthen and sustain partnership in implementation.
- This strengthened the availability and use of strategic information on indicators of interest concerning adolescent’s health for planning, implementing and evaluation of adolescent health program.
- A platform has been provided to apply innovative approaches to use mass media campaigns and advocacy on health of adolescents and youths. To ensure sustainability of adolescent health services the MoH is revisiting its systematic planning and considering integration with other services and provision of resources.
**India: Adolescent Health Programme and Early Childhood Development initiative**

**RKSK – National adolescent Health Programme**

Government of India recognizing the importance of influencing health-seeking behavior of adolescent launched Rashtriya Kishore Swasthya Karyakram (RKSK). to reach out to 253 million adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups. The programme expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health and substance misuse.

The strength of the program is its health promotion approach. It is a paradigm shift from the previous efforts that happened to focus on clinic-based services to more attention to health promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities. Key drivers of the program are community-based interventions like, outreach by counselors; facility-based counselling; Social and Behavior Change Communication; over and above strengthening of Adolescent Friendly Health Clinics across levels of care.

Adolescents often do not have the autonomy or the agency to make their own decision. RKSK takes cognizance of this and involves parents and community. Focus is on reorganizing the existing public health system in order to meet the service needs of adolescents. Under this a core package of services includes preventive, promotive, curative and counselling services, routine check-ups at primary, secondary and tertiary levels of care is provided regularly to adolescents, married and unmarried, girls and boys during the clinic sessions.

**Early Childhood Development - ECD**

The National Education Policy caters to all children under 6 years of age and commits to universal access to quality early childhood education. The Ministry of Women and Child Development (MWCD) is the nodal department for ECCE. MWCD is responsible for the Integrated Child Development Services (ICDS) programme, which is a centrally sponsored and state administered early child care and education (ECCE) programme, covering around 38 million children through a network of almost 1.4 million Anganwadi centres (a village based nutrition center). ICDS includes delivery of an integrated package of services such as supplementary nutrition, immunization, health check-up, preschool education, referral services and nutrition & health education. ECCE is one of the components and aims at psycho-social development of children and developing school readiness.

There are implementation challenges and substantial numbers of children are still not enrolled in preschools. Even in elementary education, while there is a significant rise in enrolments, the dropout rate continues to be a matter of concern, with drop outs being highest in the first two grades of elementary schooling. Learning assessments also show that literacy skills are poor in early primary grades. This points to the urgency of helping children, particularly from first generation families, develop adequate school readiness through a good quality ECE programme, to enable them to make a smooth transition.
**Sri Lanka: Early Childhood Education program**

Early childhood is considered to be the period from conception to 5 years of age. Monitoring programme for development milestones for the 0-2-year old children is well-established in Sri Lanka, with the health sector playing a lead role in ensuring the holistic development of these children. Center-based Early Childhood Development (ECD) programs for children in the 3-5 age range are less developed. Sri Lanka has more than 15,000 ECD centers staffed by nearly 30,000 teachers. Around 80% of these centers are under non-state management.

The programme presently aims to improve the provision of ECD services in Sri Lanka by: (i) improving the quality of ECD provision across the country, (ii) expanding equitable access to ECD services across the country, and (iii) improving the quality of ECD services.

**5. Working together for health of Women, Children and Adolescents**

**Aim:** To highlight the importance of coming together of various sectors and role of partnerships for improving health and wellbeing of women, children and adolescents.

Health sector must gain from and rely on actions in other sectors that address the important determinants of health. For example, keeping girls in school delays marriage of girls, female education contributes to better health and survival of children and family, water and sanitation services and hygiene reduce the risk of water borne and vector borne diseases, economic empowerment and food security that contribute to better living conditions and nutrition, social welfare/protection that supports prevention and response to violence or abuse, and promotion of positive gender roles among boys and girls.

Similarly, transport and communication sectors that improve access to facilities, referral to higher levels of care, and dissemination of health education. In this way there are several SDGs that contribute to SDG 3 for health and wellbeing of people. Thus, an inter-sectoral and multi-sectoral approach is the only way to move forward towards achieving sustainable development goals, including the Goal 3 on health.

There are multiple partners globally and locally that contribute to nation health programmes as well as health-related programmes. It is essential that there is considerable coordination and collaboration among partners that can provide a harmonized synergistic support to national governments for actions at all levels of governance.

**Panel discussion:** Members of Parliament from selected countries shared the national actions and experiences in specific thematic areas.

**Bangladesh: Education and employment opportunities for young people**

Every year, 2 million young Bangladeshis join the labor force, but too few have the essential education or technical skills to match with the needs of the job. Overcoming that mismatch is critical not only to improving the lives of those workers and their families. It can also build on Bangladesh’s impressive efforts.
to overcome poverty. For e.g. currently, the country’s garment sector employs 4.4 million workers, of whom 80% are women.

Launched by the Government of Bangladesh in 2009, STEP (Skills and Training Enhancement Project) is an initiative helping poor, undereducated students – especially women – acquire new skills that can lead to paid work domestically and abroad; offers workers vocational training, and it gives development grants to 33 public and private polytechnic institutions to improve quality of skills-training programs. STEP also provides stipends to all diploma-level female students, while adopting a poverty-targeting stipend for male students.

**Nepal: Addressing early marriage**
Nepal has progressive laws against child marriage. The country outlawed the practice long ago. Twenty years is the minimum age for marriage for both men and women. The 2015 Constitution of Nepal for the first time explicitly prohibits child marriage and affirms that this is a punishable offence. New laws aimed at advancing the cause will be effective from August 2018. The government has increased efforts to take action against child marriage. If implemented properly, the laws will provide justice to survivors and serve as a deterrent to would-be violators. Ministries of health and education along with social sector are collaborating under this initiative.

**Sir Lanka: Addressing double burden of nutrition**
Sri Lanka is facing a double burden of malnutrition with stagnant rates of undernutrition combined with growing numbers of overweight people and a rise in obesity rates. Undernutrition remains a problem of public-health proportions, despite lower rates than its South Asian neighbors. While prevalence rates have declined in recent years, the reduction was greater among the population’s better-off groups thereby leading to greater inequities.

Thus, despite impressive economic growth and improvements in other social sectors, Sri Lanka’s inequalities in undernutrition have worsened in the last decade. Undernutrition is highest among rural and Estate-sector populations and among Tamils. The prevalence of overweight is also rising among specific population groups. Micronutrient deficiencies are moderately high by regional standards and still represent a public health problem. These issues collectively constrain Sri Lanka’s economic growth.

The Government has a Vision 2025 is built upon prosperity, peace and reconciliation. It prioritizes agriculture and sustainable development as a means of addressing food insecurity, malnutrition and poverty through reform, inclusive growth and the development of underserved districts. Vision 2025 also aims to ensure environmental protection and disaster management in order to mitigate climate change. The Public Investment Programme (2017–2020) outlines capital budget resource allocations reflecting the inclusive socio-economic development vision and strategy of increasing employment, raising income, developing rural economies, expanding land ownership and strengthening the middle class through policy reforms, institutional development and other initiatives in alignment with the SDGs.

**Thailand: EMTCT and adolescent pregnancy**
Thailand has made great strides in reducing its mother-to-child-transmission (MTCT) rate. In 2015 rate of MTCT of HIV stood at 1.9%- 86 children becoming infected with HIV through this route, a decline of more
than 90% over the past 15 years. A transmission rate of 2% or below is considered by the World Health Organization (WHO) as effectively eliminating mother-to-child transmission of HIV. Thailand is the first country in the Asia Pacific region to reach this important milestone.

Thailand also recently implemented a historic policy for reducing adolescent pregnancies. The new law also states that schools are to provide courses on Sexuality Studies with content that matches each age group and with suitable teachers, who are trained or have teaching experience in the subject. Schools were also told to create a system to help and protect students who get pregnant to ensure they are properly educated. It also states that workplaces or establishments with teenage employees who are pregnant must provide support and ensure they have access to advice and reproductive health services.

State agencies also have to help with the creation of youth and children’s networks at provincial- and district-levels in order to prevent, tackle and monitor teenage pregnancy. State agencies will also have to provide vocational training that matches the pregnant teens’ interest and aptitude before and after delivery, while also contacting related agencies to find them jobs.
Conclusions

In conclusion, as lawmakers, parliamentarians were identified as agents of change who can design, adopt and oversee the implementation of legislation and policies that promotes attainment of the objectives of the global strategy. Three Key Lessons that emerged:

1. **When we work together, health service delivery improves** – partnerships allow for dialogue and understanding between citizens, health care providers, and government officials.
   - **Be champions** and represent women, children and adolescents in all their actions and demonstrate publicly individual commitment by endorsing good practices in RMNCAH
   - Introduce innovative solutions to maternal, child and adolescent health at constituency, and national level
   - Mobilize and raise awareness of maternal, child and adolescent health issues at constituency level and at public engagements
   - Put RMNCAH at the heart of the UHC agenda in the strive towards the SDGs

2. **We need to bring the “public” into the public health system** - meaningful engagement of people to improve health care delivery and connects community voices and data to action especially at the grassroots level.
   - Ensure adequate budget appropriation for cost-effective interventions and ensure that funds are allocated are efficiently used - where there is greatest need and in the most effective way

3. **Make progress and ensure accountability** (global goals, local action / delivery) along the way.
   - Global and national goals, plans, and strategies are just the first step. Transparent accountability mechanisms put in place to ensure that budgets, programs, and policies are implemented effectively can transform society

Thus, more resources and support are needed to continue strengthening skills and commitment. Limited engagement with elected representatives to advocate for corrective action and planning on issues and gaps emerging from the RMNCAH – poses a challenge to scale up. **There is still a lot of work to be done.**

The meeting ended with the adoption of the “Parliamentarians Call to Action” and commitment to undertake actions in their own countries to eliminate preventable maternal, newborn, child and adolescent morbidity and mortality. Through this first ever South-East Asia Regional Parliamentarians’ meeting, WHO-SEARO also renewed its own commitment, along with the participants to create pathways and synergies for a holistic approach to the health and well-being of women, children and adolescents- **to not only add years to their lives, but life to those years.**
Annexures

1. Regional Director’s Address
2. Programme
3. List of Participants
4. Country Fact Sheets
Annex 1: Regional Director’s Address

(Regional Director’s address was delivered by Dr Pem Namgyal, Director Programme Management, WHO-SEARO)

Honorable parliamentarians from across the South-East Asia Region, representatives of ministries of health, representatives of the H6 partnership, including from UNICEF, UNFPA, UN WOMEN, UNAIDS and the World Bank, esteemed partners from the nongovernmental sector, WHO colleagues,

Welcome to this parliamentarians’ meeting on renewing commitment to women’s, children’s and adolescents’ health across the South-East Asia Region.

Although our Regional Director would have very much liked to attend this important meeting, she is unable to do so due to a prior commitment. I therefore take great pleasure in delivering this message on her behalf.

The Regional Director emphasizes that the health and wellbeing of women, children and adolescents is critical to sustainable development – sustainable economic development, sustainable social development, and the sustainable development of the environments we live in.

Nevertheless, she says, promoting the health and wellbeing of women, children and adolescents and the sustainable development it creates is dependent on political will and high-level resolve.

The way health systems are organized and the finances they are allocated, for example, is a choice. It is a choice that operates first and foremost at the political level.

Whether early childhood development is invested in and the extent to which children are protected from harm is again a choice. It is a choice that for the most part demands political action.

And the way the social and environmental determinants of sickness and health, death and disease are managed is likewise a choice. Again, it is a choice that requires high-level political buy-in and resolve.

Indeed, the Regional Director notes that the quest to achieve universal health coverage is, at its most basic level, a choice – one to ensure all people can access quality services, when they need them, without facing financial hardship. Dr Khetrapal Singh emphasizes that making that happen is largely dependent on political will and commitment, especially in terms of financial investment and establishing stronger accountability.

In noting these truths, the Regional Director says, it must nevertheless be made clear that the science and best practices that promote the health and wellbeing of women, children and adolescents are not simply matters of choice. Rather, they are based on hard science and rigorous evidence. Naturally, they must always be adapted to country-specific contexts, however their core components are firmly grounded and capable of driving path-breaking change.

Distinguished parliamentarians and participants,

As we begin this high-level meeting on renewing political commitment to women’s, children’s and adolescents’ health, the Regional Director wishes to share with you a few axioms she has found valuable during her many years as a public health administrator, both in government and outside it: First, that politics is the art of the possible; second, that science and data are the art of the soluble; and third, that when both are harnessed and work in unison our ability to drive meaningful change is unstoppable.

Dr Khetrapal Singh takes the subject of this meeting as evidence of these truths. When the Millennium Development Goals came into effect, she says, our baseline 1990 maternal mortality ratio was 525 deaths per 100 000 live births. Under-5 mortality was at 118 per 1000 live births. Newborn mortality was at 53 per 1000 live births.

The Regional Director is pleased to note that political commitment backed by evidence-based policy changed the situation completely.

By 2015 maternal mortality had reduced 69%, down to 164 per 100 000 live births. Under-5 mortality was cut by 64%, down to 42.5 per 1000 live births. And newborn mortality was more than halved to 54%, down to 24 per 1000
live births. With regard to a number of key indicators we outperformed global averages and achieved game-changing progress. In fact, as per 2016 estimates, the Region has now achieved the MDG4 target of reducing child mortality by two-thirds.

The Regional Director also notes that as a direct result of strong political will and investment our Region is polio-free and has been certified as such for four years. She says you have also eliminated maternal and neonatal tetanus – a truly remarkable achievement, and notes that our Region is the second in the world to do so.

The Regional Director emphasizes that our collective progress has changed the lives of millions of people. That it has transformed public health and development, and with it whole economies. And that it has also transformed what we regard as politically feasible and highlighted how science and evidence-based policy can be mobilized to support the policy choices we make.

Crucially, she says, your success is also evidence of how the targets Member States devise together can focus and accelerate progress. To that end, the international architecture created by and for Member States – including at the UN – has proved immensely powerful in achieving defined and mutually agreed on objectives.

The Regional Director sees that as a key point as we seek to achieve Sustainable Development Goal 3 – to ensure healthy lives and promote wellbeing for all at all ages – and as we implement the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, as well as GPW13. As Dr Khetrapal Singh earlier mentioned, our pursuit of universal health coverage is fundamental to each of these. Notably, it will have significant implications for women’s, children’s and adolescents’ health.

With that in mind, she says, it is clear enough that despite our progress key barriers remain. At present, for example, the number of women Region-wide who received antenatal care four or more times during pregnancy is 74%. Seventy percent of deliveries are institution-based, with wide disparities between and within countries. An estimated one-third of children with pneumonia are able to receive antibiotics for treatment in some of the Region’s countries. An estimated 61 000 women in our Region meanwhile die every year during childbirth and pregnancy, while in 2016 1.4 million children did not make it beyond five years of age.

Dr Khetrapal Singh emphasizes that this is all completely avoidable.

By achieving universal health coverage – including access for all to quality antenatal and birthing services, postnatal care as well as routine immunization programmes – these barriers will be overcome. The figures the Regional Director just presented – and which represent real people with real lives, real families, and with real contributions to make to society at large – will be fundamentally altered. All 1.8 billion of the Region’s population will be better off as a result.

Importantly, as part of achieving universal health coverage, the Regional Director notes, we must also advance adolescent health. Though Dr Khetrapal Singh appreciates sexual and reproductive health can be a sensitive topic for many people, in many areas, and across many cultures, overwhelming evidence supports the need for adolescents to be able to access such services. Importantly, they must be able to do so confidentially, without parental or guardian authorization or notification, and without facing prohibitive financial barriers.

The Regional Director emphasizes that this is not an ideological issue. Rather, it is an issue with very serious consequences for the health and wellbeing of millions of our Region’s girls and young women. Every year an estimated 6 million adolescents aged 15-19 years in our Region give birth. More than 50 per 1000 young women in this age bracket do so in four of the Region’s countries. Apart from the significant health risks teenage pregnancy and childbirth pose, the fact that nearly half of these pregnancies are unintended indicates that better access to quality information on sexual health is needed, alongside access to contraception. That holds true for all women more generally. As evidence-based modelling shows, meeting the right of every adolescent and woman to access modern contraception would result in dramatic progress across the developing world, including in the South-East Asia Region. Based on 2017 data, unintended pregnancies would drop by an estimated 67 million, equating to a 75% decline. Unplanned births would be reduced by 23 million – a 76% decline. And induced abortions would decrease by 36 million, marking a 74% decline.
Distinguished parliamentarians and partners,

Beyond the health-specific points the Regional Director has outlined, part of the reason for bringing you together for this meeting is because public health – and women’s, children’s and adolescents’ health – is dependent on action across multiple sectors. Indeed, this point is fundamental to the SDGs that you as UN Member States helped devise and are now pursuing with commendable resolve.

Dr Khetrapal Singh takes the opportunity to provide a few examples of what she means:

She asks, ‘Can a pregnant woman who is unable to afford or access adequate nutrition avoid the risk – both for her and her baby – of long-term, life-defining physical and neurological disorders?’ Though the health sector can provide critical support, she says, the solutions lie elsewhere, primarily in the domain of economics and social welfare.

Another example. Can a child who is denied investment in their early development expect to attain the highest possible standard of physical and emotional health throughout their life? Or will they be disadvantaged from the outset? Again, the Regional Director says, though the health sector can provide support, solving the problem requires action from a range of actors, including in the education sector, law enforcement and even the environment sector.

And just one more scenario to consider. Can an adolescent girl forced into early marriage hope to avoid unwanted pregnancy and the life-threatening dangers it brings? Though the health sector can enhance the accessibility of key services, legislative action is needed, as are broader social and cultural shifts to prevent adolescent marriage and pregnancy.

Distinguished parliamentarians and participants,

As we look ahead to the Regional Committee in September, and to the Partners’ Forum of the Global Strategy for Women’s Children’s and Adolescents’ health in New Delhi in December, the Regional Director emphasizes the need to capitalize on the opportunities we have to drive real change for every woman, child and adolescent across our Region.

Need it be said: Those changes will come about through political will and action. They will come about through multi-sectoral action. And they will come about through harnessing the power of evidence-based policy and good science, as well as the political and financial commitment, dedication and support of WHO South-East Asia and the many partners gathered here today.

The Regional Director wishes you an engaging and informative meeting.

I echo that sentiment and wish you all the best over the coming days.

Thank you very much.
Annex 2: Programme

• **Inaugural Session**

• **Session 1: Global Vision to Regional relevance: Women’s, children’s and adolescents’ health at the centre of the SDG**
  - Global perspective on Global Strategy for women’s, children’s and adolescents’ health and its operationalization
  - From MDGs to SDGs in SEAR: Where we are & where we want to be
  - Priority actions for further reduction in maternal, neonatal and child mortality in the Region
  - Role of Parliamentarians in implementation of the Global Strategy
  - Partners’ role in operationalizing Global Strategy
  - Partners’ Forum 2018
  - Assigning of Drafting Committee for ‘Call to action’ by Parliamentarians

• **Session 2: Unfinished business: Reaching the unreached - Saving lives of mothers and children through Universal Health Coverage**
  - Universal Health Coverage for women, children and adolescents: Expanding equitable coverage with good quality and financial protection
  - Increasing domestic resources: Making a case for investment in health of women, children and adolescents
  - Panel discussion: UHC for women’s, children’s and adolescents’ health

• **Session 3: National commitment and accountability for Global Strategy**
  - Accountability for health and wellbeing of women, children and adolescents
  - Community-led accountability - Ensuring people’s ownership of Health systems
  - Panel discussion: Strengthening national commitment and accountability for Global Strategy

• **Session 4: Nurturing the next generation: Thriving for prosperity**
  - Let the babies thrive: Nurturing care for early childhood development
  - Investing in adolescent health: A triple dividend
  - Panel discussion: Actions towards thriving for prosperity

• **Session 5: Working together for health of Women, Children and Adolescents**
  - Social determinants: Intersectoral actions for making a difference in health of women, children and adolescents
  - Panel Discussion: Beyond health for transformative action

• **Session 6: Concluding**
  - Adoption of Call to Action
  - Closure
Annex 3: List of participants

**Bangladesh**

*Members of Parliament*

1. Dr Muhammad Abdur Razzaque  
   Member of Parliament and Chairman,  
   Parliamentary Standing Committee on  
   the Ministry of Finance  
   Government of Bangladesh  
   Dhaka  
   Bangladesh

2. Mr A F M Ruhal Haque  
   Member of Parliament and Chairman  
   Parliamentary Standing Committee on  
   the Ministry of Science and Technology  
   107 Satkhira-3  
   Bangladesh

3. Mr Tipu Munshi  
   Member of Parliament and Chairman,  
   Parliamentary Standing Committee on  
   the Ministry of Home Affairs  
   22 Ranpur-4  
   Bangladesh

4. Mrs Selina Begum  
   Member of Parliament  
   306 Women seat-6  
   Bangladesh

*Officials*

5. H.E. Syed Muazzem Ali  
   Bangladesh High Commissioner to India  
   New Delhi

6. Mr A T M Rokebul Haque  
   Deputy High Commissioner  
   Bangladesh High Commission  
   New Delhi

7. Ms Arsuda Khan  
   First Secretary (Political)  
   Bangladesh High Commission  
   New Delhi

8. Dr Sultan Mohammad Shamsuzzaman  
   Line Director, MNCAH  
   Directorate General of Health Services  
   Ministry of Health & Family Welfare  
   Mohakhali  
   Dhaka, Bangladesh

9. Dr Mohammad Yousuf  
   Programme Manager & Adolescent School  
   Health Programme, MNC & AH  
   Directorate General of Health Services  
   Ministry of Health & Family Welfare  
   Mohakhali, Dhaka  
   Bangladesh

**Bhutan**

*Members of Parliament*

10. Mr Sonam Dondup Dorjee  
    Member of Parliament  
    National Assembly of Bhutan  
    Royal Government of Bhutan  
    Bhutan

11. Mr Choida Jamtsho  
    Member of Parliament  
    National Assembly of Bhutan  
    Royal Government of Bhutan  
    Bhutan

12. Mr Tirtha Man Rai  
    Member of Parliament  
    National Council of Bhutan  
    Royal Government of Bhutan  
    Bhutan

*Officials*

13. Dr Tapas Gurung  
    Medical Superintendent  
    Central Regional Referral Hospital
Gelephu, Sarpang
Bhutan

14. Ms Tashi Tshomo
Assistant Program Officer
Non-Communicable Disease Division
Department of Public Health
Ministry of Health
Bhutan

DPR Korea

Member of Parliament

15. H.E. Dr Kim Song Hui
Director
Pyongyang Maternity Hospital
Deputy, Supreme People’s Assembly
DPR Korea

Officials

16. Dr Kim Kum Ran
Senior Official
Department of External Affairs
Ministry of Public Health
DPR Korea

India

Member of Parliament

17. Dr Vikas Mahatme
Member of Parliament
(Rajya Sabha)
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Dr B D Marg
New Delhi

18. Dr Heena Vijaykumar Gavit
Member of Parliament
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187, South Avenue
New Delhi, India

19. Dr K Kamaraj
Member of Parliament
(Lok Sabha)
58, South Avenue
New Delhi, India

20. Dr Sanjay Jaiswal
Member of Parliament
(Lok Sabha)
8, Ferozshah Road
New Delhi, India

Officials

21. Dr Promila Gupta
Director General of Health Services
Ministry of Health and Family Welfare
Government of India
New Delhi

22. Dr Dinesh Baswal
Deputy Commissioner (MH/I/c)
Ministry of Health and Family Welfare
Government of India
New Delhi

23. Dr S K Sikdar
Deputy Commissioner (FP)
Ministry of Health and Family Welfare
Government of India
New Delhi

24. Dr P K Prabhakar
Deputy Commissioner (CH)
Ministry of Health and Family Welfare
Government of India
New Delhi

Indonesia

Members of Parliament

25. Dra Hj Ermalena, MHS
Vice Chair of Commission IX
The House of Representatives
Republic of Indonesia

26. Ir Ketut Sustiawan
Member of Commission IX
The House of Representatives
Republic of Indonesia
27. Drg Andi Fauziah Pujiwatie Hatta  
   Member of Commission IX  
   The House of Representatives  
   Republic of Indonesia

28. Drs H Irgan Chairul Mahfiz, MSi  
   Member of Commission IX  
   The House of Representatives  
   Republic of Indonesia

Officials

29. Dr Kirana Pritasari, MQIH  
   Director General of Community Health  
   Ministry of Health  
   Jakarta  
   Republic of Indonesia

30. Dr Imran Pambudi, MPHFM  
   Head, Multilateral Health Cooperation  
   Bureau of International Cooperation  
   Ministry of Health  
   Jakarta  
   Republic of Indonesia

31. Dr Ni Made Diah Permata Laksmi  
   Head, Sub-Section of School Age and Adolescent  
   Directorate of Family Health  
   Ministry of Health  
   Jakarta  
   Republic of Indonesia

Maldives

Officials

32. Ms Maimoona Aboobakuru  
   Director General of Public Health  
   Health Protection Agency  
   Ministry of Health  
   Male  
   Republic of Maldives

33. Dr Mariyam Jenyfa  
   Senior Medical Officer  
   Health Protection Agency  
   Ministry of Health  
   Male  
   Republic of Maldives

Myanmar

Members of Parliament

34. Dr Khin Nyo  
   Member of Parliament  
   Daydaye Constituency  
   Member, Health and Sports Development Committee  
   Pyithu Hluttaw  
   Myanmar

35. Colonel Myint Han  
   Member of Parliament  
   Myeik Constituency  
   Member, Health and Sports Development Committee  
   Pyithu Hluttaw  
   Myanmar

36. Ms Aye Aye Mu @ Ms. Shar Mee  
   Member of Parliament  
   Kalay Constituency  
   Member, Health and Sports Development Committee  
   Pyithu Hluttaw  
   Myanmar

37. Dr Kyaw Ngwe  
   Member of Parliament  
   Magwe Region, Constituency (10)  
   Member, Health and Sports and Culture Committee  
   Amyotha Hluttaw  
   Myanmar

38. Dr Kyaw Than Tun  
   Member of Parliament  
   Mandalay Region, Constituency (3)  
   Member, Health and Sports and Culture Committee  
   Amyotha Hluttaw  
   Myanmar

Officials

39. Dr Myint Myint Than  
   Director (Child Health Development)  
   Department of Public Health  
   Ministry of Health and Sports  
   Naypyitaw, Myanmar
40. Dr Hla Mya Thway Einda  
Director (Maternal and Reproductive Health)  
Department of Public Health  
Ministry of Health and Sports  
Naypyitaw  
Myanmar

41. Dr Su Mon Myat  
Deputy Director (School Health)  
Department of Public Health  
Ministry of Health and Sports  
Naypyitaw, Myanmar

Nepal

Members of Parliament

42. Mr Bhupendra Bahadur Thapa  
Member of Federal Parliament  
Nepal

43. Ms Parbati Kumari Bisunke  
Member of Federal Parliament  
Nepal

44. Ms Sarita Giri  
Member of Federal Parliament  
Nepal

45. Ms Renuka Gurung  
Member of Federal Parliament  
Nepal

Officials

46. Dr Ganesh Kumar Rai  
Director  
Kanti Childrens Hospital  
Kathmandu  
Nepal

47. Dr Sangeeta Kaushal Mishra  
Consultant Gynaecologist  
Koshi Zonal Hospital  
Biratnagar  
Nepal

48. Mr Sharad Kumar Sharma  
Demographer

Sri Lanka

Members of Parliament

49. H.E. Mr Eran Wikramaratne  
Member of Parliament and  
The State Minister of Finance  
Government of the Democratic Socialist Republic of Sri Lanka  
Colombo  
Sri Lanka

50. Dr Nalinda Jayatissa  
Member of Parliament  
Kalutara District  
Government of the Democratic Socialist Republic of Sri Lanka  
Colombo  
Sri Lanka

51. Dr Thusitha Wijemanna  
Member of Parliament  
Kegalle District  
Government of the Democratic Socialist Republic of Sri Lanka  
Colombo  
Sri Lanka

Officials

52. Dr Anil Jasinghe  
Director General of Health Services  
Ministry of Health, Nutrition & Indigenous Medicine  
Colombo  
Sri Lanka

53. Dr Nethanjalie Mapitigama  
Actg. Director-Maternal & Child Health  
Family Health Bureau  
Colombo  
Sri Lanka
Members of Parliament

54. Dr Jetn Siratharanon
   Chairman of the Committee on Public Health
   Member of the National Legislative Assembly
   Thailand

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South-East Asia Regional Parliamentarians’ Meeting:
A Renewed Commitment to Women’s, Children’s and Adolescents’ Health
26-27 July 2018, New Delhi, India

Group photograph