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REGIONAL COMMITTEE DOCUMENT

Progress reports on selected Regional Committee resolutions

Progress reports on the following selected Regional Committee resolutions are covered in this document:

1. Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination **(SEA/RC65/R3)**
2. Challenges in polio eradication **(SEA/RC60/R8)**
3. South-East Asia Regional Health Emergency Fund (SEARHEF) **(SEA/RC60/R7)**
4. Capacity building of Member States in global health **(SEA/RC63/R6)**
5. 2012: Year of Intensification of routine Immunization in the South-East Asia Region: Framework for Increasing and Sustaining Coverage **(SEA/RC64/R3)**
6. Regional Action Plan and Targets for Prevention and Control of Noncommunicable Diseases (2013–2020) **(SEA/RC66/R6)**

The High-Level Preparatory Meeting held in New Delhi from 11–14 July 2016 reviewed each progress report and made recommendations which have been consolidated as an addendum (SEA/RC69/18 Add. 1) to this Working Paper for consideration by the Sixty-ninth Session of the WHO Regional Committee.

The related Regional Committee resolutions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC69/18 Add. 2).

CONTENTS

1. Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination (SEA/RC65/R3)

Background

1. The Regional Committee resolution on the Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination (SEA/RC65/R3) was the outcome of national and regional consultations on the CEWG report presented to the Sixty-fifth World Health Assembly in May 2012. The SEA Region resolution provided the basis for development and adoption of the resolution WHA66.22 in May 2013. Hence, it is appropriate to take up their outcomes together.

2. Resolution WHA66.22 calls for:

   a. Specific actions through a strategic workplan to improve monitoring and coordination, and ensure sustainable funding for health research and development (R&D), in line with the World Health Assembly resolution WHA61.21 on the Global Strategy and Plan of Action. For the strategic workplan (i) a global health R&D Observatory be established within the Secretariat to monitor and analyse relevant information on health research and development; (ii) a review be conducted of existing mechanisms to assess their suitability for performing the coordination function of health R&D; and (iii) existing mechanisms for financial contributions to health R&D be explored and evaluated and, if there is no suitable mechanism, a proposal be developed for effective mechanisms and a plan to monitor their effectiveness independently; and

   b. Identification of a few health R&D demonstration projects as a step towards achieving the goal of development and delivery of affordable, effective, safe and high-quality health products.

Progress made in the South-East Asia Region

3. The progress on the development of the strategic workplan was taken up in the open-ended meeting of all Member States held on 2–4 May 2016 at WHO headquarters in Geneva. India co-chaired the open-ended meeting and the drafting group during the Sixty-ninth World Health Assembly in May 2016.

4. Member States of the South-East Asia Region contributed to progress on the strategic workplan development by participating in a "Regional Consultation for Developing a Strategic Workplan as a Follow-up of the Consultative Expert Working Group on Research and Development: Financing and Coordination" on 25–26 July 2013 in Bangkok, Thailand. This consultation developed a classification grid for health R&D and the Global Health R&D Observatory, and also selected certain priority demonstration projects. A further "Meeting of Experts on Demonstration Projects" at the WHO Regional Office for South-East Asia on 24–25 October 2014 facilitated the submission of projects at the global level by Member States. The project titled "Multiplexed point-of-care test for acute febrile illness" has been selected for funding and further development at the global level.

Challenges

5. The Government of India contributed US$ 1 million for the development of demonstration projects to the WHO Secretariat. However, funds are yet to be made available by headquarters for the approved project titled "Multiplexed point-of-care test for acute febrile illness" for further development.

6. At the Sixty-ninth World Health Assembly in May 2016, Member States reiterated the importance of the strategic workplan mentioned in resolution WHA66.22 on CEWG. The importance of the strategic workplan for the 2030 Agenda for Sustainable Development was also emphasized. This includes the commitment to support the research and development of vaccines and medicines for communicable and noncommunicable diseases that primarily affect developing countries, and provide access to affordable medicines and vaccines in accordance with the Doha Declaration on the TRIPS Agreement and Public Health. Member States also noted the establishment of the High-Level Panel on Access to Medicines convened by the UN Secretary-General on this subject.

7. The implementation of the Regional Committee resolution SEA/RC65/R3 and World Health Assembly resolution A69/B/CONF./6 should focus on R&D for health products related to developing country needs and those of Member States of the Region. This should include mechanisms to strengthen and build R&D capacity, promote innovation and improve access to medical products, including drugs, vaccines and diagnostics. These aspects need to be reflected in the assessment of the Global Strategy and Plan of Action that is currently being taken up in accordance with resolution WHA61.21.

8. Resources should be mobilized to address diseases that disproportionately affect developing countries. There is also the need to review global norms and standards for R&D in national and regional settings, improve monitoring and coordination, and address the gaps in health R&D.

The way forward

9. At the Sixty-ninth World Health Assembly, Member States agreed to:

- Make concerted efforts – including through adequate and sustainable funding – to fully implement the strategic workplan agreed in resolution WHA66.22;
- Create, operationalize and strengthen, as appropriate, national health research and development observatories, or equivalent functions, for tracking and monitoring of relevant information on health research and development, and to provide regular information on relevant health research and development activities to the Global Observatory on Health Research and Development or to other existing data collection mechanisms which provide regular reports to the Global Observatory on Health Research and Development; and
- Provide support to the Director-General for the development of sustainable financing mechanisms for the full implementation of the strategic workplan agreed upon in resolution WHA66.22.

10. Member States have requested the WHO Director-General to expedite the further development of a fully functional Global Observatory on Health Research and Development that

will support Member States in their endeavours to establish or strengthen health research and development capacities, and to establish a WHO Expert Committee on Health R&D that will provide technical advice on prioritization of health research and development for Type-II and -III diseases and on specific research and development needs of developing countries in relation to Type-I diseases.

11. The Director-General is also requested to present a proposal with goals and an operational plan for a voluntary pooled fund to support research and development for Type-III and Type-II diseases and specific research and development needs of developing countries in relation to Type-I diseases, to be submitted to the Seventieth World Health Assembly through the 140th session of the Executive Board.

12. WHO was also requested to promote policy coherence within the Organization on its research and development-related activities – such as those in relation to the Research and Development Blueprint for Emerging Pathogens and the Global Action Plan on Antimicrobial Resistance – in terms of application of the core principles of affordability, effectiveness, efficiency and equity and the objective of de-linkage identified in resolution WHA66.22.

13. It is important to take Document A69/B/CONF./6 and resolution WHA66.22 forward along with Regional Committee resolution SEA/RC65/R3 and maintain the lead taken by South-East Asia Region at the global level in the deliberations on CEWG and the Global Strategy and Plan of Action.

2. Challenges in polio eradication (SEA/RC60/R8)

Background

14. The WHO South-East Asia Region reported the last polio case due to wild poliovirus on 13 January 2011, and the Region was certified polio-free on 27 March 2014. Despite being polio-free for five years, all Member States in the Region continue to be at risk of importation of wild poliovirus from countries currently infected and of a subsequent spread of the virus within the Region.

15. The Sixty-fifth World Health Assembly in 2012 adopted a landmark resolution declaring global polio eradication as a programmatic emergency for global public health. The resolution also included the endorsement of cessation of the use of oral poliovirus vaccine (OPV). Following this, a Polio Eradication and Endgame Strategic Plan 2013–2018 was developed and approved by the WHO Executive Board and the World Health Assembly in 2013. The plan requires a sequential removal of all oral polio vaccines (OPVs), beginning with type-2 OPV, by switching from trivalent to bivalent OPV in a globally synchronized manner. The objective is to eliminate the risks of vaccine-associated paralytic polio (VAPP) and circulating vaccine-derived poliovirus (cVDPV) associated with the continued use of type-2 OPV.

Progress made in the South-East Asia Region

16. Appropriate actions to mitigate the risk of spread of wild poliovirus following an importation are being taken by all Member States in the Region. These include sustaining high population immunity against polio, maintaining quality surveillance for poliovirus detection, and having outbreak response plans in place to respond to any wild poliovirus importation if it were to occur.

17. All Member States of the Region have withdrawn the type-2 component of OPV by switching from trivalent OPV to bivalent OPV in April 2016 as part of the implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018.

18. All Member States of the Region – except Indonesia – have introduced inactivated poliovirus vaccine (IPV). Indonesia is likely to introduce IPV in July 2016.

Challenges

19. Concerns persist over the adequacy of IPV supplies that are affecting the Member States of the SEA Region, and WHO and international partners are called upon to do everything possible to mitigate the risk of IPV shortage so that routine immunization services are not disrupted. To stretch the available IPV supplies, India has already introduced fractional-dose IPV in eight states while Sri Lanka is ready to switch from a full-dose IPV schedule to fractional-dose IPV schedule very soon.

20. Completing poliovirus containment activities in accordance with the Global Action Plan III to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of routine OPV.

21. Sustaining polio activities to maintain polio-free status as funding from the Global Polio Eradication Initiative for polio assets (people, systems and processes) declines during the period 2017–2019 and eventually stops.

The way forward

22. All Member States of the SEA Region must maintain and further strengthen actions required to keep the Region polio-free until global polio-free certification is achieved.

23. Certification-standard surveillance for poliovirus detection must be maintained by all Member States for the early detection and immediate notification of any wild polioviruses or any type-2 vaccine/vaccine-derived polioviruses, after the switch from tOPV to bOPV. Environmental surveillance should be initiated urgently in areas at high risk of type-2 poliovirus circulation, post the tOPV-to-bOPV switch.

24. Containment of polioviruses must be completed as per Global Action Plan III to mitigate the risk of exposure of communities to any type-2 polioviruses, post the tOPV-to-bOPV switch.

25. Outbreak response capacity to respond to detection of any type-2 vaccine-derived poliovirus outbreaks, post the tOPV-to-bOPV switch, must be ensured.

26. Country-specific plans for the transition of human resources and other assets for the polio programme between now and the anticipated achievement of global certification of poliovirus eradication must be developed in coordination and collaboration with national and state governments, GPEI partner agencies, donors and other stakeholders.

3. South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7)

Background

27. The South-East Asia Regional Health Emergency Fund (SEARHEF) is an operational fund of the WHO South-East Asia (SEA) Region earmarked for providing support to health sectors of Member States during humanitarian emergencies. The experience of the Region with the earthquake and tsunami of December 2004 taught valuable lessons about the need for creating a fund that could be immediately made available during such emergencies to provide instant support to relief operations. As a result, SEARHEF was established in 2007 at the Sixty-first session of the Regional Committee for South-East Asia vide resolution SEA/RC60/R7 and operationalized in 2008 by pooling a budget of US$ 1 million for each biennium from assessed contributions (AC).

28. To date, SEARHEF has supported eight out of 11 Member States in 24 emergency operations, with disbursements totalling US$ 4.2 million (Annex 1). Each Member State can request the Regional Office through its country office for SEARHEF funding support in two tranches totalling US$ 350 000. The first tranche of US$ 175 000 is requested during the first month of the emergency operations and the second tranche for the same amount may be requested for further response activities. Funds are released within 24 hours of receiving a request. SEARHEF is overseen by a Working Group comprising 11 representatives from the Member States. The Working Group has met thrice since 2008, and its last meeting was held in August 2014 through videoconferencing.

Update on SEARHEF

29. Support was provided to Sri Lanka from SEARHEF for response efforts related to the floods of May 2016 to the tune of US$ 100 000 in this biennium.

- Timor-Leste made a voluntary contribution of US$ 100 000 to the Fund at the Sixty-eighth session of the Regional Committee, and this contribution is now available for this biennium in addition to US$ 1 million. The SEARHEF balance as of date is US$ 1 000 000 for current biennium 2016–2017.
- The Fund was fully utilized at the end of the last biennium 2014–2015.
- The Regional Office organized two meetings of the SEARHEF Working Group (third and fourth) through videoconferencing in the 2014–2015 biennium. The Working Group's recommendations were to:
  - use SEARHEF for preparedness and recovery phases of disasters or during crises,
  - increase the corpus of the Fund through other contributions, and
  - use SEARHEF balances, if any, at the end of the biennium for regional capacity-building activities and prepositioning supplies.

Challenges

30. Major challenges faced by SEARHEF are well articulated in the recommendations made by the Working Group during the third meeting held in 2014. These include:

- Identifying new funding sources to augment SEARHEF for regional capacity-building activities, risk reduction and preparedness initiatives, and
- Utilizing balance funds for prepositioning supplies at the end of the biennium.

The way forward

31. Building capacity for preparedness and readiness: New policy instruments have been developed, namely, the three global policy frameworks (the Sendai Framework, the Sustainable Development Goals and the Climate Change Agreements), and relevant resolutions by the World Health Assembly and the Regional Committee have been promulgated calling for strengthening resilience of national health systems for all hazards.

32. The reform of WHO's work in emergency risk management has progressed and its structure and additional budget have been approved by the Sixty-ninth World Health Assembly. Its main features are as follows:

- All WHO's work in emergencies has been brought under a single programme, with a common structure across headquarters and all regional offices to optimize intra-agency coordination, operations and flow of information.
- A single accountability framework with clear roles for the country offices, regional offices and headquarters.
- An oversight body, the Emergencies Oversight and Advisory Committee, to oversee and monitor the performance of the WHO Emergencies Programme.
- A single budget and aligned results framework.
- One set of business processes.
- Central to the WHO Emergencies Programme is WHO's work in support of Member State preparedness and readiness. A capacity development focus is critical to how the programme is designed.

33. As such, there is a need to advocate for increased funding contributions for SEARHEF and identify mechanisms that will support the use of additional funds for building country capacity for preparedness and readiness.

34. Member States during the HLP suggested expanding the scope of SEARHEF to include a preparedness stream that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams. There is also an expressed need for increasing tranches for emergency funding from SEARHEF.

35. It was recommended during the HLP to convene the next SEARHEF Working Group meeting together with technical experts before the Regional Committee meeting and develop guidelines for the proposed preparedness funding stream. On the basis of the proposed guidelines, a resolution entitled "Expanding the Scope of the South-East Asia Regional Health Emergency Fund (SEARHEF)" could be considered by the Sixty-ninth Regional Committee Session.

36. There is a need for SEARHEF to coordinate with other funds for emergencies, in particular the Contingency Fund for Emergencies (CFE) that is being set up in WHO as part of emergency reforms.

Annex 1

SEARHEF support to Member States

(Status of fund disbursement since the operationalization of SEARHEF in 2008)

No	Emergency	Period		SEARHEF Allocation in US $
		Month	Year	
1	Cyclone Nargis in **Myanmar**	May	2008	350 000
2	Flash floods in **Sri Lanka**	June	2008	23 299
3	Kosi river floods (in two tranches) in **Nepal**	Sept.	2008	325 000
4	Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern **Sri Lanka** (in two tranches)	Sept.	2008	350 000
5	Earthquake in North Sumatra province of **Indonesia** (in two tranches)	Oct.	2009	300 000
6	Emergency health interventions for relocated IDPs affected by conflict in **Sri Lanka**	Jan.	2010	175 000
7	Fire in Dhaka, **Bangladesh**	June	2010	175 000
8	Mt Merapi volcanic eruption in East Java province of **Indonesia**	Nov.	2010	139 000
9	Critical health-care services to the resettled population affected by conflict in **Sri Lanka**	Feb.	2011	175 000
11	Floods in **Thailand** (in two tranches)	July	2011	350 000
10	Torrential rains in **Democratic People's Republic of Korea** (in two tranches)	Aug.	2011	310 000
12	Fire outbreak/explosion in Yangon, **Myanmar**	Jan.	2012	25 000
13	Support for provision of emergency health care in Rakhine State of **Myanmar**	June	2012	12 300
14	Flash floods in **Democratic People's Republic of Korea**	July	2012	134 130
15	Support to population affected by storm in **Maldives**	Nov.	2012	47 717
16	Support to **Myanmar** for procuring emergency medical supplies (fire outbreak and earthquake)	Nov.	2012	30 778
17	Support to **Myanmar** for establishing health-care services for townships affected by communal conflict in Rakhine State	April	2013	175 000
18	Support to emergency caused due to flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of **Democratic People's Republic of Korea**	July	2013	175 000

No	Emergency	Period		SEARHEF Allocation in US $
		Month	Year	
19	Support to emergency response activities to the crisis situation created due to Mt Sinabung eruption in North Sumatera province of **Indonesia**	Feb.	2014	144 068
20	To establish sustainable health-care services for townships affected by communal conflict in Rakhine state of **Myanmar**	May	2014	175 000
21	To complement the response and recovery activities conducted by the Ministry of Health of **Sri Lanka** to support short- to medium-term needs of the health sector	Nov.	2014	35 500
22	To complement the response and recovery activities conducted by the Ministry of Health of **Sri Lanka** to support response and recovery activities from heavy floods and landslides in 22 out of 25 administrative districts in **Sri Lanka**	Dec.	2014	30 000
23	To support the **Nepal** earthquake	April	2015	175 000
24	Support strengthening the capacity of health institutions to meet the immediate needs of population in drought-affected areas in South and North Hwanghae and South and North Pyongyang provinces **of Democratic People's Republic of Korea**	July	2015	137 160
25	Support operational cost for post-disaster management w.r.t floods following heavy rain that affected health facilities in the Sagaing and Magway Region and Rakhine State of **Myanmar**	Aug.	2015	26 000
26	Support to the Ministry of Health for emergency medical interventions for flood-affected populations in Rakhine and Chin states and Sagaing and Magway regions of **Myanmar**	Aug.	2015	149 000
27	Support emergency medical supplies and essential drugs for flood-affected populations in Rason City in North Hamgyong province of **Democratic People's Republic of Korea**	Sept.	2015	161 887
28	Support to the Ministry of Health of **Sri Lanka** for response and recovery activities for flood victims	May	2016	100 000
	Grand total			**4 230 839**

4. Capacity building of Member States in global health (SEA/RC63/R6)

Background

37. The broad definition of health as stipulated in the *Constitution* of the World Health Organization encompasses all dimensions of well-being – physical, mental and social, and refers to a state of health that will lead to a socially and economically productive life. In the era of rapid globalization, health interventions have moved beyond national boundaries, and have re-surfaced as a pressing global priority thus being re-conceptualized as "global health" to imply a shared global responsibility for health.

38. The term "global health" has emerged as part of the larger political and historical process and has replaced the term "international health". The term "global" is also associated with the growing importance of actors beyond governments, such as intergovernmental organizations and agencies, and international nongovernmental organizations. "Global health" conveys a sense of something that goes beyond an understanding of communication and agreements related to health issues between governments across the world, irrespective of borders.

39. The epidemic and pandemic outbreaks of various diseases, especially severe acute respiratory syndrome (SARS), influenza (H1N1 and H5N1) and Ebola have brought about a broader interdependence of nations, as well as highlighted the need for global cooperation. This situation also applies to many areas of public health, covering both prevention and control of communicable and noncommunicable diseases. The globalization of public health is a promising development that allows for diffusion of technologies, information, ideas and values as all nations cooperate in areas of public health surveillance, research and intersectoral action.

40. The current health challenges facing policy-makers include: (i) addressing the role of the health sector in national and global health security; (ii) meeting the targets of health-related areas of the UN Millennium Development Goals; (iii) ensuring access to and affordability of essential medicines; (iv) controlling emerging communicable and noncommunicable diseases; (v) sharing biological materials with pathogenic potential; (vi) increasing access to vaccines, drugs and other benefits; (vii) bolstering international support for strengthening health systems; and (viii) addressing the challenges facing global health governance and integrating health into all global and national policies and strategies.

41. In recent years, the debates on the relationship between foreign policy and global health have accelerated at international forums. The UN General Assembly in New York had adopted the resolutions A/RES/63/33 in November 2008 and A/RES/64/108 in February 2010, which recognized the close relationship between foreign policy and global health and their interdependence. The UN Secretary-General, in collaboration with the Director-General of WHO and in consultation with Member States as well as in pursuant to resolution A/RES/63/33 of the UN General Assembly, submitted a progress report to the Sixty-fourth Session of UN General Assembly in September 2009, titled "Global health and foreign policy: Strategic opportunities and challenges". The report highlighted the need to increase capacity of and raise levels of training of diplomats and health officials in global health diplomacy and develop training standards and open-source information, education and training resources for this purpose.

42. Increasingly, the interplay between global health and foreign policy has also emerged as a major issue at various global forums. It has been the subject of discussion even at the World Health Assembly. The intergovernmental negotiations organized by WHO in the last decade have produced instruments such as the WHO Framework Convention on Tobacco Control (WHO FCTC) and the International Health Regulations (IHR) 2005. WHO also organized various intergovernmental working groups – one on public health, innovation and intellectual property and another on pandemic influenza preparedness.

43. WHO also embarked on a global initiative in 2010 to support Member States in the development of their national health policies and strategies. It provides evidence-based technical and policy advice and support to Member States in enhancing understanding of the relationship between foreign policy and global health by commissioning research, sponsoring symposiums and developing an international network of governments and institutions – the Network on Global Health Diplomacy – with the support of the Rockefeller Foundation and the Global Health and Foreign Policy Initiative[1].

44. Collaborative work between this initiative and national and regional efforts on capacity-building in global health would enhance the overall development of national, regional and global health policies, strategies and plans.

Progress made in the South-East Asia Region

45. To strengthen the capacity of Member States in global health, many international training programmes on global health have been initiated to inform health professionals through multidisciplinary, didactic and experiential learning. WHO headquarters organized a training course on global health diplomacy in June 2007, in Geneva, in collaboration with academic institutions and the Swiss Agency for Cooperation and Development. The training course was attended by 18 participants comprising senior diplomats and health professionals from 10 countries.

46. Prior to the Sixty-third World Health Assembly and the 127th Session of the Executive Board, the First Regional Training Course on Global Health was organized by the Ministry of Public Health, Thailand, on 1–5 May 2010, in collaboration with the WHO Regional Office for South-East Asia and the Thai Health Global Link Initiative Programme (TGLIP). The main objective of this training course was to build up and strengthen the capacity of health and related professionals of Member States in global health, which could lead to the setting up of a global health agenda and policy formulation, taking into account the interest and concerns of Member States. Participants were expected to develop their relationship with delegates from other countries of the Region and be well prepared to serve as country delegates.

47. The first module – an introductory course on global health – was attended by participants from seven countries of the SEA Region, who were selected from among the delegates attending the Sixty-third World Health Assembly. The training was conducted on 1–5 May 2010 in Nakhon Pathom, Thailand, followed by the second module on practical experience and learning through attendance at the Sixty-third World Health Assembly from 17–21 May 2010 in Geneva. A wrap-up session – the third module – was conducted on 22 May 2010 in Geneva. The course focused on health issues that transcend national boundaries, are global in nature and are

[1] The Global Health and Foreign Policy Initiative was launched in September 2006 as an immediate outcome of the Oslo Ministerial Declaration (Foreign Ministers of Brazil, France, Norway, Senegal, South Africa and Thailand).

debated at the World Health Assembly. It involved experience-sharing among participants, who were directly exposed to the current global health scenario and movements.

48. Prior to the Sixty-fifth World Health Assembly and the 131st Session of the Executive Board, the Second South-East Asia Regional Workshop on Global Health was conducted by the WHO Regional Office for South-East Asia, in collaboration with Thai Health and Rockefeller Foundation, in New Delhi on 7–12 May 2012. The objective of the workshop was to build up and strengthen the capacity of health and related professionals on global health, which could lead to the setting up of a global health agenda and policy formulation. Three main areas identified for training in capacity-building were: (i) strengthen capacity in policy advocacy; (ii) evidence generation on global health diplomacy issues, and (iii) networking activities.

49. Prior to the Sixty-sixth World Health Assembly and the 133rd Session of the Executive Board, the Third South-East Asia Regional Workshop on Global Health was held on 6–10 May 2013 in the Regional Office. The workshop was attended by almost all Member States of the Region besides observers from the People's Republic of China, India, Nepal and Viet Nam. The objective was to ensure that participants realize the evolution and importance of global health diplomacy.

Challenges

50. The challenges being faced are, among others, the following:

- Addressing the role of the health sector in national and global health security;
- Meeting international health targets and goals;
- Ensuring universal access to health services;
- Controlling emerging CDs and NCDs;
- Sharing biological materials with pathogenic potential; and
- Securing international support for strengthening health systems.

The way forward

51. WHO needs to support Member States to organize seminars and training workshops on global health that could act as an effective tool to strengthen national capacity in global health, and enable them to participate and play active roles in international/global health forums with improved negotiation skills. Strategies and plans have to be developed to address the increasing demand for well-trained public health professionals who could address the changing context of global health challenges, including complex and persistent health issues, increasing health inequities, new and emerging diseases, the necessity for greater collaboration, and incorporation of social models and determinants.

52. Continue training in the three identified areas: (i) strengthening capacity in policy advocacy; (ii) evidence generation on GHD issues, and (iii) networking.

5. 2012: Year of Intensification of routine Immunization in the South-East Asia Region: Framework for Increasing and Sustaining Coverage (SEA/RC64/R3)

Background

53. The World Health Assembly in 2011 endorsed the proposal for recognizing the last week of April of every year as "World Immunization Week". In the same year, the Sixty-fourth session of the WHO Regional Committee for South-East Asia (September 2011) declared 2012 as the "Year of Intensification of Routine Immunization in South-East Asia" vide resolution SEA/RC64/R3. Member States committed "to develop national and sub-national-level plans of action based on risk analysis to intensify routine immunization (RI) coverage and reach the large number of children who have not been immunized over time". All countries then prepared their action plans, focusing primarily on high-risk population groups and hard-to-reach areas, to intensify routine immunization activities for enhancing coverage and reaching out to more children with immunization services. Subsequently, this regional initiative was aligned with the Immunization and Vaccine Development Strategic Plan 2014–2017 and recently with the Regional Vaccine Action Plan (RVAP) 2016–2020 in tandem with the Global Vaccine Action Plan (GVAP) that was endorsed by all Member States of WHO at the Sixty-fifth World Health Assembly.

Goal of intensification of routine immunization

54. The goal of intensification of routine immunization envisages that all Member States of the South-East Asia Region must achieve at least 90% national immunization coverage and at least 80% coverage in every district (at the sub-national level) for the six basic antigens as measured by the third dose of DTP/pentavalent vaccine.

Progress made in the South-East Asia Region

Strategic Directions identified in the framework for increasing and sustaining immunization coverage

55. The following Strategic Directions were identified to intensify routine immunization in the South-East Asia Region:

- Building and enabling the political and economic environment to support the intensification of routine immunization;
- Responding to country needs to increase and sustain high immunization coverage, including:
  - mapping performance and resources,
  - improving access to immunization,
  - implementing national stratification plans, and
  - increasing the demand for immunization services.
- Strengthening immunization service delivery, information and management capacity.

Response by Member States

56. Following the adoption of resolution SEA/RC64/R3 by the Sixty-fourth session of the Regional Committee for South-East Asia, all Member States developed plans of action to strengthen routine immunization with a focus on identifying the poorly performing or hard-to-reach areas or population groups.

57. The Region has achieved DTP3/Penta3 immunization coverage of 84% (2014) and has established national immunization technical advisory groups (NITAGs) in all countries for bolstering their decision-making capacity. There is also a network of SEA Region NITAGs for the sharing of best practices.

58. Countries have also devoted considerable attention and resources to strengthening immunization systems and capacity-building. Measures to this effect include:

- All countries have incorporated the intensification plans into their comprehensive multi-year plans and continued implementing the action identified as specific to each country.
- Bhutan, the Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand have maintained their already achieved national DTP3/Penta3 coverage at above 90% and coverage in all districts at above 80%.
- Bangladesh achieved DTP3/Penta3 national coverage of 94% in 2015. Bangladesh continues to maintain the regional and global goal of pentavalent 3 coverage targets (90% national and more than 80% in all districts). The country targeted 32 districts and four city corporations for intensification of routine immunization in 2012 with a number of activities. Since then, regular district- and sub-district-level review meetings have been held; additional vaccine transportation costs provided for hard-to-reach areas; every child has been tracked using tally sheet/registration book mentioning names and detailed addresses and listing all drop-outs; training courses for middle-level managers and on data quality strengthening offered and refresher training on adverse events following immunization (AEFI) provided; and the number of selected IRI districts with more than 90% pentavalent 3 coverage has increased from 25 in 2011 to 33 in 2014.
- India has achieved DTP3/Penta3 national coverage of 87% in 2015. The country also established an Immunization Technical Support Unit (ITSU); set up a task force for immunization in 28 out of its 35 states; and launched "Mission Indradhanush" – a major multi-phase campaign which aims to boost routine immunization under which 3.7 million children have been fully immunized and 3.6 million pregnant women vaccinated in phases. This equity-based mission applied the range of polio strategies and assets to focus on identified high-risk populations in traditionally low-coverage or underserved areas with insufficient health services in 201 high-priority districts in phase I, 352 medium-focus districts in phase II and 216 high-focus districts in phase III (which is ongoing). More than 1 million frontline health workers in different categories have been trained.
- Indonesia has achieved DTP3/Penta3 national coverage of 81% in 2015. Also in that country, a new comprehensive multi-year plan (cMYP) 2015–2019 was developed in 2015; new middle-level managers were trained at the national level and sub-nationally

in 36 districts; local area monitoring was strengthened; a new communication plan for immunization was developed; an EPI communication forum has been established including professional organizations such as the Indonesian Paediatric Society and religious bodies to conduct advocacy meetings with local governments and address issues related to "vaccine hesitancy". Effective vaccine management (EVM) assessments were done in 17 provinces and at the national vaccine store, and its recommendations are being implemented. The province of Jakarta has initiated a text message-based real-time reporting system in urban slum areas targeting the poorest communities to enhance coverage. East Java province has conducted drop-out follow-up activities in areas with low coverage (<80% DTP3) in select villages of 60 districts in 18 provinces with a total of 7646 villages targeted. A total of 151 217 children under the age of one year were targeted in 2015 alone and 130 102 of them were reached (the coverage achieved in these villages being 86%). AEFI refresher trainings were conducted for all provincial staff and an e-learning training course on AEFI has been developed in the Bahasa Indonesia language.

- Myanmar achieved DTP3/Penta3 national coverage of 75% in 2015. The country has prepared annual workplans for immunization which identify new approaches such as integrating immunization service in all hospitals, developing township-level operational annual workplans, strengthening capacity of health staff through trainings on different subject areas, strengthening training centres (developing training packages, physical infrastructure and trainers), strengthening data management at all levels with communication, social mobilization and cold chain improvement plans.
- Nepal has achieved DTP3/Penta3 national coverage of 91% in 2015. The country introduced the concept of achieving fully immunized villages through the "appreciative inquiry" method in 2012. Until now 17 districts, two sub-metros, 56 municipalities and 1300 village development committees (VDCs) have been declared as fully immunized. Immunization micro-planning for municipalities is in place and the month of Baisakh (mid-April to mid-May) is observed as "Immunization Month" in the country every year with the national immunization programme allocating a budget each year for districts to celebrate this month. An Immunization Act was passed in Parliament in 2016 ensuring the right to vaccination and the provision of quality vaccines and logistics for children. The Act also stipulates the provider's and recipient's responsibilities, a system of appeal in relation to immunization activities and norms related to compensation. The establishment of the National Immunization Fund and immunization committees (National Immunization Committee, National Immunization Advisory Committee and AEFI Committee) are also outlined in the Act.
- Timor-Leste has achieved DTP3/Penta3 national coverage of 76% in 2015. Regular meetings of expanded programme on immunization (EPI) working groups were conducted practically every week to monitor progress of the implementation of routine immunization. Five new vaccines were introduced to the national immunization programme including IPV, hepatitis B vaccine birth dose, DTP booster dose, dT and Measles and Rubella vaccine. The country has also increased the number of vaccine storage cold chain points from 68 (community health centre level) to 127 (health post-level). An effective vaccine management (EVM) assessment was conducted and its

recommendations are being implemented. A new comprehensive multi-year plan (cMYP) for immunization and VPD control for 2016–2020 was developed. Five national professional officers (NPOs) were appointed at the district level along with two international consultants (STOP team members) to provide technical assistance to the district authorities in addition to technical assistance at the national level. In addition to a middle-level management (MLM) training for all national- and district-level immunization focal points all 400 newly recruited Cuban-trained doctors were also trained on immunization, VPD and AEFI surveillance.

Challenges

59. Challenges faced during implementation of the activities related to "Year of Intensification of Routine Immunization" include the following:

- Sustaining political commitment to improve immunization coverage and quality of services; and
- Mobilizing resources, including human resources, at appropriate levels for managing uninterrupted service provision.

The way forward

60. All countries need to continue to monitor and review their immunization coverage to identify the gaps and areas for further strengthening of national programmes in line with the RVAP.

61. Countries should use the opportunity that comes with the introduction of new and underutilized vaccines and implement strategies for measles elimination to further improve routine immunization coverage.

62. There is a need for robust surveillance systems for vaccine-preventable diseases, and for conscious efforts to generate evidence for policy, to ensure that the introduction of new vaccines and technologies is appropriate, affordable and sustainable. In addition, countries need to have strong national technical advisory bodies to advise their respective governments. Furthermore, research should be conducted to measure the impact of improvements in immunization programmes on mortality and morbidity caused by vaccine-preventable diseases.

63. The security of vaccine supply should be ensured through enhanced vaccine-manufacturing capacity in the Region. In addition, innovative vaccine-procurement mechanisms can be used to improve vaccine affordability. For example, in the WHO Region of the Americas the PAHO Revolving Fund is based upon a bulk-procurement system which leverages the benefits of collective bargaining.

6. Regional Action Plan and Targets for Prevention and Control of Noncommunicable Diseases (2013–2020) (SEA/RC66/R6)

Background

64. The resolution titled "Regional Action Plan and Targets for Prevention and Control of Noncommunicable Diseases (2013–2020)" (SEA/RC66/R6) passed by the Sixty-sixth Session of the WHO Regional Committee for South-East Asia on 13 September 2013

- endorsed the Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (NCDs) (2013–2020); and
- adopted 10 regional voluntary targets for the prevention and control of NCDs to be achieved by 2025.

65. The Regional Committee resolution SEA/RC66/R6 also requested the Regional Director to submit reports on the progress achieved in attaining the 10 voluntary regional targets at the Regional Committee Sessions in 2016, 2021 and 2026.

66. In line with paragraph 3(5) of resolution SEA/RC66/R6, this report is being submitted as a summary on the progress made in attaining the 10 voluntary regional targets outlined in the Regional Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.

Progress made in the SEA Region

67. The progress made for each section of the resolution is outlined below. The resolution SEA/RC66/R6 is annexed for reference.

Developing national multisectoral policies and plans and setting national targets

68. Significant progress has been made in the development of national multisectoral action plans in line with the regional and global NCD action plans. Bhutan, Nepal and Sri Lanka have endorsed their plans; and Bangladesh, India, Indonesia, Maldives and Myanmar are in the process of securing government endorsement of their draft plans. Timor- Leste and the Democratic People's Republic of Korea have adopted the 2025 Voluntary Global Targets and intend to develop the operational plans to implement their national NCD prevention and control plans. To identify the resource needs, a costing of plans has been initiated in Bhutan, Nepal and Sri Lanka. A high-level interministerial committee has been formed in most Member States to facilitate multisectoral cooperation for NCD prevention and control.

69. All Member States have set national targets for NCDs for 2025 incorporating guidance from the global and regional NCD action plans. Baseline information on NCD behavioural and metabolic risk factors, and prevalence of diabetes and hypertension have been established through national prevalence surveys.

Strengthening surveillance and monitoring systems

70. All Member States of the Region carried out at least one NCD risk factor survey since 2013. In particular, tobacco survey systems for both adult and youth populations have been implemented in the Region as follows — Bangladesh: GYTS 2013, GSHS 2014; Bhutan: GYTS 2013, STEPs 2014; Democratic People's Republic of Korea: STEPs 2016 (field work completed, report awaited); Indonesia: GYTS 2014, GSHS 2015; Maldives: GSHS 2014; Myanmar: STEPs

2014; Nepal: STEPs 2013; Sri Lanka: GYTS 2011, STEPs 2014; Thailand: GSHS 2014; and Timor-Leste: GYTS 2013, STEPs 2014, GSHS 2014. Bangladesh and India are in the process of preparing the next generation of their Global Adult Tobacco Surveys (GATS). The Union Ministry of Health and Family Welfare of the Government of India conducted a nationwide diabetes survey and preparations for the first STEPS survey are at an advanced stage. India and Thailand have cancer registries. Other Member States, such as Bhutan, have also started developing their cancer registries.

Tobacco, diet, physical activity, alcohol and marketing of foods and non-alcoholic beverages

Tobacco use

71. The Sixty-eighth Session of the Regional Committee in 2015 endorsed the Dili Declaration on Tobacco Control. Member States increased taxes and simplified the taxation system on tobacco products. Taxes on tobacco products levied by Bangladesh, Sri Lanka and Thailand currently exceed 70% of the retail prices. Bhutan has banned the manufacture, sale and trade of tobacco products. Robust restrictions on tobacco advertising and promotion are in place in almost all Member States except Indonesia. Most countries have established national-level agencies or committees or appointed focal points for tobacco control.

72. Regulations on health warning signage are at an advanced stage in the SEA Region. Nepal introduced the highest percentage of health warning signs on tobacco packages (increasing from 75% to 90%), Bangladesh implemented 50% graphic health warnings (GHWs), India increased the GHW from 40% frontal coverage to 85% on both sides of packaging, Sri Lanka increased the same from 60% to 80% and Myanmar to 75%. Smoke-free laws have also been implemented in almost all Member States.

73. Thailand has fairly well-established tobacco cessation services. India and Thailand have also developed national tobacco dependence treatment guidelines.

Unhealthy diet

74. The Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region has been finalized in 2016. WHO is engaging with Member States on programmes to end childhood obesity, the promotion of healthy diets and low dietary intake of salt, as well as implementing WHO's recommendations on restricting the marketing of unhealthy foods to children. The development of the nutrient profile model for the Region is under progress.

Physical inactivity

75. WHO has supported public campaigns and facilities to address physical inactivity in all population groups in Member States. The Regional Office has promoted the implementation of healthy public spaces in all cities and urban planning using "Urban HEART" as the entry point for multisectoral actions for health promotion. The promotion of physical activity is ingrained in health promotion policies, school health policies, and youth and sports policies in Member States.

Harmful use of alcohol

76. In line with the Regional Action Plan on NCD Prevention and Control and the Regional Action Plan and Strategy to Reduce the Harmful Use of Alcohol (endorsed by the Sixty-seventh Regional Committee in 2014), many Member States have developed or revised their own policies and plans, including setting new targets to address alcohol problems, over the past years.

These include Bhutan, India and Sri Lanka. The Regional Office also supported the inclusion of drink-driving sections in road safety laws in Bangladesh and Sri Lanka in 2015.

Scaling up programmes for the prevention and control of cervical cancer

77. Currently Bhutan has integrated HPV vaccination in its immunization schedule, and Bangladesh and Nepal have instituted HPV demonstration projects in collaboration with WHO. Data on coverage of cervical cancer screening were collected in recent STEPS surveys in Bhutan, Myanmar, Sri Lanka and Timor-Leste. Coverage of screening of cervical cancer is variable, ranging from >64% in Bhutan to 60% in Thailand and <25% in Sri Lanka to <10% in Nepal and <5% in Myanmar to <2% in Timor-Leste. Coverage still remains low because of limitations in health systems capacity. Guidelines for cervical cancer screening are being developed in India, Nepal and other countries to increase coverage.

Early diagnosis, referral and management of oral cancers within primary health care

78. Screening for oral cancer has been included in the national multisectoral action plans of Bangladesh, Bhutan and Nepal. The WHO Package of Essential NCD (PEN) Interventions incorporates opportunistic symptomatic identification of cancers, including oral cancers. Coverage of screening for oral cancer is currently low, while implementation of the multisectoral plan and expansion of PEN to the primary health-care level in Member States is expected to improve early diagnosis, timely referral and appropriate management of potentially malignant oral disorders and cancers.

Global coordination mechanisms

79. In September 2014, Sri Lanka and Thailand were appointed as members of the Global Coordination Mechanism on Noncommunicable Diseases (GCM/NCD) Working Group 3.1 on how to realize governments' commitments to engage with the private sector for the prevention and control of NCDs, and Indoneisa and Nepal as members of the GCM/NCD Working Group 5.1 on how to realize governments' commitment to provide financing for NCDs.

80. In 2016, SEA Region Member States were appointed in the three Working Groups for 2016–2017 of the WHO GCM on the Prevention and Control of NCDs: India and Indonesia to the GCM/NCD Working Group 3.1 on the inclusion of NCDs in other programmatic areas, Nepal and Thailand for the GCM/NCD Working Group 3.2 on the alignment of international cooperation with national plans on NCDs, and Bhutan and Myanmar for the GCM/NCD Working Group 3.3 on health education and health literacy for NCDs.

WHO support to Member States

Support for the costing of national action plans and national monitoring frameworks

81. Member States were provided training on the One Health Costing Tool in 2013 to build skills to cost national plans. In the following years, at the request of Member States, the Regional Office supported costing of the national action plans in Bhutan, Nepal and Sri Lanka. The national monitoring frameworks that include indicators and national targets for NCDs have been developed as part of the national multisectoral action plans of Member States with support from WHO.

Establishing regional mechanisms for coordination, capacity-building and sharing of good practices

82. High-level advocacy and joint UN missions have been carried out to countries to advocate for integrating NCDs into the national health planning and development agenda such as UNIATF[2] Missions to India and Sri Lanka.

83. A regional guidance document "Approaches to Establishing Multisectoral Collaboration Mechanisms for Prevention and Control of NCDs" was developed in 2015. SEARO also intensively supported capacity-building for key NCDs stakeholders through numerous meetings and workshops in the areas of NCD risk factors, programme management and capacity-building.

84. In an effort to create a regional-level network for exchange of best practices and information on tobacco control measures, published NCD STEPS survey reports were shared among Member States. The WHO South-East Asia Journal of Public Health published articles and research from Member States on NCDs to promote the platform for sharing evidence. The journal's April 2016 edition was dedicated as a special issue on diabetes.

85. The Regional Office at SEAR ITAG (South-East Asia Region Immunization Technical Advisory Group) meetings since 2011 has been facilitating the sharing of experiences and best practices of HPV introduction in the Region. The regional goal for hepatitis B prevention and control is planned to be formalized in 2016.

Strengthening national surveillance and monitoring systems and supporting reporting on the global and regional voluntary targets

86. WHO has provided technical and other collaborative support to Member States in implementing national NCD-related surveys. A regional pool of survey equipment has been created to facilitate surveillance activities in countries. SEARO has strengthened its own technical capacity on NCD and tobacco surveillance through collaboration with other international agencies.

Convene a mid-course regional consultation (during 2018–2019) to review baseline data and regional targets, and make adjustments

87. A mid-course regional consultation to review baseline data and regional targets have been prioritized in the Region's 2018–2019 work plan and activity will be implemented as recommended.

Submit reports on progress achieved in attaining the 10 voluntary regional targets in 2016, 2021 and 2026

88. The progress on the 10 voluntary regional targets is summarized in Table 1 below. The majority of the baseline estimates is available for 2014 or under development. In general, the regional estimates indicate that there has not been any appreciable reduction in key indicators compared with 2010 figures. This is not surprising as major responses have not been implemented and Member States are in the planning stage for launching their comprehensive multisectoral national responses as reported in the previous sections.

[2] United Nations Interagency Taskforce (UNIATF) on prevention and control of NCDs was established to coordinate the activities of the relevant UN funds, programmes and specialized agencies and other intergovernmental organizations to support realization of the commitments made in the Political Declaration of the High-Level Meeting on Prevention and Control of NCDs, in particular, through implementation of the WHO Global Action Plan on NCDs 2013–2020. The Declaration called upon WHO, as the lead UN specialized agency for health, and all other UN system agencies and international financial institutions to work together in a coordinated manner to support national efforts to prevent and control NCDs and mitigate their impact.

Table 1: ***Progress indicators for 10 voluntary targets (% (95%CI))***

10 voluntary targets by 2025	Available indicators	2010	2014
1. A 25% relative reduction in overall mortality from cardiovascular diseases, cancers, diabetes or chronic respiratory diseases	Probability of dying from any of cardiovascular diseases, cancers, diabetes, chronic respiratory disease between age 30 and exact age 70	**25%**	To be updated in the late 2016
2. A 10% relative reduction in the harmful use of alcohol	Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption	3.4 (2.3-4.5)	3.7 (2.6-4.8)
	Age-standardized prevalence of heavy episodic drinking among adults	1.6 [1.1-2.1]	1.6 [1.1-2.1]
	Age-standardized prevalence of alcohol use disorders (15+ years old)	2.2	2.2
3. A 30% relative reduction in prevalence of current tobacco use in persons aged over 15 years	Current smoking among persons aged 15+	18.2	17.0 (Will be updated in July 2016)
4. A 10% relative reduction in prevalence of insufficient physical activity	Insufficiently active (crude rate)	14.7 (12.9–16.5)	Data under analysis and will take several months
5. A 30% relative reduction in mean population intake of salt/sodium			Data not available
6. A 25% relative reduction in prevalence of raised blood pressure	Blood pressure (SBP>=140 or DBP>=90)	25.1 (22.3–-28.2)	24.7 (20.4–28.9)
7. Halt the rise in obesity and diabetes	Overweight (BMI>= 25) (crude rate)	19.8 (17.8–21.7)	22.2 (19.3–25.4)
	Obesity (BMI>=30) (crude rate)	4.0 (3.3–4.7)	5.0 (3.9–6.1)
	Fasting blood glucose≥7.0 mmol/L or on medication (crude rate)	8.2 (6.6–9.9)	8.6 (6.4–11.0)

10 voluntary targets by 2025	Available indicators	2010	2014
8. A 50% relative reduction in the proportion of households using solid fuels (wood, crop residue, dried dung, coal and charcoal) as the primary source of cooking	Proportions of households that use SFU [% (95%CI, %)]	61[i] (52–70)	63 (2013)
9. A 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes			
10. An 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities			

Challenges

89. More than two years have passed since the endorsement of the Regional NCD Action Plan in September **2013**. Commendable **progress** has been made in implementing the resolutions in this short time. The following are some of the key challenges that need to be addressed to accelerate the ongoing response to NCD prevention and control in the Region:

- Eliciting multisectoral collaborative partnerships and sustaining those partnerships is difficult at the country level as non-health sectors have limited ownership of the health agenda.
- Specific NCD risk factor issues also need to be recognized. Tobacco: Most countries in the Region impose lower taxes on tobacco products that are consumed by the poor, such as bidis, hand-rolled cigarettes and smokeless tobacco. Poor regulation of smokeless tobacco, weak enforcement of existing laws, and heavy interference from the tobacco industry are a huge challenge. Alcohol: Alcohol control efforts are suboptimal and implementation of the "Best Buy" interventions focusing on raising taxes, restricting access and enforcing bans on alcohol advertising – that are recommended in the regional NCD action plans are inadequately implemented. Unhealthy diet: Salt consumption appears to be much higher than the safety levels for prevention of cardiovascular risks. Trans-fat and unhealthy products are widely available and public policy and programming are occurring at a slow pace among Member States. Physical inactivity: Physical inactivity is highly prevalent across all age groups. The prevalence of sedentary lifestyle among adolescents and females is high in the Region. To change this tangibly will require population-level transformation. Household air pollution: About 63% of households in the SEA Region still rely on solid fuel as the primary source for cooking. Reduction in solid fuel use by households will depend on non-health macroeconomic and social policies for the poor.
- Access to basic NCD medicines and life-saving insulin in the management of diabetes, and basic technologies for blood glucose measurement at the primary health-care level, and urine strip for glucose and ketone measurement at PHC are still not widely available in all Member States. In addition, limited capacity of the health workforce also poses a significant challenge.

The way forward

90. Member States may consider the following actions:

(1) Sustained multisectoral collaborations with ownership from non-health sectors are crucial at the country level. An economic case for NCDs should be built so that NCDs are truly acknowledged as a key to the development agenda and strategic efforts to operationalize multisectoral plans are ensured.

(2) Implementation of "Best Buys" in addressing specific NCD risk factors should be prioritized to gain maximum returns in the quest to improve population health outcomes.

(3) The health systems response to NCD prevention and control should be strengthened and good quality NCD services should be expanded at the primary health-care level to improve access to basic NCD services.

[i] Adapted from (29) Bonjour S, Adair-Rohani H, Wolf J, Bruce N, Mehta S, Pruss-Ustun A, et al. Solid fuel use for household cooking: country and regional estimates for 1980–2010. Environmental health perspectives. 2013. Epub 03 May 2013