Home to over a quarter of the world’s population, the WHO South-East Asia Region has been hit hard by COVID-19 like all other regions. The pre-existing high rates of noncommunicable diseases and mental health conditions have been aggravated by both direct and indirect impacts of the pandemic. The Region also is highly vulnerable to natural disasters that have become only more frequent due to climate change.

This biennium report of the Department of Healthier Populations and Noncommunicable Diseases captures key lessons learnt during the biennium that witnessed the global pandemic and highlights essential next steps within WHO’s mandate for NCDs, mental health and health and the environment. The report draws on the opportunity presented by the pandemic to address health issues, such as NCDs, mental health and environment determinants, in innovative ways. It comes at a critical time as we sustain, accelerate and innovate our work towards the achieving the WHO Triple Billion targets as well as 2030 Sustainable Development Goals for health and well-being of our people and the planet, ‘leaving no one behind’.
Healthier Populations and Noncommunicable Diseases

BIENNIIUM REPORT 2020–2021
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The WHO South-East Asia Region continues to intensify action to create healthier populations and address noncommunicable diseases (NCDs), in line with its Flagship Priorities, the Thirteenth General Programme of Work, and under the overall umbrella of the Sustainable Development Goals.

NCDs such as cardiovascular diseases, cancer, chronic respiratory diseases and diabetes continue to be the Region’s leading cause of mortality, accounting for around 60% of all premature deaths. An estimated 85% of all premature NCD deaths occur in low- and middle-income countries, including in our Region. Across the world and in South-East Asia, the COVID-19 pandemic disrupted essential health services, including for NCDs. It has exacerbated existing inequalities and affected the social determinants of health, throwing up immense ongoing challenges.

In every crisis there is an opportunity. Never before has the importance of mental health been so widely recognized. Most countries of the Region, for example, now have national mental health policies in place, which WHO will continue to support to implement. High-impact innovations such as telemedicine, extended prescriptions, and doorstep delivery of medicines have proven immensely successful during the COVID-19 response. Where appropriate, they must continue to be leveraged and applied to maximum potential and effect.

In 2021, five cities in the Region were selected to participate in the WHO Urban Governance for Health and Well-Being Initiative, which aims to strengthen country capacities to promote health and address health inequities through multisectoral action. The Region’s new Strategy for Primary Health Care, launched in December 2021, is set to accelerate progress made under the 2016 Colombo Declaration, bringing essential NCD interventions to all who need them.

As this HPN biennium report highlights, WHO continues to achieve real impact in all countries of the Region in its efforts to create healthier populations. The report contains
an array of case studies across key areas of work, from the social determinants of health and health promotion, to water, sanitation and climate change, as well as on chemical safety, environment and air pollution. It underscores WHO's ongoing work to create a tobacco-free Region, to achieve access for all to safe and nutritious food, and to strengthen emergency care and rehabilitative services.

It highlights several of the Region’s priorities for the coming biennium and beyond, including strengthening climate-resilient health systems, eliminating transfats, increasing access to assistive technologies, and fulfilling the Regional Roadmap for Implementation of the Global Action Plan on Physical Activity. As a Region, we have come so far, yet have so much further to go. Together, let us accelerate our journey for a healthier, more equitable and sustainable future for all.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia
# Department of Healthier Populations and Noncommunicable Diseases (HPN), WHO SEARO 2020–2021

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Executive summary

The COVID-19 pandemic has fundamentally altered the world in which we live. The changes it brought about are of a type and on a scale unseen by most people. The pandemic has reached almost every corner of the world, impacting almost every person one way or another.

The WHO South-East Asia Region, home to over a quarter of the world’s population, has been hit hard by COVID-19 like the other five WHO regions. The SE Asia Region comprises 11 diverse Member States that WHO works closely with to address persisting and emerging epidemiological and demographic challenges. All Member States in the Region have implemented an array of measures to limit the spread of COVID-19.

At the time of writing, in multiple countries across the Region, COVID-19 cases are increasing despite vaccines being available.

While the direct impact of the pandemic has been evident in statistics of the millions who have been infected, those who have lost their lives and whose livelihoods have been destroyed, the indirect health impacts are now becoming evident.

The indirect health impacts are acute, especially in relation to the disruption of essential health services. Across the Region,
noncommunicable diseases (NCDs) – such as cardiovascular diseases, chronic respiratory diseases, diabetes and cancer, which are the biggest killers across South-East Asia – have been exacerbated and so have mental health issues. Supply chains have been compromised, patients have been lost to follow-up and people have struggled to access their medications. The pandemic has also revealed and exposed the vulnerabilities and shortfalls of health-care systems and services across the Region. It has also further exposed the deep-rooted inequalities in society and highlighted the need to tackle such disparities.

As Member States across the Region implemented – and continue to implement – a range of pandemic control measures, including restricting movement, this has had an adverse effect on addressing NCD risk factors including physical inactivity, unhealthy food choices and alcohol use. In addition, prolonged social isolation has taken a toll on mental and psychosocial health. Initial and emerging estimates point towards losses in some of the critical gains in tackling NCDs.

More broadly, global efforts over the last 15 years to improve the lives of people everywhere through the achievement of the 17 Sustainable Development Goals (SDGs) by 2030 have been jeopardized. Some of the critical gains in health achieved in the past decades are at risk of being reversed, and decades of achievement lost.

At the same time, however, the pandemic has provided opportunity too. The crisis has presented an opportunity to address health issues, such as NCDs, in new, innovative ways; it has allowed conversations around mental health to flourish; and it has enabled the strengthening of pandemic response capacity, not just to combat COVID-19, but to prepare for future crises. Overall, the pandemic has reinforced the need for collective cooperation to bolster the resilience of health systems. It has given momentum to change, to innovation, to acceleration, and to bettering people’s health now and into the future.

As Member States continue to scale up efforts to expand vaccine coverage amid surging cases across the globe, it is critical to remember that a vaccine is not a panacea to creating and sustaining healthier populations and tackling NCDs. For example, there is no vaccine for the next pandemic, and there is no vaccine to prevent diabetes, hypertension and cardiovascular diseases.

The WHO Regional Office in collaboration with country offices has been working tirelessly throughout the pandemic to support the response at the country level and to collaborate with partners within and outside the organization to collect data and information on the impact of the pandemic and the response to NCDs, mental health, health risk factors and the social and environmental determinants of health.
To understand the impact of disruptions to essential health care and to identify lessons learnt and the ways forward for ongoing planning within WHO’s mandate for NCDs and mental health, the HPN Department has put together this biennium report. The report does not detail all the important policy work that has occurred in the past two years; it instead focuses on the impact of WHO’s work at the ground level.

The report comes at a time the 2030 deadline to achieve the Sustainable Development Goals (SDGs) continues to approach, and WHO continues to work towards achieving the Triple Billion targets laid out in its Thirteenth General Programme of Work (GPW13) 2019–2023: “One billion more people benefiting from universal health coverage; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being”.

At the regional level, the HPN department is proud to continue to advance the agenda of the WHO South-East Asia Regional Office in sustaining achievements, accelerating progress, and making full use of innovative policies and technologies to achieve global, regional and country targets and goals.
The “Determinants” is a sub-group of the Regional Office’s Healthier populations and noncommunicable diseases department and comprises three technical units (TUs): Social determinants and health promotion (SDH); Water, sanitation and climate change (WSC); and Chemical safety, environment and air pollution (CEA).

The social determinants of health (SDH) underpin every aspect of our lives; they are the non-medical factors that influence our health risks and our health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems that shape daily life. These forces and systems include economic policies and systems, development agendas, social norms and social policies. The health determinants are themselves mediated by a country’s sociopolitical context, health systems and quality of health services, and its commitment to applying a human rights-based approach to health care.

All these factors and more impact health literacy, nutritional status, food security, social support, and employment opportunities. In fact, social determinants can be more important than access to health care or lifestyle choices in terms of influencing people’s health.

The following chapter details the work of the three technical units listed above for 2020–2021. It was a biennium unlike any other as the COVID-19 pandemic exposed and exacerbated existing inequalities that negatively impact health and socioeconomic outcomes between and among vulnerable population groups across the Region’s 11 Member States.
The SDH unit focuses on the conditions in peoples’ daily lives that lead to better or worse health outcomes. It supports countries in identifying how these conditions relate to priority health issues to take concrete action. The team works with Member States across the Region to build capacity to monitor, analyse and make policy decisions based on factors outside the traditional health sector. It collaborates with multiple sectors and tiers of government to support settings that foster more equitable opportunities for health and well-being.

This biennium’s work predominantly focused on the COVID-19 pandemic in the areas of health equity, the impact of the pandemic on vulnerable groups, and building healthy cities and promoting health for school-age children and adolescents. A study on the impact of the pandemic on vulnerable populations was carried out, along with a study on health equity that was carried out in six Member States (Bangladesh, Bhutan, India, Nepal, Sri Lanka and Thailand).

Video documentation of the impact of COVID-19 on vulnerable populations has been used as an instrument to generate relevant policies and dialogue, ensuring that all groups of people are included in COVID-19 response and recovery operations.

The Regional Office produced a report, *Social determinants of health and equity concerns during COVID-19: Experiences from the South-East Asia Region*, that documented the inequities that have arisen due to the pandemic, along with Member States’ efforts to integrate equity concerns within countries’ strategic response to COVID-19. Several case studies were included in the report that not only highlight voices from the ground, but also provide practical solutions.

Below are some of the highlights of the biennium that bring to the forefront the impact of WHO’s work.
Building community engagement in Hulhumalé, Maldives

Hulhumalé is a reclaimed island, an extension of the capital city of Maldives, that has been designed to meet the existing and future housing, industrial and development needs of the Malé region. It has a population of just over 17,000, with around 2500 foreigners. There are about 100,000 migrant workers across Maldives, with up to 40% living in the Greater Malé area, including Hulhumalé. Most migrant workers are undocumented, so when the COVID-19 pandemic hit they did not have access to health insurance.

Like elsewhere in the world, migrant workers are a vulnerable population group, and often live in congested, sub-standard conditions with poor hygiene and sanitation. This makes it impossible to practise COVID-19-safe measures such as physical distancing. When Maldives implemented strict public health measures across the country, many migrant workers lost their jobs, and without health insurance, they were unable to afford testing and treatment for COVID-19.

In response, the government collaborated with the WHO Country Office to issue emergency identification cards that enabled migrant workers to be tested and receive care. To curb the spread of the virus, the government in collaboration with partner agencies created new accommodation blocks to ease overcrowding. Risk communication programmes were conducted in seven languages while social media groups were also created to facilitate safe conversations with WHO support.

But it wasn’t just migrant workers that were deeply affected by COVID-19. Low-income families who relied on tourism were hit hard by the suspension of visitors and strict lockdown measures. Without a source of income, this population became vulnerable. Many families were forced to pull their children out of school and move to less expensive islands.

With strict COVID-19 measures in place, new and innovative ideas were needed to mitigate the impact the pandemic was having on people. With Hulhumalé not having a city council, community groups sprung up to assist people in need. For example, the Avatteriya initiative encouraged social connection via virtual platforms to share stories, send Ramadan gifts, play games, and have movie nights for children and adolescents. The initiative received a lot of support from the younger generations who helped older, vulnerable people stay connected.

Another community initiative that was established was virtual health care whereby doctors were assigned by their healthcare facilities to provide remote care to reduce the spread of COVID-19 and eliminate travel costs for vulnerable population groups. To provide new employment opportunities and enable small businesses to thrive, local small grocery stores set up online shopping and home delivery options that allowed them to stay open, operate safely and provide unemployed people with jobs.

The collective community response to COVID-19 and the associated social innovations that sprung up in Hulhumalé throughout the pandemic illustrated that people are more connected than ever before. The experience, while difficult, provides the foundation for building a stronger, more cohesive society after the pandemic.
Social innovation in response to COVID-19: case study from Thailand

Thailand was the second country in the world to detect a COVID-19 case on 13 January 2020. Thailand’s 40 years of investing in health infrastructure and universal health coverage (UHC) had prepared a strong foundation for the country to respond to the public health crisis effectively and swiftly. Thailand responded to COVID-19 by combining strong public health interventions with community engagement and effective governance.

WHO collaborated with the National Health Commission Office and Thammasat University to produce a report that highlights the role played by different stakeholders in Bangkok such as local government, community leaders and citizens to combat COVID-19 and promote health equity. It also highlights the social innovations that emerged in four diverse districts in the capital city.

The report found that while the pandemic has left people vulnerable, it also created opportunities for communities to solve problems together. Based on the findings of the report, recommendations will be made to communities and local government bodies for facing future challenges. The recommendations will not only be of use to Thailand but to other countries in the WHO South-East Asia Region and beyond.

One of the social innovations that emerged in the four districts during COVID-19 was:

Count me Too campaign: voices of the vulnerable

The COVID-19 pandemic has impacted almost every single person across the Region of more than 1.6 billion people. As part of World Health Day 2021, under the theme of “health equity”, the Regional Office launched the “Count me Too” campaign. The purpose of the campaign was to amplify voices of the vulnerable who had been impacted by COVID-19, and who were at risk of being left behind.

Six videos were produced to document how communities remained resilient and strong in the face of adversity and how they rose to the challenges. The visual stories included street vendors and the street artist community in an urban slum in New Delhi, India; women with disabilities in Nepal; youth living with disability in Bhutan; single women who head households in Bangladesh; elders in Sri Lanka; and the homeless population in Bangkok, Thailand. The virtual campaign sought to raise awareness and demonstrate how communities and relevant sectors can play their parts in mitigating potential catastrophes.

On a large scale, the campaign is a reminder to society that the lives of vulnerable people matter; that they
should always be included in society. In addition, two webinars were held to showcase empowering stories of the vulnerable displaying resilience during the pandemic. The webinars brought together public health emergency response advisers, members from vulnerable groups including persons with disabilities, academics, and social workers to provide advice on how society can be better prepared for inclusive responses to such emergencies.

Healthy cities during COVID-19

What is a healthy city? What does it look like? Why should we care?

More than 55% of the world’s population live in urban areas, a proportion that is expected to increase to 68% by 2050. Urbanization has a significant impact on health. Despite more than half of the world’s population living in cities, millions continue to suffer from inadequate housing and transport, poor sanitation and waste management, and air pollution. As most future urban growth will take place in developing cities, a unique opportunity has presented itself: the chance to guide urbanization and other major urban development trends in a way that promotes and protects health.

The Healthy Cities initiative is a global movement that was conceived 30 years ago with the goal of placing health high on the social and political agenda of cities by promoting health, equity, and sustainable development through innovation and multisectoral change.

In 2020, the WHO Urban Governance for Health and Wellbeing initiative was established to strengthen country capacities to work across different sectors to promote health and address health inequities.

The COVID-19 pandemic has demonstrated the need for dynamic Healthy Cities, since overcrowded living conditions, casual employment, presence of low-income migrants and refugees, as well as inadequate access to hygiene and sanitation magnify cities’ vulnerability to infectious disease spread. As part of WHO’s response to the pandemic,
the Regional Office provided valuable guidance to cities that had previously participated in the Healthy Cities initiative to strengthen their capacity to respond to COVID-19, which included adapting community engagement strategies used successfully by Indonesia, Sri Lanka and Thailand.

This biennium, in collaboration with the Swiss Development Cooperation, six cities across the world have been selected for the WHO Urban Governance for Health and Wellbeing initiative, five of which are in the SEA Region.

Khulna in Bangladesh, Thimphu in Bhutan, India’s Bengaluru, Jakarta in Indonesia and Bangkok in Thailand have been selected as experimental cities of the first phase of the initiative, and to develop prototypes for urban settings.

In addition, this biennium the South-East Asia Regional Laboratory on Urban Governance for Health and Wellbeing is being set up at Chulalongkorn University, Thailand, to act as a repository for healthy city case studies and practices in the Region, and as a hub to build regional capacities.

The laboratory has developed a framework and indicators for urban governance and well-being in the Region and is continuing to map different typologies of cities to support them to set up systems to address the social, economic and environmental determinants of health and promote health equity through good governance.
Work also began in Bhutan and Indonesia, which included the development of an urban health profile for Thimphu, with WHO facilitating multisectoral partnerships with different stakeholders.

Countries across the Region could benefit greatly from the attention provided at the city level to the COVID-19 pandemic and could use it as an opportunity to build back better than ever before and develop improved social and environmental structures to support their populations.

A snapshot from Khulna city, Bangladesh’s third-largest city, follows:

**Revitalizing health-promoting schools:**
**making every school a health-promoting school**

Children and adolescents spend most of their time growing up at school. The South-East Asia Region is home to about 627 million children under the age of 18. Although children and adolescents are generally considered healthy, there is significant mortality and morbidity in this age group.

The COVID-19 pandemic continues to affect the health and well-being of people around the world, and schoolchildren and adolescents are no exception. Children of all ages across the 11
countries in the Region have been severely impacted by the closure of schools and the shift to home-based learning, as well as the socioeconomic impact the pandemic has had on their families. This is a universal crisis in education, and the effects on child development and other health-related consequences can be lifelong. In the aftermath of the pandemic, governments around the world will need to reassess learning systems to better confront challenges and prepare for future crises.

In June 2021, WHO and UNESCO launched a new initiative, “Making every school a health promoting school”. The initiative is expected to serve over 2.3 billion school-aged children and will contribute to WHO’s GPW13 target of achieving “One billion lives made healthier” by 2023 and to meeting the SDGs in the field of education and health. As part of the initiative global standards have also been developed titled, *Making every school a health-promoting school: global standards and indicators for health-promoting schools and systems.*

Recognizing the need to revitalize comprehensive health promoting schools to support Member States across South-East Asia to prepare schools to recover from the COVID-19 pandemic, restore health promotion activities, and scale up health-promoting schools to meet global standards introduced in 2021, the Seventy-fourth session of the WHO Regional Committee passed a resolution on “Revitalizing school health and health-promoting schools in the South-East Asia Region”.

In response to the Regional Committee resolution and to enhance the political commitment to revitalize health-promoting schools and consider ways of implementation, a three-day virtual Inter-Ministerial Meeting was held for ministries of health and ministries of education along with other officials and UN agencies in the WHO South-East Asia Region in October 2021.

To build back from the ongoing pandemic, the participants committed to health-promoting schools for healthier generations and societies, and for schools to remain operational during public health emergencies and be resilient and well prepared for future crises. A “Call to Action” was adopted to scale up the implementation of comprehensive school health...
programmes that promote the health and well-being of children and adolescents.

As a prelude to the Inter-Ministerial Meeting, the Regional Directors of WHO, UNICEF, UNESCO, UNFPA and WFP held a Summit to deliberate on strengthening school health programmes in the Region. The leadership signed a Joint UN Statement on strengthening education, school health, nutrition and well-being to collectively advocate for a healthier generation and provide harmonized joint technical support to all countries in the Region.

The Joint UN Statement advocates that, “Every school should be health-promoting to protect and improve the learning, health, nutrition and overall well-being of students and the school community”. Read the statement in full here: https://www.unicef.org/rosa/media/16351/file
Nearly a quarter of all deaths every year globally can be attributed to environmental risk factors. In the South-East Asia Region, 3.8 million deaths in 2012 (about 28% of total deaths in 2012) were attributed to environmental risks in people’s homes, workplaces and communities.

The overarching goal of the Chemical Safety, Environment and Air Pollution Unit in the department is to reduce the burden of disease related to occupational health and workplace safety, environmental health, air pollution, chemical safety and risk management and climate change, by developing the capacity of health systems and communities to reduce the health impacts from the environment.

**Healthy environments for a healthier population**

The goals laid out in the SDGs, Thirteenth General Programme of Work (GPW13) and the Regional Flagship Priority Programme on NCDs, that includes addressing air pollution, provide impetus for tackling the environmental determinants of health. The WHO Global Strategy on Health, Environment and Climate Change 2020–2030: Healthy Environments for Healthier Populations calls for a transformation in the way we live, work, produce, consume and govern, with actions on the upstream determinants of health, and on the emerging threats of climate change.

To realize this strategy at the regional level, the Regional Office is now implementing the Regional Plan of Action for implementing the WHO Global Strategy. The Regional Plan of Action is aligned with the Global Strategy but has been tailored to the priorities and contexts of the 11 Member States.

It calls for action in four strategic areas: scaling up primary prevention; building cross-sectoral action, governance, and political and social support; strengthening the health sector; and enhancing the evidence base and risk communication. In August 2020 the Regional Office supported Indonesia to organize a kick-off meeting ahead of taking over as the incoming Chair of the Asia-Pacific Regional Forum on...
Environment and Health, that will plan the activities during the first two years of its leadership. The Forum was established in 2004 in recognition of the threat that environmental hazards pose to human health. The Forum seeks to create greater synergy among relevant government departments to address environmental and health issues.

Addressing air pollution

The South-East Asia Region accounts for 34%, or 2.4 million, of the 7 million premature deaths caused globally by household and ambient air pollution. Air pollution accounts for the largest combined burden of disease among all environmental risks, and is a leading contributor to the NCD epidemic. For people living in cities in the Region, 99% are breathing air with pollutants far in excess of WHO Guideline stipulations. Around 63% of households are still using solid fuels and are exposed to unacceptable levels of household air pollution.

WHO is focused on raising awareness on the need for long-term sustainable solutions to address the threat of air pollution such as tackling the sources of polluted air. During the biennium WHO released new global air quality guidelines that have adjusted almost all the acceptable levels of different pollutants downwards following increasing evidence that shows how air pollution affects health.

The Regional Office is continuing to provide support to countries to implement these new guidelines, including the procurement of air quality monitoring equipment. The COVID-19 pandemic further highlighted the importance of clean air, with WHO hosting a meeting on the link between COVID-19 and air pollution.
BreatheLife campaign

The BreatheLife campaign is a partnership between WHO, the Climate and Clean Air Coalition, the United Nations Environment Programme (UNEP) and the World Bank, that mobilizes cities and individuals to protect health and the planet from the effects of air pollution.

Following the important example of Greater Malé, Maldives which became the first BreatheLife member in the Region in 2019, there are now 11 cities across India, Indonesia and Nepal that have joined the campaign, which is promoting and sharing clean air solutions that will have an immense impact on people living in these cities, now and in the future. As the campaign continues to expand, it is hoped that more cities across the Region will join.

It is no coincidence that Greater Malé was the first city in the Region to join the campaign: in 2015 Maldives became the first country in South-East Asia to reach the target of a 50% increase...
in the number of households with access to clean fuel for cooking. The speed of Maldives’ transition to clean energy makes it a global leader in tackling household air pollution, with just 6% of households exposed to this form of pollution. Its experience shows that air pollution can be rapidly reduced when appropriate solutions are acted upon. In continuing to implement the BreatheLife Campaign during the pandemic, Greater Malé is focused on addressing the open burning of waste, occupational exposure to chemicals and dust, and vehicle emissions.

In an effort to further engage the BreatheLife Network members, sectoral experts, and local government leaders, the Regional Office partnered with Clean Air Asia to hold a Regional Workshop on enabling sectoral interventions for clean air in cities through the BreatheLife Initiative at the end of 2021. The two-day virtual workshop was attended by 125 participants, comprising technical officers, health officials, environmental specialists, consultants, and researchers from different environment, climate, planning and health agencies. Through this workshop, participants were given the opportunity to learn from expert advice and case study presentations from BreatheLife Network city government representatives and practitioners, and share their own insights.

The very first International Day of Clean Air for Blue Skies was observed on 7 September 2020. The day aims to raise public awareness at the individual, community, corporate and government level that clean air is important for health, productivity, the economy, and the environment. But while countries are committed to addressing this problem, action remains largely focused on advocacy rather than implementing evidence-based solutions.

This biennium the Regional Office developed a standard operating procedure with other UN agencies based in New Delhi for additional protective actions against air pollution to be taken for UN staff.

Addressing chemical safety

In May 2017, the Seventieth World Health Assembly approved the roadmap to enhance health sector engagement in the Strategic Approach to International Chemicals Management. The roadmap identifies concrete actions where the health sector has either a lead or important supporting role to play in the sound management of chemicals, recognizing the need for multisectoral cooperation.

This biennium, country training was carried out in Bhutan on the roadmap, which can be used as a tool for assisting
countries to identify priorities for improvements in chemicals management. Based on the priorities Bhutan identified, WHO supported the development of a proposal for establishing a poison centre in the country. This coincided with a WHO video on “Why the world needs more poison centres” featuring the work of the WHO Collaborating Centre at Ramathibodi Hospital in Bangkok, Thailand. Other related activities included supporting Myanmar and Sri Lanka to assess their health sector needs for implementing the Minamata Convention on mercury.

**Keeping workers safe during COVID-19**

Occupational health and safety (OHS) is an area of work in public health to promote and maintain the highest degree of physical, mental, and social well-being of workers in all occupations. The protection of health workers has been at the forefront of WHO’s response to COVID-19 in and outside of the health sector.

The Regional Office held a webinar on COVID-19 and health workers’ health and safety in 2020 along with a regional webinar on “new norms of OHS” contributing to guidelines on the safe return of WHO staff to work. At the country level, WHO undertook a situation analysis of the health system in Sri Lanka to improve OHS among health-care workers in collaboration with the University of Colombo.

Other activities with the university included developing a model curriculum for pre-service training on occupational health for doctors, nurses and midwives. WHO also supported the National Institute of Occupational Health, India, to implement several critical interventions on COVID-19 and OHS, including guidelines on returning to the workplace.
Among the six WHO regions, South-East Asia continues to have the highest estimated deaths due to climate change. Between 2030 and 2050, climate change is expected to cause an additional 250,000 deaths per year.

Climate change is, and will continue to, exacerbate current and underlying burdens of disease. It will exacerbate infectious diseases and will continue to affect the social and environmental determinants of health – clean air, safe drinking water, sufficient food, and secure shelter.

The effects of climate change will be felt by the most vulnerable – those living in countries where health systems are weak, and the capacity to adapt and respond are low. In addition, climate change and extreme weather events can also damage health facilities, and affect sanitation systems, water resources, water services, and other social and governance systems on which sanitation depends.

Climate and environmental change have been identified as a priority programme by WHO and are key parts of the GPW13 and SDGs. In 2017 Member States in the Region signed the Malé Declaration on Building Health Systems Resilience to Climate Change and the corresponding Framework for Action in the South-East Asia Region (2017–2022).

In the wake of the COVID-19 pandemic, focus on water supply, sanitation and hygiene (WASH) as well as infection prevention and control (IPC) in health-care facilities has never been greater. In 2019, WHO Member States approved a resolution on WASH in health-care facilities that called on countries to set targets and embed WASH in key health programmes and budgets. The resolution was bolstered in 2020 by ministers of health of the South-East Asia Region with a Declaration on collective response to COVID-19 at the Seventy-third session of the Regional Committee.

The Water, Sanitation and Climate Change Unit aims to reduce the burden of disease linked to drinking water, sanitation, hygiene and climate change. It provides technical support to national authorities through guidelines and tools, improving knowledge, skills and capacity of the health workforce, and raising awareness on water quality surveillance, sanitation and climate change.
Addressing WASH and IPC in the wake of COVID-19

One of the key challenges prior to and during the ongoing COVID-19 pandemic has been addressing the proper management of health-care waste. In response, the Regional Office developed a white paper on health-care waste management in the SEA Region, which proposes effective, low-cost and sustainable measures to manage COVID-19 waste. In addition, five webinars for stakeholders were held on water, health-care waste management, hand hygiene and environmental cleaning and sanitation.

Guidance on WASH in health-care facilities to prevent COVID-19 was developed and distributed to all countries. Further complementing this work was another webinar on health-care waste management during COVID-19 and beyond, which was joined by hospital staff working on IPC across the Region along with policy-makers.

At the country level, WHO supported Bhutan to develop its strategy for WASH in health-care facilities, which included an ambitious programme to install hand hygiene stations and drinking water stations in all health-care facilities, across the country.

An advocacy toolkit for WASH in health-care facilities that targets governments, health-care facilities and health professionals was developed in 2020. The toolkit aims to support advocacy efforts to accelerate action on WASH in health-care facilities. It introduces and applies key concepts in advocacy for WASH in facilities, and provides tools, resources, and case studies to support advocates in planning, implementing, and monitoring advocacy efforts.

The parent toolkit consists of three smaller toolkits, with content tailored to support advocacy, targeting three key audiences: national and local governments, health-care workers, and communities.
WHO SEARO web-based advocacy toolkit on climate change and health

In 2020 work began on a website funded by the Department for International Development (DFID) (http://thepagecraft.com/who19/index.html) that serves as an advocacy toolkit on climate change and health. It was officially launched virtually at the COP26 in Glasgow in 2021 by the Regional Director, Dr Poonam Khetrapal Singh. The launch was also covered on Twitter Live, engaging hundreds of people across the world.

“The toolkit aims to inspire policy-makers, individuals and communities in the Region to act on health and climate, and do so based on the best available evidence. It provides a summary of key health-related issues faced by each of the Region's countries, offering tools, factsheets and infographics that can be adapted for use in local campaigns,” Dr Poonam Singh said during the launch.

Recognizing that decades of progress in reducing deaths and disease and building strong health systems could be undone due to climate change, the toolkit inspires individuals and communities to act. It includes a summary of key health and climate issues in the Region (such as air pollution, heat, clean water access, vector-borne diseases) so that campaigns are grounded in evidence, along with a guide to plan an advocacy strategy or campaign. It describes WHO’s work with governments across all 11 Member States to respond to climate change impacts on health. Importantly, it provides users with
the ability to explore how climate change may affect health in different countries and what people can do to advocate for health-climate resilience.

**Capacity-building for action: addressing climate change and health**

There has never been a time as now when education and training on climate change and health is so important in the Region. This biennium the HPN Department in collaboration with a variety of partners ran several critical training and advanced education programmes to increase awareness of the link between climate and health and promote ways to mitigate the consequences.

In 2020, WHO developed eLearning courses on climate change and health to increase opportunities for self-paced training on key topics for staff in ministries of health and in public health and health-care organizations.

The topics included: climate-resilient water safety planning; climate-resilient and environmentally sustainable health-care facilities; integrated disease surveillance and early warning systems; health national adaptation plan (HNAP) development processes; and climate change and health vulnerability and adaptation assessments.

The Green Climate Fund (GCF) is one of the main sources of global multilateral climate finance. WHO is a GCF Readiness Delivery Partner, enabling the organization to support countries in accessing GCF readiness funds to strengthen adaptation planning, and develop strategic frameworks to build their programming with the GCF.

The GCF Readiness Programme provides up to US$ 1 million per country per year to support institutional capacity-building, coordination, policy and planning, and programming for investment, and up to US$ 3 million per country for the formulation of national adaptation plans (NAPs) and/or other adaptation planning processes.

To provide further guidance in accessing GCF financing for health-related readiness activities, WHO headquarters, the SEA Regional Office and GCF co-organized a webinar on accessing green climate fund readiness programme funding for climate change and health. The webinar brought together high-level representatives from the ministries of health and national designated authorities from countries in the Western Pacific and South-East Asia regions.

The two-day webinar helped to strengthen knowledge on the interlinkages between climate change and health as well as strengthening capacity to prepare readiness proposals on climate change and health to be submitted to the GCF and build and strengthen partnerships between the health sector and national designated authorities. It was attended by more than 70 participants from across the SE Asia Region. This biennium, the Regional Office also developed a regional readiness proposal to be submitted to GCF in 2022.
As part of UNDP’s Global Environment Facility (GEF) project to increase the adaptive capacity of national health systems and institutions to respond to and manage climate-sensitive health risks in the Region, the Regional Office began measures to integrate climate/weather information into surveillance systems of mapping health datasets to existing health information systems in the countries for better surveillance.

This will allow real-time detection of outbreaks of climate-sensitive diseases and health outcomes through specific climate-informed early warning models. In 2021, WHO supported the development of a standard operating procedure (SOP) framework that will help to build core capacities in the WHO SE Asia Region Member States for aggregating climate and disease surveillance data, integrating climate models and hydrometeorological data into disease surveillance systems, mounting a response to outbreaks, and monitoring the effectiveness and efficiency of the entire system.

**Climate-resilient water safety planning training**

Safe drinking water is a basic human right and must be available for everyone. Extreme weather events associated with climate change are major drivers of waterborne diseases. Tropical cyclones, flooding events, and prolonged droughts create conditions in which bacteria, parasites and other pathogens can thrive. And that is why WHO is committed to investing in climate-resilient water safety planning.

To achieve safe drinking-water, WHO recommends in its Guidelines on drinking water quality and water safety planning (WSP), a comprehensive risk assessment and risk management approach that encompasses all steps in water supply from catchment to consumer.

In response to increasing evidence on the impacts of the climate on drinking water, in recent years the WSP approach has been extended towards climate-resilient water safety planning.

This biennium, WHO has been at the forefront of building Member States’ capacity on climate resilient water safety plans (CR-WSPs) to equip government officials and water treatment plant operators with the knowledge and tools to develop and implement these plans and ensure its inclusion in national surveillance programmes.

A four-day virtual training supported by DFAT and UNDP/GEF was held in 2021 with more than 85 participants from all 11 countries, including health, drinking water and environment ministry staff, government partners and WSP master trainers. The training not only strengthened the capacity of countries to implement CR-WSPs, but also provided an important opportunity to bring together key stakeholders and facilitate
knowledge exchange between countries. This follows another training in 2020 on WSP principles and auditing that was attended by more than 60 participants across the Region.

Climate change has a great impact on our country. The multiple disasters over the Melamchi water supply project are examples. The interaction with participants during the presentation was excellent.

Nabin Tiwari, training participant, Kathmandu Valley Supply Management Board

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The Regional Plan of Action for Climate Change and Health, that was adopted in 2019, outlines priorities related to reducing vulnerabilities and strengthening resilience and preparedness of health systems in response to climate change.

One critical aspect of that is developing and implementing vulnerability and adaptation assessments and health national adaptation plans (H-NAPs) that help countries address the impacts of climate change on their economies, communities and ecosystems.

While many countries across the Region have made significant progress on adaptation planning, several have not developed an H-NAP or had the process suspended due to COVID-19. Member States are also at varying stages with respect to carrying out vulnerability and adaptation assessments (VAAs) which serve as the first point of call to understand vulnerabilities and design appropriate adaptation strategies.

Lessons learned from capacity building in Nepal

Nepal shared its experience of the VAA and H-NAP process at the virtual training which demonstrated how critical it was to receive buy-in from all stakeholders, including academics who have strong ties to the research community.

One critical lesson learned is that capacity-building starts with advocacy and needs to be sustained through trainings given in the local language with local examples of specific climate-sensitive health issues and which are regularly updated to stay relevant. In addition, master trainers were needed to conduct trainings at both the national and subnational levels.
In the second half of 2021, a virtual training was held to build Member States’ capacity on H-NAPs and VAAs, which also provided a critical opportunity for countries to share experiences and learn from one another. The training, which brought together key climate change and health stakeholders from across the Region, included 100 participants from national health ministries, subnational government staff, academics, researchers, and NGO staff.

It also enabled independent country work on the development of plans and roadmaps for updating or developing VAAs and HNAPs. A key element of the training, that was funded by UNDP/GEF, was the engagement of country teams in co-designing action plans specific to their contexts. This unique partnership approach will catalyse and sustain action long after the training.

**Responding to climate change and WASH inclusively: a case study**

Given that women are usually the primary managers of water and carers of children and other dependents, it is critical that they are not left behind in responses to climate change impacts on WASH.

This biennium the WHO Regional Office developed guidelines to mainstream gender, disability, and social inclusion (GEDSI) in WASH and climate change programmes and activities at the country level with financial support from DFAT. Another important way WHO is working to mainstream GEDSI in WASH is through the inclusion of women’s groups and women’s committees in the development of water safety planning.

The case study below from Nordash, Bangladesh, illustrates the impact engaging the most disadvantaged groups can have on the development of inclusive and equitable WSP. Some good practices that emerged from the case study that other countries in the Region and beyond could learn from are as follows:

1. **Aiming for equitable participation in the WSP team:** The village education resource centre (VERC) in Nordash encouraged at least one member of the WSP to be female and from a disadvantaged group such as people living with disability to be part of the team.

2. **Identifying different water practices and hazardous events in the community:** The VERC and WSP team through a community meeting mapped the water supply system and community characteristics to identify different water practices of the diverse communities and to document the hazardous events experienced by these groups of people to inform and improve their WSP. Recognizing different water practices and different standards of collection points will help ensure all hazards are identified and dealt with.
3. **Recognizing the most disadvantaged users in the community:** The WSP team believed the most disadvantaged group in Nordash was the poor, who are more vulnerable to the consequences of unsafe water. As part of mapping the water supply system, the WSP team identified and mapped the income level of water users using their own locally relevant definition for wealth ranking.

4. **Prioritizing the needs of the most disadvantaged:** The WSP team felt that the whole community benefited by ensuring that the needs of the disadvantaged were met first in the WSP. This included: constructing latrines, tube wells and tube well platforms for the poor; facilitating land purchase to construct latrines for the poor; and prioritizing the location and construction of tap stands for easy access for the maximum number of users.

**Climate-resilient health-care facilities**

Health-care facilities are one of the essential components of health-care delivery systems; they play a critical role in emergency and disaster response. Since they are instrumental in disaster response, it is then essential to build resilient infrastructure and operations to ensure continuum of care.

Throughout the biennium the WSC team with financial support from UNDP/GEF has been developing guidelines and tools to promote and support countries in the building of climate resilient and environmentally sustainable health-care facilities (CRESHCF).

In 2020, WHO published the *Guidance for climate resilient and environmentally sustainable health-care facilities*, which provides direction on enabling health-care facilities to become more climate resilient and sustainable. It acts as a guiding tool for decision-makers in strengthening capacity to conduct surveillance of climate-related diseases and to monitor, manage and adapt to the health risks associated with climate change. It aims to provide tools to health-care facilities to assess their resilience in four key areas: health workforce; water, sanitation, hygiene, and health-care waste management; energy; and infrastructure and technology.

To enhance climate resilience and environmental sustainability of health-care facilities in the Region, facilities need to assess climate change risks and adopt adaptive strategies. In this context, WHO developed regional guidance tools and conducted a situational assessment of health-care facilities in the Region. An in-depth assessment of the existing status of health-care facilities in the Region was completed, along with the identification of interventions to integrate climate resilience into the operations of such facilities.

The next biennium will see the development of two model climate-smart health-care facilities that will support the development of replicate facilities in other countries. Myanmar
and Timor-Leste have expressed interest in developing these two models.

In another step to support countries to create model CRESHCF, this biennium WHO developed a ready reckoner for climate resilient and environmentally sustainable health-care facilities. This ready reckoner will attempt to simplify guidance by identifying actions for stakeholders, such as facility management, and state governments, and contextualizing its applicability based on type of the health-care facility (primary, secondary, tertiary).

The primary goal of the ready reckoner is to enable countries to make informed decisions about building climate-smart health-care facilities. It focuses on developing the capacity of health-care workers who will be able to apply, influence and encourage climate resilience and adopt environmental sustainability. The next step is to disseminate it to countries. The ready reckoner, funded by UNDP/GEF, will also further WHO’s work in establishing model climate resilient and environmentally sustainable health-care facilities in the upcoming biennium.

Simultaneously, the WHO team is also developing a mechanism for “Star rating of green and clean health-care facilities” to enable facilities to evolve into a model facility, with improvements made according to the Water and Sanitation for Health Facility Improvement Tool (WASHFIT) and the Guidance for climate resilient and environmentally sustainable health-care facilities.

WASHFIT was developed in 2020 and provides guidance for improving and sustaining water, sanitation and hygiene and health-care waste management infrastructure and services in health-care facilities in low- and middle-income countries (LMICs).

(ref: WHO & UNICEF)
The seven-star rating tool for countries has been designed to create an enabling ecosystem for health-care facilities to establish climate resilience, environmental sustainability, and accelerate WASH initiatives. This project is being funded by the Australian Department of Foreign Affairs and Trade (DFAT) and UNDP/GEF.

A health-care facility that is both climate resilient and environmentally sustainable will:

- deliver quality health-care services and enable an ecosystem for health-care strengthening;
- mitigate risk to hospital infrastructure and equipment in case of disasters and continue functioning and provide services under emergency conditions to those affected by a disaster;
- enable provision of safe, hygienic, and quality care through WASH and infection prevention and control;
- protect the surrounding environment by responsible waste management and promote efficient use of scarce resources by being cost-effective; and
- promote and improve on existing adaptation strategies to cope with climate change and any kind of risk.

WHO guidance defines a climate resilient and environmentally sustainable health-care facility as: “Climate resilient health systems that are capable of anticipating, responding to, coping with, recovering from and adapting to climate-related shocks and stress, so as to bring about sustained improvements in population health despite an unstable climate.”

By 2030, every health-care facility, in every setting, should have safely managed reliable water, sanitation and hygiene facilities and practices that meet staff and patient needs.
The NCD epidemic, including heart disease, stroke, cancer, diabetes, and chronic lung disease, is responsible for almost 70% of all deaths worldwide. More than three-quarters of these deaths occur, and 82% of the 16 million people who die prematurely or before reaching 70 live, in low- and middle-income countries, including the 11 countries of the SEA Region.

In 2018, at the third UN High-Level Meeting on NCD Prevention and Control, the United Nations General Assembly reaffirmed global political commitment to tackle the global NCD epidemic. And at the Seventy-second World Health Assembly the following year, the Global Action Plan on NCD Prevention and Control and the Global Comprehensive Action Plan on Mental Health was extended by a decade to 2030. Accelerating progress towards UHC is essential in tackling the Region’s NCD burden, and along with it, addressing the out-of-pocket payments that propel millions into poverty every year.

However, this biennium the COVID-19 pandemic slowed the momentum that had been built over many years to tackle NCDs while simultaneously also impacting the health risk factors that cause NCDs. Across the Region and the world there has been an unabated increase in consumption of unhealthy ready-to-eat foods, decrease in physical activity and increased use of tobacco, alcohol and other harmful substances. Similarly, the COVID-19 pandemic has impacted people with disabilities due to the increased risk of poor outcomes from the virus itself, reduced access to routine health and rehabilitation services, and the adverse social impacts of efforts to mitigate the pandemic such as lockdowns that led to extended periods of isolation.

The rise in NCDs has been driven primarily by four major risk factors: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets. WHO has recommended a set of cost-effective interventions to combat NCDs known as “best buys”, which target the four risk factors and also now includes air pollution.

Preventing and controlling NCDs requires a multipronged approach, which involves reducing exposure to risk factors through health promotion and primary prevention. WHO’s mission is to provide leadership and the evidence base for action on surveillance, prevention and control of NCDs.
The work on risk factors spans four technical units in the department, each with their own set of priorities.

The Disabilities, Injury Prevention and Rehabilitation (DPR) Unit aims to prevent injuries, violence and disabilities, and reduce their consequences by providing evidence-based information and technologies to Member States. WHO also promotes prevention and rehabilitation measures across the Region.

Access to safe and nutritious food is one of the key pillars of good health. Food safety, nutrition and food security are closely entwined – food can be a vehicle of disease transmission if it is contaminated with a range of harmful bacteria, viruses or toxins. Unsafe food creates a vicious cycle of disease and malnutrition that particularly affects infants, children, elderly and the vulnerable. Around the world, an estimated 600 million people fall ill after eating contaminated food each year, which results in more than 400 000 deaths. In the South-East Asia Region, this equates to 150 million cases of illness and 175 000 deaths.

The Food Safety (FOS) Unit within the HPN department is focused on building country-level capacity to prevent, detect and respond to public health threats associated with unsafe food. The FOS unit also works together with the Nutrition and Health for Development (NHD) Unit. Rapid urbanization and changing lifestyles of millions of people across the Region have led to a shift in dietary patterns that has impacted the consumption of healthy diets, which is necessary to protect against malnutrition and NCDs.

The increased production, access to, and availability of, highly processed convenience foods, along with people’s sedentary lifestyles, have led to a greater consumption of foods high in saturated fat, sugar and salt. What has emerged in the Region is a double burden of nutrition wherein undernutrition remains stubbornly high and cases of obesity are rising in urban settings. The NHD Unit advocates and provides technical support to all 11 countries to implement policies that promote healthy diets, which include targeting lifestyle choices and mitigating challenges in the food environment.

Tobacco is the world’s leading cause of preventable death, killing nearly 8 million people every year. Of these deaths, 1.6 million occur in the SEA Region, which continues to be among the largest producers and consumers of tobacco products. The Regional Office has been at the forefront of implementing tobacco control activities in Member States this biennium despite the pandemic, continuing to build momentum in efforts to curb tobacco use. But tobacco control remains a huge challenge in the Region, especially with the growing use of new and emerging products such as electronic nicotine delivery systems (ENDS).

This biennium, WHO continued to address insufficient physical activity, which is one of the leading causes of NCDs. Increasing
physical activity requires a whole-of-society and culturally relevant approach that demands collective efforts across sectors.

WHO recognizes that tackling NCDs calls for a paradigm shift from addressing each NCD separately to collectively addressing a cluster of diseases in an integrated manner, and from taking a biomedical approach to a public health approach guided by the principles of UHC and equity. WHO remains committed to advancing multisectoral action to curb NCDs and pursuing the “Sustain, Accelerate, Innovate” agenda.

Narrated hereinafter are key highlights from the work done by the HPN Department in 2020–2021
Injuries as a cause of death are sixth on the list of common causes of death and are responsible for 11.4% of all deaths in the SEA Region annually.

In 2021, WHO published the Regional Status Report on Drowning in South-East Asia. Drowning is the third leading cause of unintentional injury-related deaths in the Region. In 2019 more than 70 000 deaths were attributed to drowning, but this is likely to be an underestimation of the true burden. Current global estimates do not include deaths from climate-related extreme weather events or disasters, which could increase the burden by as much as 50% in countries where such events are common.

Since the launch of the WHO Global Report on Drowning: Preventing a leading killer (2014), and the follow-up resource Preventing Drowning: an implementation guide in 2017, WHO has been working to scale up advocacy and action for drowning prevention in the South-East Asia Region. The 2021 report presents the findings of the first assessment of drowning prevention in the Region. Ten countries took part, shared their knowledge and experience, and initiated their first collective step towards addressing drowning across the Region. The report makes seven key recommendations, including designating a lead agency to drive drowning prevention efforts and developing and implementing a national water safety plan that has national indicators for drowning prevention.

Saving lives: taking action on road safety

Every year approximately 1.3 million people around the world die in road traffic crashes and up to 50 million people are injured. The WHO South-East Asia Region accounts for about 25% of the global toll in road traffic deaths, which equates to more than 865 deaths a day. Pedestrians, cyclists and motorcyclists make up almost 50% of road traffic deaths in the Region.

This biennium, the Regional Office undertook a study that examined all data available across all countries in the Region to understand the relationship between national income and road traffic safety; relative risk of different categories of road
users; fatalities by travel mode; and differences in traffic crash patterns among countries. The mapping study provides a comprehensive overview of road safety in the Region and will be used to recommend road safety priorities in all countries.

**Strengthening emergency care services in India**

All around the world, millions of acutely ill and injured people seek care every day. Frontline providers manage children and adults with a wide range of emergency conditions, including acute injuries (from road traffic crashes, falls, burns), infections (pneumonia, sepsis, malaria), complications of pregnancy and exacerbations of noncommunicable diseases (heart attacks and strokes).

Emergency care is an integrated platform to deliver time-sensitive healthcare services for acute illness and injury across the life-course. It extends from care at the scene of injury to transport and emergency unit care, and it ensures access to early operative and critical care when needed.

The COVID-19 pandemic has further exposed the challenges that emergency care systems in Member States of the Region face, in the delivery of integrated emergency care and over the deficiencies in their response preparedness.

This biennium, the HPN department funded a pilot project in the northeastern Indian state of Arunachal Pradesh to strengthen emergency care services at two primary health care centres during the pandemic and beyond.
The purpose of the project was to build the almost non-existent emergency care services at two satellite sites and subsequently also respond effectively to the pandemic. Emergency response capacities were strengthened by setting protocols on issues such as triage and COVID-19; managing patients; strengthening referral; and bolstering critical equipment such as diagnostics and human resources.

The project not only achieved its primary objective – to build capacities to strengthen emergency services (highlights below) – but also garnered huge investment from Arunachal Pradesh's state health department through additional staff, an ambulance, ultrasonography and X-ray machines and communication equipment.

With patient attendance increasing threefold, the project had a ripple effect in that it created high-level impetus to revamp emergency services across the state, with multiple senior government officials actively contributing to the
project. The project has changed health administrators’ perceptions regarding the need to establish emergency care systems in primary care. More locally, the team played a pivotal role not only in implementing the project but also in motivating local health-care providers to actively participate, which over time led to cultural change in the provision of emergency care.

The two centres are now working as model reference centres and possible centres of excellence in emergency care. Arunachal Pradesh now has a dedicated “State Emergency Care & Services Cell” in the health directorate that is focused on strengthening the emergency care systems in the entire state.

While the project has been completed, the WHO Collaborating Centre (JP Apex Trauma Centre) continues to provide support to the two centres. This project, with the support and funding of WHO, is testament to the Organization’s ability to bring about change on the ground.

At the two centres, there has been:

- a 300% increase in emergency admissions from a monthly average of 24 patients to 70,
- a 200% increase in the number of patients,
- an increased community engagement in injury prevention and emergency response, and
- 100% successful triage of patients.

Transforming lives: rehabilitating people with disabilities

It is estimated that at least 15% of the global population lives with some form of disability. People with disabilities (PwDs) are amongst the world’s most vulnerable and least empowered groups – they experience stigma and discrimination, and have limited access to health care, education and employment opportunities.

It is critical that people with disabilities are seen as a valuable resource, and that they can contribute actively to society and the economy. Based on the community-based rehabilitation model that emphasises empowerment and employment among youth with disabilities in community settings, a pilot project in Delhi, run by the NGO Trust Cradle and supported by WHO, has been developed.

The Government of India has a scheme for employing PwDs at common service centres (CSCs), which are Internet-enabled access points for the delivery of various online services to citizens. The purpose of a CSC is to bring about transparency, accountability and efficiency in the delivery of key services at the local level such as birth and death registration, property taxes, licences and banking and insurance services.

The Government of India has allocated 100 CSCs to be run exclusively by PwDs. These CSCs will be established in slums
Healthier Populations and Noncommunicable Diseases

and rural areas of Delhi. Trust Cradle will identify, train and mentor PwDs, and provide long-term support. The unique project will create a sustainable and replicable model of providing equal economic opportunities to PwDs and also ensure their community participation and dignity.

Unlike other conventional rehabilitation programmes which tend to be simply medical and institutional, the project is based within a community development framework, placing equal emphasis on inclusion, equality, and socioeconomic development as well as economic rehabilitation of PWDs. To date, 50 such centres across Delhi have been set up with WHO technical and financial support.

In addition to establishing and implementing the project in 100 CSCs in Delhi, Trust Cradle is also collaborating with the Disabled People’s Organization of Bhutan to pilot a similar project in the Himalayan nation. So far, nine centres in Bhutan have been set up with WHO support which are run entirely by PwDs. The pilot has allowed the programme template to be tested in terms of identifying personnel and setting up centres. This will allow it to be customized based on country contexts in the future.

During the next biennium the project will continue to promote the economic inclusion of PWDs through its adoption in more countries in the Region and beyond with sustained WHO financial and technical support.

Improving access to assistive technology (AT) to those in need

WHO’s Global Cooperation on Assistive Technology (GATE) promotes the provision of assistive products as an integral component of community and primary health care services in order to make these important devices more accessible, particularly in rural and remote areas.

Assistive technology (AT) encapsulates assistive, adaptive and rehabilitative devices for people with disabilities or the elderly population. WHO recognizes that establishing “one-stop shop” provision models of the most-needed assistive products will improve access to AT and strengthen screening and referral pathways for those who need more complex assistive products such as prosthetics and wheelchairs and other care such as vision and hearing assistance.

Fig. 1. Assistive Technology Framework consisting of five interlinked areas (SPs):
people-centred policy, products, personnel and provision

This biennium, the WHO Regional Office has been working on a series of initiatives to improve access to AT in all 11 countries that fall under the
AT service provision framework: person, policy, products, personnel and provision (Fig. 1). Some of the initiatives include the following:

- **Rapid assistive technology assessment:** This biennium, the WHO rapid Assistive Technology Assessment (rATA) was supported in seven countries – Bangladesh, Bhutan, Indonesia, Maldives, Myanmar and Nepal. The rATA is a household survey that measures need of, unmet need, and barriers to AT. Preliminary analysis of the data will be published in the *Global Report on Assistive Technology* in 2022. The successful completion of rATA in the Region required coordination of all WHO levels and the pivotal role of the country office to liaise with ministries to advance the AT programme.

- **Impacting advocacy and awareness – influencing the ‘need-demand-supply’ triad:** One of the main strategies to positively impact the triad, particularly the need-demand part, is to make people from caregivers to rehabilitation personnel more familiar with AT products, especially those that are locally-made, by making them available in specific centres. This would then increase demand. In 2021, the Regional Office carried out an exploration of innovative AT products available across the Region. With the support of an expert review committee, a final list of ATs was compiled. The goal of the exercise was to procure both global and local innovative products from countries in the Region and supply them to selected centres. By the end of the biennium, mobility, vision, hearing and self-care products were procured, which will be sent to identified centres in Bangladesh, Maldives, Myanmar and Nepal. The products will be used to support capacity-building to fill crucial gaps and build awareness through interactive demonstrations.

- **Workforce strengthening – enhancing skills and capacities of health-care workers, caregivers and other stakeholders:** This biennium, a Twinning Programme was established between the All India Institute of Medical Sciences (AIIMS) RP Centre and the National Institute of Ophthalmology (NIO) in Dhaka, Bangladesh, to strengthen low vision services. The programme provided a platform to exchange knowledge, technology and strengthen capacity of personnel at the NIO. A customized list of AT products has been provided to both centres to support the training programmes that will be rolled out in the next biennium.

- **AT skills laboratory:** This biennium, three AT skills laboratories were established to equip rehabilitation centres to strengthen themselves and in turn strengthen other organizations across the Region (Fig. 2). Three centres were selected: Dr Rajendra Prasad Centre for Ophthalmic Sciences (RP Centre), AIIMS, in the area of vision; Christian Medical College (CMC), Vellore, in Tamil Nadu, India, for mobility; and the Kara Medical Foundation in Bihar, India for neuro-rehabilitation. By establishing
Improving access to AT for the blind in New Delhi

There are 24 schools for blind children and adolescents in India’s capital, New Delhi. Most of the schools are run by NGOs, societies and trusts, and all are residential schools that care for about 3500 children. The work these schools do is crucial – children with disabilities in India are five times more likely to be excluded from schools than those who are not, while illiteracy among children with visual loss is 80%.

While blind schools provide invaluable support, education, and care to some of the country’s most vulnerable, they face major challenges ranging from a lack of access to assistive technology to a lack of special educators who are crucial for injury prevention. Visually challenged students can be taught to use various assistive technologies if they have access.

In 2021, the WHO Regional Office and the All India Institute of Medical Sciences (AIIMS) launched an initiative to improve access to AT for visual impairment at blind schools across New Delhi. To begin, two such schools have been chosen. The first phase of the project, that began in late 2021, involved a needs assessment visit to the Swami Vijananda School for Blind Girls. During the visit a digital library was also set up for the girls. The project will continue to gather pace during the next biennium, that will also include WHO carrying out AT training to key staff at schools.

Eye, ear and hearing care in the Region

The ear and hearing care initiatives undertaken in the Region this biennium include promotion activities related to the launch of the World Report on Hearing 2021 through the distribution of advocacy materials to all countries.

The report presents epidemiological and financial data on hearing loss, outlines available cost-effective solutions, and sets the way forward through “integrated people-centred ear and hearing care” (IPC-EHC). The report proposes a set of key H.E.A.R.I.N.G1: interventions that must be delivered through a strengthened health system to realize the vision of IPC-EHC.

In addition, Nepal, Myanmar and Thailand have begun their respective country analysis using the Ear and Hearing Care hubs for skills-building including virtual and in-person training on the use of low- and high-tech products, caregivers, health-care workers and others will have the capacity to properly utilize AT. WHO supported the selected AT skills laboratory to procure technology and products and to facilitate training programmes.

1 H.E.A.R.I.N.G.: Hearing screening and intervention; Ear disease prevention and management; Access to technologies; Rehabilitation services; Improved communication; Noise reduction; and Greater community engagement
Situational Tool. The tool supports the compilation of information that can be used for advocacy, for the development of a new strategy or updating of existing strategic plans for ear and hearing care. It facilitates the review of ear and hearing care services, highlights the gaps and identifies needs for service provision. The results can inform evidence-based decision-making, ensuring efficient use of available resources.

There has been great interest this biennium in eye health. WHO’s *World report on vision (WRV)* predicts a substantial increase in the number of people with eye conditions and vision impairment in the coming years. This is largely due to demographic trends, including population aging and lifestyle factors.

In response, WHO has developed key strategic recommendations around integrated people-centred eye care (IPEC), which are outlined in the *WRV*. On World Sight Day in October 2021, WHO launched a revised version of the Eye Care Situation Analysis Tool (ECSAT). The ECSAT intends to support countries in the planning, monitoring of trends and the evaluation of progress towards implementing IPEC. The revised tool now aligns with the WHO strategic recommendations made in the *World report on vision*.

Four countries in the Region – Bhutan, India, Maldives, and Thailand – are participating in the initiative and adding this
into their national eye care programmes, with more countries to follow. Importantly, the WHO Regional Committee for South-East Asia decided to develop a Regional Action Plan on Integrated Eye Care in 2022.

**Strengthening diagnosis and treatment of diabetic retinopathy in the South-East Asia Region**

Diabetic retinopathy has been recognized as an increasingly significant cause of vision impairment and blindness in the WHO South-East Asia Region, where the prevalence of diabetes is rising. However, diabetic retinopathy is preventable; periodic eye examinations by ophthalmologists, accompanied by standard treatment of diabetic retinopathy, can postpone serious loss of vision.

Member States requested WHO to develop technical guidance on the subject which led to the publication of a guidance document in this biennium, titled *Strengthening diagnosis and treatment of diabetic retinopathy in the SEA Region*. The document developed in collaboration with the International Agency for the Prevention of Blindness highlights the critical need for countries to adopt a coordinated and multisectoral approach to reduce the incidence of diabetes and the onset of diabetic retinopathy.

The guideline specifically focuses on the need for preventive, diagnostic and therapeutic interventions that are standardized, clear and can easily be implemented at all levels of care. The document is relevant to a large range of stakeholders, particularly programme managers who must identify and implement evidence-based, well-planned and feasible strategies at all levels of the health system.
Food safety is a major public health concern in the Region and is closely related to the SDGs and WHO’s Triple Billion targets. Food safety is a shared responsibility and demands multisectoral collaboration among all stakeholders from governments to food business operators and consumers. But food safety in the Region continues to be compromised by fraudulent practices such as illegal substitution, mislabelling, contamination and counterfeiting of food products. Unsafe food not only undermines food and nutritional security but also human development and international trade.

In 2020, the Framework for Action on Food Safety in the WHO South-East Asia Region (2020–2025) became operational. The Framework identifies key activities for six years and provides guidance to food safety authorities across the food chain, as well as those involved in food safety emergencies, preparedness and response. Priorities include strengthening national codex committees and Member States’ active participation in the Codex standard setting process through multicountry activities along with developing a food safety risk analysis training model, among other priorities. In 2020 the World Health Assembly also passed a resolution to strengthen global efforts in addressing food safety.

In late 2021 a Regional Roundtable Meeting was held on advancing the implementation of the Framework for Action on Food Safety. The meeting, which included 96 participants from 10 countries, recommended establishing of a network of food safety regulatory authorities and developing training modules for risk assessments and foodborne disease surveillance and response, among other interventions.

In September 2021, the Regional Office in collaboration with the Food and Agriculture Organization (FAO) of the United Nations and the World Organization for Animal Health (OIE) organized a tripartite webinar on the “One Health approach” to antimicrobial resistance (AMR) mitigation and safer food in the Asia-Pacific Region. The purpose of the webinar was to brief policy-makers on AMR as a food safety issue and its implications on public health and the food trade, along with
advocating for multisectoral action using the One Health approach, among others.

The Codex Alimentarius, or "Food Code", is a collection of standards, guidelines and codes of practice adopted by the Codex Alimentarius Commission. The Commission, also known as CAC, is the central part of the Joint FAO/WHO Food Standards Programme and was established by FAO and WHO to protect consumer health and promote fair practices in food trade.

Codex standards ensure that food is safe and can be traded. The 188 Codex members have negotiated science-based recommendations in all areas related to food safety and quality.

**Empowering countries on food safety through South–South collaboration**

Several countries in the Region lack the capacity to meet the international food safety and quality standards established by the Codex Alimentarius Commission. This lack of capacity to monitor and regulate food safety is problematic because it can not only lead to unsafe domestic food supplies but also problems over international food trade. For example, the Food Safety and Standards Authority of India, which is well-versed in Codex standards and practices, has frequently ordered ginger, tea and other foods imported from Bhutan and Nepal to be kept in isolation for some time.

It is within this context that Bhutan, India and Nepal applied for a Codex Trust Fund project, which has been established by the Food and Agriculture Organization and WHO to support Member States to build capacity to engage in Codex. With WHO technical support the three countries prepared their application jointly, with the goal of strengthening the function of national Codex structures through engagement with essential stakeholders in Codex activities and standard setting processes, improving scientific and technical capacity of national experts, and promoting subregional cooperation.

The successful three-year project costing (US$ 435 000), that continued into this biennium, was the first multicountry project by the Codex Trust Fund, and the first project in Asia designed to promote South–South cooperation. The collaboration between three neighbouring countries presented a unique opportunity to build trust, confidence and mutual understanding through bilateral and multilateral activities to move towards developing and harmonizing Codex standards. The project illustrated the importance of working together and one of the greatest lessons was the need to establish a subregional network of food safety authorities. The project, which began in 2019, has been extended for one more year, as the COVID-19 pandemic affected activities in 2020.
Despite the pandemic, in 2021 WHO continued to support capacity-building to bring safer foods to countries across the Region. WHO ran a five-day training workshop on Codex and food safety in Nepal with participants from different ministries and agencies. The workshop trained officials on Codex and imparted practical knowledge through mock-drill exercises.

One of the challenges in Nepal is limited technical knowledge and expertise to run a National Codex Committee and participate in the Codex standard setting process. More specifically, Nepal has faced challenges in meeting requirements for the export of indigenous agricultural products including ginger and cardamom. The workshop was followed by a policy and advocacy meeting with policy-makers and food safety officials. A virtual Codex workshop was also organized in Bhutan in late 2021 to build capacity to accelerate action in food safety.

Working together during workshops and training has enabled increased cooperation and confidence-building, which has already resulted in agreements by India with both Bhutan and Nepal that recognize each others’ food safety laboratories. WHO also supported capacity-building on chemical risk analysis for food safety.

The next biennium will see WHO collaborate with the Asian Development Bank to operationalize this network. Importantly, this biennium Maldives and Timor-Leste were also successful in receiving Codex Trust Fund support that will establish and/or strengthen Codex activities in their respective countries.
A healthy diet is integral to health; it protects people against malnutrition and various noncommunicable diseases (NCDs) such as heart disease, diabetes and cancer. Eating a variety of foods from multiple food groups, including whole grains, pulses, fruits and vegetables, and consuming less salt, sugars and saturated and industrially produced transfats, are essential for a healthy diet.

However, poverty and food insecurity along with increasing urbanization and access to affordable highly processed foods that impact people’s lifestyles, have led to a double burden of malnutrition across the Region. In many countries, undernutrition continues to cause hundreds of thousands of deaths every year. At the same time, rates of overweight and obesity are rapidly rising, often within the same communities, and even in the same households.

The double burden of malnutrition is evident in the data reported for children aged under 5 years; stunting and wasting are prevalent in Bangladesh, Bhutan, India, Myanmar, Nepal and Sri Lanka while overweight and obesity rates are rising, particularly in urban areas, in these countries too.

This biennium WHO has focused on supporting the creation of healthy food environments, where the appropriate energy balance is supported as part of a healthy diet that meets nutrient needs without excess consumption of unhealthy foods.

The Seventy-fourth session of the WHO Regional Committee for South-East Asia approved a regional guide for healthy and active meetings. The Committee recognized the benefits of promoting healthy and active meetings and continuing existing practices within the Regional Office to support efforts in controlling NCDs, such as physical activity during the workday. The Committee adopted the guide to healthy meetings and urged Member States to also adopt the guide, particularly during health-related meetings.

Progress on front-of-pack labelling for foods (FoPL)

WHO continues to support countries to address the dietary risk factors for NCDs including salt reduction and the elimination of transfatty acids from the food supply. This biennium,
for example, Sri Lanka implemented FoPL (front-of-pack labelling), Indonesia developed regulations on FoPL, and India continued work on designing the most appropriate FoPL for their population.

Food labelling can empower consumers to choose healthier products and has the potential to incentivize the reformulation of products. Other countries were supported to examine the feasibility of taxing certain foods and setting food standards for product reformulation. Impressively, in the past two years, nine countries have implemented national public awareness programmes or campaigns on healthy diets.

As with the powerful tobacco industry, changing the food landscape does not come without major challenges. For example, commercial determinants continue to impede the move towards healthy diets, with the increasingly aggressive marketing and availability of cheap ultra-processed foods. In addition, the COVID-19 pandemic has resulted in reduced access to fresh, healthy foods and an increased reliance on ultra-processed foods.

**Eliminating transfats from the Region**

Every year, almost 260,000 deaths in the Region are attributed to the consumption of transfats. The elimination of industrially-produced transfats is one of the priority targets identified in WHO’s Thirteenth GPW, which is guiding the Organization’s work from 2019–2023.

WHO recommends that the total transfat intake be limited to less than 1% of total energy intake – this translates to less than 2.2 grams/day of transfat for a person on a 2000-calorie diet.

The elimination of industrially produced transfats will protect over 1.5 billion people from cardiovascular disease and contribute greatly to reducing premature deaths from NCDs in the Region.

This biennium, the Regional Office worked with countries to act towards eliminating transfats through advocacy and technical support to develop and implement best-practice policies to set transfat limits or to ban partially hydrogenated oils (PHOs) that are the main source of artificial transfat.

Prior to the 2020–2021 biennium, in 2019 Thailand became the first country in the South-East Asia Region to enact a transfat policy. Thailand opted to ban PHOs, becoming the third country in the world to do so following Canada and the United States of America.

This biennium, despite the COVID-19 pandemic, significant steps were taken to protect the health of millions of people across the Region through the promotion of healthier food. WHO supported projects in Bhutan, Maldives, Nepal and
Sri Lanka to assess the dietary sources and consumption of TFA and evaluate the policy landscape on edible oils and fats to inform policy development on the subject.

This was funded by WHO’s partner in transfat elimination, Resolve to Save Lives. In 2020 and 2021, the Regional Office organized technical discussions, a capacity-building workshop on transfat legislation and monitoring, as well as laboratory capacity-building sessions for six countries to spur action towards enacting WHO recommended best-practice policies. These have resulted in two countries expediting the drafting of transfat elimination regulations: Bangladesh and Sri Lanka.

In December 2021, the Bangladesh Food Safety Authority passed a best practice policy to reduce TFA content of food to <2% effective from December 2022. In Sri Lanka, food regulatory authorities drafted a best practice policy to eliminate trans-fatty acids, with the regulatory process currently ongoing. Bhutan, Maldives, and Nepal are at various stages of the policy process.

In the next biennium WHO will continue to work with the remaining countries in the Region to take action on transfat and also build capacity to enforce regulations. However, there are ongoing challenges to policy development and implementation across the Region, including a dearth of data on sources of transfat in diets, the use of alternative oils, and a lack of information and awareness about transfat in food among the population, given that some products lack nutrition labelling.

### India to be free from transfats in 2022

In December 2020, the Food Safety and Standards Authority of India (FSSAI) – the national food regulator – lowered its existing 5% transfat limit in fats and oils to 2%. In early 2021, the FSSAI extended the 2% limit to apply to all foods, aligning with WHO recommended best practices.

A movement called “India@75: Freedom from transfats by 2022”, was launched by the FSSAI in mid-2018. It aims to catalyse the elimination of transfats from India by the country’s 75th anniversary of independence.

A critical part of India’s efforts to garner support for the elimination of transfat was raising consumer awareness about its harmful effects. Mass media campaigns were launched along with education and other communication materials including videos featuring celebrities.

The campaigns not just targeted consumers, but also food suppliers and producers. The videos provide valuable information to the population on a range of related topics including the dangers of using repurposed cooking oil and the need to look out for the “Fortified Food” logo when shopping for wheat flour, rice, salt, oil and milk.
Healthy start to life through a healthy food environment for young children

Poor diets among infants and young children under the age of five have long-term effects on their development and health and ultimately increase their risk of morbidity and mortality. Poor diets contribute largely to the suboptimal nutrition status of young children across the Region and are likely to impede the achievement of the global nutrition targets by 2025, and the targets of SDGs 2 and 3 on childhood stunting, wasting and overweight by 2030.

In recent years, the flourishing and ubiquitous commercial food industry has compounded existing challenges in the delivery of healthy diets for young children.

The increased availability, accessibility, and promotion of low-cost commercially processed or ultra-processed snacks and meals, not expressly meant for children but which are often fed to them, is significantly affecting their nutritional status.

Ready-to-use food products such as packet dried noodles, biscuits and other snacks offer convenience to feeders and caretakers; however, they do not meet the nutrition needs of infants and young children and risk replacing nutrient-rich, locally available foods. There is also a flourishing commercial complementary food industry with increasing sales across many countries. Though heavily marketed, the contents and composition of these products are largely unstudied and unregulated.

To address these new and emerging problems, this biennium the Regional Office in collaboration with other stakeholders began work on a three-stage project to support improved young child nutrition by addressing dietary intake behaviours and the food environment surrounding young children across the Region. The project was funded by the Norwegian Agency for Development Cooperation (NORAD).

The first phase of the project focused on undertaking a landscape review of five countries (Bangladesh, Nepal, India, Sri Lanka and Thailand) of the intake of commercial meals and snacks by young children. As part of this work, the Regional Office also profiled commercial complementary foods in four countries using the WHO Regional Office for Europe nutrient profile model.

Based on the results of the assessment, WHO will develop a nutrient profile model for commercial complementary foods to benchmark products that are in excess of nutrients of concern, including sugars, sodium, saturated fat and transfatty acids, and assess inappropriate marketing tactics used by the industry to promote foods that replace home foods and breastfeeding.

During the second phase of the project in late 2021, a Regional Expert Group consultation was held to provide direction on improving the food environment and policy landscape. The expert consultation recommended that countries be supported to fill nutrient gaps through a food-based approach.
Healthier Populations and Noncommunicable Diseases

and that innovative interventions be designed to address the widespread consumption of ultra-processed snacks and meals by children.

The experts also recommended that WHO develop regional composition standards and a nutrient profile model to ensure optimum nutrient composition for commercial complementary foods. The nutrient profile model will be useful for countries in regulating the promotion of unhealthy commercial complementary foods, thereby supporting healthy diets in young children.

The third phase of the project will be carried out during the next biennium, which will involve WHO supporting countries on implementation. The recommendations will help protect and support breastfeeding, improve complementary feeding practices through a better dietary environment for young children in the Region, and contribute to improved nutritional status of children.

Tackling unhealthy out-of-home foods

In South-East Asia, out-of-home foods, which include food from street vendors, stalls and markets, as well as online food delivery, contribute significantly to people's food intake. However, much of this food is fried, highly salted and full of sugar. The Regional Office recognizes that this issue is something that needs to be addressed beyond WHO's focus on processed packaged foods.

Despite other pressing priorities, this biennium the HPN departmental team published a case study-based framework for healthier out-of-home foods. The framework serves as a guide for policy-makers to consider how street-food and other out-of-home food service providers could be supported to provide healthier foods.

The actions identified in the framework emerged out of a 2019 meeting between WHO and FAO in Bangkok, Thailand. While progress on taking this forward has been halted by the pandemic, the team hopes to renew interest in addressing this issue of great regional importance in the next biennium.
Tobacco use is a major risk factor for cardiovascular and respiratory diseases, over 20 different types or subtypes of cancer, and many other serious health conditions.

All forms of tobacco are harmful, including various smokeless tobacco products, which are hugely popular in several countries of the Region.

Since 2010 the South-East Asia Region is where tobacco use rates have been declining the fastest among all WHO regions. India and Nepal are on track to meet the 30% reduction in prevalence of current tobacco use by 2025 while other countries are also showing downward trend. The voluntary target of 30% reduction is included in the Member States’ National NCD Action Plans under the Global NCD Monitoring Framework.

Around 29% of adults in the Region are current tobacco users, which is approximately 432 million people, of whom 351 million are men, according to the 4th edition of the WHO Global Report on trends in prevalence of tobacco use 2000–2025 published in November 2021. Smokeless tobacco use also remains a challenge, particularly among women. The WHO South-East Asia Region is home to 80% of all smokeless tobacco users globally. Every year, 1.6 million people across the Region die from tobacco use.

Most tobacco-related deaths occur in low- and middle-income countries, which are often targets of intensive tobacco industry interference and marketing. This is also the case for the South-East Asia Region with the tobacco industry continuing to make well-researched, calculated and unscrupulous attempts to redesign and rebrand their products. They specifically target young people and the next generation of tobacco users.

Compounding industry interference is among the myriad challenges to curbing tobacco use, including lack of political will, gaps in enforcement of tobacco laws and low taxation on tobacco.

Nevertheless, the South-East Asia Region has the highest proportion of its population covered by tobacco surveillance,
translating into excellent monitoring for tobacco use prevalence and tobacco control policies. In addition, Thailand was the first country in Asia to implement plain packaging; India, Maldives, Nepal and Sri Lanka have implemented large-sized graphic health warnings on tobacco packs; six countries have banned ENDS; Bangladesh, India, Indonesia and Sri Lanka are working towards moving tobacco farmers away from growing tobacco; and Bhutan, Nepal, Maldives, Sri Lanka and Timor-Leste have established and scaled-up tobacco cessation services.

COVID-19 is a disease that primarily attacks the lungs and tobacco use is a known risk factor for a range of respiratory infections and increases the severity of respiratory diseases. Smokers are more likely to have worsened COVID-19 symptoms, are more likely to be hospitalized, more likely to be admitted to intensive care units, and require help with breathing. Ultimately, smokers are more likely to die from COVID-19 than non-smokers.

Considering the close link between tobacco use and COVID-19, advocacy material was disseminated widely for use at the country level. A regional webinar on tobacco and COVID-19 was organized, with countries supported to act on tobacco control during the pandemic.

By addressing and curbing tobacco use, not only are lives saved, but the economic costs of tobacco use are also prevented. These include significant health-care costs for treating the diseases caused by tobacco use, lost human capital that results from morbidity and mortality, and the diversion of household spending on tobacco and away from basic needs such as food, education and shelter. It is a win-win situation and covers more than just health.

Commit to quit: WHO partners with Timor-Leste to expand tobacco cessation

Timor-Leste has one of the highest tobacco prevalence rates in the world, with more than 56% adults using tobacco (70.6% men and 28.9% women).

The use of smokeless tobacco among women in Timor-Leste is the highest among all countries in the Region, while 30% of students use tobacco, according to the 2019 Global Youth Tobacco Survey.

Timor-Leste ratified the WHO FCTC in 2004 and continues to implement key provisions such as graphic health warnings on cigarette packs, ban on tobacco advertising, promotion and sponsorship, smoke-free policies, the restriction of sale to minors, and a ban on sale and advertising of ENDS.

But Timor-Leste lagged in providing cessation support to quit tobacco use. To address this, during the biennium WHO initiated a series of trainings of "master trainers" to
Moving away from tradition – replacing tobacco cultivation in Magelang, Central Java: a personal story

“Growing tobacco is a tradition that is passed down from generation to generation in our village. However, in 2013, our farm started to cultivate other commodities to improve our profits as we felt that tobacco prices tended to be low. We chose to grow sweet potatoes because the seeds are easy to obtain, the price is low, maintenance is easy, and it can be harvested all year round. We were pleasantly surprised that the harvest of sweet potatoes was quite profitable. As a result, we decided to stop growing tobacco and switch completely to the sweet potato of the cilembu type. The farmers in the village around us also followed suit to plant sweet potato, which we later gave the name ‘Madusari’.

“The profit that we get from planting Madusari is more than what we get by growing tobacco. Madusari is not affected by seasons. This enables us to grow Madusari all through the year with no other competitive crop. In addition, the Madusari market is open and not controlled by certain parties, so farmers have the right to determine prices.

“Besides Madusari we also grow both robusta and arabica coffee. We obtained coffee seeds from the Department of Agriculture and the Department of the Environment of Magelang Regency. Besides selling fresh, we also process the coffee beans into powder which is ready to be served in the form of drinks. Coffee cultivation is also profitable for us. We also cultivate various other commodities such as flowers, edamame beans and garlic.

“Even though prices fell during the COVID-19 pandemic, we still believe that growing various commodities is much more profitable than depending on only one commodity. Therefore, we urge tobacco farmers to not depend on one commodity only. In addition to providing greater financial benefits than tobacco, Madusari will also help maintain soil fertility.”

– Mr Istanto, a former tobacco farmer from Magelang, Central Java, Indonesia
build country capacity in providing tobacco cessation. WHO supported the development of guidelines for tobacco cessation clinics in primary health centres and the National Tobacco Quitline Programme.

All three levels of WHO also conducted a tobacco control delivery chain exercise in partnership with the Ministry of Health. In a key step towards establishing tobacco cessation services at the primary health care level, the Regional Office coordinated the provision of nicotine replacement therapy (NRT) in late 2021.

A tobacco cessation clinic and Quitline have since been refurbished, while human resources including doctors, nurses and counsellors have been recruited and trained. Establishing this clinic and Quitline is an important step forward in reducing Timor-Leste’s tobacco use and ultimately improving people’s health.

**Regional tobacco testing laboratory**

Tobacco product regulation has the potential to contribute to reducing tobacco-related disease and premature deaths by
not only minimising the attractiveness of products but also by lowering their addictiveness or overall toxicity. Despite knowledge of the toxic risks associated with tobacco use, little effort has been made to regulate its ingredients. The Region has limited capacity to test tobacco products for their contents and emissions. This biennium WHO therefore took the lead to support countries to scale up efforts to test tobacco products to generate new evidence and aid tobacco control programmes.

As part of this, WHO supported the drug toxicology laboratory at the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, India, to establish a Regional Tobacco Testing laboratory. WHO provided the laboratory with the latest equipment, including a smoking machine for testing tobacco products, which will test products from all countries in the Region to enable governments to better regulate tobacco use.

WHO also collaborated with the laboratory to test smokeless and smoked tobacco products and e-liquids used in ENDS. The procurement was done through funds received from the Federal Ministry of Health, Germany.

With WHO support the laboratory has become a member of the TobLabNet of WHO and actively participated in the preparation of SOPs for testing tobacco products globally. The laboratory will be the driving force behind the successful implementation of Articles 9 and 10 of the WHO Framework Convention on Tobacco Control (WHO FCTC) in the Region. It is an important step towards meeting global tobacco control targets, NCD goals and the SDGs.

Monitoring tobacco use and prevention policies

Effective surveillance of prevalence, patterns and determinants of tobacco consumption among adults and youth is a critical component of tobacco policies and interventions including the WHO FCTC and the MPOWER package.

Tobacco surveys are carried out under the Global Tobacco Surveillance System which is funded by the CDC Foundation with technical support provided by CDC Atlanta. The Tobacco Questions for Surveys (TQS) are being increasingly integrated in national health surveys or multiple risk factor surveys, with the aim to harmonize regional tobacco surveillance and monitoring activities. Meanwhile, countries continue to implement Global Adult Tobacco Surveys (GATS) and Global Youth Tobacco Surveys, with an increasing number of Member States also monitoring ENDS use.

Regular monitoring of tobacco use and prevention policies has enabled countries to enhance the relevance and effectiveness of tobacco control policies, programmes and research. Appropriate legislative, regulatory and administrative measures have been put in place to address supply- as well
as demand-side issues related to tobacco control, while the Region is continuing to implement the MPOWER measures to reduce the demand for tobacco at the population level.

Supply side issues – addressing illicit trade in tobacco products, restricting access of tobacco products to minors and providing alternative livelihoods for tobacco growers and workers – are being prioritized by governments.

Bhutan is the only country in the world that had banned the production, manufacturing and sale of all tobacco products until 2020, when the government allowed the sale of tobacco products through designated Customs outlets as the borders were closed due to the pandemic and imports were not possible.

Smokeless tobacco is banned in DPR Korea, Sri Lanka and Thailand while India evokes food safety laws to ban smokeless tobacco products at the subnational level. Nepal has banned the use of smokeless tobacco in public places. ENDS are banned in DPR Korea, India, Nepal, Sri Lanka, Thailand and Timor-Leste and regulated in Maldives. Additionally, DPR Korea, India and Timor-Leste have completely banned heated tobacco products.

Evidence-informed measures have been implemented to effectively tackle tobacco industry interference and enhance tobacco product regulation across the Region. Tobacco control is additionally supported through the FCTC2030 project in Nepal, Myanmar and Sri Lanka. Bhutan and Timor-Leste have joined this project in 2021.

**The Tobacco Atlas**

With the WHO South-East Asia Region having the highest burden of tobacco use prevalence, Member States have ambitious targets to achieve effective tobacco control. As such, sustained technical support, guidance and sharing of best practices for effective implementation...
of tobacco control policies along with competent laws for achieving time-bound targets and goals is required at the country level.

WHO supports building on every country’s capacity to ensure healthy lives and promote well-being for all at all ages. While controlling the tobacco epidemic, there is an urgent need to prevent children and youth from initiating use of tobacco products, especially the new and emerging ones. A balance of implementation of policies to reduce demand as well as supply of tobacco is to be achieved to ensure a tobacco-free South-East Asia in the future. The first edition of the *Tobacco Atlas: Perspectives from the South-East Asia Region*, was published in 2020 to assist informed policy-makers to implement evidence-based policies in a more rational manner in the quest for a tobacco-free South-East Asia Region.

A Special Issue of the *Asia Pacific Journal of Cancer Prevention on Progress in Tobacco Control in the WHO South-East Asia Region* was also published this biennium. Member States across the Region contributed articles and scientific papers which captured best practices and challenges related to tobacco control.
Insufficient physical activity is one of the leading risk factors for death worldwide. While the WHO South-East Asia Region has a relatively young population, the prevalence of NCDs is increasing premature mortality.

For example, people who are physically inactive have a greater risk of developing high blood pressure, type 2 diabetes, and coronary heart disease, even after smoking, alcohol use and diet are factored in. Moreover, physical inactivity burdens society through the hidden and growing cost of medical care and loss of productivity.

According to the WHO Global Report on NCDs, 15% of adults and up to 74% of adolescents in the South-East Asia Region do not meet the global recommendations for physical activity.

This biennium WHO continued to work with countries to encourage physical activity and integrate its promotion within existing policy frameworks for NCD prevention and control.

The impact of COVID-19 has only underscored the importance of increasing physical activity, as the pandemic has further exacerbated the problem with movement restrictions and work from home mandates. This has fuelled sedentary lifestyles. Pandemic aside, there are other environmental and lifestyle factors that prevent people from exercising including air pollution, road safety, increased workloads, and mental health challenges.

To prevent or reduce inactivity, WHO designed the Global Action Plan on Physical Activity (GAPPA) (2018–2030) and adopted a new voluntary target of a 15% improvement in global levels of physical activity in adults and adolescents by 2030.

This biennium a Regional Roadmap for the Implementation of the Global Action Plan on Physical Activity (2018–2030) was developed. The Roadmap serves as a guide for countries to identify priority areas and adapt policy actions to their own country’s context over a period of five years from 2021–2025. The Roadmap has a voluntary target of a 10% relative reduction in the prevalence of insufficient physical activity by 2025, with
Green, open spaces in New Delhi, India

Access to green spaces, parks and urban forests provide a gamut of health benefits going beyond those of physical activity, from improving mental health, lowering air pollution, and reducing the risk of chronic disease.

New Delhi is one of the few cities in India where land for green spaces was allocated during its town planning. In addition, open-air gyms were set up in parks across the city from 2014 onwards. This biennium, WHO undertook a situational analysis of parks and open space gyms in Delhi. The analysis came up with the following findings:

The study’s findings reinforced the need for the allocation of land for parks in Delhi to be replicated in other cities, towns and urban settlements across the Region. Critical to this is access: parks need to be opened within a 500-metre radius of every individual and family for the greatest benefits to accrue. The analysis found that the bigger the park or urban forest, the better the health outcomes.

The study recommends that sidewalks within cities need to be as wide as roads and that beautification of parks should not impact sidewalk width, because this makes them unsafe. The analysis concluded that access to green spaces should be “non-negotiable” in the remodelling of cities. Looking ahead, it is hoped that as countries embark on remodelling their cities and towns to evolve into smart, green and healthy cities, they learn from New Delhi’s experience.
global progress reports on country implementation to be presented at the World Health Assembly in 2026.

In 2021, at the regional meeting with health officials and partners from Member countries, the Regional Roadmap for the Implementation of the Global Action Plan for Physical Activity was launched. The two-day meeting was organized by WHO, the Thai Health Promotion Foundation and the International Health Policy Programme. Meanwhile, countries continued to implement nationwide public education and awareness campaigns on physical activity.

WHO will continue to use each and every opportunity to promote physical activity even in its internal functioning, such as the Walk the Talk challenge at the World Health Assembly plenary and Regional Committee sessions, and to publish promotional materials to increase awareness of physical inactivity and sedentary behaviour.
Noncommunicable diseases and mental health

Two thirds of deaths across the 11 countries of the Region are from NCDs. Cardiovascular disease, cancer, diabetes and chronic respiratory disease are the biggest killers in South-East Asia. Shockingly, of the 55 million global deaths in 2019, 42 million were due to NCDs. In the Region, nearly half of the almost 9 million deaths every year from NCDs occur prematurely, between the ages of 30 and 69 years. Today, a quarter of the adult population in the Region has hypertension and one in 12 adults has diabetes.

Not only does this have a huge impact on people’s health, but individuals and families living with NCDs face tremendous health-care costs along with a reduced ability to work. Health-care expenses and reduced productivity burden developing economies and impede social and economic development. In fact, it has been estimated that every 10% rise in NCDs is associated with 0.5% lower rate of annual economic growth.

The prevention and control of NCDs is one of the Regional Flagship Priorities in the SE Asia Region and is a critical part of the SDGs and UHC. Since 2014, Member States have made concerted efforts implementing multisectoral plans, providing and scaling up NCDs at the primary health care level, and addressing NCD risk factors from tobacco to physical inactivity.

The COVID-19 pandemic has further exposed the vulnerabilities of people living with NCDs. The pandemic caused widespread disruptions to health services across the Region while simultaneously highlighting countries’ NCD burdens.

Those living with NCDs are at increased risk of becoming severely ill and dying from the virus, so COVID-19 disruptions have been particularly severe for them. For example, a WHO rapid assessment found that screening, case identification and referral systems for cancer have all been affected by the pandemic, which has resulted in a substantial decrease in cancer diagnoses. The disruption in rehabilitation services has potentially impacted people’s functional outcomes and increased the burden of care.
As COVID-19 spread across the Region, most countries repurposed NCD programme staff for response activities. The disruption in the delivery of essential NCD services and prevention and policy activities has threatened to slow progress and even reverse the gains made in recent years in controlling NCDs.

The challenges the pandemic brought with it, however, have also provided countries with the opportunity to rethink how they deliver NCD care. How can services be delivered in an effective and safe way during a pandemic? How can we ensure continuity of care during this crisis and future ones? In response, innovative ideas sprung up and took off, such as telemedicines ensuring that patients could access their medication without delay during periods of restricted movement.

The pandemic has also forced WHO at all levels to reconsider and change how it works, from onsite to remote, with far fewer in-person gatherings. The shift to remote working has provided an opportunity for people who previously couldn’t join workshops or trainings in person to now join virtually.

In recent years there has been increasing acknowledgment of the important role mental health plays not only in our day-to-day health but also in achieving global development goals. Depression is one of the leading
causes of disability, while suicide is the second leading cause of death among 15–29-year-olds.

The pandemic has exacerbated pre-existing mental health and substance use conditions spurred by fear, worry and stress. Adding to the fear of contracting the virus, other significant changes occurred in our daily lives, ranging from increased unemployment to working and schooling from home. Throughout the biennium, WHO together with partners provided interactive guidance and advice to health workers, carers, adults, adolescents, people in isolation, the elderly, and members of the public to help us look after our mental health.
Noncommunicable diseases (NCDs)

Guided by the Regional Strategic Action Plan to prevent and control NCDs (2013–2020), this biennium WHO continued to provide policy advocacy and technical support to all countries in the Region to develop better health governance structures, multisectoral action plans and a stronger evidence base to tackle the leading causes of death. Following the decision to extend the Regional Action Plan to 2030, a Regional Implementation Roadmap will be developed in 2022 to accelerate the implementation of cost-effective interventions in all countries.

Importantly, multisectoral NCD action plans are now fully institutionalized in most Member States of the Region, while some countries have either completed or are in the process of developing the second round of these plans.

Innovative NCD service delivery during COVID-19

Due to their chronic and sometimes life-long nature, NCDs usually require frequent interactions with the health system over a long period of time for disease management, rehabilitation and essential medicines. That has meant that the disruption of health services due to the pandemic has been problematic for those living with NCDs.

Understanding the extent of the impact of the disruptions and the factors associated with them is critical to build back stronger and better health systems with integrated NCD services. With routine services for hypertension, diabetes and other NCDs disrupted across the Region, and patients living with chronic illnesses unable or reluctant to visit health facilities, thinking outside the box was required to ensure that patients got the care they needed. Listed below are examples of some of the innovations that countries have implemented during this biennium.
India

With the pandemic restricting access to routine health care, the districts covered under the India Hypertension Control Initiative (IHCI) implemented critical mitigation measures, including community-level distribution of anti-hypertensive medications and drug refills for up to three months for patients with high blood pressure. The IHCI teams also conducted virtual capacity-building sessions for frontline workers from more than 1700 health-care facilities with WHO support.

Sri Lanka

Despite island-wide movement restrictions, Sri Lanka’s central, provincial and local governments were able to ensure that essential health services continued. For the continuation of NCD services, the government initiated a system that enabled pharmacists to prepare medicines, with refill packages delivered using the country’s postal service.

From April 2020 onwards, people on insulin for diabetes received their doses at home while outdoor mobile clinics were established in areas with prolonged lockdowns. As a part of this initiative, WHO HQ and the Regional Office facilitated the donation of 18 000 vials of insulin and 100 glucagon hypokits to the MoH.

Thailand

In early 2020, routine services for hypertension, diabetes and other NCDs were disrupted, and patients living with chronic illnesses were unable or unwilling to visit health facilities.

Pakkred is a densely populated, semi-urban district near Bangkok. Almost one-fifth of the population is over 60 years old and most older individuals live in pre-existing chronic NCDs that require ongoing management.

As COVID-19 spread, the health leadership of Pakkred Hospital prioritized maintaining essential health services for patients with chronic diseases. Several changes to primary health care were instituted to improve patient-centred care including decentralizing care, telemedicine, home BP monitoring, and community delivery of medicines.

Strong primary health care infrastructure in Pakkred, a vast network of community health volunteers (CHVs), and communications infrastructure provided the foundation for an innovative programme to maintain NCD services. Throughout 2020 hypertension control rates were maintained, and the diabetes control rate increased compared with 2019. In addition, no health-care worker or NCD patient was diagnosed with COVID-19 during this period.
Addressing palliative care: leaving no one behind

Palliative care is an approach that improves the quality of life of patients and their families who are coping with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Whether the cause of suffering is cancer, drug-resistant TB or very old age, palliative care must be available at all levels of care.

Each year, an estimated 40 million people need palliative care; 78% of them live in low- and middle-income countries, including the 11 countries of the Region. But despite its importance, only 14% of patients who need palliative care receive it. The need for palliative care is growing due to ageing populations around the world and the rising burden of NCDs.

Despite a resolution at the Sixty-seventh World Health Assembly in 2014 that urged Member States to integrate palliative care into health systems, far more needs to be done to address the issue in a Region that hosts more than one-fourth of the world’s population.

A country capacity survey carried out in 2019 across the Region recommended that access to palliative care should be improved by strengthening policy frameworks, strategies or plans as well as by expanding availability of opioids and provision of ambulatory and community-based palliative care.

In 2021, a Regional Workshop was held to draw attention to the urgency of strengthening palliative care services within primary health care across all 11 countries and take an important step towards developing community-based palliative care.

The two-day workshop hosted by the HPN department and the WHO Collaborating Centre for Palliative Care in India focused on drawing attention to policy-makers and health officials to improve palliative care. It involved more than 100 participants from palliative care professionals to researchers and academics.

The workshop focused on facilitating countries to strengthen their national palliative care policies, fast-tracking the integration of palliative care in primary health care systems, and ensuring the availability of opioids. The major outcome following the workshop was that WHO engaged the Institute of Palliative Care Medicine to draft a Regional Acceleration Framework for palliative care, which was completed by the end of 2021.

In another crucial step to realizing palliative care in the Region, in 2021 WHO commissioned a situation analysis of palliative care across all 11 countries. The assessment looked at the availability of medicines, the training of health-care professionals and the policy environment. It found that the background of palliative care services, their drivers and the barriers to their development and mainstreaming are too complex to be tackled by a single strategy.
A meeting of stakeholders from across the Region discussed the innovative ways in which many countries and areas have tried to transcend the difficulties faced. One of the suggestions which came up repeatedly was that countries and Regions should share information and ideas so that they can learn from each other.

A series of seven case studies were put together to share ideas and highlight the role of locally appropriate strategies in the development of palliative care services. Two case studies are detailed below, while the remaining will be available online in 2022. Furthermore, a regional guidance document on palliative care will be developed in the next biennium.

**Home-based palliative care in Thimphu, Bhutan**

Bhutan’s efforts to support people living the last days of life can serve as a source of inspiration for those in areas which lack palliative care services. This story is about the evolution of the country’s first-ever home-based palliative care service at the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) in Thimphu that underlines the role of nurses in pioneering such a service.

In 2018, the JDWNRH created the first home-based palliative service in the country with the aim of providing holistic, compassionate care and the best possible support to patients at the end of their lives. The JDWNRH management has entrusted three nurses with the task of providing home-based palliative care. These nurses are supported by a team of specialists including a surgical oncologist, medical officer and a nurse anaesthetist who take turns to make home visits. The service caters to cancer patients residing in urban and suburban areas of the capital and home visits are made three times a week.

The introduction of home-based palliative care has not only placed the community in a better position to play a more meaningful role in addressing the non-medical spectrum of palliative care needs of individuals, but has also led to wider changes within the medical system. For example, after the introduction of home-based palliative care services, the pharmacy department at JDWNRH decided to prioritize the need for a sustainable supply of opioids, adding morphine and the fentanyl patch to its list of essential drugs.

With the WHO Regional Office, Bhutan has worked to develop its first national training manual for palliative care, the first step in building the capacity of health workers to deliver such an essential service. Looking forward it is essential that Bhutan works to develop its national strategy and national action plan on palliative care, based on the country’s experiences.
The joy I derive from palliative care comes from understanding that it is a privilege to reach out to people when they are at their weakest point of life. Although it is a tougher job, it is a deeply enriching experience. We get to associate with suffering people in such proximity that it changes not only their lives, but ours as well.

A nurse in the palliative care team

Integrating palliative care services into primary health care in Kerala, India

As the example below illustrates, it is possible to integrate palliative care into primary health care, even in low- to middle-income countries. Two major features of Kerala’s success have been the active participation of the community and the involvement of civil society in the implementation of the government’s palliative care policy.

The state’s palliative care policy and action plan that involved civil society in its development takes a socially innovative approach and pioneers community- and home-based palliative care. The Kerala model places strong emphasis on community participation and volunteerism.

- The first palliative care unit in Kerala was started in 1993 by the Pain and Palliative Care Society, a civil society organization. The services were managed entirely by CSOs in the first decade.
- Fast forward to today and Kerala has more than 1400 palliative care services of which 1000 are in the government sector and 400 are run by civil society organizations. Together, these services take care of up to 90,000 patients at a time.
- Of the patients covered, 20% have incurable cancer and the remainder have other chronic illnesses or are living with advanced old age.
Though Kerala accounts for just 3% of India’s population, 90% of the country’s palliative care services operate in the state. Many countries can learn from Kerala’s bottom-up model of the development of palliative care services and its integration into the health-care system, as well as the emphasis on civil society participation. But there is always room for improvement and the following recommendations have been made to help Kerala strengthen its services:

- Better integration of services run by CSOs and by the local government;
- Improvement in capacity-building for palliative care at the primary health care level to ensure the availability of trained professionals and essential medicines; and
Strengthening of palliative care facilities at the secondary and tertiary care levels and greater involvement of the private health care system.

From disease to monitoring patient outcomes

The monitoring of patients with NCDs such as hypertension and diabetes has emerged in recent years as a critical part of NCD management. While NCDs are often managed in tertiary or secondary-level hospitals across the Region, there’s an urgent need to integrate the management and monitoring of patients and their treatment outcomes into primary health care.

On a larger scale, monitoring of NCDs also contributes to better prevention and management. One of the major differences between communicable and noncommunicable diseases is that most NCDs are asymptomatic to begin with and thus require periodic screening for their early detection after a certain age.

Surveillance is crucial because it contributes to better prevention and management. Through the data collected thereof, countries can set goals and targets.

Digital solutions to improve hypertension control

Simple App is used for measuring patient follow-up, retention to care and control rates of hypertension across India. It’s used in districts across the country that are implementing India’s Hypertension Control Initiative, a multi-partner initiative that began in 2017 to strengthen hypertension management at the primary health care level.

Monitoring hypertension control rates are proving to be a useful tracer for quality and performance measures for NCD services. In addition to India, Thailand is also measuring control rates with plans for other countries in the Region to follow soon.

Preventing and controlling NCDs in the Region – monitoring progress

In 2020, the results from the NCD Country Capacity Survey 2019 were published in a report titled National capacity for prevention and control of noncommunicable diseases in the WHO South-East Asia Region. To monitor progress on implementing WHO’s global and regional NCD plans of action, since 2013 the Region has carried out an NCD country capacity survey every two years.
This report comes at a critical time as now countries are in their final decade of achieving the targets of the 2030 SDGs. Now is the time to accelerate action to halt and reverse the NCD burden and create a healthier future for all.

The survey highlights the significant progress countries have made, while also identifying and emphasising where gains are needed. Some critical areas that require intervention include strengthening the delivery of priority NCD services at primary health care facilities through increasing the availability of essential medicines; increasing the resources allocated to NCD programmes to strengthen policy development and implementation; and building capacity for regulatory and financial reforms including the strengthening of fiscal policies on tobacco, alcohol and unhealthy food products.

Some of the Region’s achievements as covered in the NCD Country Capacity Survey 2019 that have not been mentioned herein are enumerated below.

**Early detection, treatment and care of NCDs within health systems**

- All countries in the Region have evidence-based guidelines/protocols for CVDs, cancer, chronic respiratory diseases and diabetes, and include referral criteria.
- The health system response is gearing up in all countries. Basic diagnostic equipment – such as those needed for measurement of height and weight, blood pressure and blood glucose – is generally available in both public and private health facilities, except for one or two countries.

**Governance**

- All countries in the Region have a unit, branch, or department exclusively responsible for NCDs in their MoH and have implemented at least one fiscal intervention related to NCDs.
- All countries, except Timor-Leste, have a nationwide multisectoral commission, agency or mechanism to oversee NCD engagement, policy coherence and accountability in sectors other than health.
- All countries, except Myanmar, dedicate funds for NCDs and associated risk factors.

**Health information systems, monitoring and surveillance**

- All countries, except Indonesia, have a system for routine collection of mortality data by cause of death.
Almost all countries have conducted at least one national integrated risk factor survey among youth in the past five years.

All countries have concluded at least one round of population-based integrated NCD risk factor survey (WHO STEPs survey or its equivalent) among adults, and thus have their own data on prevalence of main risk factors for NCDs.

Expanding early detection and screening of NCDs at the PHC level

The next few years are critical to strategize the support of WHO as countries move towards ensuring at least 80% availability of essential NCD medicines and technologies in health facilities and reaching 50% of high-risk populations with treatment and counselling therapies to prevent heart attacks and strokes by 2025.

This biennium the Regional Office continued to step up and provide technical and financial support to enable countries to integrate the WHO Package of Essential NCD Interventions (PEN) and the HEARTS technical package into their primary health care systems.

Following the endorsement of the Colombo Declaration on strengthening health systems to accelerate the delivery of NCD services at the primary health care level at the Sixty-ninth session of the WHO Regional Committee for South-East Asia in 2016, there has been widespread expansion of NCD services available at the primary health care level. This has resulted in scaling up early detection and screening of major NCDs and greater availability of treatment. In particular, standardized management of cardiovascular diseases, hypertension, and diabetes have expanded at frontline health services across the Region.

The ongoing COVID-19 pandemic has tested the resilience of primary health care systems, largely due to the disruption of essential health services. With the focus on continuity of essential services within the Strategic Preparedness and Response Plans to COVID-19 at the country level, there are signs of improvement in the provision of NCD services as reported in WHO PULSE surveys.
The geographical coverage of WHO PEN interventions in selected countries include:

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>WHO PEN-HEARTS have been scaled up to 66 sub-districts so far and interventions are being scaled up to 34 more sub-districts, taking the total to 100 out of 492 sub-districts.</td>
</tr>
<tr>
<td>Bhutan</td>
<td>The updated version of WHO PEN was scaled up in 2021 under the new brand of ‘Service with Care and Compassion Initiative (SCCI)’; health personnel in nine out of 20 districts have been trained on SCCI to improve care delivery focusing on team-based care, clinical mentoring of primary health care teams, patient recalls and follow-up, and prescription refills at the primary health care facilities and home visits for homebound patients.</td>
</tr>
<tr>
<td>India</td>
<td>Population-based screening has been expanded to more than 600 districts covering 50,481 sub-centres and 21,072 PHCs. More than 110 million people have been screened as of June 2021.</td>
</tr>
<tr>
<td>Maldives</td>
<td>Since the launch of the first training session in Male’ and Addu Atoll in 2017, PEN training has been now been conducted in nine out of the country’s 20 atolls.</td>
</tr>
<tr>
<td>Myanmar</td>
<td>The PEN programme was expanded from 20 townships in 2017 to 177 in 2018 and 232 townships in 2019. This translates into 5058 health facilities in 2018 and 9518 health facilities in 2019. This has led to 429,400 and 205,945 patients diagnosed with hypertension and diabetes respectively.</td>
</tr>
<tr>
<td>Nepal</td>
<td>Since the pilot implementation of WHO PEN in two districts 2017, the programme has been scaled up to 51 districts. The MoH plans to cover all 77 districts by 2022. In addition, six districts were identified in 2021 to implement a comprehensive chronic care model in the country.</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>WHO PEN services have been expanded to 37 community health centres (CHCs) in six municipalities since the programme was first launched in six CHCs in Dili Municipality in 2017. NCD services are also being delivered to the community through domiciliary visits, mobile clinics, and the School Health Service.</td>
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Regional initiative for childhood cancer: saving kids from cancer

Children living with cancer in less developed regions of the world are four times more likely to die compared with those in more developed regions. In response to the inequity, in 2018 WHO launched the Global Initiative for Childhood Cancer (GICC) to achieve at least a 60% survival rate for children living with cancer by 2030 and to save one million additional lives this decade. In the South-East Asia Region, an estimated 59,000 children are diagnosed with cancer annually, and almost 60% succumb to the disease.

In 2020, the Region launched the South-East Asia Regional Childhood Cancer Network, which brings together key institutions and stakeholders to advance evidence-based, cost-effective interventions to enhance the quality and reach of childhood cancer services. At present, 15 institutions from 10 Member States are participating.

The network runs a series of regular capacity-building activities, which includes a collaborative programme between Cipto General Hospital in Jakarta, Indonesia, and the HNGV Hospital in Timor-Leste, whereby online biweekly case consultations have been held since early 2021.

In 2021, WHO also launched three innovative tools to help countries in the Region accelerate progress against childhood cancer. First, the CureAll technical package provides policymakers and programme managers actionable guidance on how best to implement the four pillars of the Global Initiative. Second, the WHO Knowledge Action Portal will provide ministries of health and other stakeholders an online hub to share resources and establish new partnerships and collaborations. And third, a new assessment tool will help harmonize data collection and enable ministries of health to carry out rapid situational analyses that reflect their unique national context.

In August 2021 a Regional tumour board for childhood cancer was established to facilitate peer consultation on complex case management with WHO support. The Board is coordinated by the Tata Memorial Hospital in Mumbai as the Secretariat. The Board discussed 18 complex cases across Member States between August and November 2021.

Multicountry stroke care improvement initiative

Globally, stroke is the second leading cause of death and the third leading cause of disability. One in four people are in danger of suffering from a stroke in their lifetime. Lifestyle risk factors for stroke include being overweight or obese, physical inactivity, tobacco use and alcohol-related harm. Medical risk factors include high blood pressure, high cholesterol, diabetes
and a personal or family history of stroke or heart attack. An estimated 70% of strokes occur in low- and middle-income countries. Stroke care services in the South-East Asia Region face several gaps in terms of the availability of services and quality of care.

Mortality and morbidity from stroke could be significantly reduced through organized stroke care, including the implementation of evidence-based clinical practice guidelines and quality care programmes. However, countries across the Region do not have well-structured guidelines for stroke care. This biennium, the Comprehensive Stroke Programme, a collaborative effort of Christian Medical College, Ludhiana, India, and WHO, was launched, with the aim of improving stroke care services in Bhutan, Maldives, Myanmar, and Timor-Leste. It was later also expanded to Nepal and Sri Lanka.

The programme is supporting countries to strengthen stroke management and referrals through the training of multidisciplinary teams consisting of doctors, nurses and rehabilitation therapists.

As part of this, in 2021 a series of trainings on scales used for stroke assessments was conducted, while Bhutan, Maldives and Timor-Leste set up stroke care teams and continuous training on stroke care in their respective national referral hospitals.

**Impact of training in Bhutan**

Following stroke assessment training in Bhutan, the first patient diagnosed with ischaemic stroke was successfully thrombolized at Jigme Dorji Wangchuck National Referral Hospital, Thimphu. Dedicated stroke beds for patients have been set up in the hospital, as part of the stroke care improvement initiative.
The Mental Health and Substance Dependence Unit of the HPN Department at the WHO South-East Asia Regional Office works to promote mental health and prevent mental, neurological and substance use disorders.

While mental, neurological and substance use disorders are common worldwide, almost three-quarters of people affected in many low-income countries do not have access to treatment and care. This biennium, particularly considering the COVID-19 pandemic, WHO continued to support and advocate for the expansion of access to affordable, quality care for everyone who needs it.

In disaster situations such as COVID-19, protecting the mental health of those who work in this field is equally important for them to deliver services effectively. In 2021, the Regional Office launched a mental well-being portal for its staff to communicate, share information and support each other.

To address the mental health impacts of the COVID-19 pandemic, the WHO South-East Asia Regional Collaborative Framework for coordinated response to mental health and psychosocial support (MHPSS) in emergencies was published in 2020. The Framework identifies six domains of action through which Member States can strengthen services for MHPSS support.

This includes integration of MHPSS into the national policy and legal framework, building resilience, establishing linkages and collaborative mechanisms, developing comprehensive and integrated responses, and strengthening information systems, evidence and research.

This biennium, the World Health Assembly approved an extension and update of the WHO Comprehensive Mental Health Action Plan (2021–2030) that replaced the WHO Mental Health Action Plan (2013–2020). The action plan has guided activities for the Region and when first developed, reflected a paradigm shift in the fundamental guiding principles for prevention, management and care for people with mental disorders, recognizing the essential role of mental well-being in achieving health for all.

The updated action plan includes four new targets and updated indicators, which reflect the knowledge gained over the past eight years since the previous plan was developed.
Two of the new targets relate to increasing the integration of mental health in community-based and primary health care services, while another relates to the inclusion of MHPSS in emergencies. Importantly, the action plan recommends the promotion of more responsible media reporting in relation to suicide – something that the team has been focused on this biennium.

WHO also launched a special initiative on mental health in two countries in the Region, Bangladesh and Nepal, funded by the Norwegian Agency for Development Cooperation (NORAD). This is a global initiative rolled out in all six WHO regions to increase access to comprehensive mental health services to at least 100 million people between 2019 and 2023.

With the COVID-19 pandemic affecting all aspects of life, this biennium more than ever illustrated the need for ongoing social investment in this area of work. Social restrictions and curtailment of activities, leading to a loss of daily income, added to the fear of the disease.

WHO, together with partners, facilitated the provision of guidance and advice to health workers, managers of health facilities, people looking after children, older adults, people in isolation and members of the public on how to promote and protect their mental health.

Similarly, this biennium the Mental Health Unit continued to address the harmful use of alcohol by supporting the
Regional Action Plan to implement the Global Strategy to reduce harmful use of alcohol in the South-East Asia Region (2014–2025).

The Plan aims for at least a 10% relative reduction in total adult per capita consumption per year by 2025 for all 11 countries of the Region. With the pandemic leading to unprecedented stress from unemployment, precarious work status and home-schooling, some countries took strong and swift measures to prevent widespread alcohol-related harm such as banning online sales.

**Enhancing media responsibility on reporting suicide**

The media plays a critical role in educating the public on mental health and suicide. But what is equally important is that journalists report sensitively and respectfully: the sensitive portrayal of suicide by the media is an important suicide prevention intervention. Responsible reporting also helps to educate the public and can encourage those at risk to take alternative action.

Throughout the pandemic, the reporting of deaths by suicide became newsworthy and was heavily publicized across the WHO South-East Asia Region. In response, the HPN Department engaged the Centre for Mental Health Policy and Law in India to undertake a desk review of the existing guidelines for suicide reporting in the Region. The review found that while several countries have formal guidelines in place, effective implementation remains a challenge.

The review made several recommendations including to the ministries of health and ministries in charge of media and communication to strengthen media regulatory bodies at the national and state levels in order to adopt, implement and monitor media guidelines on mental health and promote the responsible reporting of suicide. It also made recommendations to urgently engage with media professionals and the entertainment industry in a collaborative way to ensure the responsible depiction of mental health and suicide.

Simultaneously, two virtual focus group discussions with mental health and suicide prevention experts and media personnel from eight countries in the Region were also held. The purpose of the discussion was to discuss how the recommendations could be implemented.

**Efforts to curb alcohol misuse**

Despite efforts to reduce alcohol use, global alcohol consumption is rapidly increasing and expected to rise by more than 10% by 2030. The WHO South-East Asia Region is not immune to this growth. WHO’s *Global Status Report on*
Thailand addresses mental health during the COVID-19 pandemic

In March 2020 when the Royal Thai Government announced a national lockdown, the Ministry of Public Health (MoPH) reported that 18% and 76% of the population experienced high and moderate anxiety respectively. In response, the MoPH developed a national action plan to respond to mental health issues during the pandemic with WHO support.

As part of this, mass communication around mental health was strengthened. This included establishing hotlines and a LINE App chatbot. To help people at the individual, family and community levels to deal with COVID-19 mental health challenges, a “Community Mental Health Vaccine” was launched with 23 model communities established nationwide to design specific activities to promote a sense of safety and calm and to destigmatize COVID-19 infection. In addition, mental health services were adapted to the context, that included enabling patients to refill their medications through the postal service or drive-through services.

At the global level Thailand co-sponsored a resolution on “Promoting Mental Health Preparedness and Response for Public Health Emergencies” that was adopted at the 148th session of the WHO Executive Board. The resolution highlighted the need to support recovery from COVID-19 by promoting mental health and psychosocial well-being, building mental health services, strengthening preparedness and response capacity, and building system resilience for future public health emergencies.

Alcohol and Health 2018 estimates that alcohol is responsible for more than 25% of global deaths among people aged 20–39 years and kills more than 3 million people annually.

In the substance dependence arena, WHO’s work focuses on alcohol use – on advocating for policy change, particularly around taxation, marketing and restricting physical availability, and prevention of abuse. WHO recognizes that mental health problems and increased substance dependence are bidirectional – poor mental health may lead to increased substance use and vice versa.
India acts on alcohol during COVID-19

The COVID-19 pandemic threw up many challenges throughout the biennium and among them was increased substance use, with lockdown, isolation and the increased availability of alcohol making a potentially deadly combination. With several Indian states permitting online sales and home delivery of alcohol, WHO responded by preparing a policy brief on the harmful effects of alcohol use and the implications of new sale and delivery platforms. Seven states withdrew their online sale platforms after repeated advocacy on the harmful effects this would have on communities, illustrating the importance of advocacy at the policy level.

Other countries also followed India’s lead, including several provinces in Thailand that temporarily outlawed the sale of alcohol and Sri Lanka, where the National Authority on Tobacco and Alcohol (NATA) requested the government to ban the home delivery of alcohol.

Helping those in need: Telehealth and online resource hub for mental health and addictive disorders

Health-care providers from a range of disciplines encounter patients with mental health conditions and substance use disorders. Health-care providers need enhanced capacity to detect and treat mental, neurological and substance use disorders as co-occurring health conditions.

Given the dearth of resource allocation for mental health by national governments, strengthening of the health system...
Bhutan accelerates action on mental health during COVID-19

Before the virus arrived at Bhutan’s doorstep, a national COVID-19 task force was established to not only prevent the spread of the disease but also look after the mental well-being of the population. Not long after, Bhutan set up a national COVID-19 Mental Health and Psychosocial Response Team (MHRT) in Thimphu with WHO funding support. A 16-member team comprising mental health and counselling professionals was formed to:

- formulate national policy and plans on how to provide mental health counselling and psychosocial support to people affected by the COVID-19 pandemic;
- set up mental health and psychosocial counselling teams at the national, regional, district, municipal and community levels;
- set up telephone and online counselling services at the national, regional, district, municipal (Thromde) and community levels;
- develop standard operating procedures (SoPs) on providing mental health and psychosocial counselling services;
- train health workers, school counsellors, addiction counsellors, social workers, CSO workers and volunteers on the SoPs;
- provide psychological first aid (PFA) training to health workers, counsellors, volunteers (De-Sungs), security personnel, CSO staff and other frontline workers; and
- train health workers, counsellors and volunteers on mental health and substance use management and suicide prevention.

The MHRT has had a phenomenal impact on addressing mental health in Bhutan. For example, MHRTs were formed in all 20 districts of the country. These conducted over 200 online training sessions in mental health and substance use management for frontline workers; trained more than 20 000 frontline workers and volunteers on PFA; answered over 1600 calls for counselling services; and delivered numerous mental health messages through the media.

The project took advantage of one of the opportunities that arose out of the pandemic: to use technology to communicate, mobilize resources and train people. Bhutan’s strong telecommunication network allowed the MHRT to reach Bhutanese in the most remote parts of the country with life-saving mental health services, with WHO support.
through developing trained human resources poses a challenge.

The COVID-19 pandemic highlighted the relevance and importance of telehealth-based online platforms for learning. This biennium, a telehealth and online resource hub on mental health and addictive disorders for the WHO South-East Asia Region was established. The platform provides resources on suicide and alcohol use disorders, which continues to be used by health-care workers to enhance their capacity to detect and treat associated disorders.

By supplementing onsite training, health care can help overcome barriers such as time constraints and funding concerns, and can prepare the trainees for a better experiential learning during the hands-on training. The next step is to develop resources on other common mental health and addictive disorders.

Addressing the mental health needs of people engaged in health-care delivery during COVID-19

The COVID-19 pandemic led health systems across the world to be inundated with people needing mental health support. Equally important to supporting needs in the community is ensuring that health-care providers are adequately prepared and equipped to address and support their mental health needs. In response, WHO developed recommendations to address the mental health needs of health-care providers involved in the COVID-19 response. Such recommendations included self-help interventions and a self-assessment for the emergence of mental health issues that require external interventions.

Spreading mental health measures through the arts

This biennium, WHO took its guidance on mental health and turned it into a wide range of animated videos on an array of topics from a nine-part series on How to manage stress better, and a seven-part series on COVID-19 and mental health that included topics such as Working from home, Caring for the
elderly and Staying mentally healthy at home. The engaging videos are just a few minutes long and provide valuable health information to people across the Region including children, adolescents, health workers or parents.

WHO also conducted a “Healthier Population webinar series” to support countries in the Region to promote health and maintain essential health services during COVID-19. The eight-part series provided participants with invaluable knowledge on suicide prevention in the context of the pandemic by discussing with expert panelists suicide prevention strategies in the light of the COVID-19 pandemic; tools and guidelines on suicide prevention; and ways to address challenges within countries to the prevention of suicide.
This biennium brought unprecedented challenges with the pandemic dominating not just work in the Region, but across the globe. Despite the rapid development of vaccinations against COVID-19, new variants continue to emerge and cause havoc.

Ongoing challenges notwithstanding, the Regional Office for WHO South-East Asia remains committed to the health of every single person across the 11 countries of the Region.

Following are some of the areas of work that WHO will focus on in the coming biennium.

The NCD team will continue to provide strategic guidance to Member States to track and accelerate progress towards achieving the GPW13 and SDG 3 goals on NCDs prevention and control, including the Regional Implementation Roadmap. Work will continue to strengthen the delivery of NCD services through WHO PEN and PEN-plus interventions; strengthen stroke care by building on existing initiatives; build capacities including innovative solutions for diabetes and hypertension prevention, care and control; expand childhood cancer activities; and improve palliative care across the Region.

With COVID-19 still raging due to the emergence of new variants, and notwithstanding efforts in containing it through measures such as vaccination and movement restrictions, the mental health fallout from the pandemic will continue.

WHO, as the UN Specialized Agency for health, has an even a bigger role to play in the next biennium to advocate, advise and support countries to respond to the situation effectively, to coordinate efforts to prevent further pandemics, and address health-related issues including mental health in the aftermath of this global crisis.

Looking to 2022 and beyond, the Regional Office will support Member States to develop and implement national mental health action plans in line with the Global Mental Health Action Plan 2013–2030.
Building on the foundations laid in this biennium, the Water, Sanitation and Climate Change Unit will focus on further strengthening the climate resilience and environmental sustainability of health-care facilities, accelerating efforts towards integrated disease surveillance of climate-sensitive diseases, improving water quality surveillance, and promoting water and sanitation safety planning.

This will enable countries to progress towards meeting WASH health-care facility targets and related SDGs while contributing to reducing the burden of disease linked to drinking water, sanitation, hygiene and climate change. Addressing environmental determinants of health such as air pollution will continue to be a priority for the Region.

To continue the momentum, guidelines and tools will be further disseminated, along with additional training and capacity-building. There will be a sustained focus on addressing and including marginalized groups, to ensure that “no one is left behind”.

The Nutrition and Health for Development Unit will focus on addressing the double burden of nutrition. The team will continue to support countries in ensuring optimum diets for young children through appropriate complementary feeding and will consolidate efforts made in supporting regulatory attempts to reduce unhealthy diets such as elimination of transfat and reducing salt intake. The unit will continue to build capacity of countries to implement primary care life-course interventions to tackle child and adult overweigh/obesity, and will focus on addressing micronutrient deficiencies, which are a significant burden across the Region.

WHO will continue to build on the robust progress it has made on tobacco control in the Region. Tobacco control initiatives with focus on “Best Buys” – specifically raising taxes, strengthening smoke-free policies, and enforcing bans on TAPS (tobacco advertising, promotion and sponsorship) – will continue throughout 2022 and 2023.

In 2022, WHO will launch its “Commit to Quit” campaign with several new programmes that will build capacity for tobacco cessation. In addition, critical research on tobacco control will continue, especially smokeless tobacco in collaboration and coordination with partners at the regional and country level, while tobacco regulation will be strengthened and supported in view of new and emerging nicotine and tobacco products.

The Disabilities, Injury Prevention and Rehabilitation (DPR) Unit will focus on developing programmes and policies on strengthening efforts to reduce drowning and improve road safety across the Region by implementing recommendations that have been identified in previous reports.

This biennium there has been significant progress in building AT awareness and the next two years provide an opportune
time to build on the momentum to develop national AT policies and programmes in the Region. Additionally, working closely with country office counterparts, WHO will expand training programmes for the AT skills laboratory and advocacy initiatives to strengthen demand and referral pathways and increase access to appropriate technology and services, particularly in remote areas.

In the area of food safety, the team will continue to support Member States in implementing the Framework for Action on Food Safety in the Region and support Codex Trust Fund project activities in five countries. On physical activity, WHO will support the implementation of the Regional Roadmap for Implementation of the Global Action Plan on Physical Activity and will assist in the inclusion of physical activity in multisectoral action plans for the prevention and control of NCDs.

WHO is committed to sustaining achievements, accelerating progress, and making full use of innovative policies and technologies to achieve global, regional and country targets and goals. Health for all is not just a slogan – it can be a reality.
Home to over a quarter of the world’s population, the WHO South-East Asia Region has been hit hard by COVID-19 like all other regions. The pre-existing high rates of noncommunicable diseases and mental health conditions have been aggravated by both direct and indirect impacts of the pandemic. The Region also is highly vulnerable to natural disasters that have become only more frequent due to climate change.

This biennium report of the Department of Healthier Populations and Noncommunicable Diseases captures key lessons learnt during the biennium that witnessed the global pandemic and highlights essential next steps within WHO’s mandate for NCDs, mental health and health and the environment. The report draws on the opportunity presented by the pandemic to address health issues, such as NCDs, mental health and environment determinants, in innovative ways. It comes at a critical time as we sustain, accelerate and innovate our work towards the achieving the WHO Triple Billion targets as well as 2030 Sustainable Development Goals for health and well-being of our people and the planet, ‘leaving no one behind’.