Health and Development Challenges of Noncommunicable Diseases in the South-East Asia Region

Report of the Regional Meeting

Jakarta, Indonesia
1–4 March 2011

World Health Organization
Regional Office for South-East Asia

SEA/NCD/83
Distribution: General

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Printed in India

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Introduction

The WHO South-East Asia (SEA) Region is in the midst of an epidemiological transition—while infectious diseases are still prevalent, noncommunicable diseases (NCDs), such as cancers, chronic respiratory diseases, cardiovascular diseases and diabetes, are emerging as the most common causes of death. In addition, other NCDs such as mental disorders also significantly contribute to the disease burden. The increasing burden of NCDs is being fuelled by demographic changes (ageing population), unplanned urbanization, globalization of trade and marketing, social and economic determinants and progressive increase in unhealthy lifestyle patterns among populations of Member countries in the Region. In addition to their enormous negative impact on the health of populations, NCDs pose a serious social, economic and developmental challenge to the Region and are closely linked to poverty. The evolving epidemic of NCDs is, however, largely preventable by means of known, efficient and feasible public health interventions that tackle major modifiable risk factors — tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

To date, NCDs have largely been neglected in the health and development agenda by national and international leaders. However, global momentum is now building up to garner support for NCD prevention and control. The UN General Assembly Resolution A/RES/64/265 on the prevention and control of NCDs is a major recent development that could be a turning point in the global struggle against NCDs. The decision by the United Nations General Assembly to convene a High-level Meeting on NCDs in September 2011, with the participation of Heads of State and governments, presents a unique opportunity to get NCDs on the global development agenda, mobilize the international community to take action, secure the commitment of Heads of State to lead the cross-government effort necessary to reverse the epidemic, and send a clear message to donors and funding agencies to include NCDs on their agenda.

As a part of the preparation for and in particular to harmonize regional inputs for the High-level Meeting on NCDs planned for September 2011, the WHO Regional Office for South-East Asia (SEARO) organized a Regional Meeting for its Member States from 1 to 4 March 2011 in Jakarta, Indonesia with the following objectives:

- to share information on the NCD burden, and policies and programmes for the prevention and control of NCDs in Member States of South-East Asia (SEA) Region;
- to review information on the socioeconomic determinants and developmental implications of NCDs in the Region;
- to identify regional issues and challenges as inputs for the UN General Assembly High-level Meeting on NCDs; and
- to formulate recommendations on strengthening NCD surveillance, prevention and control using primary health-care approaches, capacity development, as well as building multisectoral and multilevel partnerships.

The Meeting was attended by 103 participants representing national governments of all the 11 Member countries of the Region, nongovernmental organizations and other civil society partners, international agencies, as well as the WHO Secretariat from country and regional offices and WHO headquarters (see Annex 1 for the complete list of participants). The technical deliberations of the four-day meeting spanned six plenary sessions, six panel discussions and three working groups (see Annex 2 for the complete programme of the Meeting).

Opening Session

The opening session included an address by Dr Samlee Plianbangchang, Regional Director for WHO South-East Asia Region followed by an inaugural speech by Her Excellency, Dr Endang Rahayu Sedyaningsih, the Health Minister of Indonesia. The objectives and expected outcomes of the meeting were presented by Dr Jai Narain, Director Sustainable Development and Healthy Environments WHO SEARO.

Dr Samlee Plianbangchang, welcomed the participants and emphasized the importance of the Jakarta meeting in contributing to the global voice against NCDs. He added that the socioeconomic determinants of NCDs including the vulnerability of life under constant pressure due to chronic stress and strain, need urgent attention. The evolving epidemic of NCDs is largely preventable by means of effective and feasible public health interventions that tackle the major modifiable risk factors, namely tobacco use, improper diet, physical inactivity and harmful use of alcohol. NCDs and their risk factors are closely linked to poverty. The economic fallout of NCDs is due to escalating cost of medical care, reduced productivity from premature deaths and disability and the increasing social and economic dependence. The Regional Director added that inaction in this priority public health area cannot be accepted or justified any longer. The WHO call for investment in health promotion and primary prevention of NCDs and the call for application of evidence-based approaches in NCDs management still needs to be translated into practice, from verbal commitments to concrete allocation of human and financial resources. Concerted multidisciplinary and multisectoral efforts in NCD prevention and control, for example through the national and regional networks (such as SEANET-NCD), are imperative to address the problems of NCDs.

The upcoming UN High-level Meeting on NCDs will focus on galvanizing multisectoral actions at global and national levels to address the health and socioeconomic impacts of NCDs in a more comprehensive manner through effective "multisectoral approaches". This UN meeting will be another important entry-point for advocating "Health in All Policies". The UN High-level Meeting is also expected to generate unwavering global commitment and momentum for the implementation of the WHO strategy for the prevention and control of NCDs.

The Government of Indonesia is showing a high commitment to NCD prevention and control and is among the leaders in this

regard in the SEA Region. Dr Plianbangchang hoped that the recommendations emanating from this meeting would further strengthen the determination and commitment to the effective implementation of the Regional Framework and Global Strategy on NCD prevention and control. The full text of his address is presented in Annex 3.

Her Excellency, Dr Endang Rahayu Sedyaningsih, Minister of Health, Government of Indonesia, in her inaugural address welcomed the participants to Indonesia and thanked WHO for organizing the meeting in Indonesia. Dr Sedyaningsih said that NCDs are a threat to development and impede poverty reduction initiatives. Her Excellency also highlighted some of the initiatives being adopted by the Indonesian government for the prevention and control of NCDs, such as their commitment on attaining Social Health Insurance and the establishment of Special Health Units to control NCDs. Dr Sedyaningsih shared the vision of the Ministry of Health to set up "self reliant healthy people within a just health care system" during 2010–2014. Efforts are being made to achieve this vision by reducing inequities as well as improving community access to health care in different geographical regions and socioeconomic groups. This health development reform, which includes NCDs, is being conducted to empower people on health issues, strengthen public health institutions by building up human resources and ensure the availability of drugs and equipments in health facilities.

Achieving universal coverage with social insurance schemes is important for NCDs as they cause catastrophic expenditures and push individuals and families into poverty. Her Excellency, provided data from Basic Health Research (of Indonesia's Ministry of Health) to show that NCDs contribute to 59.5% of deaths in Indonesia (up from 41.7% in 1995). The survey also highlighted the high prevalence of many NCDs and their common risk factors. Indonesia has given serious attention to tackling NCDs by setting up a special unit within its Ministry of Health for NCDs. It has adopted a comprehensive approach by including all stakeholders from the Government, private sector, professional organizations and civil society through the establishment of local and national networks. Dr Sedyaningsih also emphasized the need for international networking to speed up implementation of programmes and share information.

In Indonesia, NCD-related activities have been integrated into community-based health services and are implemented through Posbindu. Indonesia is highly committed to tobacco control, including an appropriate legislation to support it. There is also a programme to integrate Jamu (Indonesian traditional medicine). Dr Sedyaningsih called for more research on traditional drugs for the management of NCDs in Member States and strengthening cooperation between them in this regard. Her Excellency then declared the Regional Meeting officially open. The full text of her speech is given in Annex 4.

Overview of the Global and Regional Situation of NCDs

The first plenary of the meeting titled "Setting the scene—Global and regional overview of NCDs" was chaired by Dr Poonam Khetrapal Singh, WHO Deputy Regional Director for South-East Asia. Providing a context to the plenary session, Dr Singh mentioned that developing countries, while still having to deal with the control of communicable disease and maternal and child health issues, are also faced with the growing burden of NCDs. NCDs have long been neglected by international partners and by national policy makers. However, we can no longer afford to ignore NCDs. The Regional Meeting on Health and Development Challenges of Noncommunicable Diseases is an important opportunity to identify and discuss regional issues in the prevention and control of NCDs that can be taken forward and highlighted in the UN High-level Meeting in September 2011. The plenary included four presentations starting with the global situation, then moving to the magnitude of the burden and scoioeconomic impact at the regional level and finally to country perspectives from the host country, Indonesia.

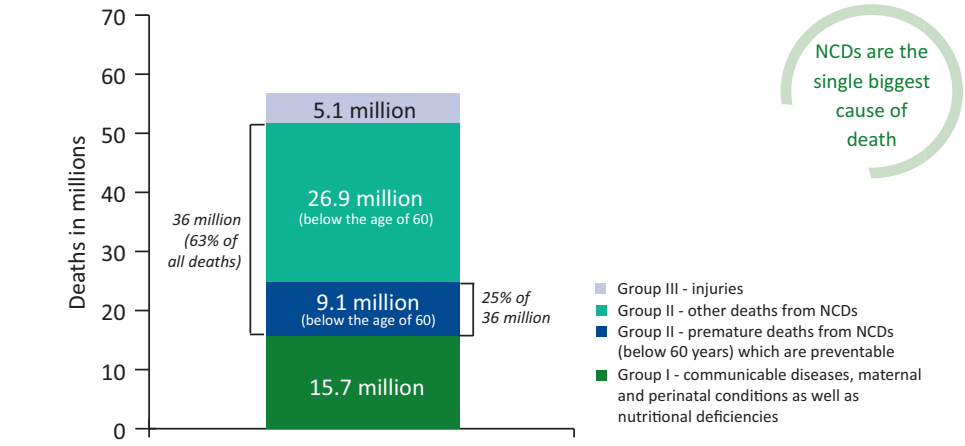
Disease burden

Dr Shanthi Mendis, Coordinator, Chronic Diseases Prevention and Management, WHO headquarters (HQ) made a presentation on the global situation of NCDs.

Noncommunicable diseases are the world's biggest killers causing 36 million deaths every year—63% of all deaths globally. Of the 36 million NCD deaths, about 9.1 million were premature (before 60 years) (Fig. 1). Almost 90% of these premature deaths occur in low- and middle-income countries and affect all WHO regions. Four major NCDs (cancers, cardiovascular diseases, chronic respiratory diseases and diabetes) and four behavioural risk factors (inappropriate diet, inadequate physical activity, tobacco use and harmful use of alcohol) are chiefly responsible for the NCD burden.

Dr Renu Garg, Ag Regional Adviser NCD, WHO/SEARO presented data on mortality, morbidity and risk factors of NCDs in the Region. An estimated 8 million deaths or 55% of the 14.5 million annual deaths in the Region occur on account of NCDs; this represents 22% of the global NCD deaths.

Figure 1. Number of deaths worldwide, by cause, 2008



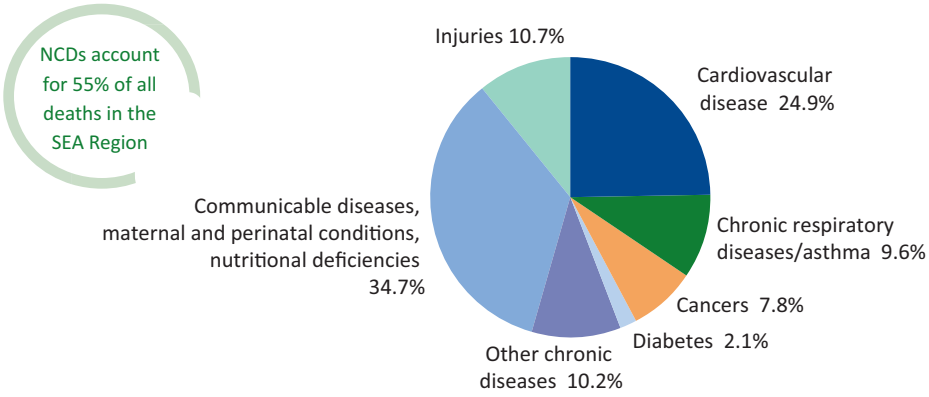
Source: Global status report on noncommunicable diseases. Geneva: WHO; 2010.

Among the NCDs, cardiovascular diseases (24.9%), chronic respiratory diseases/ asthma (9.6%) and cancers (7.8%) are the leading causes of all deaths in the Region (Fig. 2). Furthermore, the burden of NCDs in the SEA Region is expected to rise significantly in the coming years. A 21% increase in the number of deaths due to NCDs in the Region is projected during 2006–2015, whereas deaths due to infectious diseases are likely to fall by 16% during the same period. A significant proportion of NCD deaths in the Region are premature, i.e. occur in those below 60 years of age. Based on estimated attributable risk, raised blood pressure, raised blood glucose and tobacco use were rated as the three top risk factors for the Region. The available information from countries shows a high burden of all the risk factors in Member States of the Region. While the information on trends for risk factors from this Region is limited, available data show an increasing trend in some risk factors.

Socioeconomic dimensions

Dr JS Thakur, National Programme Officer, WHO India in his presentation elaborated on the social, cultural, economic and environmental determinants, which influence the development of risky behaviours in individuals and populations. The occurrence of disease in younger age groups, especially in the most productive years along with the reversal of the social gradient, in this Region was emphasized. High rates of illiteracy and poverty as well as low allocation of government budget on health persists in many Member States of the Region. Health systems are characterized by inadequate capacity of its workforce both in terms of quality as well as quantity to address NCDs. Health-damaging behaviours (such as smoking, drinking, consuming unhealthy diets) are driven by urbanization, technological change, market integration and foreign direct investment. The social

Figure 2. Estimated percentage of deaths, by cause, SEA Region, 2008

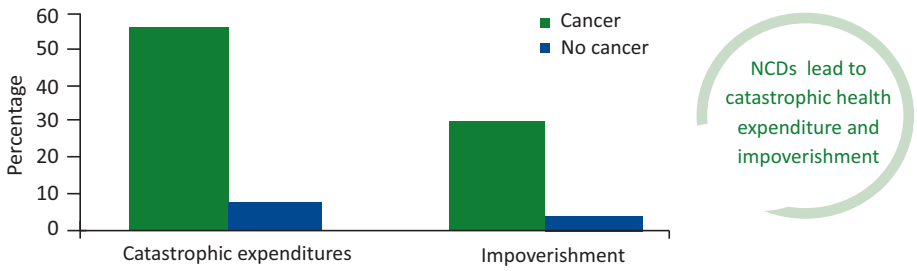


Source: SEARO website (http://www.searo.who.int/en/Section1174/Section1459_15765.htm), 2011.

gradient has started to reverse, especially in tobacco where the poorest in the poorer countries smoke the most and diseases like cancer lead to catastrophic expenditure and impoverishment (Fig. 3).

Poverty increases the risk of diseases, especially of NCDs due to high exposure to risk factors, and hampers access to diagnosis and treatment resulting in further worsening of disease. This results in higher disabilities and reduced work output as well as premature mortality. These, along with high treatment costs, result in catastrophic expenditure and further impoverishment. It is estimated that India loses rupees one trillion annually due to loss of income from NCDs; its GDP would have been four to ten times higher if not for NCDs. The total direct and indirect costs due to diabetes in India is estimated to be US$ 31 billion (US$ 28.5 billion to 38 billion). Poor coverage of health insurance and lack of a public health system

Figure 3. Percentage of patients with and without cancers, experiencing catastrophic expenses and impoverishment, India, 2004



Source: Mahal A, Karan A, Engelgau M. The economic implications of non-communicable disease for India. HNP Discussion paper. Washington:World Bank, 2010.

results in high out-of-pocket expenditure for individuals. Thus interventions addressing socioeconomic dimensions of health should focus on microeconomics (microfinancing and social health insurance), macroeconomics (higher allocation to health, taxation and other fiscal measures), and regulatory approaches to industry and marketing of unhealthy products and strengthening of primary health-care systems.

Dr Tjandra Yoga Adhitama, Director-General of Disease Control and Environmental Health, Ministry of Health, Indonesia, presented "An overview of NCD prevention and control in Indonesia". He showed evidence of increasing burden of NCDs in Indonesia. The proportion of deaths due to NCDs in Indonesia increased significantly from 42% in 1995, to 50% in 2001 to 60% in 2007. Among the NCDs, strokes, heart diseases, hypertension, diabetes and cancers account for the majority of the deaths. Tobacco use, lack of physical activity, insufficient intake of fruits and vegetables and overweight/obesity are among the most common risk factors for NCDs in Indonesia. Dr Adhitama also called attention to the increasing trend of smoking among teenage boys and girls. To address the increasing burden of NCDs, the Directorate of Noncommunicable Disease Control was started in 2005 to focus on strengthening legislation for prevention of NCDs, surveillance, information, education and communication and early detection of NCD risk factors. Dr Adhitama concluded his presentation by re-emphasizing that NCDs are increasing and the Government of Indonesia consider NCDs as an important public health problem.

Status of prevention and control of NCDs

In the plenary titled, "Strategies and interventions for NCD prevention and control", chaired by Dr Tjandra Yoga Adhitama, Director-General of Disease Control and Environmental Health, Ministry of Health Indonesia, a broad overview of the global and regional strategies for prevention and control of NCDs was discussed.

Dr Shanthi Mendis, Coordinator, Chronic Disease Prevention and Management, WHO presented the current scenario and new developments in NCD prevention and control at the global level. Dr Mendis emphasized that NCDs need to be addressed by all sectors of the government and society for creating environments conducive to healthy lifestyles. The World Economic Forum estimates that NCDs are the third most important global risk, ranking only after food pricing volatility and oil spikes in severity and much ahead of the recent global financial crisis. However, global commitment to NCDs and the official development assistance do not reflect this importance.

Dr Mendis outlined the global endeavours to galvanize efforts for NCD prevention and control from the Caribbean Community and Common Market (CARICOM) in 2007 and the Economic and Social Council (ECOSOC) and Commonwealth States in 2009. These provided the initial fillip, which culminated in the "United Nations General Assembly Resolution A/RES/64/265 Prevention and Control of NCDs". This resolution mandates the holding of the UN High-level Meeting in

September 2011 to which this meeting will also provide inputs. WHO is facilitating the process of consultation with all stakeholders including the private sector and civil society as well as among the different WHO regions. Dr Mendis also traced the major initiatives undertaken by the WHO since 2000 when the Global Strategy for Prevention and Control of NCDs was formulated. The Strategy is three-pronged — surveillance (mapping the epidemic), prevention (reducing the level of exposure to risk factors) and management (strengthening health system for people with disease), and along with the six objectives of the Global Plan of Action (that focus on advocacy, policy development, primary prevention, research and partnership development, as well as monitoring and evaluation), can address the problem of NCDs. Dr Mendis apprised the participants of the different activities undertaken by the WHO to fulfil these objectives.

The Regional Framework for NCD Prevention and Control, developed in 2006 and endorsed by the Regional Committee in 2007, was presented. Elements in the Framework include: situation assessment, surveillance, reduction in major risk factors for NCDs through population-based approaches, early disease detection and management through primary health care and monitoring and evaluation. Dr Anand Krishnan, All India Institute of Medical Sciences, New Delhi presented the findings of the 2010 national capacity assessment survey. The survey was based on an adapted WHO Questionnaire with national NCD focal point persons as the respondents. The Questionnaire included five major segments relating to different aspects of NCD prevention and control: (i) public health infrastructure; (ii) policies/strategies/plans; (iii) health information systems; (iv) health system; and (v) partnerships, which also reflect the different aspects of the Regional Framework.

It is evident from Table 1 that most Member States in the SEA Region are responding to the NCD epidemic through an integrated plan, including legislation. The result of this survey was compared to two similar surveys conducted in the Region in 2000 and 2006. Significant progress has been noted since 2000 in the Member States on different aspects of NCD prevention and control particularly in the following areas:

- presence of separate units/departments within the ministries of health working in NCD prevention and control;
- allocation of the government budget for NCD activities;
- presence of policies/strategies/ programmes which are integrated and comprehensive;
- establishment of mechanisms to broaden the base of stakeholders involved in NCD prevention and control;
- use of fiscal and regulatory measures for influencing behaviour;
- move from ad hoc surveys to a more sustainable surveillance mode for NCD risk factors; and
- presence of guidelines for the management of certain NCDs, such as diabetes mellitus and hypertension.

The areas of concern where little progress was noted included:

Table 1. Progress in capacity for NCD prevention and control achieved by Member countries of the WHO South-East Asia Region, 2001–2010

Indicators	Number of countries 2001[a]	2006	2010
Total number of participating countries	*10*	*11*	*11*
1. Unit or department for NCD prevention and control in MOH present	4	8	11
2. Allocation for NCD prevention and control in regular budget of MOH	6	7	11
3. Public health policy/strategy in the areas of NCDs present	4	7	9
4. Legislation related to tobacco present	8	10	10
5. Measurable targets set for NCD prevention and control	4	6	11
6. Population-based mortality data available	7	NA	5
7. Morbidity data included in national health information system	7	8	11
8. Risk-factor surveys based on STEPs approach	0[b]	9	10
9. National guidelines for management of hypertension available	6	4	8
10. National guidelines for management of diabetes available	7	8	8
11. Equipments at PHC level for diagnosis of hypertension available	10	NA	11
12. Equipments at PHC level for diagnosis of diabetes available	8	NA	9

[a] *Timor-Leste was formed in 2002 and therefore is not included in the survey for 2001.*
[b] *STEPs NCDRF surveys were introduced in the Region in 2001.*
MoH = Ministry of Health, PHC = primary health care

Source: Country reports submitted by Member countries to WHO SEARO.

- persisting weak mortality and morbidity surveillance systems;
- inadequate workforce capacity and equipment support at primary care level;
- lack of focus on home care for chronic diseases; and
- inadequate availability of high-cost treatment in the public sector and poor insurance coverage.

The need for a more comprehensive assessment of national capacities, which includes a qualitative component, stronger capacity development initiatives and generating evidence for effectiveness of interventions in the Region to support advocacy initiatives, was emphasized.

The first panel discussion titled" Policies and programmes for scaling up NCD prevention and control interventions" was moderated by Dr Praveen Mishra, Secretary, Ministry of Health and Population, Government of Nepal and Dr Dorji Wangchuk, Director General Health Services, Ministry of Health, Royal Government of Bhutan. Country presentations were made by representatives from India, Srilanka, Thailand, Timor-Leste and Bangladesh. The panel discussed key challenges in scaling up interventions at the country level. The Member countries also presented posters on the situation in their respective countries, which are summarized in Annex 5.

Strategies for Prevention and Control of NCDs

Building evidence for action

The important issue of building an evidence-base for NCD prevention and control was discussed through two panel discussions. The first one on strengthening surveillance was moderated by Professor Tint Swe Latt and Professor Rajesh Kumar. The speakers for this discussion were Anand Krishnan, M Mostafa Zaman, Jureephon Congprasert and Ri Yu Hyok. The second panel discussion on developing and taking the NCD research agenda forward, which was moderated by Ms Maw Maw and Dr Jai Narain, had Bela Shah, Ahmed Masud, Chandrika Wijeyaratne and Shanthi Mendis as the speakers. The gist of the presentations and discussions that followed are presented below.

Surveillance

A sustainable surveillance system is essential for regular collection and provision of information for programme planning and monitoring. Surveillance systems help to assess the current burden of a problem. They are both an entry point for programme planning as well as an end point in terms of evaluating the impact of prevention and control programmes by measuring the change in the burden. The information requirements for NCDs include data on mortality, morbidity, risk factors and underlying socioeconomic determinants.

Currently, not much information is being collected on health systems (cost and quality of care as well as equity and access to care) and non-health factors (such as social determinants, fruit and vegtetable pricing and amenities for physical activity) in the Member States of the SEA Region. The deliberations revealed that collection of data on non-health determinants, which can complement this information (such as urbanization, legislative and fiscal measures), and health system needs should also be initiated. Similarly, more information on the economic aspects of NCDs are also required to be collected from Member countries to enable them to make an "economic" case for investment in NCD prevention and control.

Several issues regarding weak surveillance systems, such as inadequate commitment to NCDs surveillance, inadequate funding of surveillance and inadequate capacity in Member States for

NCD surveillance, were identified during the discussions (Annex 6). In addition to risk factor surveillance, the need to improve disease and mortality surveillance were also emphasized. Strengthening of institutional and human resource capacity to conduct NCD surveillance and prioritizing these suggestions to country-specific conditions were also proposed. Improving data utilization for programme planning especially at lower levels of the system and better mapping and linkage of data through networking were also suggested.

Research

A prioritized research agenda for NCDs has already been developed by WHO through a process of multiple stakeholder consultations. In the process of the deliberations, 111 research priorities were identified within 11 specific and cross-cutting NCD domains (viz. cancers, cardiovascular diseases, chronic respiratory diseases, diabetes, human genetics, nutrition, obesity and physical activity, social determinants, primary health care approach, tobacco, translation of evidence into policy and programmes). The research priorities were ranked by expert groups and scored for: relevance for low- and middle-income countries (score 1–5), feasibility in low-resource settings (score 1–5), potential public health impact (score 1–5), and estimated time to perceive the effect of research applications (<5 years, 5–10 years, >10 years). Finally, 20 research priorities across five categories were identified (Annex 7). These related to domains for: placing NCDs in the global development agenda and for monitoring (2 domains); understanding and influencing the macroeconomic and social determinants of NCDs (9 domains); translating research and health system research for global application of proven cost-effective strategies (8 domains); and enabling expensive but effective interventions to become accessible and be used appropriately in resource-constrained settings (1 domain).

The presenters from the Region identified the knowledge gaps related to burden of disease and its risk factors, and low-cost interventions for NCD prevention and control as important areas for further research. The need for formative research (to understand behaviours for designing culture-sensitive health interventions) and operational research (to integrate NCDs management into primary health care), as well as research for strengthening an economic or investment case for NCDs were discussed. The lack of data on economic determinants of NCDs was highlighted. The key strategies recommended to promote research in Member countries were to increase funding for research, create partnerships and collaborations with different research agencies/councils, and for a stronger focus on dissemination and linkage to action. The participants reiterated the importance of involving policy makers and programme managers at the research formulation stage, and also the need to sensitize them as they usually do not have a technical background.

Primary prevention

The treatment of NCDs is lifelong and costly. Thus, reducing the exposure to risk factors and thereby impeding the development of disease is the primary and most cost-effective strategy. The involvement of sectors other than health has a major impact on shaping the physical and social environments that determine "risk" behaviours. Therefore, interventions for NCD prevention and control have to be multisectoral and multidisciplinary and act at multiple levels. The deliberations emphasized that mechanisms need to be created for such interactions and involvement. Since the private sector has a major role to play in influencing the consumption levels of tobacco, alcohol and dietary items, the participants felt that its involvement needs to be regulated by fiscal and legislative measures.

Identification of key strategies for the primary prevention of NCDs was covered through two panel discussions (important strategies of health promotion and legislation). The panel discussion on health promotion was moderated by Dr Gopal Acharya and Dr Azimal, and Ismoyowati, Surendra Shastri, Ugen Norbhu, Ali Murthala and Adisak Sattam were the speakers who shared their regional experiences. The panel discussion on the role of legislation in NCD prevention and control was moderated by BK Prasad and Hajera Mahtab, and the speakers were Prakit Vathesatogki, Lakshmi Narayan Deo, Dhirendra Sinha and Azam-E-Sadat.

Health promotion

Primary prevention through health promotion has been adopted as a strategy in all Member countries. All countries reported the presence of mechanisms for establishing partnerships between different sectors. While the use of fiscal measures to influence behaviours and legislation for tobacco control was being used in 10 countries, legislation for regulating the marketing of foods to children is being practiced in only three of the Member countries.

Regional experiences shared from Bhutan, India, Indonesia, Maldives and Thailand showed that the key strategies for health promotion are about building healthy policies, creating supportive environments, strengthening community action and developing personal skills for behaviour change. These need to be supported by reorienting health services. The challenges identified by the participants were lack of policy support due to non-inclusion of NCDs in the Millennium Development Goals (MDGs) and underestimation of its burden a well as lack of competence and capacity of health professionals. This has resulted in poor advocacy efforts and lack of active community participation. The absence of an integrated approach and coordination among partners were also identified as challenges. The role of media and marketing of products were discussed and identified as important opportunities.

Dr Shanti Mendis apprised the participants of WHO's efforts to prepare price tags for "best buys" in NCD prevention.

An intervention was defined to be highly cost-effective if the cost of one extra year of healthy life was less than the per capita gross domestic product (GDP) of that country. Based on available evidence, interventions identified under the Framework Convention on Tobacco Control (FCTC), such as taxation and restriction of availability of alcohol, and reducing salt intake in diet, are considered as "best buys". Estimates of their cost and effectiveness were also presented.

The discussions emphasized the need for generating information on costs and benefits of other preventive strategies and highlighted that such estimations of cost-effectiveness should be at the national level to support evidence-based policy formulation. The participants requested WHO to strengthen the regional capacity to conduct such economic evaluations. Not much experience was shared on the role of urban planning or on promotion of diet and physical activity or reducing harm due to alcohol. The use of a healthy settings approach especially in schools and workplaces was emphasized. Modification of school curricula and provision of healthy food alternatives in schools and workplaces has already been attempted and the effectiveness of these strategies has been proven in the Region, however these need to be disseminated.

Legislation

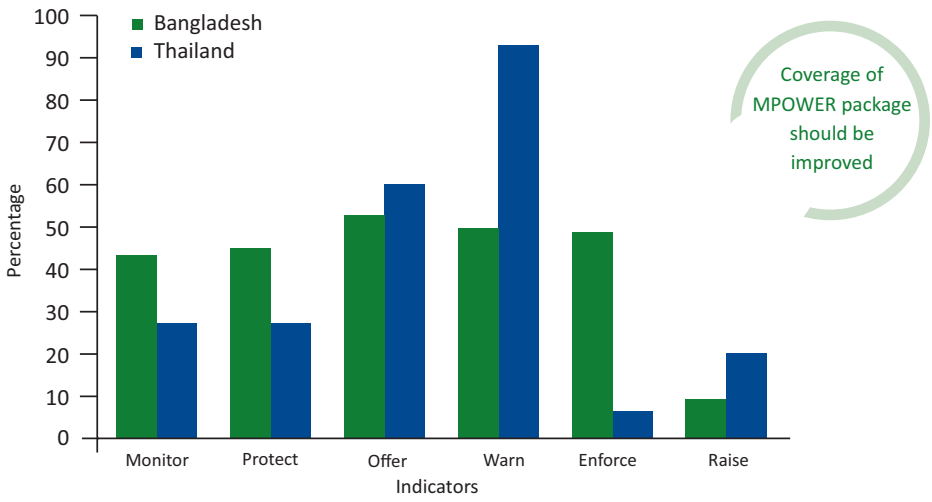
The discussion on the role of legislation primarily focused on the implementation of FCTC in the Member States. The FCTC has been ratified by 172 countries globally and 10 countries in the SEA Region. The MPOWER policy package formulated based on the FCTC includes the following

- **M**onitor tobacco use and prevention policies (Article 20-22)
- **P**rotect people from tobacco smoke (Article 8)
- **O**ffer help to quit tobacco use (Article 14)
- **W**arn about the dangers of tobacco (Article 11)
- **E**nforce bans on tobacco advertising, promotion and sponsorship (Article 13)
- **R**aise taxes on tobacco (Article 6).

Data and experiences that were presented from Member countries emphasized the differences in the nature and implementation of the legislation among the Member States of the Region. Figure 4 compares the different aspects of the MPOWER package in Thailand and Bangladesh. The experience from Myanmar, which reduced tobacco taxes in the country to encourage local production, demonstrates the complexity of tobacco taxation and the need to address other sectors, such as finance and commerce.

There was a concern over non-inclusion of smokeless tobacco in most of the legal provisions and the possibility of people shifting from smoked to smokeless tobacco use. The deliberations brought forth that no global legal frameworks exist for alcohol, diet and rational use of drugs. A need for global instruments, especially for marketing foods for children, generating evidence for proving the effectiveness of these

Figure 4. Status of implementation of MPOWER package in Thailand and Bangladesh, 2009



Monitor: Current tobacco user
Protect: Adults exposed to tobacco smoke at the workplace during the past 30 days
Offer: Smokers who were advised to quit by a health care provider in past 12 months
Warn: Current smokers who thought about quitting because of a warning label
Enforce: Adults who noticed cigarette marketing in stores where cigarettes are sold
Raise: Cigarette expenditure of per capita income

Source: Global Adult Tobacco Survey, Bangladesh and Thailand Reports, 2009.

interventions, and resources for implementation of legislative and fiscal measures, was reiterated. The discussions also revealed that a high-level national multisectoral committee to monitor the progress under FCTC has contributed to effective implementation of the WHO MPOWER package.

Continuum of prevention, early detection, treatment and care

While prevention is the key strategy for reducing the burden of NCDs, the outcome of the discussions emphasized the need to address the requirements of people already affected with NCDs. An example of continuum of care from prevention of diseases to early detection to curative services and palliative care can be illustrated from prevention and control of cancers. Evidence presented from clinical trials on primary preventive strategies for common cancers (cervical, breast) showed that these are effective and doable even in low-cost settings.

While access to curative care through primary health care is necessary, one often-neglected component of comprehensive care, especially for NCDs, such as cancers, is

palliative care. The experience of providing palliative care at the community level in Kerala, India has shown encouraging results. Of the 350 palliative care units in India, 305 (90%) are in Kerala. More than 50% of the subjects requiring palliative care in Kerala are being covered which is far higher than the national average of 1%. This has been achieved through the development of a network of trained volunteers in the community who are supported by trained professionals, institutions and organizations. The services include emotional and social support to patients and family as well as institutional care. This has proved to be a successful local model, which needs to be replicated in other parts of India and the Region.

Primary Health Care Approach for Prevention and Control of NCDs

Health systems need to be reoriented to a primary health care approach to effectively respond to the increasing burden of NCDs. The treatment costs of many of these diseases (such as cancers, acute coronary syndrome, etc.) are prohibitive, which is one of the important reasons for families being pushed into the debt–poverty cycle. Many of these diseases are chronic, thereby requiring life-long treatment. Modifying health systems to provide equitable and cost-effective management of major NCDs is a key challenge in low-resource settings. Provision of these services at the primary health care level in public health facilities can protect the population from the adverse effects of high treatment costs of these diseases. The results of the national capacity survey showed that countries are already addressing NCDs through primary health care.

A panel discussion on "using primary health care approach to prevent and control NCDs", moderated by Dr Shanthi Mendis and Dr Dorji Wangchuk, had Sudhansh Malhotra, WMCP Wijesinghe, Dorji Wangchuk, Suresh Kumar and Arjun Karki presenting their experiences. The deliberations brought forth that the underpinning principles of primary health care are equity, universal coverage, intersectoral collaboration, community participation and use of appropriate technology. All of these are valid for NCD care services as well. While, the concept of primary health care has evolved since it origin in 1978 at Alma Ata and grown to include NCDs, it has also been realized that primary health care is not "cheap" care. Primary health care requires considerable investment but is good value for money.

The WHO Package of Essential Noncommunicable (PEN) Disease Interventions is a relevant initiative in this regard. The components of PEN include political commitment, community mobilization, training of health workers, availability of essential drugs and technologies, intersectoral collaboration, and supervision and monitoring. The experiences of implementing PEN in Sri

Lanka and Bhutan demonstrated that this intervention resulted in bringing NCD prevention and control more accessible to the community. The constraints identified were inadequate human resources, need for standard recording tools, interrupted drug supply and inadequate coordination between curative and preventive services. There is however a need to revise protocols and referral linkages, and standardize training of health workers. Both the countries are planning on the expansion of the project.

The participants recognized that underfinancing of primary health care has been a major problem in the past and that costs for NCDs need to be calculated and advocacy increased for better financing. It was also emphasized that the health system should provide a continuum of care from primary to tertiary level.

Advocacy, Innovative Financing and Resource Mobilization

A prerequisite for expanding NCD prevention and control activities in the Member countries of the SEA Region is the availability of necessary resources in terms of human, institutional and financial support. The commitment of countries to NCD was evident from the results of the capacity survey, which showed that these programmes were now being increasingly funded by a regular government budget. Health insurance was not a major source of funding in any of the countries, and "sin tax" was important only in two countries. Out-of-pocket expenditure was the main source of funding for NCD management services in the Member States of the Region. Innovative approaches are needed to improve the financing of NCD programmes. A panel discussion on innovative financing and resource mobilization for the prevention and control of NCDs, moderated by Hasbullah Thabrany and Chet Raj Pant, deliberated on what strategies can be used for resource mobilization, what lessons can be learnt from the countries, and the way forward for resource mobilization in the Region. The panelists were Louise Baker, Supreda Adulayanon, Kulakarn Tantitemit and Cherry Mang Mann.

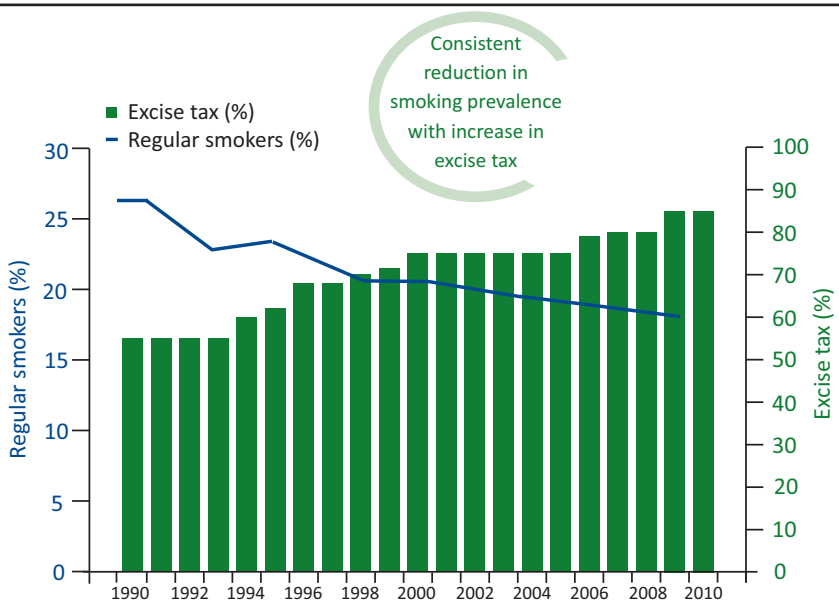
The discussions revealed that the possible sources of funding could be public or private. A publically funded programme is preferrable as it ensures equity and sustainability. The source of public funds could be through taxes (income, sales, property, export/import and on specific items labeled as "sin tax") and social health insurance. The amount earned as taxes from the sale of cigarettes was more than the health budget in many countries. The current government allocation to health and NCDs within the health budget is inadequate. The example of the Thai Health Promotion Foundation demonstrates that increase in taxes on tobacco led to a decrease in smoking prevalence (Fig. 5). This should be promoted as an important strategy for resource mobilization. The scope for taxation should expand beyond cigarettes and alcohol to include handrolled bidis, smokeless tobacco products, junk foods, etc.

The panel discussion highlighted that an increase in investments is important to push NCDs as a good "political" case to policy-makers and an "investment case" to economists and planners. There is a need to put a "face" to the hardships caused by NCDs to make an "emotional" case (e.g. death and disability of an adult in a family also has implications for children and their education). The participants felt that sufficient economic evidence also needs to be generated to highlight NCDs as a developmental challenge. They also felt the need to convincingly show that prevention and control of NCDs reduces poverty and promotes equity. They felt that many lessons can be learnt from the HIV/AIDS experience in this regard.

Apart from increasing government allocation, considerable funds are also available in the Region as philanthropies and charities, which are not being adequately tapped for NCDs. The participants, however, realized that the current financial crisis made it difficult to generate resources in the international arena where it has not been possible to even keep the commitments made under MDG 8 by the partners.

Finally, the participants agreed that the focus has to be on generation of resources within the country as the only means to ensure a sustainable programme. It is also important to put appropriate mechanisms in place to manage the funds so generated, so that these are utilized in an efficient and transparent manner.

Figure 5. Trends in smoking prevalence and excise tax, Thailand, 1990–2010



Source: National Statistics Office 2010; Excise Department, Ministry of Finance, Thailand.

Perspectives from Partners and Civil Society

On behalf of the Nepal Public Health Foundation, Dr Mahesh Maskey presented the deliberations and recommendations from the "Regional Civil Society meeting on NCDs" held in Kathmandu in January 2011. The meeting in Kathmandu was attended by civil society partners from eight Member countries of the SEA Region who presented the situation in their respective countries with regard to NCD prevention and control initiatives. These were followed by panel discussions on the role of civil society partners, policy options on NCDs in relation to MDGs and the UN High-level Meeting and promotion of regional collaboration. Finally after intensive discussions, a "Kathmandu call for action on NCDs" was drafted (Annex 8).

Ms Ranjit Singh, representative from the Union for International Cancer Control, made a statement on behalf of the 17 partner agencies present at the meeting (Annex 9). She called upon the Member States to ensure the highest level of political support for investing in the consultation process leading up to the UN High-Level Meeting and encouraging strong participation of civil society at the UN High-Level Meeting.

Ms Vanessa Baugh of the Commonwealth Secretariat remarked that for NCDs to remain a Commonwealth priority, it is imperative to maintain country support, ministerial enthusiasm as well as encourage and empower civil society organizations in the field. She said that the Secretariat is committed to supporting Member countries to conduct assessments of their NCD burden and determinants, develop analytical products, develop a media strategy to increase reporting on NCD-related issues at the country level, as well as organize and participate in dialogues across sectors.

On behalf of the Global Health Council, Dr Craig Moscetti emphasized and supported five major points: (i) that civil society is a key partner to prevent and control NCDs and should be enabled to serve an active role in partnership; (ii) that national governments must play a central role in prioritizing and implementing NCD programmes, including those in partnership with international donors; (iii) that existing infrastructure and platforms, in part due to communicable disease investments, can serve as important strategic links for NCDs

and contribute to improving overall health systems; (iv) that WHO plays an essential technical and normative role for NCD prevention and control; (v) and that the UN High-Level Meeting is an unprecedented opportunity to put NCDs on the global health and development agenda.

Dr Ratna Devi of the Chronic Care Foundation, reiterated that civil society should be an essential partner in the advocacy for prevention and control of NCDs, and that the voice of civil society should be included in key messages for the upcoming UN High-level Meeting.

Dr Vijay Vishwanathan, representing the WHO Collaborating Centres, briefly highlighted the possible role of WHO Collaborating Centres in implementing the Action Plan for the Global Strategy for Prevention and Control of NCDs by WHO. He ensured that the Centres, in accordance with the expected outcomes of the UN High-level Meeting, were eager to help WHO to implement building of capacity for epidemiological research in NCDs and support community-based interventions at the regional level.

All partners assured their support in advocacy efforts to ensure high-level political support. They also agreed that the UN High-level Meeting is a critical opportunity to put NCDs on a global health and development agenda. They requested the WHO on the need for greater involvement of civil society partners in WHO meetings preceding and at the UN High-level Meeting. They also requested the appointment of a high-profile NCD champion under the UN to liaise with the task force and the private sector, to act as a special envoy for the UN High-level Meeting, and to work closely with UN and WHO staff responsible for organizing and coordinating the UN High-level Meeting.

Regional Inputs for the UN High-level Meeting on NCDs

The particpants of the meeting conferred in three working groups on the key messages for the UN High-level Meeting. The broad areas discussed by the working groups were: (i) policy issues, (ii) resource mobilization, and (iii) intersectoral collaboration and partnerships. The three groups were provided with special guidelines for discussion. Each group discussed the issues in the area assigned and presented their recommendations and key messages to the all the groups in the subsequent plenary session. The three group presentations were subsequently summarized into ten key messages emanating from the South-East Asia Region for the UN High-level Meeting.

Ten Key Messages

1. Declare NCDs as a global health and development emergency requiring an urgent response, and declare 2011–2020 as the Decade of Combating NCDs.
2. Include NCDs in the current UN Millennium Development Goals and any subsequent similar global commitments.
3. Use a public health approach based on the principles of primary health care for combating NCDs; for this, strengthening health systems, particularly delivery of health services is critical.
4. Mobilize, facilitate and monitor multisectoral involvement in the government agencies, nongovernmental organizations (NGOs) and the private sector in the planning and implementation of NCD programmes with health as the nodal agency and including other agencies such as education, agriculture, transport, urban planning, industry, finance, media, law, food and drug, pharmaceuticals, environment, religion, human resources and youth affairs.

5. Develop and implement a multisectoral national NCD policy and integrate it into the existing national health and development programmes/five-year plans.
6. Establish high-level national NCD committees with multisectoral involvement to plan, implement, monitor and coordinate national NCD control programmes, headed by the highest office, such as the Prime Minister/President.
7. Provide specific allocation for NCDs within the health budget and prioritize allocation for primary prevention of NCDs; ensure adequate support for research on NCD prevention and control.
8. Generate revenue for NCDs from taxes levied on tobacco, alcohol and sugary beverages; provide appropriate incentives to producers of healthy food choices, such as fruits and vegetables; and consider concession for industries that reimburse workforce costs of NCD prevention interventions.
9. Generate resources for NCDs through domestic and international sources and ensure that NCDs are an essential part of official development assistance budgets.
10. Set measurable indicators and targets and monitor progress in the prevention and control of NCDs at regular intervals, at the national and global levels.

Conclusions and Recommendations

The Jakarta Call for Action, drafted during the three-day Meeting, was presented during the concluding plenary. It was unanimously adopted as a Regional input for the UN High-level Meeting (Annex 10).

The participants noted that NCDs are the leading cause of preventable morbidity and premature mortality and a development threat to all countries of the Region. In view of the overwhelming health, social and economic burden posed by NCDs, the prevention and control of NCDs merits urgent attention by all stakeholders at national, regional and global levels. The following specific recommendations are made for Member countries, WHO and other partners.

Recommendations for Member Countries

1. Accord top priority to the prevention and control of NCDs by including it in the development and health policies and plans of the country.
2. Allocate sufficient resources within the health budget for NCDs and prioritize funding of prevention and early detection and management of NCDs at the primary health care level.
3. Set up sustainable mechanisms for conducting systematic surveillance for priority NCDs and their biological and behavioural risk factors as well as underlying social determinants.
4. Scale up a package of cost-effective interventions, including health promotion and primary prevention interventions as well as appropriate legislations to create an enabling environment for healthy choices.
5. Develop and support implementation of priority national NCD research agenda with a particular focus on generating evidence on socioeconomic determinants and economic consequences of NCDs.
6. Explore and tap resources for NCDs from domestic and international sources.

Recommendations for WHO and other partners

1. Continue to create high-level advocacy for NCDs at international, regional and national levels.
2. Support Member countries in conducting high-level multisectoral meetings on NCDs at the country level as preparation for the UN High-level Meeting in September 2011.
3. Support Member countries in NCD policy formulation and implementation.
4. Provide technical support in NCD surveillance, monitoring and evaluation and promote research at the country level.
5. Calculate a country-wise price tag for NCDs in SEA Region.
6. Provide technical support to countries in resource mobilization.
7. Include an agenda item on NCDs in the WHO SEA Region Health Ministers Meeting in September 2011.
8. Organize a Regional Meeting of NCD programme managers after the UN Summit to discuss the way forward.

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Annex 2
Programme

Tuesday, 1 March 2011

0830 – 0900 Registration

0900 – 1000 Opening Ceremony

- Welcome – Master of Ceremony
- Meeting objectives and expected outcomes, Director SDE, WHO SEARO
- Address by WHO Regional Director for South-East Asia
- Inaugural address by Her Excellency the Minister of Health, Republic of Indonesia
- Group photograph
- Tea/coffee

1030 – 1230
Plenary: Setting the NCD scene—an overview of the global and regional situation
Chair: Dr Poonam Khetrapal Singh, WHO Deputy Regional Director for South-East Asia
Speakers:

- Global situation of NCDs and new initiatives: Shanthi Mendis
- NCDs in South-East Asia Region - Magnitude of the problem: Renu Garg
- Socioeconomic dimensions of NCDs in the South-East Asia (SEA) Region: JS Thakur
- Country perspectives, Indonesia: Tjandra Yoga Adhitama

Discussion

1230 – 1400 Lunch and display of country posters

1400 – 1515
Plenary: Strategies and interventions for NCD prevention and control
Chair: Tjandra Yoga Adhitama
Speakers:
Global Strategy, Action Plan and Priority Activities: Shanthi Mendis
Regional NCD framework and progress made: Renu Garg/Anand Krishnan

Discussion

1515 – 1530 Tea/Coffee break

1530 – 1700
Panel Discussion 1: Policies and programmes for scaling up NCD prevention and control interventions: what are the challenges and opportunities at the country level?
Moderators: Praveen Mishra/Dorji Wangchuk
Speakers:
BK Prasad/CJ Aluthweera/Boonruang Triruangworawat/Rafael dos Santos Ximenes/ Shefayet Ullah

Discussion

1900
Reception by WHO at Mutiara 2, Hotel Gran Melia

Wednesday, 2 March 2011

0830 – 1000
Panel Discussion 2: Generating an evidence base for NCD prevention and control
Moderators: Tint Swe Latt/Rajesh Kumar
How to improve NCD disease surveillance and risk factor surveillance in SEAR?
Speakers:
Anand Krishnan/M Mostafa Zaman/Jureephon Congprasert/Ri Yu Hyok

1000 – 1115
Panel Discussion 3: Developing and taking NCD research agenda forward
What are the priority areas for research in NCDs? How to translate data/evidence to policy formulation and implementation?
Moderators: Jai Narain/Ms Maw Maw/
Speakers:
Bela Shah/ Ahmed Masud/Chandrika Wijeyaratne/Shanthi Mendis

1115 – 1130 Tea/Coffee break

1130 – 1300
Panel Discussion 4: Role of Legislation in NCD prevention and control
Moderators: BK Prasad/Hajera Mahtab
How legislative frameworks such as FCTC being developed and implemented in the Member countries in SEAR?

Speakers:
Prakit Vathesatogki/Lakshmi Narayan Deo/ Dhirendra Sinha/Azam-E-Sadat

1300 – 1400 Lunch

1400 – 1530
Panel Discussion 5: Prioritizing primary prevention—Health promotion
Moderators: Gopal Acharya/ Dr Anwar Santoso
What are the key strategies for health promotion and disease prevention?
Speakers:
Ismoyowati/Surendra Shastri/Ugen Norbhu/Ali Murthala/Adisak Sattam

1530 – 1545 Tea/Coffee break

1545 – 1730
Panel Discussion 6: Innovative financing and resource mobilization for prevention and control of NCDs
Moderators: Hasbullah Thabrany/Chet Raj Pant
What strategies can be used for resource mobilization? What are the lessons from the countries and the way forward for resource mobilization in the Region?
Speakers:
Louise Baker/Supreda Adulayanon/Cherry Mang Mann

Thursday, 3 March 2011

0830 – 1030
Plenary: Using primary health care approach to prevent and control NCDs
Chair: Shanthi Mendis/Dorji Wangchuk

- Principles of Primary Health Care and their relevance to NCD prevention and control: Sudhansh Malhotra
- Package of Essential Interventions for NCDs (PEN): The lessons from the field, Sri Lanka: WMCP Wijesinghe
- Bhutan: Dorji Wangchuk
- PHC-based palliative care for chronic diseases: Suresh Kumar
- Importance of health systems strengthening for NCD prevention and control: Arjun Karki

Discussion

1030 – 1045 Tea/Coffee break

1045 – 1230
Breakaway sessions: What are the desired outcomes of the High-level Meeting of the United Nations General Assembly on NCDs in September 2011?: Renu Garg

GROUP MEMBERS
Each group to focus their deliberations specifically on:

Group 1: Policy promotion
What are possible new NCD policy areas? - How can the High-level Meeting in September 2011 increase the effectiveness of national NCD policies? - How can the High-level Meeting increase support for effective structural policies to reduce NCD burden, including raising taxes and prices, enforcing bans on advertising, promotion and sponsorship, warning people about the dangers, offering help to people, protecting people from risk factors in public places, monitoring policies, etc?

Group 2: Resource mobilization
How can the High-level Meeting increase official development assistance to support countries in building sustainable institutional capacity to tackle NCDs and their risk factors?

Group 3: Inter-sectoral collaboration and partnerships
How can the High-level Meeting increase civil society support to rally stakeholders and people to the prevention and control of NCDs? How can Ministries of Planning, Agriculture, Food Security, Social Affairs, Education, Industry, Justice, Transport and Finance help reduce the burden of non-communicable diseases?

1230 – 1330 Lunch
1330 – 1530 Group work continued…

1530 – 1545 Tea/Coffee break

1545 – 1700
Plenary: Presentation of group work
Chair: Shanthi Mendis/Dorji Wangchuk

Speakers:
Representatives of working groups

- How the partners and stakeholders can collaborate to contribute towards prevention and control of NCDs? – interventions by partner agencies

Friday, 4 March 2011

0800 – 1000
Chair: Dr Jai P Narain
Perspectives from the Partners
- Global price tags and targets for best buys: Shanthi Mendis
- Feedback from regional civil society meeting on NCDs held in Kathmandu in January 2011: Mahesh Maskey

1000–1130
Towards the UN High-level Meeting on NCDs—Regional perspectives
- Jakarta Call for action on NCDs: Mahesh Maskey
- Key messages for UN High-level Meeting on NCDs: Surendra Shastry
- Conclusions and recommendations: Renu Garg

Closing

1230 Lunch

Annex 3
Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia

Excellency, Dr Endang Rahayu Sedyaningsih, Minister of Health, the Government of the Republic of Indonesia, distinguished participants, honorable guests and partners, ladies and gentlemen,

I warmly welcome you all to the Regional Meeting on Health and Development Challenges of Noncommunicable Diseases, and would like to thank all participants and partners for their interest and time in attending this Regional Meeting.

Ladies and gentlemen,

More attention is now being paid globally to noncommunicable diseases, or NCDs. Last year, the United Nations General Assembly passed a resolution calling for a high-level meeting on prevention and control of NCDs. This UN meeting on NCDs will take place in September this year with participation of Heads of State and Governments of Member States. It will be a "UN NCD Summit".

Ladies and gentlemen,

NCDs contribute to an unacceptably high burden of avoidable morbidity and mortality in WHO's South-East Asia Region. This burden is growing unabatedly. The same trend can also be seen in low- and middle-income countries all over the world. This evolving pandemic of NCDs is largely preventable by means of effective and feasible public health interventions that tackle the major modifiable risk factors, namely tobacco use, improper diet, physical inactivity, and harmful use of alcohol.

The socioeconomic determinants of NCDs, including the vulnerability of life under constant pressure due to chronic stress and strain, need urgent attention and concerted multidisciplinary and multisectoral efforts in NCD prevention and control. Inaction in this priority public health area cannot be accepted or justified any longer. The WHO call for investment in health promotion and primary prevention of NCDs and the call for application of evidence-based approaches in NCDs management still need to be translated into practice, from words to actions, from verbal commitments to concrete allocation of human and financial resources.

The burden of NCDs in the Region is growing at an accelerated pace. There will be a 21% increase in the number of deaths caused by these conditions over the coming decade. During the same period, there will be a decrease by 16% in the number of deaths caused by infectious diseases. This phenomenon exemplifies the scale and rapidity of the prevailing epidemiological transition. The increasing burden of NCDs is the outcome of three main factors:

- ongoing demographic change;
- acquisition of unhealthy lifestyles; and
- failure of health systems to promote and protect health of the people.

Today, we understand better the processes whereby NCDs constitute a major impediment to socioeconomic development. NCDs and their risk factors are closely linked and contribute to poverty. The economic fallout of NCDs is due to escalating cost of medical care, reduction of productivity from early lives lost of labour force, the increasing loss of productivity due to disability from NCDs and the increasing social and economic dependence. The rapidly increasing disease burden and growing socioeconomic impact of NCDs in low- and middle-income countries are driven by globalization, modernization and market forces.

The contemporary development paradigm that emphasizes profit maximization at the cost of preserving and enhancing the health of people cannot be considered sustainable. The challenges in this connection are momentous, but at the same time, there are also opportunities to slow down and reverse the mounting pandemic of NCDs. The upcoming UN High-level Meeting on NCDs will focus on galvanizing multisectoral actions at global and national levels in order to address health and socioeconomic impact of NCDs in a more comprehensive manner through effective "multisectoral approaches". This UN meeting will be another important entry-point for advocating "Healthy Public Policies" / "Health in All Policies". It is expected that the UN High-level Meeting will also generate unwavering global commitment and momentum for the implementation of WHO Strategy for the Prevention and Control of NCDs.

As far as WHO in this Region is concerned, our action on prevention and control of NCDs is guided by a Regional Framework, which was endorsed by WHO Regional Committee for South-East Asia. The Regional Meeting being inaugurated today is a part of our preparation for participation in the UN High-level Meeting. This meeting will be the platform for information-sharing on NCD burden, as well as on policies and programmes of our Member States. We will review information on socioeconomic determinants and on development implications of NCDs, and we will also identify regional issues and challenges for our collaborative efforts in this important area in the years to come.

We expect to come out of the meeting with key recommendations on strengthening NCD surveillance, prevention and control through the PHC approach and by building strong multisectoral and multi-level partnerships.

Distinguished participants,

The growing commitment and capacity of Member States in the Region to scale up the integrated prevention and control of NCDs is well documented by the results of a series of national NCD surveys conducted in 2001, 2006 and 2010.

As indicated by the surveys' results, Indonesia, the host of this meeting, is among the leaders in high-level commitment to NCD prevention and control. The first NCD Policy and Strategy was developed for the country in 2003. The National Plan for Prevention and Management of NCDs, 2010–2014, is being implemented. There is a directorate with strong cadre of capable staff members in the Ministry of Health to lead and coordinate NCD actions in the country.

Considerable efforts have been made, and some progress have been noted in the Region with regard to strengthening partnerships among the stakeholders in NCD prevention and control; both within and outside the health sector. Among others, NCD networks have been formed at national and regional levels. The functioning of these networks has been fully funded and technically supported by WHO. The regional network (SEANET-NCD) has been formed and it meets biennially; the meeting of SEANET-NCD greatly facilitates WHO advocacy for multisectoral and multilateral approaches in integrated NCD prevention and control.

I trust that, with your experiences and your combined wisdom, the recommendations emanating from this meeting will further strengthen our determination and commitment to the effective implementation of Regional Framework and Global Strategy on NCD prevention and control.

I am certain that this meeting will effectively contribute to the preparation for our effective participation in the UN High-level Meeting on NCD, to take place in the coming September.

Ladies and gentlemen,

I gratefully thank the Honorable Health Minister of the Republic of Indonesia for her gracious presence to inaugurate this meeting.

Finally, I wish you all success in your deliberations and hope you have a pleasant stay in Jakarta.

Thank you.

Annex 4
Inaugural speech by Her Excellency Dr Endang Rahayu Sedyaningsih, Minister of Health, Republic of Indonesia

Honorable Dr Samlee Plianbangchang, Regional Director, WHO, South-East Asia,

Professor Tjandra Yoga Adhitama, Director General of Disease Control and Environmental Health,

Dr Kanchit Limpakarnjanarat, WHO Representative to Indonesia,

Participants of the Regional Meeting on Health and Development Challenges of Noncommunicable Diseases,

Distinguished Guests,

Ladies and Gentlemen,

It is a great pleasure for me to deliver the opening speech of this *Regional Meeting on Health and Development Challenges of Noncommunicable Diseases*. This meeting is very relevant to the current situation of noncommunicable diseases in the world and in Indonesia. The results of this regional meeting will be important for harmonizing the regional inputs for the High-level *UN General Assembly Meeting on Noncommunicable Diseases* planned to be conducted in September 2011.

On this opportunity let me welcome all the participants who have come from various parts of the world to Jakarta—Indonesia—to participate in this very important regional meeting. I hope that all of you will have a pleasant stay in Jakarta and have fruitful deliberations during the meeting.

Ladies and Gentlemen,

Indonesia is an archipelagic country which consists of more than 17 500 islands with a population of more than 230 million. The country is extending 5120 kilometers from east to west and 1760 kilometers from north to south. Indonesia's territory—land and sea—is 5 million square kilometers and the total land area is around 1.9 million square kilometers. This geographical situation of the country and the large number of population are the main challenges in delivering equitable health services for the people —including providing noncommunicable disease control services. Therefore, the vision of the Ministry of Health during the period of 2010–2014 is set to be *A Self Reliance Healthy People Within A Just Health Care System*.

To materialize this vision, Indonesia is now conducting health development reform in order to reduce the discrepancy of community access to quality health care among different geographical areas, among groups of community, and among socio-economic levels. This health development reform is meant to empower people in health issues, to strengthen public health institutions by strengthening human health resources, ensuring the availability of drugs and health equipment, ensuring community access to quality health care in remote areas, and implementing bureaucratic reform.

One important effort of the health development reform is to attain universal coverage of social health insurance. During the period of 2005–2010, only the poor, the near poor, and certain segments of the community have been covered by social health insurance or other health insurance in Indonesia. In the near future the whole population in the country should be covered.

The efforts in attaining universal coverage is crucial to the prevention and control of noncommunicable disease, since certain noncommunicable diseases are catastrophic and may cause the patients and their families fall into poverty due to the high cost of treatment. Attaining

universal coverage is a way to avoid negative economic implications of catastrophic noncommunicable diseases and also to improve the access of noncommunicable disease patients to quality health care.

Ladies and Gentlemen,

Another public health challenge that Indonesia faces today in health development is the double burden of diseases, namely in one hand there are still many communicable disease problems to be addressed, while on the other hand noncommunicable disease problems are on the rise. According to the last Basic Health Research, conducted in 2007, the proportion of noncommunicable disease mortality rate increased from 41.7% in 1995 to 59.5% in 2007.

The Basic Health Research also revealed the high prevalence of certain noncommunicable diseases in Indonesia, such as hypertension, cardiovascular disease, and stroke (39.7%), musculoskeletal diseases (30.3%), and road traffic injuries (25.9%), and the main cause of deaths in all ages is stroke (15.4%). Furthermore, the most prevalent noncommunicable disease risk factors in Indonesia are obesity, frequent consumption of salty and fatty food, eating less vegetables and fruits, lack of physical activity, emotional disorders, and the habit of smoking everyday.

The Government of Indonesia has given serious attention to noncommunicable disease problem by establishing a special unit within the Ministry of Health, which is responsible for the control of noncommunicable diseases in the country. The priorities of noncommunicable disease control program in Indonesia are cardiovascular diseases, cancer, chronic and degenerative diseases, diabetes mellitus, metabolic diseases, and injuries.

One of the activities of noncommunicable disease control program is facilitating the establishment of a network of noncommunicable disease control. The network involved various government sectors and community organizations and this is done by forming local, national and international networks. This kind of networking approach is also done in other health development efforts in Indonesia, such as in communicable disease control, environmental health, mother and child health, and nutritional programs.

We all realize that the success of health development efforts in developing countries can only be achieved by involving all stakeholders in the government sector, in the private sector and the whole community, including religious organizations, professional organizations, and civil society. Therefore, *inclusive* belongs to the values of the Ministry of Health in achieving the health development goals—together with the other 4 values, namely *pro poor, responsive, effective and clean*.

In addition to the networking in the local and national scope, networking at the regional and global level is also important to speed up coordination and communication in implementing health development among various countries in the world—in order to share information, confirm rumors, and consultation in addressing health problems.

To increase the participation and empowerment of the community in noncommunicable risk factor control—efforts in developing and strengthening the community based health service activities have been conducted. At present, these activities have been integrated into the available community based health services activities. The *Posbindu* or *Pos Pembinaan Terpadu* is one example of the community based health services in noncommunicable disease control. The activities of the *Posbindu* include screening of the noncommunicable disease risk factors and promotion and prevention efforts. These *Posbindu* is fully organized by the community under the supervision of the local health authority of technical aspects.

Community participation and community empowerment are parts of the missions of the health development in Indonesia—in materializing its vision of 2010–2014. Moreover, the involvement of the community in noncommunicable disease control is crucial. Since noncommunicable disease prevention include risk factor control with should be initiated and implemented starting from each individual and each family before it can develop to cover the entire community.

To minimize the negative effects tobacco consumption on health, a tobacco control program has been conducted in Indonesia. It also belongs to the noncommunicable disease control program. The program includes various activities, namely: 1) advocating the decision makers and stakeholders, including the establishment of the *Mayor Alliance for Tobacco and Noncommunicable Disease Control*, 2) monitoring of tobacco consumption, to identify the pattern and change of tobacco consumption, and 3) development of relevant regulations, such as labeling of cigarette package and assigning free smoking areas.

Indonesia is highly committed to tobacco control and efforts in tobacco control are done in various aspects—including health and legal aspects. The Health Law number 36 of 2009 has stipulated tobacco as addictive substance and its utilization must not cause problems to individual, family, community or environmental health.

Noncommunicable disease control in Indonesia is also strengthened by integrating Jamu—the Indonesian traditional drugs—to the health care system. The program is called the Scientific Based Jamu Development, which among others aimed at integrating Jamu into the health care system. The program includes the studies on the utilization of substances to prevent hyperglycemia, hypertension, hypercholesterolemia, and hyperuricemia.

As each countries has their own traditional drugs, so cooperation in the development of traditional drugs and their integration into the health care system—among countries in this region—should be explored. Not only in dealing with noncommunicable diseases, but also in dealing with other health problems.

Ladies and Gentlemen,

Let me end my opening speech by wishing all the participants and the organizers to have a very successful meeting, which will yield important results for the improvement of the health status, the quality of life, and the welfare of our people in the region. I like to conclude my speech by quoting inspiring words of Dale Carnegie, which goes: *Most of the important things in the world have accomplished by people who kept on trying when there seemed to be hope at all.*

Finally, by asking the grace of God The Almighty, here I declare this *Regional Meeting on Health and Development Challenges of Noncommunicable Diseases* officially open.

Thank you.

Annex 5
Summary of country reports

Bangladesh

Burden: The data from hospitals indicate that about 27% of the deaths are due to selected noncommunicable diseases (NCDs). In 2002, the top 10 causes of death in Bangladesh included cardiovascular disease, stroke, asthma/chronic obstructive pulmonary disease (COPD) and diabetes. In terms of the number of years of lives lost due to ill-health, disability and early death (DALYs), NCDs (inclusive of injuries) accounts for 61% of the total disease burden while 39% is from communicable diseases, maternal and child health, and nutrition all combined. According to Global Adult Tobacco Survey (GATS) Bangladesh report 23% adults aged over 15 years are smokers, around 27.2% use smokeless tobacco and overall 43.3% use tobacco in either form. Besides tobacco around 45% are exposed to second-hand smoke.

According to NCD risk factor survey 2010, 95.7% did not consume adequate fruits or vegetables on an average day. According to the NCD survey report, based on metabolic equivalent (MET)–minute, 27% of the subjects fell into low physical activity category, 22.2% fell into moderate physical activity category and 52.8% fell into the high physical activity category. Based on body mass index around one fourth (25%) of the population was underweight, 57% were normal weight and 18% were overweight. Proportion of overweight in women (22%) exceeds the proportion of those in men (13%). About 98.7% have at least one risk factor, 77.4% had two or more risk factors and 28.3% had three or more risk factors.

Based on wealth indices derived from household assets, diabetes, hypertension, low physical activity and obesity were more in rich people but tobacco use, binge drinking, low fruit and vegetable intake were more in the poor. However, when presence of three or more risk factors was considered, it is the higher socioeconomic groups that are affected.

National response

Surveillance: The present system for disease surveillance of the Directorate General of Health Services (DGHS) is mainly hospital-based and focused on communicable diseases. Some major NCDs, such as ischaemic heart disease, cancer and COPD had not been included in the routine reporting forms of the hospitals. The Bangladesh Network for Noncommunicable Diseases Surveillance and Prevention (BanNet) is a forum for active collaboration of organizations and institutes involved in NCD surveillance. BanNet has been established at DGHS with technical support from WHO and will be further strengthened under the next five year plan. Registries for major NCDs should be initiated and NCD surveillance system at population level is indispensable.

Policy/strategy/plan: The current health sector plan identifies cardiovascular disease, cancer and diabetes as major public health problems. The National Strategic Plan for Surveillance and Prevention of NCD in Bangladesh has been adopted and is under review for upgradation. Bangladesh has ratified the Framework Convention on Tobacco Control (FCTC). Strategies for responding to specific NCDs have been adopted.

Health System: Facilities for diagnosis and management of NCDs are still inadequate at the primary care level. At the district level and in some upazillas specialists for major NCDs except cancers are made available. The national essential drugs policy and a list of essential drugs, that includes NCD related drugs, have been developed.

Challenges of NCD prevention and control in Bangladesh

- Unplanned rapid urbanization
- Unfettered tobacco and food industries
- Emerging fast-food and beverage industries
- Translation of NCD strategies into activities
- Limited resources (manpower and logistics)
- Capacity development of the service providers for providing quality services
- Provision of essential drugs for NCDs.

Bhutan

Burden: No epidemiological studies have been conducted so far in Bhutan to ascertain the prevalence of NCDs, such as cardiovascular diseases, cerebro-vascular diseases, chronic renal failure, chronic respiratory diseases, diabetes and hypertension. Most of the available data are hospital based which does not give a true representation of the problem in the population.

The hospital data in Bhutan indicates that NCDs account for more than 50% of inpatient mortality. This is an important cause of a large proportion of mid-life preventable deaths. The 2007 Thimphu based survey on Risk Factors and Prevalence of Non Communicable Diseases found that a vast majority of the population (93.1%) is exposed to at least one of the NCD risk factors, 56.5% is exposed to one or two risk factors and 38.4% exposed to three to five risk factors.

The major risk factors include tobacco consumption, alcohol intake, physical inactivity and improper diet. The survey speculated that there is a huge potential of upsurge of NCDs in the country. Given that a vast majority of the population in Thimphu is exposed to at least one of the risk factors (93.1%) or 56.5% is exposed to one or two risk factors and 38.4% is exposed to three to five risk factors, it can be speculated that there is a huge potential of upsurge of NCDs. The downstream NCDs as a result of such risk exposures is already being manifested with prevalence of raised blood pressure of nearly one-fifth (17.1%) and diabetes of 2.5% among the respondents. Nearly half (44.3%) of the respondents had a high level of cholesterol (> 190 mg/dl). Although the prevalence is relatively low, the figures can rise.

National response

Policy/strategy: The Royal Government recognizes that NCDs are a growing problem in the country and accords high priority to their prevention and control. This may be achieved by minimizing exposure of the population to NCD risk factors through multisectoral approaches and the provision of appropriate preventive, treatment and care services to reduce avoidable morbidity, disability and mortality of NCDs. These are components of the proposed national NCD policy.

The NCD policy will be supported by strategies, programmes and projects for NCD prevention and control, which will be developed, instituted and implemented by relevant stakeholders. NCD prevention activities will involve a multidisciplinary approach that engages, but is not limited to, key ministries and departments including Education, Agriculture, Trade and Industries, Finance, National Provident Fund, Royal Bhutan Police, Home Ministry, Judiciary, Army Welfare Project, Department of Urban Development, Home Ministry, RSTA, BICMA, BCCI, as well as private institutions and nongovernmental organizations.

Health system: The Ministry has piloted the WHO recommended intervention package for NCDs (PEN) in Paro and Bumthang Dzongkhags in 2009. The lessons of the pilots are yet to be assessed but preliminary experiences indicate that health facility based NCD intervention is worth expanding to other Dzongkhags.

DPR Korea

Burden: The stroke-related death rate has increased from 3.8% in 1960s to 24.9% in 1991; heart disease-related death rate increased from 7.1% to 18%. The result of the NCD risk factor survey conducted in 12 areas of the country under the standard guidance of WHO shows a 52.3% smoke rate and 22.6% alcohol use (more than 1 unit in the last one month) Alcohol use of more than 5 units in the last month accounts for 25.9%, which is 34.3% as the highest in 45 to 54 years. Mean BMI was 21.6 in men, 21.3 in women and prevalence of BMI >25 was 4.1% in men and 4.7% in women. Nearly 20.4% men and 17.1% women had 140 mmHg systolic blood pressure and 90 mmHg diastolic pressure.

Last year, a survey on NCD risk factors including biochemical risk factors was initiated.

National response

Surveillance: An integrated NCD surveillance system would be established in the country soon based on experiences and lessons learnt from previous activities of NCD prevention and control. Workshops and consultations of NCD focal points

and stakeholders at the central level have been undertaken for integrated surveillance system on NCD prevention and control.

Policies/strategies: Prevention and control of NCDs is considered a priority in the public health agenda of the country. It is one of important areas of health policies in preventive medical services of the country to combat NCDs, such as cancer, cardiovascular disease and diabetes. Many legislations, including legislations on public health and tobacco control have been adopted in the country. National policies and programmes on prevention and control of NCDs are included in the prospective project at the national level and all activities are being planned and conducted according to these programmes. A national workshop for establishment of Multi Year Strategic Plan on prevention and control of NCDs was conducted in October 2010 and 'Strategic plan for prevention and control of Non-communicable diseases in DPR Korea' (2011–2015) was established.

It has the following four objectives.

Objective 1: To reduce reversible common risk factors, such as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity.

Objective 2: To strengthen research work on NCD prevention and control.

Objective 3: To establish integrated surveillance system for NCD prevention and control.

Objective 4: To raise social awareness and intensify exchange and cooperation for NCD prevention and control.

Efforts are being made to formalize a non-standing steering committee on national NCD prevention and control, which is authorized to comprehensively oversee and control NCD prevention and control. The Committee involves responsible officers from concerned sectors including the Ministry of Public Health, National Institute of Public Health Association, Ministry of Sports, and the Ministry of Commerce and Youth and Women Organization. Finally the strategic objective in the area of NCD prevention and control of the Medium Term Strategic Plan is to decrease the burden of NCDs by reducing the morbidity by 2% annually and morbidity to two thirds that of the present situation by 2015 with the improvement in prevention and treatment of NCDs.

Health system: A well-organized health care delivery system has been established, and is providing all people with universal free medical care in the country.

India

Burden: As per WHO estimates NCDs account for about 53% of all deaths which is expected to rise to 59% by 2015. Cardiovascular diseases will be the largest cause of death and disability in India by 2015. The current estimates of number of persons with main NCDs in India are as follows: diabetes 51 million, ischemic heart disease 30 million, chronic obstructive lung disease 39 million, cancers 2.5 million, cerebro-vascular disease (stroke) 2 million. As per GATS 2010, prevalence of tobacco use is summarized below.

- Current tobacco use in any form: 34.6% of adults
- Use of smokeless tobacco: 25.9% of adults
- Smoking amongst adults: 14% of adults
- Average age at initiation of tobacco use: 17.8 years
- >25% women started tobacco before 15 years of age
- 14.6% tobacco use in age 13-15 years in India (Global Youth Tobacco Survey)

National response

Realizing the magnitude and implication of key NCDs, the Government of India recently (September 2010) initiated a National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS) and National Programme for Health Care of the Elderly (NPHCE). The objectives of the programmes are

- to prevent and control common NCDs through behaviour and lifestyle changes;
- to provide early diagnosis and management of common NCDs;
- to build capacity at various levels of health care facilities for prevention, diagnosis and treatment of common NCDs;
- to develop trained human resource within a public health set up; and

- to establish and develop capacity for palliative and rehabilitative care.

Issues and challenges:

- Political commitment for a multisectoral approach to prevent and control NCDs
- Need for evidence-based policy and planning for controlling NCDs
- Identify priority areas for population-based and individual-based interventions
- Need to accord higher priority to NCDs by the states
- Programme implementation is heavily dependent on public sector

Indonesia

Burden: The causes of death for all ages has changed significantly from 1995 to 2007. In 1995, it was dominated by communicable diseases while in 2007 the major causes were NCDs. The pattern of NCDs cause-of-death from the Basic Health Research 2007, showed that stroke ranked first at 15.4% followed by hypertension 6.8% (ranked third) and diabetes was 5.7% (ranked sixth). From the same survey the prevalence of diagnosed NCDs was reported as follows: hypertension (31.7%), stroke (0.83%), heart diseases (7.2%), arthitis (30.3%), asthma (3.5%), diabetes mellitus (1.1%), tumor/cancer (4.3%) and land traffic injuries (25.9%). This survey also collected data on NCD risk factors that showed the following:

- Less than five servings of fruits and vegetables (93.6%)
- Overweight and obesity (19.1%)
- Lack of physical activity (48.2%)
- Tobacco use (34.7%)
- Alcohol use (4.6%).

National response

The NCD programme in Indonesia was started in 2006 based on Ministry of Health Indonesia decree. The goal is to establish risk factor control to decrease morbidity, mortality and disability of NCD. The programme focuses on controlling cardiovascular diseases, cancer, diabetes mellitus and others metabolic problems, other chronic diseases and degenerative diseases, and injury/violence.

The NCDC programme strategies are: strengthening the legal aspect of prevention and NCD control, increasing the epidemiological surveillance and the early detection (screening) of NCD risk factors, increasing the information, education and communication (IEC), partnership and active roles of the community of prevention and NCD control, increasing the quality of NCD management. The main programme activities are: 1) develop related regulations and guidelines; 2) advocacy and social mobilization; 3) programme development and programme innovation (integrated plan and coordinative action) for example pilot project integrated prevention and control of NCD based on community; pilot projects on early detection for cancer cervix, smoke free environment; 4) capacity building; 5) establish national NCDC network; 6) logistic and supply management; 7) develop early detection of NCD risk factors (including case management), surveillance epidemiology and information system; 8) monitoring and evaluation; and 9) budget development.

Key challenges:

- Strengthening the legal aspect of prevention and control of NCDs.
- Increasing the epidemiological surveillance and the early detection (screening) of NCD risk factors.
- Increasing the information, education and communication, (IEC), partnership and active roles of the community of prevention and NCD control.
- Political support and financing of local government as well as partners in the NCD.
- Integration of a cross-sectoral NCD prevention and control programme into primary health care.

Maldives

Burden: As per WHO estimates, NCDs account for about 62.3% of all deaths in Maldives; six out of 10 deaths (hospital based) were due to NCDs. NCDs cause 44.6% of premature deaths (less than 70 years of age), and about 35% of the years of life lost. WHO estimated that one-fifth of all deaths in the country were due to cancers, and another one-

fifth of all deaths was caused by cardiovascular diseases. Country reports show that cardiovascular diseases death rates are remarkably higher in males. Maldives has the highest percentage of population with raised blood cholesterol level (54.4%) among all SEAR countries and the second highest percentage of people with hypertension (31.5%). Respiratory diseases account for 4.8% and diabetes for 4.3% of all deaths in the country. The International Diabetes Federation (IDF) 2010, estimated diabetes prevalence to be 7.4 per 1000 population and a relatively high (12.7%) prevalence of impaired glucose tolerance in Maldives. Respiratory diseases (including chronic obstructive pulmonary disease and asthma) accounted for 4.5% of the country's NCD burden.

- 24.1% of the population more than 25 years old smoked tobacco (STEPS survey 2007)
- 40% of males and 10% of females were daily smokers (one of the highest among SEAR countries)
- 97.3% of the adult population did not eat adequate fruits and vegetables (highest among SEAR countries)
- One third of adults were found to be physically inactive, with more inactive males than females.
- Almost 50% of the women population was overweight or obese, compared to 38% of men.

National response

Policies/strategies: Maldives has developed a Health Master Plan (HMP) 2006–2015. The plan includes specific national targets for NCDs by 2015, and intends to combine private and public sector efforts in the management and care of priority NCDs. There is a ban on the consumption of alcohol in the country.

Challenges:

- Inter-sectoral collaborative mechanisms are needed to address social, economic and environmental determinants that underlie NCDs.
- Implementation and enforcement of tobacco control policy, early formulation of regulations including the needed enforcement capacity across the implementing agencies.
- An assessment of human resource needs for the current and future is needed.
- The gradual creation of a national NCD surveillance system, to inform strategic planning and policy development. The system should include NCD mortality, morbidity, health services utilization, and economic burden data (available from national health accounts).
- Development of capacity is required to evaluate policies and programmes.

Myanmar

Burden: The ranking of NCDs out of the priority list of diseases and health conditions (42) mentioned in National Health Plan (2006-2011) are 18 for cardiovascular diseases, 22 for cancer and 24 for diabetes. Most of the data concerning NCDs are available from the annual hospital statistics report which show increasing trends in leading grouped causes of morbidity and mortality attributed by NCDs during 2004-2007. In 2003-2004, a survey on the prevalence of diabetes mellitus in rural and urban areas of Yangon Division reported prevalence of diabetes among 12.6% females and 11.5% males. In 2009, the WHO STEPS Chronic Diseases Risk Factor Surveillance Survey was conducted. The results of the survey are shown as follows.

National response to the NCDs epidemic

- Major national policies and programmes
  - National Strategic Plan on DPAS (Draft)
  - National Policy on Tobacco Control
  - Control of Smoking and Consumption of Tobacco Product Law (2006)
  - National Policy and Action Plan on NCDs (Draft in process)
  - Specific Projects on Prevention and

Risk factors	Male 2009	Female 2009
Current daily smoker	33.61 %	6.13 %
Smokeless tobacco use	37.73 %	12.24%
Fruits and vegetables	89.8 %	90.6%
Physical activity	10.44 %	14.1%
Overweight or obese	17.74 %	30.27%
Hypertension	30.99 %	29.34%

Control of NCDs in National Health Plan (2006-2011)

For tobacco control, the Control of Smoking and Consumption of Tobacco Products Law was adopted in 2006 and came into effect in 2007. This Act prohibits smoking at public places and in public transport, prohibits sale of tobacco to and by minors and prohibits all forms of tobacco advertisement.

Challenges

1. National policy on NCDs (still in process, draft only)
2. Weakness in multisectoral collaboration
3. Resource constraints (financial allocation and human resource)
4. Community awareness and participation still unsatisfactory
5. Increasing prevalence of NCDs
6. Fragmented approach to NCDs
7. Constraint on advocacy to policy makers and stakeholders
8. Need for appropriate legislation
9. Need for health system reforms
10. To promote collaboration with NGOs and civil society, industry and the private sector
11. To develop norms and guidelines for cost-effective interventions

Nepal

Burden: Alcohol and smoking are major behavioural problems. About 67.5% men in Nepal have ever consumed alcohol and this is higher in urban areas (75%) than in rural areas (66.7%) and highest in the Mid-hills (77%), lowest in Terai (59.9%) and in-between in the High Mountains (72.7%) – MoHP, New Era and ORC Macro, 2002). The World Health Organization's STEP-wise approach to NCD risk factor surveillance was carried out in Nepal in 2007. The survey revealed that 35.5% men and 15% women smoked tobacco products and 31.2% men and 4.6% women used smokeless tobacco.

National response

Policies/ strategies: The Nepal Health Sector Program (NHSP) IP 2010–2015 has recently given priority to these issues. The Ministry of Health and Population, Ministry of Finance, Ministry of Education, Ministry of Home and Affairs, Ministry of Women, Children and Social Welfare and other related ministries are involved in tobacco and alcohol control activities.

Opportunities and challenges:

- Non-cooperation from industrialists
- Less people suffer from NCDs
- Saved budget can be used for human health development
- Human resource development
- Funding for programme support
- Commitment from the policy makers and parliamentarians.

Sri Lanka

Burden: Sri Lanka is now in the advanced stages of the demographic transition with life expectancy at 71 years. With this rapid ageing, NCDs now account for 87% of the disease burden. During the past half-century the proportion of deaths due to cardiovascular diseases increased from 3% to 24% while that due to communicable diseases decreased from 24% to 12%. Mortality rates from NCDs are currently 20–50% higher in Sri Lanka than in developed countries. NCD risk factors in Sri Lanka, compared to developed countries, range from some that are lower (for example, hypertension, obesity, and alcohol use) to some that are higher (for example, tobacco use among men, dyslipidemias, and physical inactivity). Most risk factor levels can be expected to increase in the coming years. Tobacco use is almost exclusively found among men (32% men vs 2% women) and is also higher among the poor. Obesity, a risk factor for cardiovascular disease, is more common among women and in urban areas.

National response to the NCD Epidemic

Policies/strategies: Currently, national NCD prevention and control efforts are spread across the directorate for cancer and NCDs. A major achievement is the NCD policy and strategic framework, which is in place together with the medium term operational plan. In addition, all the

districts also have their own district plans. Policy development, planning and assessments are coordinated at the central level.

Surveillance: A national NCD surveillance system needs to be facilitated and discussions have already been initiated that would assist in strategic planning and assessing progress. Also, improving the inpatient and outpatient return data is needed to allow more refined analyses. The public sector provides 85–90% of all inpatient care within a network of strategically placed hospitals, and 40–50% of the outpatient care within a network of strategically placed health units.

Health system: NCD pilots are underway for the prevention and treatment of NCDs, including the Package of Essential NCD interventions (PEN) supported by WHO, a project on health promotion and preventive measures of chronic NCDs supported by JICA and the Nirogi Lanka project funded by WDF. Along with these, the Diabetes Prevention Task Force of the Sri Lanka Medical Association is piloting an enhancement of primary tertiary care partnership in managing NCDs while encouraging a team approach to care by training a cohort of nurse educators and a community empowerment project in the urban settings of Colombo.

Key challenges
Inequitable distribution of staff (89% of staff work in curative care and 11% in preventive care) across provinces is common and is found to be a challenge. Essential clinical investigations and medical equipment necessary to diagnose and manage NCDs are often not available at primary and secondary care levels. Low availability of essential medications for treating NCDs is an issue. Both inpatient and outpatient data lack key information on patient characteristics and diagnosis, limiting data usefulness for assessment and planning. A formal referral system is not in place and government policy allows self-referral on demand to secondary and tertiary facilities. Insufficient intersectoral coordination has been identified as a priority in the way forward to achieving policy goals.

Thailand

Burden: The estimated magnitude of burden from NCDs from the National Health Examination Survey (NHES) 2009 and Behavior Risk Factor Surveillance Survey (BRFSS) 2005 show that Thailand is going to face a huge burden due to NCDs in 2011: hypertension, diabetes, asthma and cardiovascular diseases around 7.3, 3.5, 1.9 and 1.45 million, respectively. Data from surveys on health status and health risks of Thais in 1996 compared with that in 2004 indicate the increasing prevalence of major biological risk factors for NCDs, such as diabetes mellitus, hypertension, and trends a slow increase in 2009. Mostly, the prevalence of NCDs and risk factors in urban areas is higher than rural areas except for low-density lipoprotein-cholesterol, tobacco consumption and low intake of fruit and vegetable.

National response
Surveillance: NCDs and risk factors surveillance data and information in Thailand are collected from many sources; such as Population-based Sources: Vital Statistics & Verbal Autopsy study, Chronic Diseases Surveillance System, Population-based Cancer Surveillance, National Health Examination Survey, Behavioral Risk Factors Surveillance System, National Health Surveys Tobacco surveys–GTSS, Alcohol survey in youth, Nutrition Health Survey and others from Facility-based Sources (i.e. Routine reports from facilities, primary care health information system, National Health Accounts, etc.). The responsible agencies are mainly supported by Ministry of Public Health.

Policies/ strategies: Thailand has employed several cost-effective health interventions for disease control and prevention. The health related NCDs interventions implemented in Thailand include health promotion, early detection, disease prevention, cure, rehabilitation that are responsible by several departments in the Ministry of Public Health (MOPH) and non-health related interventions, such as law enforcement, tax increases in tobacco and alcohol consumption, reconstruction of infrastructure and public transport, food safety and healthy environment. Campaigns against tobacco and alcohol

consumption, and health promotion campaigns are financially supported by the Thai Health Promotion Foundation (THPF).

Health system: On curative care, Thailand has also achieved high quality of health service provision recommended by the DCP2. Essential medicines, for example, aspirin, anti-diabetic and anti-hypertensive drugs, are included in the National Essential Drug list.

Key challenges

- Increase in supply of healthy foods and products, and subsidies for health foods
  - Law enforcement on control of alcohol and tobacco consumption control, unhealthy food and beverages
  - Arrangements of environment for encouraging the increase in physical activities
  - Design cities and towns to promote health
  - Health literacy
  - Address NCD-related issues as human development among stakeholders in all levels
  - NCD as health for all policies
  - Multisectoral collaboration and cooperation
- Significant reorientation of health investment on priority disease, risk factors and more investment on disease prevention and health promotion both in and outside the health sector.

Timor-Leste

Burden: Among SEAR countries, Timor-Leste has the lowest NCD burden; NCDs accounts for 36.2% of all deaths in the country. Age-standardized NCD death rate was 662.7 per 100 000 population and NCDs caused more deaths in males (764.0 per 100 000) than females (567.6 per 100 000). Risk mortality among younger ages 15-59 years was 275 per 100 000 population in males, the highest among SEAR countries. Cardiovascular diseases accounted for 17.8% of all deaths in the country, followed by cancers 5.5%, respiratory diseases 4.1% and diabetes 1.3%. There was a relatively high prevalence (11.0%) of impaired glucose tolerance estimated by International Diabetes Federation and was projected to increase by 2030.

Information on majority of the risk factors, especially alcohol use, unhealthy diet, physical inactivity, obesity is mostly lacking in Timor-Leste. The GYTS 2009 revealed that cigarette smoking among boys (38.2%) and girls (14.6%) and use of other tobacco products among boys (18.8%) and girls (16.9%) was one of the highest in the Region. It also indicated that 64% of students were able to purchase cigarettes and were not refused because of their age.

National response

Policies/strategies: Decree-Law No. 9, 2006, on Health Warning Labels and Tax Control of Manufactured Tobacco Products of Timor-Leste states that health warning labels shall be visibly printed on packs. Some of the other interventions for NCDs include: community based education and blood pressure measurement through SISCa activity, free smoking areas in health facilities and advocacy to all goverment employees on physical activity.

Challenges and constraints:

- Health policy is focused on controling communicable diseases and maternal and child health
- Limited surveillance for NCDs in the Health Management Information System
- Inadequate financial support from donors
- Lack of health workforce at the district level
- Lack of research on NCDs
- There is no restriction on the sale of tobacco products to minors.

Annex 6 Summary of weaknesses identified and measures for strengthening NCD surveillance

Domains	Weaknesses identified	Suggested measures
Mortality	Lack of population-based representative data on causes of death	Adopt verbal autopsy on a representative sample of national deaths (as is being done in India and Indonesia)
	Poor coverage with medical certification	Adopt sentinel sites in different geographical regions and cover all deaths at those sites. These sites could be already existing sites with academic institutions or Health and Demographic Surveillance Sites
.		
Disease	Disease registries are present only for select diseases in few countries	Prioritize disease surveillance
	Available information is mainly hospital based, that too from which private sector health facilities are excluded	Explore alternative strategies including rapid assessment surveys and mandating reporting by private sector health facilities
Risk factor	STEPS surveillance focuses on behavioural risk factors only	Adding biochemical risk factors (raised fasting blood sugar and cholesterol and urinary sodium) to the list of risk factors
	Few countries have nationally representative surveys	Integrating risk factor surveys to existing other behavioural surveys (HIV/AIDS, Demographic and Health Surveys (DHS))
	Regular periodic national surveys funded through government budget in only two countries (Indonesia and Thailand)	Avoiding vertical single risk factor based surveys (tobacco, alcohol, nutrition) were also suggested. The need to integrate needs to be balanced by the need not to overload the system

Annex 7
Prioritized research agenda in NCDs

1. Monitor country-specific information on risk factors, disease burden, trends, economic and social costs and impact of globalization and urbanization on behaviours, in order to make the policy case for political leadership to give high priority for NCD on the development agenda.
2. Assess the economic impact of tobacco use, to evaluate the economic impact of tobacco control and to investigate the interrelationships between tobacco use and poverty.
3. Determine the impact of NCD policies on social inequities in populations and to develop Interventions for reducing them, e.g. design, implement and evaluate pro-poor NCD prevention and control programmes.
4. Develop comprehensive and cost-effective sets of interventions (policy, environmental and health systems) to address NCD risk factors in diverse cultural and economic settings and evaluate their effectiveness.
5. Estimate the impact of tax and price policies, on tobacco use and tobacco control, taking into account country-specific price elasticity, differential impact, tax structure, and effective tax administration to curb tax avoidance and tax evasion.
6. Determine effective programmes and policies to improve dietary quality and food security and prevent weight gain and obesity including measures of economic viability, overall effectiveness, sustainability and differential social impact.
7. Investigate the appropriate use of food regulation, legislation and price controls to improve nutrition and reduce the risk of obesity.
8. Understand the individual, social and environmental determinants of physical activity and sedentary behaviours across the life course.
9. Optimal implementation and evaluation of community-based primary prevention models (e.g. for prevention of CVD and diabetes), with particular attention to the effects of rural–urban migration and changing food preferences, physical activity patterns and transportation policies.
10. Ways to mobilize community resources , and develop mechanisms to enable civil society to play a role in social mobilization for addressing NCDs.
11. Evaluate changes in the urban and peri-urban environments, including studies of urban redevelopment, installation and modification of transport systems, changes in regulations and legislation in sectors other than health to assess their impacts on physical activity and sedentary behaviours.
12. Validate cost-effective screening approaches (e.g. for cancer and other NCDs), risk prediction methodologies and clinical algorithms (e.g. to identify people at high risk of developing diabetes and CVD) that are applicable to low- and middle-income country settings.
13. Establish and evaluate cancer prevention strategies in the context of local culture and local resources (including primary prevention, effective early detection, cost-effective vaccination programmes for hepatitis B and oncogenic human papilloma viruses).
14. Assess gaps in availability and affordability of essential medicines and basic technologies and develop strategies to address these gaps.
15. Identify contextual factors in relation to knowledge translation and research utilization to inform measures to facilitate

research use, including policy diffusion and readiness and capacity of (health) systems to accept and implement policies and programmes.

16. Determine the key requirements (human resources, technologies and medicines), cost estimates and impact of implementing a package of essential NCD interventions with a special focus on primary care.
17. Define health system-related opportunities and barriers to access for early detection, diagnosis, treatment, rehabilitation and palliative care and develop feasible and integrated approaches to apply cost-effective NCD interventions at all levels of health care.
18. Develop effective tools for training of health workers for NCD prevention and control and innovative approaches for evaluation and improvement of their performance with a special focus on the primary care workforce.
19. Develop cost-effective approaches to deliver patient education, improve adherence and strengthen self-care.
20. Improve affordability of expensive but effective technologies for diagnosis and treatment of NCDs in the context of varying resource settings and health care systems (e.g. cost-effective investigative and surgical procedures for CVD and cancer and radiotherapy techniques for cancer).

Annex 8
Kathmandu Call for Action

(Emanating from the Regional Civil Society Meeting on Noncommunicable Diseases organized by the Nepal Public Health Foundation, 19 January 2011)

Recognizing that noncommunicable diseases (NCDs) have emerged as the major cause of mortality and morbidity in the countries of the South-East Asian Region (SEAR), which is home to 26% of the world's population and 30% of the world's poor. More than half of the deaths occurring in the Region are due to NCDs and is increasingly being seen in poorer, younger and female populations causing great burden to the national health system and economy;

Observing that this higher risk of NCDs among the poor and marginalized populations of SEAR impoverishes them further, creating a vicious cycle of poverty, and with the NCDs causing adverse socioeconomic impact;

Emphasizing that without addressing the NCDs effectively, neither can poverty be alleviated nor can health and development goals be achieved;

Realizing that the prevention and control of NCDs is cost effective and feasible; early and appropriate interventions could reduce the current and future burden of NCDs;

Noting with concern that even though the prevention and control of NCDs substantially contribute to the better achievement of other MDGs, it has neither been included nor have adequate resources been allocated;

We, the participants of this Regional Civil Society Meeting on Noncommunicable Diseases, call for concerted action to:

- advocate for the inclusion of NCDs in the Millennium Development Goals (MDGs) in the forthcoming UN General Assembly and other appropriate international fora, and for creating an enabling global environment in its realization;
- create and/or strengthen appropriate mechanisms to promote national and regional networks to effectively collaborate in addressing the NCDs challenges;
- mobilize civil society and other sectors to engage in evidence-based development and effective implementation of national policies and programmes for the prevention and control of NCDs in an integrated manner;
- urge the national government to mobilize national and international resources to implement NCD prevention and control programmes;
- promote the adoption of healthy lifestyle by health professionals in the Region to become role models for the general population.

Annex 9
Statements from partner agencies

Union for International Cancer Control

The Breast Cancer Welfare Association Malaysia, Chronic Care Foundation India, Framework Convention Alliance, Family Health International, Global Health Council, HRIDAY (Health Related Information Dissemination Amongst Youth), Indonesian Cancer Foundation, Indonesian Diabetes Association, Indonesian Heart Foundation, Indonesian Society of Health Promoters and Educators, Livestrong, National Heart Foundation of Bangladesh, Pain and Palliative Care Society India, Population Services International, Reach to Recovery International, Thai NCD Net and the Union for International Cancer Control (UICC) as members and partners of the global NCD Alliance representing over 880 NCD organizations from across the globe, wish to commend the WHO Office for South-East Asia for organizing this important regional meeting and consultation on Health and Development Challenges of Non-Communicable Diseases. This is a critical opportunity to define our priorities for the UN High-Level Meeting on NCDs taking place this September.

To ensure we make the most of this unprecedented opportunity, the NCD Alliance and other civil society coalitions are driving a global civil society movement united in addressing cancer, cardiovascular disease, chronic respiratory disease and diabetes, and their common risk factors of tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol. Together with our partners, we represent over 1,200 organizations across the globe.

NCDs have been a silent killer for too long. They are a major cause of poverty, a barrier to economic development, and a serious threat to achievement of the MDGs. The 8 million premature deaths they cause each year in low and middle-income countries represent nothing less than a development emergency in slow motion. NCDs have no borders or boundaries– they are the world's number one killer and devastate the bottom billion and G20 countries alike.

Ladies and gentlemen, the NCD Alliance commits to supporting member states, WHO and UNDESA in catalysing this process and calls on member states to:

- One: Ensure the highest level of political support, we ask that you request the attendance of your Head of State or Head of Government.
- Two: Support the strong participation of civil society in the UN High-Level Meeting. The imminent appointment of a Civil Society Taskforce under the office of the President of the General Assembly is a welcome development. In addition, we urge the appointment of a high-profile NCD Champion under the UN to liaise with the Taskforce and the private sector, to act as a special envoy for the UN High-Level Meeting, and to work closely with those UN and WHO staff responsible for organising and coordinating the UN High-Level Meeting.
- Three: Invest in the consultation process leading up to the UN High-Level Meeting to ensure that the meeting produces an outcomes document with strong recommendations and a concrete plan of international action. This should include:
    - Acknowledgement of the health, social and economic burden of NCDs in the world and particularly in low- and middle-income countries;
    - an increase in the international development funds to NCD prevention and control, including support for international instruments such as the Framework Convention on Tobacco Control;
    - Measures that address the availability and affordability of quality medicines to

ensure that people living with NCDs can access life-saving treatments; and,

- Agreement on global accountability, monitoring, reporting, and follow-up mechanisms.

The UN High-Level Meeting is a once-in-a-generation opportunity to put NCDs on the global agenda. It has the potential to secure commitment from Heads of Government for a coordinated response, substantially increase resources, and save millions from premature death and debilitating health complications. Together with strong leadership from the WHO and its Member States, we can make significant progress in curtailing this epidemic. Join us in ensuring the UN High-Level Meeting is the turning point for NCDs.

Ms Ranjit Pritam Singh, UICC
Chief Executive Officer
Breast Cancer Welfare Association, Malaysia

Commonwealth Secretariat

Chair, Dr Narain;

Distinguished participants;

Honourable guests and partners;

Ladies and gentlemen.

The Secretariat wishes to express thanks for the invitation to participate in this important meeting relating to the health and development challenges of NCDs in the SEAR region. It has been a pleasure to participate in dialogue and to learn of your commitment to respond to the rising burden of NCDs and their determinants within the region.

The Commonwealth has been described as a unique family of 54 countries. The world's largest and smallest, richest and poorest countries make up the Commonwealth and are home to two billion citizens of all faiths and ethnicities. The Commonwealth accounts for a third of the world's population Over half of the population within the Commonwealth are aged 25 years or younger. Membership to the Commonwealth continues to grow; with Rwanda, Cameroon and Mozambique our most recent members. In the SEAR region, members include Bangladesh, India, Sri Lanka and the Maldives.

The Secretariat works to implement plans mandated by the Commonwealth Heads of Government through technical assistance, advice, knowledge generation and dissemination, advocacy and policy development.

In the field of Health, there exist five programmes of work. These are: HIV and AIDS, health workforce, e-Health, maternal and child health and NCDs. Non-communicable diseases are now a priority within the Commonwealth. We acknowledge the early precedence given to these diseases by many of our member countries and regions. We recognise the commitment given by the People's Republic of Bangladesh to push through the UN Resolution on Diabetes in 2006. The Secretariat also acknowledges the work within the Caribbean region; a region that has uniquely accelerated global action in this field.

In September 2009, the Commonwealth Heads of Government met in Trinidad and Tobago and released a statement on "Action to Combat NCDs". This called for a UN High Level Meeting and endorsed member governments to address the burgeoning incidence of NCDs.

You may be aware that Commonwealth Health Ministers meet together each year on the eve of the World Health Assembly. At their last meeting there was unanimous support for our programme of work regarding NCDs to be accelerated. A Commonwealth Road Map relating to NCDs was agreed, together with the theme of this year's Health Ministers Meeting to be held on 15 May 2011 to be that of NCDs. Our Chair this year is the Honourable Professor Haque, Minister of Health, Bangladesh.

The Commonwealth NCD Road Map mandates the Health Section of the Secretariat to focus upon four main areas. These are that of assisting member countries to conduct assessments of their NCD burden and determinants; to develop

analytical products; to develop a media strategy to increase reporting on NCD-related issues at country level and finally, to organise and participate in dialogues across sectors.

To date, the Secretariat has hosted a Consultation relating to NCDs in November 2010, London. Attendance by representatives from across civil society organisation, academia, and some Commonwealth member countries (including representation from the Maldives) and related Commonwealth organisations. Last month, the Secretariat hosted an advocacy meeting for High Commissioners to brief them on the NCD pandemic and to seek their contribution in engaging participation from their Heads of State at the forthcoming UN High-Level Meeting.

The Secretariat is proposing to host a media training workshop on NCDs for regional health journalists from across the Commonwealth. Additionally, the Secretariat is seeking to commission an advocacy film relating to youth and NCDs.

The Secretariat continues to work alongside partners in responding to the NCD pandemic. We continue to work with and alongside the World Health Organization, the Lancet and the National Heart Forum, amongst others, to increase a collective evidence-based response to NCDs at national and international levels, and to avoid duplication.

If NCDs are to remain a Commonwealth priority, then we must continue to seek to maintain country support, Ministerial enthusiasm and encourage and empower civil society organisations working in this field. Therefore, the Secretariat is committed to supporting member countries to respond to their NCD situation and to ensure that Commonwealth Heads of State are equipped and in attendance at the UN High-Level Meeting on NCDs in September 2011. We are dedicated to maintain our work in this field up to, during and beyond the High-Level Meeting.

Ms Vanessa Baugh
Adviser (Health), Social Transformation Programmes Division, Commonwealth Secretariat

Global Health Council

Mr. Chairman, and colleagues, on behalf of the Global Health Council, I would first like to thank WHO SEARO for allowing the Global Health Council to participate in this important meeting.

As mentioned, Global Health Council has already endorsed the previous statement read on behalf of the NCD Alliance and its partners.

The Global Health Council is an international coalition devoted to improving all aspects of health worldwide. We are working in support of the NCD Alliance to mobilize our international membership of more than 600 organizations and thousand more individuals, including many in the South East Asia region.

On behalf of the Global Health Council's NCD Roundtable, I want to emphasize and support five major points that have been made throughout the meeting.

1. Civil Society is a key partner to prevent and control NCDs and should be enabled to serve an active role in partnership with WHO and others in preparations for the UN High-Level Meeting, its respective outcomes and the development and implementation of NCD policies and programs in collaboration with national and local governments.
2. National governments must play a central role in prioritizing and implementing NCD programs, including those in partnership with international donors.
3. There are existing infrastructure and platforms, in part due to communicable disease investments, that can serve as important strategic links for NCDs and contribute to improving overall health systems.
4. WHO plays an essential technical and normative role for NCD prevention and control and should be empowered by Member States through adequate and appropriate funding.

5. Reiterate that the UN High-Level Meeting is an unprecedented opportunity to put NCDs on the global health and development agenda.

Dr Craig Moscetti
Policy Manager, Policy and Government Relations
Global Health Council

WHO Collaborating Centre for Research, Education and Training in Diabetes

Chairman and respected delegates: I will briefly mention about the possible role of WHO Collaborating Centres in implementing the Action Plan for the Global Strategy for Prevention and Control of NCDs by WHO.

Our WHOCC for Research, Education and Training in Diabetes has been working for the past 6 years in building capacity for epidemiological research in NCDs, research in socioeconomic determinants and also community based interventions.

WHOCC all over the world can link up several partners within the Region to achieve the Global Strategy of WHO for NCD Prevention.

Just to mention two initiatives of our WHOCC.

One recent publication showed that 22% of school children in India are overweight. We are working closely with the Central Board of Secondary Education (CBSE) an important agency for school education, in India to implement the health manuals developed by the CBSE in association with WHO India. This programme has been called Slim and Fit Programme.

We have been working with the International Union Against Tuberculosis and Lung Disease and the Revised National Tuberculosis Control Programme, the main agency working on control of TB in India, to study the prevalence of diabetes among TB patients and to study the effect of diabetes on TB treatment outcomes.

We hope the UN High-level Meeting can help in building capacity for epidemiological research in NCD and support community-based interventions, which we at WHOCC can then take up and help WHO to implement at regional levels.

Dr Vijay Vishwanathan
Head WHOCC for Research, Education and Training in Diabetes, Chennai, India

Annex 10
Jakarta Call for Action

(Jakarta, Indonesia, 4 March 2011)

We, the participants of the Regional Meeting on Health and Development Challenges of Noncommunicable Diseases appreciate the role of WHO in focusing attention on noncommunicable diseases, and note with concern that:

- noncommunicable diseases (NCDs) are now the leading cause of death in the Member States of the WHO South-East Asia Region, accounting for 54 per cent of all deaths;
- deaths from noncommunicable diseases are projected to increase by 21 per cent over the next ten years; in the South-East Asia Region, the death rates in middle-aged adults are disproportionately higher than in high-income countries;
- noncommunicable diseases have a substantial economic impact as working-age adults account for a high proportion of the NCD burden. NCDs will reduce the Gross Domestic Product by an estimated 1–5 per cent in low- and middle-income countries; and
- the epidemic of noncommunicable diseases exacerbates poverty, is a barrier to societal and economic development, and could reverse hard-won development gains.

We acknowledge that:

- low-cost and cost-effective interventions for prevention and control of noncommunicable diseases at the population and individual level are available;
- prevention and control of noncommunicable diseases will contribute to economic development through cost savings for medical care, improved quality of life and increased productivity;
- to ensure equitable access to comprehensive health care for people at risk of or already suffering from a noncommunicable disease, strengthening of health systems based on primary health care (PHC) is imperative; and
- to be effective, programmes for the control of the NCD epidemic require coordinated and collaborative action by all sectors within government, civil society, the private sector and the media.

We call upon governments and parliaments to:

- accord a high priority to prevention and control of NCDs in national health policies and programmes and accordingly increase overall budgetary allocations for health and especially budgets for combating NCDs;
- galvanize a multisectoral response to NCDs through development of integrated national plans of action involving relevant sectors, civil society and communities to control and reverse the rising burden of noncommunicable diseases. This should include the ratification and effective implementation of the WHO Framework Convention on Tobacco Control, and community empowerment and education about diet, physical activity and harmful use of alcohol;
- scale up a package of proven effective interventions such as health promotion and primary prevention, and also develop and enforce evidence-based legislation, regulations and fiscal measures to reduce consumption of tobacco, alcohol and processed/packaged foods while promoting consumption of healthy foods and physical activity;
- invest in and strengthen primary health care by introducing a package of preventive, promotive and curative care interventions for NCDs at the primary care level to ensure access to care among the poor and vulnerable;
- develop sustainable mechanisms including surveillance to monitor and evaluate the impact of interventions in a systematic and ongoing manner;

- support research for prevention and control of noncommunicable diseases; and
- build capacity of the health workforce, including community-based health workers, for prevention and control of NCDs.

We call upon global leaders, donor partners and UN agencies to:

- include NCD prevention and control in internationally agreed developmental goals, including the MDGs;
- assist countries in integrating NCD control in their PHC-based health systems strengthening initiatives in a harmonized manner;
- in accordance with national priorities, enhance capacity building, technical and financial support to Member States to supplement national efforts for sustainable NCD prevention and control programmes; and
- support countries in research for prevention and control of noncommunicable diseases.

The WHO South-East Asia Region is in the midst of an epidemiological transition. While infectious diseases are still prevalent, noncommunicable diseases (NCDs) are emerging as the most common cause of death. The increase in NCDs is being fuelled by demographic changes (ageing population), unplanned urbanization, globalization of trade and marketing, socioeconomic determinants and progressive increase in unhealthy lifestyle patterns among populations of Member countries in the Region. This report, of the "Regional Meeting on Health and Development Challenges of Noncommunicable Diseases" in the South-East Asia Region held in Jakarta, Indonesia during 1–4 March 2011, discusses socioeconomic determinants and developmental implications of NCDs in the Region, provides regional inputs for the UN High-level Meeting on NCDs planned for September 2011 and formulates recommendations on various aspects of NCD prevention and control using primary health-care approaches as well as multisectoral and multilevel partnerships.

SEA-NCD-83

World Health Organization
Regional Office for South-East Asia