

# Action plan for prevention and control of noncommunicable diseases in the South-East Asia Region

---

DRAFT

31 July 2013



## Table of Contents

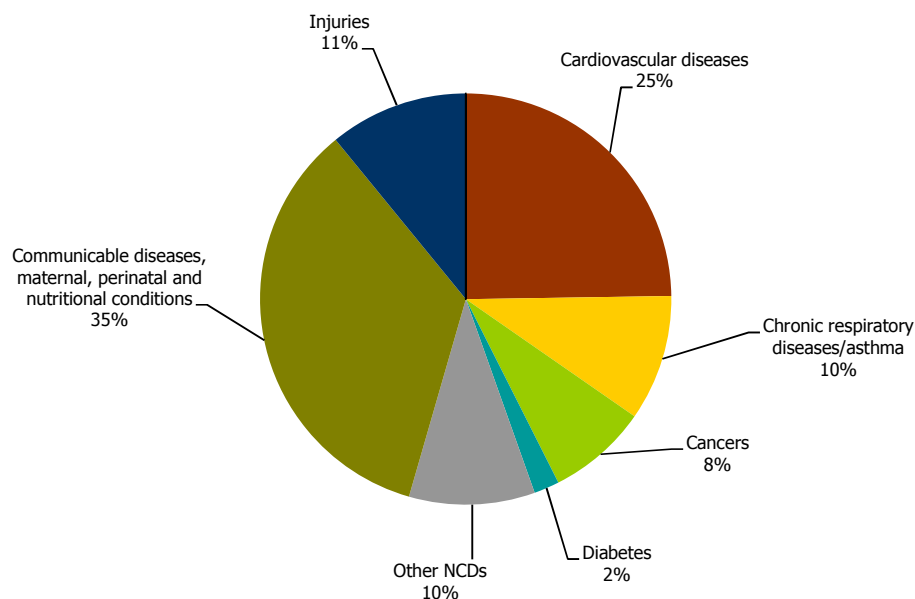
Part I Situation analysis .....	3
Burden of NCDs.....	3
NCD determinants and risk factors.....	4
Global initiatives.....	6
Regional initiatives.....	6
Progress and challenges in prevention and control of NCDs in the South-East Asia Region.....	8
Part II Action plan for prevention and control of NCDs in the South-East Asia Region (2013–2020) .....	9
Purpose.....	9
Vision .....	10
Goal.....	10
Targets .....	10
Guiding principles.....	11
Priority action areas .....	12
Strategic action area 1: Advocacy, partnerships, and leadership.....	14
Strategic action area 2: Health promotion and risk reduction .....	17
Strategic action area 3: Health system strengthening for early detection and management of NCDs and their risk factors.....	26
Strategic action area 4: Surveillance, monitoring and evaluation and research.....	30
References .....	34

## Part I Situation analysis

### Burden of NCDs

1. Noncommunicable diseases (NCDs) are the leading cause of death in the South-East Asia Region. Each year, an estimated 7.9 million lives are lost due to NCDs, accounting for 55% of all deaths in the Region<sup>i</sup>. NCDs claim lives at a younger age in the South-East Asia Region compared to the rest of the world. In 2008, the proportion of NCD deaths occurring among people under the age of 60 was 34% in the South-East Asia Region, compared to 23% in the rest of the world. Cardiovascular diseases are the most frequent cause of NCD deaths, followed by chronic respiratory diseases, cancers, and diabetes (Figure 1).
2. In addition to the four main NCDs listed above, many other chronic conditions and diseases contribute significantly to the NCD burden in the Region, such as renal, endocrinal, mental, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and genetic disorders, as well as oral diseases including dental caries, periodontal diseases and oral cancers. Thalassaemia is also a serious health problem in some Member States including in the Maldives where approximately 18% of the population carries the *Beta thalassaemia* trait.

Figure 1. Estimated proportion of deaths by cause, South-East Asia Region, 2008



Source: WHO SEARO Regional Health Observatory, <http://apps.who.int/searo-rho/>

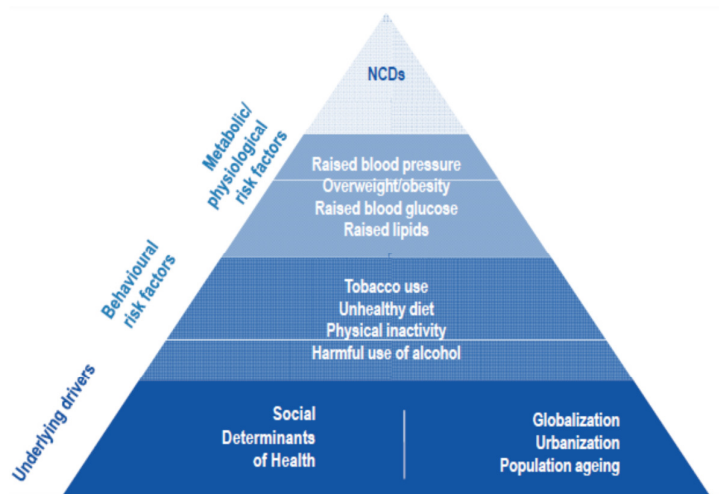
3. Besides being an enormous health burden, NCDs have serious socioeconomic implications. NCDs disproportionately affect the poor, leading to loss of household income from unhealthy behaviours, poor physical capacity and loss of wages. Due to long-term treatment costs and high out-of-pocket costs, NCDs can result in

catastrophic health expenditures and impoverishment. In India, the share of out-of-pocket expenditure due to NCDs increased from 32% in 1995 to 47% in 2004; of this NCD-related expenditure, 40% was financed by household borrowing and sale of assets.<sup>ii</sup> In addition to exacerbating household poverty, NCDs and their risk factors exact a huge toll on national economies. In Thailand, for example, the economic burden of the harmful use of alcohol was estimated to be equivalent to 2% of the gross domestic product in 2006.<sup>iii</sup>

## NCD determinants and risk factors

4. The increasing burden of NCDs is attributed to determinants such as population ageing, rapid and unplanned urbanization, negative effects of globalization (such as trade and irresponsible marketing of unhealthy products), low literacy, and poverty (Figure 2). From 2000 to 2025, it is projected that the proportion of the population aged above 65 years will increase from 3.6% to 6.6% in Bangladesh, from 4.4% to 7.7% in India and from 6.3% to 12.3% in Sri Lanka. As the prevalence of NCDs increases with age, these progressively aging populations will result in a corresponding increase in NCD cases.
5. Urbanization in the South-East Asia Region is occurring at a rapid rate and increased from 26% in 1990 to 33% in 2009. It is projected that the percentage of populations residing in urban areas will more than double by 2050 in most Member States. Several studies in the Region show that behavioural, anthropometric and biochemical risk factors for NCDs are more prevalent in urban than rural areas. Unplanned urbanization reduces options for physical activity and increases exposure to air pollution.
6. Globalization has brought processed foods and diets high in total energy, fats, salt and sugar into millions of homes. Nearly 30% of the Region's population remains non-literate. Low levels of literacy affect health behaviours and lifestyle choices. Poor levels of awareness can also result in high consumption of salt, as well as saturated fats and trans fats, and thus aggravate development of NCDs. Studies in Bangladesh, India, Indonesia, Sri Lanka and Thailand have revealed that both smoking and smokeless tobacco use are more prevalent among the less educated.

Figure 2. Determinants of NCDs



7. Globalization and underlying social determinants are driving unhealthy lifestyle behaviours. Four modifiable lifestyle related risk behaviours, namely tobacco use, unhealthy diet, insufficient physical activity and harmful use of alcohol are responsible for the majority of NCDs. The prevalence of these unhealthy risk behaviours is very high in the Region. Tobacco use is responsible for at least one million deaths each year. There are nearly 250 million smokers and an equal number of smokeless tobacco users, who often use tobacco together with other carcinogenic substances (such as betel nut); 90% of the world's smokeless tobacco users live in the South-East Asia Region. In some Member States, the prevalence of smoking among males is above 60%, making it the number one public health problem in the Region.
8. Unhealthy diets are very common. Approximately 80% of the population does not consume the recommended five portions of fruits and vegetables a day. The mean intake of salt per day varies from 8 to 13 g/day, much higher than the recommended levels of <5 g/day. There is a wide variability in the prevalence of physical inactivity ranging from 3% to 41% in males and 6.6% to 64% in females. Annually, an estimated 800 000 deaths in the Region are attributed to inadequate physical activity.
9. Harmful use of alcohol claims an estimated 350 000 lives each year in the Region. The prevalence of alcohol consumption varies from 2% to 44% in males and 0.1% to 26% in females. The harm from alcohol use extends much beyond medical conditions to social, psychological and economic problems as well as injuries and violence.
10. The four behavioural risk factors described above lead to four metabolic risk factors, namely overweight/obesity, high blood pressure, raised blood sugar and raised blood lipids. These four behavioural risk factors are highly prevalent in the Region. The prevalence of overweight varies from 8% to 30% among males, and from 8% to 52% among females. Childhood obesity is an emerging issue of increasing relevance, particularly in urban areas. Approximately a third of the adult population has hypertension, the principal risk factor for heart attack and stroke. In 2010, the prevalence of raised blood sugar in adults aged  $\geq 25$  years ranged from 6.6% to 12.2%. The prevalence of raised cholesterol in the adult population is as high as 50% in some Member States. Clustering of more than one risk factor is found in a significant proportion of individuals.
11. Infections and environmental factors also increase the risk of NCDs. Infections may be responsible for a fifth of cancers in developing countries. For example, human papillomavirus (HPV) is responsible for the leading cancer among women – cancer of the cervix – and for an increasing number of oral cancers in men and women; hepatitis B virus and hepatitis C virus cause hepatocellular carcinoma; and *Helicobacter pylori* causes cancer of the stomach. Household air pollution due to solid fuel combustion is an important risk factor for chronic respiratory diseases. In the South-East Asia Region, the proportion of households using solid fuel in 2010 was 61% (range 8–92%). Important environmental and occupational risk factors for NCDs include exposure to asbestos, diesel exhaust gases and ionizing and ultraviolet radiation, indiscriminate use of agrochemicals in agriculture and discharge of toxic products from unregulated chemical industries.

## Global initiatives

12. Global initiatives to address NCDs started in the year 2000, with the adoption of the World Health Assembly resolution WHA53.17, endorsing the global strategy for the prevention and control of such diseases, with a particular focus on developing countries. The strategy rests on three pillars: (i) surveillance; (ii) primary prevention, and; (iii) strengthened health care.
13. Since 2000, the World Health Assembly has adopted several resolutions in support of specific tools for the global strategy, including the WHO Framework Convention on Tobacco Control (FCTC) in 2003, the Global Strategy on Diet, Physical Activity and Health in 2004, and the Global Strategy to Reduce the Harmful Use of Alcohol in 2010. In 2008, the Health Assembly endorsed the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, with a particular focus on developing countries.
14. To draw the attention of global leaders to the rising crisis of NCDs, the United Nations (UN) General Assembly convened a High-level Meeting on the Prevention and Control of Non-communicable Diseases in September 2011. It was only the second time in history that the General Assembly met with the participation of Heads of States and governments on a health issue. The main outcome of the meeting was the adoption of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,<sup>iv</sup> which acknowledges the rapidly growing magnitude of NCDs in developing countries and its increasingly devastating health and socioeconomic impact, and calls for concrete and comprehensive actions by Member States and the international community.
15. As a follow-up to the Political Declaration of the High-level Meeting on NCDs, WHO led a consultative process in developing a global action plan for prevention and control of NCDs 2013–2020, including a comprehensive monitoring framework with indicators and voluntary global targets. The Sixty-sixth World Health Assembly in May 2013 endorsed the global action plan, including indicators and voluntary targets, through resolution WHA66.10.<sup>v</sup> The resolution urges Member States to implement the global action plan and consider the development of national NCD monitoring frameworks, with targets and indicators based on national situations, taking into account the global monitoring framework, and to establish and strengthen a national surveillance and reporting system to enable reporting against the 25 indicators and 9 voluntary global targets.

## Regional initiatives

12. Parallel to the global NCD movement, several important activities have been undertaken at the regional level. The South-East Asia Network for NCD Prevention and Control (SEANET-NCD) was created in November 2005 to strengthen partnerships and regional cooperation among Member States for implementing policies and programmes for NCDs. Five meetings of the SEANET-NCD have taken place, with participation of multiple stakeholders from the government, academia, WHO collaborating centres, and nongovernmental organizations (NGOs). These meetings facilitated exchange of information, sensitized stakeholders about new

guidelines and tools, and advocated for acceleration of global policies and strategies such as the WHO FCTC, the Global Strategy for Reducing Harmful Use of Alcohol and the Global Strategy for Diet and Physical Activity for Health.

13. High-level advocacy has been carried out for prevention and control of NCDs through various forums including the Twenty-ninth Meeting of the Health Ministers, and the Sixtieth, Sixty-third and Sixty-fifth sessions of the Regional Committee for South-East Asia. These high-level meetings resulted in adoption of important decisions and resolutions related to NCDs, which form the basis for continued advocacy as well as a framework for future actions.
14. To develop culturally appropriate salt reduction strategies, an expert group meeting was convened in New Delhi, India in December 2012. The meeting concluded that reducing population salt intake is a high priority, cost-effective intervention for Member States of the Region in the context of prevention and control of hypertension, cardiovascular disease and other NCDs. It was also reaffirmed that a salt reduction strategy is compatible with efforts to iodize salt and called for increased collaboration between salt reduction programmes and salt iodization programmes for increased efficiency and public health gains. In June 2013, a technical working group (TWG) meeting on the regional action plan and regional targets was organized in Bangkok, Thailand. The TWG recommended 10 regional targets and a set of priority actions for prevention and control of NCDs. To develop capacity for research, a regional workshop was conducted in Kandy, Sri Lanka in August 2012. The workshop resulted in prioritization of a regional research agenda and initiation of research protocols on key priorities.
15. Recognizing the enormous burden of oral diseases, and considering the common risk factors responsible for NCDs and oral diseases, the integration of oral diseases into the NCD context is an important priority area. A regional oral health strategy has been developed that calls attention to priority areas: (i) integrating oral diseases and NCDs; (ii) addressing oral cancer; (iii) promoting oral health through fluorides; (iv) increasing and diversifying the oral health workforce, and; (v) oral health through school health. Effective implementation of priority actions in the regional oral health strategy should also contribute to reducing other NCDs.
16. Technical support is being provided to Member States in three main areas of work. First, in the area of surveillance, regional capacity was built through a training workshop on the WHO STEPwise approach to Surveillance (STEPS) in June 2012 in New Delhi, India. National implementation of STEPS surveys has been supported in several countries, particularly for developing protocols, training, data analyses and report writing. During 2007–2009, WHO supported seven Member States to conduct school-based student health surveys to collect data on NCD risk factors from adolescents. Second, technical assistance is being provided to Member States for developing national multisectoral policies, strategies and action plans. The national action plans should serve as a blueprint for Member States to focus on key priorities and actions related to NCD prevention and control. The national action plans should also help in assessing resource needs and mobilizing the necessary resources from domestic and international sources. Third, technical and financial support has been provided to several Member States to introduce the WHO Package of Essential Noncommunicable Disease Interventions (PEN) into the primary health care system. Five countries are at various stages of PEN

implementation, namely Bhutan, Indonesia, the Democratic People's Republic of Korea, Myanmar and Sri Lanka. In Bhutan, WHO provided technical support for assessing the impact of the PEN pilot project in two districts. This evaluation indicates that implementation of PEN resulted in a reduction of cardiovascular risk among patients attending health clinics in the pilot project area.

17. The future thrust of WHO's regional work will be to support Member States in developing or strengthening national multisectoral action plans, scaling-up of cost-effective interventions for NCD prevention and control, documenting best practices in the Region, facilitating information exchange and assisting in resource mobilization.

### **Progress and challenges in prevention and control of NCDs in the South-East Asia Region**

18. NCDs have been recognized as a public health priority in all Member States. There is high commitment for prevention and control of NCDs. The Government of Sri Lanka, for example, declared 2013 as the "Year for Prevention and Control of Noncommunicable Diseases". Increased domestic budget allocations for NCDs have been announced in some countries. The health ministries are taking a leadership role in coordinating prevention and control activities. All 11 Member States have a designated unit for prevention and control of NCDs at the central level. In most countries, the central NCD unit is staffed by at least one full-time staff to manage the programme. Eight Member States report having a national policy or strategy for prevention and control of NCDs; however, operational multisectoral mechanisms to coordinate actions are available in less than half of these countries. Guidelines for management of NCDs or risk factors are available in all Member States. The WHO FCTC has been ratified by all except one Member State. Exemplary legislative actions in the Region towards tobacco control include pictorial warnings to cover 85% of the front and back of the cigarette packets in Thailand and Sri Lanka. Innovative financing through "excise tax" on tobacco and alcohol has yielded funds and at the same time promoted public health.
19. Continued progress is being made towards strengthening NCD surveillance and monitoring systems. At least one national or subnational survey (WHO STEPS or equivalent) has been completed in 10 of the 11 Member States to assess prevalence of behavioural and metabolic risk factors. Global Adult Tobacco Surveys (GATS) have been conducted in 4 countries and Global Youth Tobacco Surveys (GYTS) have been conducted in 10 countries. One round of school-based multi-risk factor surveys have been conducted in seven countries. Thus, data on NCD risk factors is available in almost all Member States. NCD morbidity data are collected through the routine health information system. In addition, disease-specific registries have been established, most commonly for cancers (although not all cancer types are necessarily recorded), followed by diabetes and stroke. However, most mortality/morbidity data and disease-specific registries are hospital-based.
20. All Member States are providing one or more NCD-related services at the primary care level in public health facilities. This includes primary prevention and health promotion (11 Member States), early diagnosis of NCD risk factors (9 Member



States), and risk factor and disease management (10 Member States). However, programmes for self-care and home-based care are missing in most countries. All Member States have an essential drugs list and many of the NCD-related drugs are included. Essential drugs to treat metabolic risk factors of NCDs are generally available in the public health systems, but not always at the primary health care level.

21. Despite this significant progress, important challenges need to be overcome to further scale-up and sustain an effective response to the NCDs epidemic. Partnerships among different development sectors need to be fully operationalized and sustained. Data on overall mortality and disease-specific mortality is generally based on estimates, due to incomplete registration of deaths and limitations in reporting of cause of death. There is a need to invest in strengthening vital statistics systems and cause of death ascertainment (including through verbal autopsy). NCD risk factor surveillance systems should be institutionalized and better integrated into the national health information systems. Greater resource allocation is required for primary prevention and for strengthening the capacity of primary health care systems to address NCDs. Health workers, particularly at the primary care level, need orientation and training in addressing NCDs and their risk factors. Overall funding levels for NCD programmes are disproportionately lower than is required to scale-up programmes to result in the necessary health impacts. Innovative financing mechanisms, such as those used in Thailand, should be explored in other Member States for generating funds for NCD prevention and control. Reducing the NCD burden will require moving beyond pilot projects to nationwide scaling-up of cost-effective interventions, with emphasis on population-based interventions. Focus should be put on reducing exposure to risk factors and early detection and treatment of “high-risk” groups through a strengthened primary health care system.

## **Part II Action plan for prevention and control of NCDs in the South-East Asia Region (2013–2020)**

### **Purpose**

22. The regional action plan for prevention and control of NCDs is intended to provide a roadmap for regional and national actions for developing and implementing policies and programmes to reduce the burden of NCDs within the regional socioeconomic, cultural, political and health system contexts. The regional NCD action plan is consistent with the draft global action plan 2013–2020<sup>vi</sup> and consolidates follow-up actions of the Political Declaration of the High-level Meeting on NCDs. While taking specific regional issues into account, it is coherent with the major global strategies for prevention and control of NCDs. Moreover, it provides a framework to support and strengthen the implementation of existing regional resolutions, strategies and plans as well as recommendations of the various regional consultations with Member States.
23. The regional action plan also aims to inform relevant national and regional stakeholders, as well as international development partners and donors, about regional priorities for prevention and control of NCDs. This should facilitate the

provision of technical and financial support to Member States by partner agencies through alignment along common goals and targets.

24. Successful implementation of the regional action plan requires high-level political commitment, sustainable resources and concerted involvement of governments, communities and other stakeholders in society. Implementation of the plan will be monitored through a set of indicators which are consistent with the global monitoring framework. Reports on progress in implementing the action plan and achieving regional targets will be submitted to the Regional Committee sessions in 2016, 2018 and 2021.

### **Vision**

25. All people of the South-East Asia Region enjoy the highest attainable status of health, well-being and quality of life at every age, free of preventable NCDs, avoidable disability and premature death.

### **Goal**

26. To reduce preventable morbidity, avoidable disability and premature mortality due to NCDs in the South-East Asia Region.

### **Targets**

It is aimed to achieve the following 10 targets in the Region by 2025:

1. 25% relative reduction in overall mortality from cardiovascular diseases, cancers, diabetes, or chronic respiratory diseases
2. 10% relative reduction in the harmful use of alcohol
3. 30% relative reduction in prevalence of current tobacco use in persons aged over 15 years
4. 10% relative reduction in prevalence of insufficient physical activity
5. 30% relative reduction in mean population intake of salt/sodium
6. 25% relative reduction in prevalence of raised blood pressure
7. Halt the rise in obesity and diabetes
8. 50% relative reduction in the proportion of households using solid fuels (wood, crop residue, dried dung, coal and charcoal) as the primary source of cooking
9. 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
10. 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities

## Guiding principles

27. The regional action plan relies on the following overarching principles and approaches.

**Focus on equity:** Policies and programmes should aim to reduce inequalities in NCD burden due to social determinants such as education, gender, socioeconomic status, ethnicity and migrant status.

**Multisectoral actions and multi-stakeholder involvement:** To address NCDs and their underlying social determinants and risk factors, functioning alliances are needed within the health sector and with other sectors (such as agriculture, education, finance, information, sports, urban planning, trade, transport) involving multiple stakeholders including governments, civil society, academia, the private sector and international organizations.

**Life-course approach:** A life-course approach is key to prevention and control of NCDs, starting with maternal health, including preconception, antenatal and postnatal care and maternal nutrition; and continuing through proper infant feeding practices, including promotion of breastfeeding and health promotion for children, adolescents and youth; followed by promotion of a healthy working life, healthy ageing and care for people with NCDs in later life.

**Balance between population-based and individual approaches.** A comprehensive prevention and control strategy needs to balance an approach aimed at reducing risk factor levels in the population as a whole with one directed at high-risk individuals.

**Empowerment of people and communities:** People and communities should be empowered to promote their own health and be active partners in managing disease.

**Health system strengthening:** Revitalization and reorientation of health care services are required for health promotion, disease prevention, early detection and integrated care, particularly at the primary care level.

**Universal health coverage:** All people, particularly the poor and vulnerable, should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative basic health services, as well as essential, safe, affordable, effective and quality medicines and diagnostics without exposing the users to financial hardship.

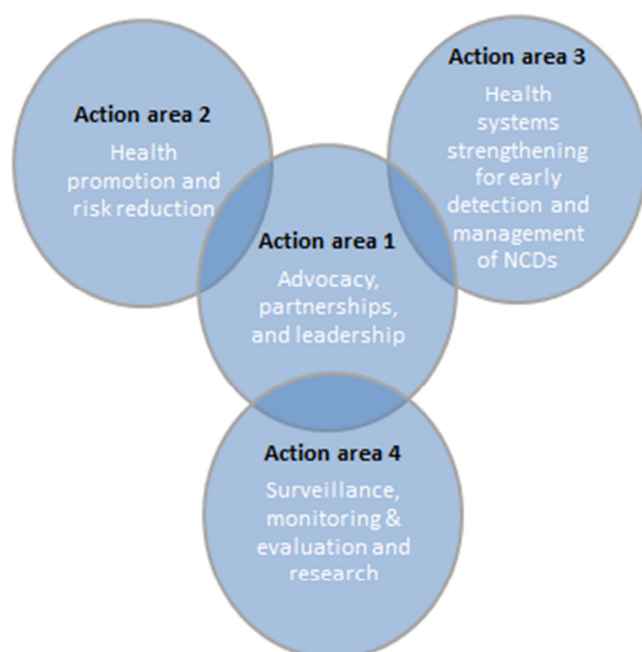
**Evidence-based strategies:** Policies and programmes should be developed based on scientific evidence and/or best practice, cost-effectiveness, affordability, and public health principles..

**Management of real, perceived or potential conflicts of interest:** Public health policies for the prevention and control of NCDs should be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed.

## Priority action areas

28. To achieve the 10 regional targets, the priority activities for WHO and Member States are structured around four strategic action areas (Figure 3). Implementation of these priority actions will lead to a reduction in overall mortality from the four main NCDs.

**Figure 3. Priority action areas for the prevention and control of NCDs**



**Action area 1: Advocacy, partnerships and leadership.** Actions under this area aim to increase advocacy, promote multisectoral partnerships and strengthen capacity for effective leadership to accelerate and scale-up the national response to the NCD epidemic. Effective implementation of these actions should result in increased political commitment, availability of sustainable resources, and setting functional mechanisms for multisectoral actions and effective coordination by ministries of health.

**Action area 2: Health promotion and risk reduction.** Actions under this area aim to promote the development of population-wide interventions to reduce exposure to key risk factors. Effective implementation of these actions should lead to reduction in tobacco use, increase in intake of fruits and vegetables, reduced consumption of saturated fat, salt and sugar, reduction in harmful use of alcohol, increase in physical activity and reduction in household air pollution.

**Action area 3: Health systems strengthening for early detection and management of NCDs and their risk factors.** Actions under this area aim to strengthen health systems, particularly the primary health care system. Full implementation of actions in this area should lead to improved access to health-care

services, increased competence of primary health care workers to address NCDs, and empowerment of communities and individuals for self-care.

**Action area 4: Surveillance, monitoring and evaluation, and research.** This area includes key actions for strengthening surveillance, monitoring and research. The desired outcome is to improve availability and use of data for evidence-based policy and programme development

All actions should be implemented, as far as possible, through close collaboration with other health programmes such as infectious diseases control, maternal and child health, immunization, school health and occupational health services.

**The following tables list priority actions for Member States and WHO in each of the four strategic action areas. Partners needed for implementing these priority actions are also indicated. Key indicators to track progress in implementation of the action plan are also provided.**

**Member States are encouraged to adapt this framework according to national priorities and create a detailed national action plan with specific activities and budget. A national action plan could serve as useful blueprint for action and also facilitate resource assessment and resource mobilization.**

## Strategic action area 1: Advocacy, partnerships, and leadership

### 1.1 Advocacy

**Partners: parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; UN agencies, developmental partners, civil society, NGOs, media, private sector**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
NCDs prioritized in the national health and development agenda	<ul style="list-style-type: none"> <li>NCDs are included in the national health plan or national development agenda, or both</li> </ul>	<ul style="list-style-type: none"> <li>Continue to strengthen advocacy to Heads of State, parliamentarians and policy-makers to give a high priority to NCDs</li> <li>Provide technical support to integrate NCDs into national health planning processes, development agenda and poverty-alleviation strategies</li> <li>Support Member States in resource mobilization and facilitate intercountry exchange of information on innovative financing</li> <li>Liaison with UN Country Teams, to integrate NCDs into the United Nations Development Assistance Framework (UNDAF) processes</li> </ul>	<ul style="list-style-type: none"> <li>Integrate NCDs into health planning processes and development plans with special attention to social determinants of health</li> <li>Generate and disseminate evidence on the relationship between NCDs and other development issues such as poverty alleviation, economic development, food security and gender equality</li> <li>Raise public and political awareness/ understanding about NCDs through social marketing, mass media and responsible media reporting</li> <li>Provide adequate and sustained resources for NCDs by increased domestic budgetary allocations, innovative financing and other means</li> <li>Explore resources for NCD prevention and control from existing initiatives such as GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Bill and Melinda Gates Foundation</li> <li>Mobilize the UN Country Teams and link NCDs into the UNDAF processes</li> </ul>

## 1.2 Partnerships

**Partners: parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; UN agencies, developmental partners, civil society, NGOs, media, private sector**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
<p>National and subnational mechanism/s for multisectoral actions established and functioning</p>	<ul style="list-style-type: none"> <li>• Multisectoral national NCD policy, strategy or action plan, which integrates several NCDs and shared risk factors, developed and operational</li> </ul>	<ul style="list-style-type: none"> <li>• Provide guidance to Member States for developing effective partnerships for multisectoral actions</li> <li>• Provide technical support to Member States for health impact assessment of public policies for maximizing intersectoral synergies</li> <li>• Coordinate activities related to NCDs of various UN agencies, funds, and programmes</li> <li>• Collate and publish regional best practices for effective public policy development and implementation in the Region</li> <li>• Facilitate intercountry collaboration for exchange of best practices in the areas of “health in all policies”, “whole-of-government” and “whole-of-society” approaches</li> </ul>	<ul style="list-style-type: none"> <li>• Set up an effective national multisectoral mechanism (commission, agency or task force) reporting to the Head of State (or delegate) to plan, guide, monitor and evaluate the enactment of multisectoral national NCD policies and plans and to secure the necessary budget</li> <li>• Establish new, or strengthen existing, national multisectoral NCD policies and plans through multi-stakeholder engagement, and with adequate budget, taking into account global and regional action plans as well as national priorities</li> <li>• Assess the health impact of policies in non-health sectors e.g. agriculture, education, trade, environment, energy, labour, sports, transport, urban planning</li> <li>• Mobilize a social movement engaging and empowering a broad range of actors, including women as change agents, to catalyse a systematic society-wide national response to address NCDs and the underlying social, environmental and economic determinants of health</li> </ul>

### 1.3 Leadership

**Partners: parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; UN agencies, developmental partners, civil society, NGOs, media, private sector**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
<p>Health ministry effectively leading and coordinating the national NCD prevention and control programme</p>	<ul style="list-style-type: none"> <li>An operational NCD unit/department in the health ministry with adequate staff and funds for major NCD activities including primary prevention and health promotion; early detection and treatment, and; surveillance monitoring of NCDs</li> </ul>	<ul style="list-style-type: none"> <li>Examine the capacity of Member States through capacity assessment surveys to identify needs, and tailor the provision of technical support</li> <li>Develop appropriate training programmes to strengthen skills of national programme managers in dealing with the complex issues involved in implementation of NCD programmes</li> </ul>	<ul style="list-style-type: none"> <li>Set up and/or strengthen a national unit on NCDs in the health ministry with suitable expertise and resources for: needs assessment, strategic planning, policy development, multisectoral coordination, programme implementation and evaluation</li> <li>Implement the national multisectoral policies and action plans through collaborative partnerships with multiple stakeholders, including government agencies, NGOs, civil society, academia, and the private sector</li> <li>Strengthen skills and capacity of workforce for implementing the national action plan and to deal with the complex issues relating to NCDs including multisectoral action, advertising, behavioural change, health economics, food and agricultural systems, law, business management, trade, commercial influence and urban planning, and education, among others</li> </ul>



## Strategic action area 2: Health promotion and risk reduction

### 2.1 Reduce tobacco use

Partners: parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; UN agencies, developmental partners, civil society, NGOs, media, private sector

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
Tobacco use reduced	<ul style="list-style-type: none"> <li>• Adoption of comprehensive national policies and legislations to reduce tobacco use</li> <li>• Age-standardized prevalence of current tobacco use among persons aged 18 years and older</li> <li>• Prevalence of current tobacco use among adolescents</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical support to Member States in drafting tobacco control legislations/regulations/directives and support their enforcement</li> <li>• Develop and disseminate standard guidelines for tobacco cessation services for use by health professionals (e.g. physicians, dentists, nurses, pharmacists) and allied professions and train them.</li> <li>• Provide technical support in training health professionals on tobacco cessation</li> <li>• Strengthen national capacity in establishing community-based tobacco cessation services</li> <li>• Provide technical support to Member States to conduct surveillance to monitor tobacco use</li> <li>• Maintain a database of pictorial warnings to facilitate sharing of best practices among Member States</li> <li>• Promote and support priority</li> </ul>	<ul style="list-style-type: none"> <li>• Accelerate full implementation of the WHO FCTC; Members States that have not yet become party to the WHO FCTC, to consider action to ratify, accept, approve, formally confirm or accede to, at the earliest opportunity</li> <li>• Strengthen tobacco surveillance system to monitor tobacco use and prevention policies</li> <li>• Assess the prevalence of habitual use of carcinogenic substances (betel nut chewing, pan masala, gutka, etc.) and develop effective regulations for its prevention and control</li> <li>• <b>Raise taxes and inflation-adjusted prices on tobacco products (in line with WHO FCTC Article 6)</b></li> <li>• <b>Legislate for 100% tobacco-free environments in all indoor workplaces, public transport, indoor public places and, as appropriate, other public places (in line with WHO FCTC Article 8)</b></li> <li>• <b>Warn people about the dangers of tobacco, including through hard-hitting mass-media campaigns and large, clear, visible and legible text</b></li> </ul>

		<p>research including effectiveness of taxation policies to reduce tobacco use</p>	<p><b>and pictorial health warnings (in line with WHO FCTC Articles 11, 12)</b></p> <ul style="list-style-type: none"> <li>• <b>Implement comprehensive bans on tobacco advertising, promotion and sponsorship (in line with WHO FCTC Articles 13)</b></li> <li>• Offer help to people who want to stop using tobacco (in line with WHO FCTC Article 14)</li> <li>• Protect tobacco control policies from commercial and other vested interests of the tobacco industry in accordance with national law (in line with WHO FCTC Article 5.3)</li> <li>• Regulate the contents and emissions of tobacco products, tobacco product disclosures and the methods by which they are tested and measured (in line with WHO FCTC Article 9 and 10)</li> <li>• Take measures to eliminate the illicit trade of tobacco products, including smuggling, illicit manufacturing and counterfeiting (in line with WHO FCTC Article 15)</li> <li>• Prohibit sales of tobacco products to and by minors (in line with WHO FCTC Article 16)</li> <li>• Consider taking action to deal with criminal and civil liability, including compensation where appropriate and to offer one another related legal assistance (in line with WHO FCTC Article 19)</li> </ul>
--	--	--	--

## 2.2 Reduce harmful use of alcohol

**Partners: parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; UN agencies, developmental partners, civil society, NGOs, media, private sector**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
Harmful use of alcohol reduced	<ul style="list-style-type: none"> <li>• Adoption of comprehensive national policies and legislations to reduce harmful use of alcohol</li> <li>• Total (recorded and unrecorded) alcohol per capita (15 years and older) consumption within a calendar year in litres of pure alcohol as appropriate, within the national context</li> <li>• Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen advocacy to all stakeholders for reducing harm from alcohol</li> <li>• Communicate and promote the common understanding of the terminology “harmful use of alcohol” agreed at global level, and its policy implication in the Region</li> <li>• Provide technical assistance to support the implementation of global strategy to reduce harmful use of alcohol</li> <li>• Facilitate operational research to scale-up effective interventions for reducing harmful use of alcohol and disseminate data to inform policy and programme development</li> <li>• Promote networking and exchange of experiences and best practices among Member States</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen leadership and political commitment to reduce harmful use of alcohol</li> <li>• Accelerate implementation of the Global Strategy to Reduce the Harmful Use of Alcohol</li> <li>• <b>Regulate the commercial or public availability of alcohol through laws, policies and programmes</b></li> <li>• <b>Restrict or ban alcohol advertising and promotions</b></li> <li>• <b>Introduce and adjust pricing policies, such as excise taxes on alcoholic beverages to reduce alcohol-related harm</b></li> <li>• Implement effective drink-driving policies and countermeasures</li> <li>• Reduce the public health impact of illicit alcohol and informally produced alcohol through identified measures</li> <li>• Reduce the negative consequences of drinking and alcohol intoxication and providing consumer information</li> <li>• Strengthen health services to provide prevention and treatment</li> </ul>

			<p>intervention to individuals and families at risk of, or affected by, alcohol-use disorders and associated conditions</p> <ul style="list-style-type: none"><li>• Support and empower communities to use their local knowledge and expertise in adopting effective approaches to prevent and reduce harmful use of alcohol</li><li>• Develop and strengthen surveillance systems to monitor the magnitude and trends of alcohol related harm, to strengthen advocacy, to formulate policies and to assess impact of interventions</li></ul>
--	--	--	---

## 2.3 Promote healthy diet high in fruits and vegetables and low in saturated fats/trans fats, free sugars and salt

**Partners:** parliamentarians, government agencies including ministries of health, finance, trade, education, legal, agriculture, sports, youth affairs, information, and local government; **Private:** food manufacturers, food processors, retailers; media, civil society, NGOs, consumers

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
<p>Increased intake of fruits and vegetables</p> <p>Reduced consumption of saturated fats/trans fats, sugar and salt</p> <p>Reduced cardiometabolic risk</p>	<ul style="list-style-type: none"> <li>Adoption of national policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt</li> <li>Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply</li> <li>Prevalence of persons aged 18 years and older consuming less than five total servings (400 g) of fruit and vegetables per day</li> <li>Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18 years and older</li> <li>Mean population intake of salt (sodium chloride) per person per day</li> <li>Prevalence of raised total cholesterol among persons aged 18 years and older, and</li> </ul>	<ul style="list-style-type: none"> <li>Provide technical support to Member States to develop and implement national policies and regulations</li> <li>Provide technical support to Member States for development and/or updating of the food composition database tables</li> <li>Provide technical support to Member States to develop national sodium reduction strategies</li> <li>Strengthen country capacity to conduct surveys on population sodium consumption</li> <li>Dialogue with the private sector and build pressure to reduce sodium content of processed food</li> <li>Provide technical support to Member States to develop national policies and regulations to reduce saturated fats and eliminate trans fats in the food supply</li> </ul>	<ul style="list-style-type: none"> <li>Accelerate implementation of the Global Strategy on Diet, Physical Activity and Health</li> <li>Implement WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children, including mechanisms for monitoring</li> <li>Develop policy measures and guidelines in collaboration with various stakeholders such as food producers, processors, retailers and consumers to promote affordability, availability and acceptability of healthier food products</li> <li>Establish regulations and fiscal policies including taxes and subsidies to promote consumption of fruits and vegetables and discourage consumption of unhealthy food options high in saturated fat, sugar and salt</li> <li><b>Carry out public campaigns through mass media and social media to inform consumers about a healthy diet high in fruits and vegetables and low in saturated fat, sugar and salt</b></li> <li>Promote and support exclusive breastfeeding for the first six months of life, continued breast feeding until two years and beyond and timely complementary</li> </ul>

	<p>mean total cholesterol</p> <ul style="list-style-type: none"> <li>• Age-standardized prevalence of raised blood glucose concentrations/diabetes among persons aged 18 years and older (defined as fasting plasma glucose concentration <math>\geq 7.0</math> mmol/L (126 mg/dL) or on medication for raised blood glucose concentration, respectively)</li> <li>• Raised blood pressure among persons aged 18 years and older, and mean systolic blood pressure</li> </ul>	<p>chain</p>	<p>feeding</p> <ul style="list-style-type: none"> <li>• Promote nutrition labelling, according but not limited to, international standards, in particular the Codex Alimentarius, for all pre-packaged foods including those for which nutrition or health claims are made</li> <li>• Strengthen capacity of national intuitions for testing and monitoring the content of saturated fat, salt and sugar in processed food</li> <li>• Develop and implement national salt reduction strategies in line with WHO recommendations</li> <li>• Increase collaboration between salt/sodium reduction programmes and salt iodization programmes for increased public health gains and higher programme efficiency</li> <li>• Regulate private industry to voluntarily reduce salt in packaged food and monitor compliance.</li> <li>• Undertake representative surveys to measure population salt/sodium intake</li> <li>• <b>Establish policies and regulations to eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and limit saturated fatty acids and monitor compliance of private sector with the regulations</b></li> <li>• Replace saturated fat and trans-fat with unsaturated fat</li> </ul>
--	---	--------------	--

## 2.4 Promote physical activity

**Partners: Ministries of health, finance, trade, education, sports, youth affairs, legal, information, local government, infrastructure/transport, planning and urban development; media; civil society, NGOs**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
Physical inactivity reduced	<ul style="list-style-type: none"> <li>• Prevalence of insufficiently active persons aged 18 years and older</li> <li>• Prevalence of insufficiently active adolescents (defined as less than 60 minutes of moderate to vigorous intensity activity daily)</li> <li>• Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference as: <i>overweight</i> – one standard deviation body mass index for age and sex; and <i>obese</i> – two standard deviations body mass index for age and sex)</li> <li>• Age-standardized prevalence of overweight and obesity in persons aged 18 years and older (defined as body mass index greater than 25 kg/m<sup>2</sup> for overweight and 30 kg/m<sup>2</sup> for obesity).</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and disseminate model legislation for supportive environments for physical activity</li> <li>• Provide support for establishing collaboration with architects and town planners in countries to advocate urban planning to increase public spaces supportive of physical activity</li> <li>• Disseminate guidelines for physical activity</li> <li>• Facilitate sharing of best practices and lessons learned among countries</li> </ul>	<ul style="list-style-type: none"> <li>• Adopt and implement national guidelines on physical activity for health</li> <li>• Develop policy measures and guidelines in conjunction with relevant sectors and stakeholders to promote physical activity through activities of daily living including through “active transport”, recreation, leisure and sports.</li> <li>• Advocate to town planners for designing increased public spaces supportive of physical activity</li> <li>• Establish legislation to ensure new housing developments include safe spaces for walking and cycling</li> <li>• Carry out mass-media campaigns and social marketing to raise awareness on benefits of physical activity throughout the life cycle</li> <li>• Evaluate interventions aimed at increasing physical activity throughout the life-course and use data to inform policy and programme development</li> </ul>

## 2.5 Promote healthy behaviours and reduce NCDs in key settings

**Partners:** Ministries of health, education, trade, sports, youth affairs, information, local government, infrastructure/transport, planning/urban development; corporate sector; media; civil society, NGOs

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
<p>Reduced risk of NCDs among school children/students at educational institutes, and workforce</p>	<ul style="list-style-type: none"> <li>• National guidelines for health promoting schools/students at educational institutes developed and adopted</li> <li>• National guidelines for workplace wellness programmes developed and adopted</li> </ul>	<ul style="list-style-type: none"> <li>• Promote and facilitate intersectoral action through the development and dissemination of model healthy schools/workplace policies and programmes</li> <li>• Develop and disseminate model comprehensive workplace wellness policies and programmes to reduce the risk of NCDs</li> <li>• Provide technical support to countries in developing and implementing school, workplace, policies and programmes</li> <li>• Develop curricula modules for prevention and control of NCDs, including counselling techniques for integration in teacher training</li> <li>• Facilitate sharing of experiences and best practices among Member States</li> <li>• Establish evidence and best-practices for effective interventions in school and workplace settings</li> </ul>	<ul style="list-style-type: none"> <li>• Enable and facilitate intersectoral action in schools and workplaces through establishment of intersectoral working groups, task teams or focal persons in charge of developing and coordinating health promoting activities</li> <li>• Appoint and train focal persons or other appropriate coordination mechanisms between Ministry of Health and Ministry of Education to promote effective interventions in schools and pre-schools</li> <li>• Establish health promoting schools with guidelines for implementation and mechanisms for monitoring and evaluation</li> <li>• Conduct advocacy and training workshops to promote healthy behaviours in schools and workplaces</li> <li>• Establish health promoting workplaces with guidelines for implementation and mechanisms for monitoring and evaluation</li> <li>• Ban foods high in saturated fat, sugar and salt from school premises and workplace catering facilities</li> </ul>



## 2.6 Reduce household air pollution

**Partners:** Ministries of health, finance, trade, education, legal, agriculture, urban development and housing, environment, petroleum, energy, industries, information, media, civil society, NGOs, community

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
Household air pollution due to solid fuel use for cooking and passive smoking reduced	<ul style="list-style-type: none"> <li>• 50% reduction in proportion of households with solid fuel use as primary source of cooking</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen advocacy to all stakeholders for reducing harm from household air pollution</li> <li>• Provide technical support for developing new and revised indoor air quality guidelines</li> <li>• Support research for evaluating interventions aimed at reducing household air pollution</li> <li>• Strengthen Global Household Energy Database</li> <li>• Facilitate sharing of experiences and best practices among Member States</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen advocacy in support of transition to cleaner technologies and fuels (LPG, bio-gas, solar cookers, electricity, other low-fume fuels such as methanol, ethanol)</li> <li>• Develop and maintain national databases on key variables to support decision-making for transition to clean sustainable household energy</li> <li>• Develop and implement programmes aimed at encouraging the use of improved cook-stoves, good cooking practices, reducing exposure to fumes, and improving ventilation in households</li> <li>• Create awareness and develop appropriate strategies to reduce exposure to second-hand tobacco smoke in households</li> </ul>

### Strategic action area 3: Health system strengthening for early detection and management of NCDs and their risk factors

#### 3.1 Access to health services

**Partners: Ministries of health, other relevant ministries, local government authorities, regulatory councils, civil society, medical associations, private health providers, NGOs, pharmaceutical agencies, media**

Desired outcome	Indicators	Actions by WHO	Recommendations for actions by Member States
Universal health coverage and equitable access to prevention, early detection and treatment of NCDs	<ul style="list-style-type: none"> <li>• Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities</li> <li>• Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer</li> <li>• Availability, as appropriate (if cost-effective and affordable), of HPV vaccines according to national programmes and policies</li> <li>• Proportion of eligible persons receiving drug therapy and counselling to prevent heart attacks, strokes and chronic</li> </ul>	<ul style="list-style-type: none"> <li>• Provide support to Member States in integrating cost-effective interventions for NCDs and their risk factors into health systems, including essential primary health care packages</li> <li>• Deploy an interagency emergency health kit for treatment of NCDs in humanitarian disasters and emergencies</li> <li>• Develop and disseminate standard guidelines, tools and training materials for early detection, treatment and palliative care to address NCDs including oral cancers at primary health care centres</li> <li>• Provide support to countries in integrating cost-effective interventions for reducing risk factors for oral cancer into health systems, especially at primary health care level</li> </ul>	<ul style="list-style-type: none"> <li>• Integrate and scale-up cost-effective NCD interventions, based on national policies and priorities, into the basic primary health care package with referral system to all levels of care in order to advance the universal health coverage agenda</li> <li>• Establish quality assurance and quality improvement systems with emphasis on primary health care</li> <li>• Strengthen referral systems for management of NCDs</li> <li>• Develop policies for sustainable and equitable health financing (including insurance, tax funding, health savings account) to cover costs of prevention, treatment, rehabilitation and palliative care</li> <li>• Include essential medicines and technologies specifically for NCDs, in national essential medicines and medical technologies lists</li> <li>• Improve efficiency in the procurement, supply management and access to essential NCD medicines and technologies including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities</li> <li>• Promote procurement and use of generic</li> </ul>

	<p>respiratory diseases</p> <ul style="list-style-type: none"> <li>• Proportion of women aged 30–49 years screened for cervical cancer at least once, or more often</li> <li>• Proportion of “at risk” population screened for oral cancer at least once or at regular intervals</li> <li>• Vaccination coverage against hepatitis B virus monitored by number of third doses of hepatitis B vaccine (HepB3) administered to infants</li> </ul>	<ul style="list-style-type: none"> <li>• Negotiate with pharmaceutical producers and wholesalers to reduce cost of essential drugs</li> <li>• Facilitate technology transfer for manufacture of medicines, vaccines, medical technologies, and information technologies for prevention and control of NCDs</li> <li>• Facilitate development, adaptation and use of rapid screening/diagnostic tests and kits at community level for early detection of NCDs and their risk factors.</li> <li>• Facilitate sharing of experiences, best practices and lessons among Member States</li> </ul>	<p>medicines for prevention and control of NCDs by quality assurance of generic products, preferential registration procedures, generic substitution, financial incentives and education of prescribers and consumers</p> <ul style="list-style-type: none"> <li>• Ensure the availability of life-saving technologies and essential medicines for managing NCDs in the initial phase of emergency response</li> <li>• Develop and implement a palliative care policy using cost-effective treatment modalities, including opioid analgesics for pain relief</li> <li>• Improve coverage of hepatitis B vaccination</li> <li>• Strengthen education and awareness on early detection of common cancers including breast cancer, cervical cancer and oral cancer</li> <li>• Strengthen basic facilities of primary health care facilities for prevention and early diagnosis of cervical cancer and oral cancer</li> <li>• Review existing programmes, such as nutrition, HIV, tuberculosis and reproductive health, for opportunities to integrate service delivery for prevention and control of NCDs</li> <li>• Increase capacity of health-care services to deliver prevention and treatment interventions for hazardous drinking and alcohol use disorders at primary care and other settings.</li> <li>• Facilitate access to preventive measures, treatment and vocational rehabilitation, as well as financial compensation of occupational NCDs, such as cancer and chronic respiratory disease, consistent with international and national laws and regulations on occupational diseases</li> </ul>
--	---	--	--

### 3.2 Health workforce

**Partners: Ministries of health**, other relevant ministries, local government authorities, regulatory councils, **civil society, medical associations, private health providers, NGOs, pharmaceutical agencies, media**

Desired outcome	Indicators	Actions by WHO	Recommendations for Actions by Member States
Improved competence of health workforce for prevention, early diagnosis and management of NCDs	<ul style="list-style-type: none"> <li>• Percentage of primary health care workers trained in integrated NCD prevention and control</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical support to develop competency-based curriculum for training of health workforce in NCD prevention and control, with an emphasis on primary care</li> <li>• Train health workers in use of available WHO NCD tools, such as WHO PEN</li> <li>• Encourage innovative health workforce models, including task shifting and capacity building for low- and mid-level providers in primary health care settings</li> </ul>	<ul style="list-style-type: none"> <li>• Manage health workforce to adequately address current NCD burden as well as planning for future needs in light of population ageing</li> <li>• Identify competencies required and invest in improving the knowledge, skills and motivation of the current health workforce to address NCDs, including common co-morbidity conditions</li> <li>• Incorporate prevention and control of NCDs in the pre-service and in-service training of all health workers, professional and non-professional (technical, vocational), with an emphasis on primary care</li> <li>• Provide adequate mechanisms (compensation) and incentives for health workers, paying due attention to attracting and retaining them in underserved areas</li> <li>• Develop career tracks for health workers through strengthening postgraduate training, with a special focus on NCDs, in various professional disciplines and career advancement for non-professional staff</li> <li>• Explore and promote innovative health workforce models, including task shifting, and capacity building for low- and mid-level providers in the context of prevention and control of NCDs in primary health care settings</li> </ul>

### 3.3 Community-based approaches

**Partners: Ministries of health**, other relevant ministries, local government authorities, regulatory councils, **civil society, medical associations, private health providers, NGOs, pharmaceutical agencies, media**

Desired outcome	Indicators	Actions by WHO	Recommendations for Actions by Member States
Communities/patients empowered for self-care	<ul style="list-style-type: none"> <li>• National guidelines on self-care for prevention and management of NCDs developed and adopted</li> </ul>	<ul style="list-style-type: none"> <li>• Develop innovative tools for self-care, for example through information technology</li> <li>• Develop and disseminate guidelines for monitoring and evaluation of community-based initiatives for NCD prevention and control</li> <li>• Facilitate best practices on community-based care for prevention and control of NCDs</li> </ul>	<ul style="list-style-type: none"> <li>• Use participatory community-based approaches in designing, implementing, monitoring and evaluating NCD programmes across the life-course and continuum of care</li> <li>• Create awareness to empower people to seek care and detection for better management of their conditions</li> <li>• Develop patient education/self-care guidelines for prevention and control of NCDs in consultation with a wide variety of stakeholders</li> <li>• Encourage the formation of community coalitions and patient groups, and build their capacity</li> <li>• Meet the needs for long-term care of people with NCDs, related disabilities and co-morbidities through innovative and effective models of care (connecting occupational health services and community health resources with primary care and the rest of the health-care delivery system)</li> <li>• Monitor and evaluate community-based initiatives for prevention and control of NCDs</li> </ul>

## Strategic action area 4: Surveillance, monitoring and evaluation and research

### 4.1 Strengthen surveillance

**Partners:** Ministries of health, other relevant ministries/government agencies, professional bodies, NGOs, academia, National Research Council/other research institutions, UN agencies/bilateral and multilateral development partners

Desired outcome	Indicators	Actions by WHO (Regional Office and country offices)	Recommendations for actions by Member States
Improved availability and use of information on NCD mortality, morbidity, risk factors and health system response	<ul style="list-style-type: none"> <li>National risk factor surveys using standard methods conducted every three to five years</li> </ul>	<ul style="list-style-type: none"> <li>Disseminate standard tools and guidelines for NCD surveillance/surveys</li> <li>Build capacity of Member States in strengthening national surveillance and monitoring systems (including vital registration, risk factor surveys and health facility surveys) and support implementation</li> <li>Procure a regional pool of data collection tools (e.g. PDAs, blood pressure instrument) and other materials for facilitating surveillance in Member States</li> <li>Strengthen technical capacity in Member States in conducting surveillance, with a focus on building capacity for data management, data analysis and data use for advocacy, as well as for planning and monitoring</li> </ul>	<ul style="list-style-type: none"> <li>Adapt and implement WHO surveillance framework that monitors exposure (risk factors), outcome (morbidity and mortality), and health system response</li> <li>Allocate adequate funds for NCD surveillance</li> <li>Explore resources from existing initiatives such as GAVI Alliance, the GFATM for strengthening NCD surveillance and monitoring, including vital registration, risk factor surveillance (including salt surveys) and health system response.</li> <li>Institutionalize NCD surveillance through an appropriate governing mechanism to enhance ownership, sustainability and coordination at country level.</li> <li>Build national capacity for data management, data analysis and data use for advocacy, as well as for programme planning and monitoring progress in prevention and control of NCDs.</li> <li>Strengthen vital registration and civil registration systems and improve</li> </ul>

			<p>medical cause of death reporting by proactively engaging relevant stakeholders/sectors</p> <ul style="list-style-type: none"> <li>• Strengthen national cancer registration including population-based registries</li> <li>• Strengthen national cancer registration including correct diagnosis, encoding and recording of oral cancer</li> <li>• Integrate surveillance for NCDs into other national health surveys</li> <li>• Carry out STEPS survey (including Step 3) or equivalent surveys, every five years. All Member States are encouraged to use eSTEPS</li> <li>• Carry out national school health surveys (age 13–17 years) using the global school-based student health survey (GSHS) every five years to collect data on multiple risk factors (e.g. physical activity, tobacco, overweight and obesity, alcohol)</li> <li>• Undertake secondary data analyses</li> <li>• Use surveillance information for policy and programme development</li> <li>• Disseminate results of surveillance widely to all stakeholders</li> </ul>
--	--	--	--

## 4.2 Improve monitoring and evaluation

**Partners:** Ministries of health, other relevant ministries/government agencies, professional bodies, NGOs, academia, National Research Council/other research institutions, UN agencies /bilateral and multilateral development partners

Desired outcome	Indicators	Actions by WHO (Regional Office and Country Office)	Recommendations for actions by Member States
Timely reporting and use of information to improve NCD programme	<ul style="list-style-type: none"> <li>• National progress report on key national, regional and global indicators and targets published periodically</li> </ul>	<ul style="list-style-type: none"> <li>• Assess national capacity for prevention and control of NCDs at regular intervals and use this information to plug gaps in capacity</li> <li>• Provide technical support to Member States to develop a national NCD monitoring framework including indicators and national targets; mechanisms for data collection; frequency of data collection; and use of data</li> <li>• Set up a regional mechanism to track achievements of Member States against key targets and facilitate exchange of information</li> </ul>	<ul style="list-style-type: none"> <li>• Develop national targets and indicators based on the global and regional monitoring framework and linked to a national multisectoral policy and action plan</li> <li>• Integrate NCD monitoring system into national health and management information systems</li> <li>• Design and conduct evaluation of NCD interventions periodically</li> <li>• Publish periodic reports on progress made in NCD prevention and control including reporting on key national, regional and global indicators and targets</li> </ul>



### 4.3 Strengthen research

**Partners: Ministries of health**, other relevant ministries/government agencies, **professional bodies**, NGOs, academia, **National Research Council**/other research institutions, **UN agencies** /bilateral and multilateral development partners

Desired outcome	Indicators	Actions by WHO (Regional Office and Country Office)	Recommendations for actions by Member States
<p>Relevant evidence generated and used for national policy and programme development</p>	<ul style="list-style-type: none"> <li>• Availability of a national research agenda and a prioritized research plan for prevention and control of NCDs</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical support to develop national NCD research agenda and assist in resource mobilization to carry out priority research</li> <li>• Strengthen capacity of national institutions and staff in development of research protocols, analyses of data and preparation of scientific peer-reviewed manuscripts</li> <li>• Foster partnerships and linkages between academia, research institutions and health service agencies to translate research into policy and action</li> <li>• Organize intercountry meetings and conferences to facilitate sharing of new research findings among Member States</li> <li>• Encourage multi-country data collection and analysis to determine diagnostic cut-off for overweight/obesity among South-East Asian adults</li> <li>• Promote sharing of data and research databases among Member States</li> </ul>	<ul style="list-style-type: none"> <li>• Allocate adequate funds for NCD research</li> <li>• Develop, implement and monitor a priority national research agenda for prevention and control of NCDs, based on consultation with universities, WHO and other stakeholders</li> <li>• Strengthen national capacity for research and development, including research infrastructure, equipment and supplies in research institutions, and the competence of researchers to conduct good-quality research</li> <li>• Enhance cooperation between universities, research institutes and health services to ensure speedy utilization of research findings and scientific basis for decision-making for NCD policy/programme development</li> <li>• Strengthen collaboration between national, regional and international research centres</li> <li>• Build formal linkages between research and policy/programme</li> </ul>

## References

---

<sup>i</sup> World Health Organization Regional Office for South-East Asia. *Regional Health Observatory*. <http://apps.who.int/searo-rho/>.

<sup>ii</sup> Ajay Mahal, Anup Karan, Michael Engelgau. The economic implications of noncommunicable diseases for India. World Bank Health HNP discussion paper 2010.

<sup>iii</sup> Montarat Thavorncharoensap, Yot Teerawattananon<sup>1</sup>, Jomkwan Yothasamut, Chanida Lertpitakpong, Khannika Thitiboonsuwan, Prapag Neramitpitagkul and Usa Chaikledkaew. The economic costs of alcohol consumption in Thailand, 2006. *BMC Public Health* 2010, **10**:323.

<sup>iv</sup> United Nations General Assembly resolution 66/2 ([http://www.who.int/nmh/events/un\\_ncd\\_summit2011/political\\_declaration\\_en.pdf](http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf)).

<sup>v</sup> WHA 66.10. Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_R10-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf)

<sup>vi</sup> WHO Global Action Plan (2013-2020). [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_R10-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf)