Regional Action Plan and Targets for Prevention and Control of Noncommunicable Diseases (2013–2020)

Noncommunicable diseases (NCDs) are the leading cause of mortality globally and in the South-East Asia Region. In May 2013, the Sixty-sixth Session of the World Health Assembly unanimously adopted resolution WHA66.10 endorsing the global action plan for prevention and control of NCDs covering the period 2013–2020. The action plan focuses on the four types of NCD – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – which make the largest contribution to morbidity and mortality, and on four shared behavioural risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. The World Health Assembly also adopted the global monitoring framework, including 25 indicators, and a set of nine voluntary global targets and urged Member States to consider setting national targets based on country situation and capacity.

To provide normative guidance to Member States on developing national action plans and setting national targets, the WHO Regional Director for South-East Asia convened a technical working group meeting on the “Regional Action Plan and Targets for Prevention and Control of Noncommunicable Diseases” in Bangkok, Thailand, from 11 to 13 June 2013. The TWG took stock of the current data availability and capacity of Member States to report on the nine global voluntary targets; deliberated on three additional regional targets, namely cervical cancer, oral cancer and household air pollution; discussed mechanisms to build national capacity and strengthen national surveillance and monitoring systems; and provided inputs to finalize the regional action plan for prevention and control of NCDs.

The High-Level Preparatory (HLP) Meeting held in the Regional Office in New Delhi, India, from 1 to 3 July 2013 reviewed the working paper and made the following recommendations:

**Recommendations**

**Actions by Member States**

(1) To develop/strengthen national action plans for prevention and control of NCDs and set national targets based on country context, taking into account global and regional action plans and voluntary targets.
(2) To consider the recommendations of the Technical Working Group on strengthening national surveillance and monitoring systems including collecting baseline data on key indicators by 2015.

(3) To consider drafting a resolution on noncommunicable diseases, including operative paragraphs on cervical cancer and oral cancer, for consideration by the Sixty-sixth Regional Committee.

Actions by WHO-SEARO

(1) To consider including oral health as a separate agenda item in the Sixty-sixth Regional Committee with consideration to the Regional Oral Health Strategy discussed at the regional consultation in November 2012 in Nepal.

(2) To support Member States in mobilizing resources and building capacity for prevention and control of NCDs including for collecting baseline data for tracking progress on achievement of NCD targets.

(3) To convene a mid-course review meeting in 2018–2019 to review the available data and make adjustments in the NCD targets as needed.

The working paper and the HLP recommendations are submitted to the Sixty-sixth Session of the Regional Committee for its consideration.
Background

1. Noncommunicable diseases (NCDs) have emerged as 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. Four major NCDs – cardiovascular diseases, chronic respiratory diseases, cancers and diabetes – make the largest contribution to mortality in the Region. These four major NCDs share four behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. Besides being an enormous health burden, NCDs have serious socioeconomic consequences. They disproportionately affect poor, impoverished families, and place a growing burden on health care systems. The macroeconomic impact of NCDs is profound, resulting in loss of productivity and gross domestic product.

2. Recent global events, particularly the High-Level Meeting of the United Nations General Assembly on Prevention and Control of Non-communicable Diseases held in September 2011, have galvanized global momentum and commitment to address NCDs. The resulting Political Declaration of the High-Level Meeting acknowledges the rapidly growing magnitude of NCDs in developing countries and its devastating health and socioeconomic impact. The Political Declaration calls for concrete and comprehensive actions by Member States and the international community to address NCDs. It also requested WHO to lead and coordinate global action against NCDs and to support Member States in implementing effective interventions to address NCDs.

3. To follow up on the Political Declaration on NCDs, the WHO Regional Office for South-East Asia convened a regional consultation to develop a regional strategic action plan with indicators and targets for prevention and control of NCDs in the South-East Asia Region held in New Delhi, India, from 25 to 27 February 2013. Participants of the meeting provided inputs to the draft regional strategic action plan, discussed the role of different stakeholders, and deliberated on the regional voluntary targets for prevention and control of NCDs. Supporting the nine global targets, participants highlighted the need to address additional regional issues, particularly cervical cancer, oral cancer and indoor air pollution. Although it was felt that the voluntary global targets were ambitious for the Region, Member States agreed to comply with the global targets in order to strengthen political and administrative commitment. Member States recommended setting up a technical working group (TWG) to further discuss and finalize the regional strategic action plan and regional voluntary targets.

4. In May 2013, the Sixty-sixth Session of the World Health Assembly unanimously adopted resolution WHA66.10 endorsing the global action plan for prevention and control of NCDs covering the period 2013–2020. The Health Assembly also adopted the global monitoring framework, including 25 indicators, and a set of nine voluntary global targets. 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 comprehensive global monitoring framework, and to establish and strengthen a national surveillance and reporting system to enable reporting against the 25 indicators.
5. As a follow-up on the regional consultation held in February 2013 and resolution WHA66.10, a TWG meeting was organized from 11 to 13 June in Bangkok, Thailand. The TWG took stock of the current data availability and capacity of Member States to report on the nine global voluntary targets; deliberated on three additional regional targets, namely cervical cancer, oral cancer and household air pollution; discussed mechanisms to build national capacity and strengthen national surveillance and monitoring systems; and provided inputs to finalize the regional action plan for prevention and control of NCDs. Key discussions and recommendations of the TWG are summarized in the following section.

Regional targets

6. The TWG members reiterated that the global voluntary targets were ambitious for the Region. However, considering the global voluntary targets to be aspirational targets, and as earlier agreed by Member States at the regional consultation in New Delhi in February 2013, it was recommended that the nine global voluntary targets be adopted in the South-East Asia Region without adjustment. The TWG took stock of the current situation in the Region regarding the availability of baseline data and mechanisms for data collection to report on the nine global targets. Key observations and recommendations of the TWG pertaining to each of the nine voluntary global targets is provided in Annex 1.

7. As well as the nine global targets, the TWG discussed three additional regional voluntary targets: cervical cancer, oral cancer and household air pollution. As a result of these discussions, the TWG recommended an additional regional target on household air pollution, namely: “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.”

8. Observations and recommendations of the TWG on the three additional targets are as follows.

**Household air pollution:** Household air pollution, a leading health risk factor in the Region, remains a neglected issue and needs affirmative actions by sectors beyond health. Two major sources of household air pollution are solid fuel use and second-hand smoke. Second-hand smoke is partly addressed through tobacco control policies aimed at reducing smoking. For further reduction of second-hand smoke at household level, households should be encouraged to adopt a smoke-free environment.

Given the public health significance of household air pollution, the TWG recommends setting a new voluntary regional target of 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. Countries can adjust the target to their own national context. The proposed indicator to measure this target is: “proportion of households with solid fuel use as the primary source of cooking”. Baseline data are available and being periodically collected in almost all countries of the Region.

**Cervical cancer:** Countries in the South-East Asia Region contribute to over 35% of the global incidence and mortality burden of cervical cancer. There are no organized national
screening programmes in most Member States, since Pap smear screening is not feasible. New evidence on the efficacy of a simple cost-effective technique, namely visual inspection with acetic acid, is now available and appears to be a promising strategy for cervical cancer control in the Region.

Mechanisms to collect data to measure the coverage of interventions are currently limited in most countries. Due to lack of baseline data and wide variation in the current coverage of interventions and capacity of Member States, it is recommended to defer setting a regional target on cervical cancer to the agreed mid-term review date and to revisit the data availability again at this point.

However, in view of the availability of effective interventions, all Member States are encouraged to develop national cervical cancer screening programmes. Member States are encouraged to set national targets for screening coverage alongside the development of cervical screening programmes. It is recommended that countries aim for a target of 80% coverage of women aged 30–49 years being screened one or more times. These data can be collected using the updated version of the WHO STEPwise approach to Surveillance (STEPS) instrument.

**Oral cancer:** Oral cancer is a major public health problem unique to the South-East Asia Region, which carries the highest burden of all WHO regions with cancer of the lips and oral cavity ranking second for males and third for females among the most common types of cancer. Key risk factors for oral cancer include tobacco and alcohol use, as well as additional regionally endemic risks such as widespread chewing of betel nut and other carcinogenic substances. Oral cancer disproportionally affects the lower socioeconomic strata of society which show not only higher risk exposure and higher incidence, but also higher mortality and worse outcomes of care and rehabilitation.

The TWG members were concerned about the low priority given to this important public health problem and thus recommended addressing oral cancer by including specific interventions and recommendations in the regional action plan for prevention and control of NCDs. These should cover, but are not limited to: strengthening surveillance and registration of oral cancer; establishing periodic screening programmes for at-risk populations (tobacco and alcohol users, betel nut chewers) consisting of simple visual screening; building capacity within appropriate health workforce cadres to conduct such screenings; and ensuring early diagnosis, timely referral and appropriate management of oral cancer patients.

Due to lack of reliable baseline data and wide variation in terms of disease burden and capacity of health systems to address the problem, it is suggested to defer the definition of a regional target to the agreed mid-term review date and to revisit the data availability again at this point.
The TWG members furthermore recommended encouraging the development of national oral cancer-related targets based on the national situation, in terms of disease burden and health system capacity to address the burden, which varies significantly across Member States. A possible process indicator in this context could be formulated similarly to that of cervical cancer – “proportion of ‘at-risk’ population screened for oral cancer periodically”.

**Regional action plan for prevention and control of NCDs**

9. Achieving the ten regional targets will require concerted actions and nationwide implementation of cost-effective interventions to address NCDs. The regional NCD action plan provides a framework to support and strengthen the implementation of existing cost-effective strategies. It is consistent with the global action plan and includes additional issues and actions that are unique to the Region. It consolidates follow-up actions of the outcomes of the high-level meeting and recommendations of the various regional consultations with Member States.

10. The regional NCD action plan should serve as a reference document to help Member States in developing and implementing national action plans for reducing the burden of NCDs within their respective socioeconomic, cultural, political and health system contexts. The regional monitoring framework, including ten regional voluntary targets, should be integrated into the regional action plan. The proposed strategic action areas were considered to be appropriate and inclusive of the actions listed in the global action plan. These are (i) advocacy, partnerships and leadership; (ii) health promotion and risk reduction; (iii) health system strengthening for early diagnoses and management of NCDs and their risk factors, and; (iv) surveillance, monitoring and research. In addition, the TWG suggested including specific actions related to oral and cervical cancer and a separate table on household air pollution. It was reiterated that successful implementation of the plan would need high-level political commitment, sustainable resources and the concerted involvement of governments and society, in addition to building capacity of the Member States and WHO.

**Recommendations for Member States**

- Develop new or strengthen existing national action plans taking into account global and regional action plans and targets, by end of 2013; subsequently, undertake an exercise to cost the action plans by end of 2014.

- Set national targets for prevention and control of NCDs according to the country situation and capacity and taking into account the global and regional targets, and collect baseline data by the end of 2015. Countries should use national data for setting national targets wherever possible but in the absence of national data, estimates generated by WHO can be used.

- Promote and sustain political commitment and resource allocation for NCD surveillance and monitoring.
• Institutionalize NCD surveillance through an appropriate governing mechanism to enhance ownership, sustainability and coordination at country level.

• Develop a comprehensive national surveillance and monitoring framework for prevention and control of NCDs including: indicators and national targets; mechanisms for data collection; frequency of data collection; use of data, and; responsible agencies.

• Strengthen vital registration and civil registration systems. Proactively engage relevant stakeholders/sectors for strengthening mortality surveillance.

• Incorporate civil registration and vital statistics capacity-building activities within in-service and pre-service education of the health workforce.

• Strengthen cancer registration, including population-based cancer registries.

• Invest in multi-risk factor surveys which are more cost-effective and sustainable.

• Carry out STEPS survey (including Step 3) or equivalent, every five years. All countries are encouraged to use eSTEPS.

• 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, and alcohol).

• Use data for action at the country level. Generate effective advocacy messages based on surveillance and additional data, such as data on economic burden of NCDs.

• Explore resources from existing initiatives such as GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Bill and Melinda Gates Foundation for strengthening NCD surveillance and monitoring, including vital registration, risk factor surveillance (including salt surveys) and health system response.

• Build national capacity for data management, data analyses and data use for advocacy, as well as for programme planning and monitoring progress in prevention and control of NCDs.

• Institute mechanisms for ensuring quality in data collection, management, analysis and use.

• Establish coordination mechanisms at various levels to track progress in prevention and control of NCDs.

• Strengthen resources for Member States as well as for WHO at all levels for prevention and control of NCDs.

**Recommendations for WHO**

• To provide technical support to Member States, as required, to develop national action plans supported by national monitoring frameworks, including indicators and national targets for prevention and control of NCDs.
• To build capacity of Member States in strengthening national surveillance and monitoring systems, including vital registration, risk factor surveys and health facility surveys, as well as to provide support for reporting on the global and regional voluntary targets.

• Convene workshops to increase capacity of Member States in translating data into effective messages that appeal to policy-makers and politicians.

• Support Member States in conducting national school health surveys (based on GSHS) to collect behavioural and anthropometric data for the adolescent age group (13–17 years).

• Convene workshops for three to four “country subgroups” with similar issues, to develop country-specific strategies for improving mortality surveillance.

• Set up a task force/technical group to discuss appropriate regional parameters and cut-off values for measuring overweight and obesity among adults.

• Communicate to Member States to include an operative paragraph in the NCD resolution for the Sixty-sixth Regional Committee for South-East Asia on prevention and control of cervical cancer and oral cancer.

• Include oral health as an agenda item for the Sixty-sixth Regional Committee giving special consideration to the regional oral health strategy.

• Facilitate availability and exchange of datasets on national NCD surveys to researchers for further analyses.

• Continue to advocate for NCD prevention and control to policy-makers, including parliamentarians.

• Advocate to Member States and partner agencies to mobilize additional resources for strengthening NCD surveillance and monitoring, including vital registration, risk factor surveillance (including salt surveys) and health system response.

Conclusions

11. NCDs are a major public health and development challenge, urgently requiring the attention of policy-makers. To fulfil the commitments of the Political Declaration of the UN High-Level Meeting on NCDs, Member States should develop/strengthen national action plans and set national targets taking into account global and regional action plans and voluntary targets, by end 2013. In addition, Member States should strengthen national surveillance and monitoring systems to collect baseline data and to report on the global and regional voluntary targets. A mid-term regional consultation should be organized in 2018–2019 to review the situation and make necessary mid-course adjustments in the regional targets.
Annex

Key steps to improve availability and use of data pertaining to the nine global voluntary targets

Target 1: 25% relative reduction in overall mortality from cardiovascular diseases, cancers, diabetes, or chronic respiratory diseases

- Mortality surveillance is inadequate in all Member States. In the absence of local data, estimates are being used to measure baseline levels.
- Member States are encouraged to establish sample registration systems as an interim source for mortality measurement, while simultaneously strengthening vital registration and cause of death ascertainment (including through verbal autopsy). This will benefit several health and development initiatives such as reporting on Millennium Development Goals 4 and 5, tuberculosis and injury (road traffic injuries, drowning, burns, poisoning and falls) prevention programmes, as well as the NCD programmes.
- Much experience and local resources are available for mortality surveillance in the countries. Furthermore, Member States should build synergies with ongoing initiatives, such as the GAVI Alliance and GFATM, and explore existing resources to strengthen mortality surveillance.
- Increased political will and multisectoral collaboration is needed to improve mortality surveillance in Member States. Ministries of health and policy-makers should demand accurate, timely and reliable mortality indicators from the vital registration systems. This demand should drive the political will to strengthen vital registration systems.
- Progress towards, and achievement of the other eight global targets, will ensure the achievement of target 1.

Target 2: 10% relative reduction in the harmful use of alcohol

- Baseline data for adult per capita consumption of alcohol is available for most countries in the Region.
- The preferred indicator for this target is average adult per capita consumption. There is a need to strengthen capacity to measure unrecorded consumption. This could be included in STEPS or similar surveys.
- In addition to adult per capita consumption, Member States should also monitor “heavy episodic drinking” to understand the pattern of alcohol consumption. This can be collected using STEPS or similar surveys.
• Countries with current low levels of alcohol consumption are also encouraged to set a national target in order to keep a check on any future rise in alcohol consumption.

• There is the need to communicate and promote a common understanding of the terminology “harmful use of alcohol”, agreed at global level, and its policy implications in the Region.

Target 3: 30% relative reduction in prevalence of current tobacco use in persons aged over 15 years

• Baseline data on this target is available for most countries in the Region.

• Tobacco is used in multiple forms (smoking and smokeless) in the Region and the target should be achieved for all forms of tobacco use.

• Member States are encouraged to collect data on multiple risk factors for efficiency and sustainability.

• Achieving this target will require continuing strong advocacy and enforcement of policies specified in the WHO Framework Convention on Tobacco Control.

Target 4: 10% relative reduction in prevalence of insufficient physical activity

• Baseline data on this target is available for adults in most countries in the Region; however, data for adolescents is either missing or outdated.

• Strong multisectoral collaborations and interventions (beyond the health sector) are needed for promoting physical activity.

• As the evidence-base is weak for effective interventions in this area, Member States are encouraged to undertake research on the cost-effectiveness of interventions for promoting physical activity and their impact on prevention and control of NCDs.

Target 5: 30% relative reduction in mean population intake of salt/sodium

• Few countries in the Region have nationally represented data on this target.

• However, lack of data should not be a deterrent to initiate national interventions to reduce salt intake. Urgent actions including strong advocacy and culturally appropriate interventions are needed to reduce population salt intake in the Region.

• Member States are encouraged to carry out nationally representative surveys to measure spot urine sodium in conjunction with a 24-hour urine sodium measurement on a subsample. In the near future, it should be possible to collect these data using the salt protocol in the STEPS survey.

• In addition to mean salt intake, Member States are encouraged to collect data on dietary sources of salt in order to devise culturally appropriate salt reduction strategies.
Target 6: 25% reduction in prevalence of raised blood pressure

- Most countries in the Region have baseline data and capacity to monitor this target through STEPS or equivalent surveys.
- Achieving this target will require scaling-up of primary prevention interventions (such as salt reduction, promoting physical activity, and reducing tobacco and alcohol use) as well as access to treatment for controlling high blood pressure.

Target 7: Halt the rise in obesity and diabetes

- Nationally representative data on prevalence of raised blood glucose are unavailable in some countries of the Region. Moreover, data on adolescent obesity are either unavailable or outdated.
- Concerns were expressed that the cut-off for adult obesity of body mass index (BMI) ≥30 kg/m² might not be appropriate for the Asian population. Countries are encouraged to use additional national indicators, and to use lower cut-offs for BMI as appropriate; however, for the purpose of global reporting, the cut-off of BMI ≥30 kg/m² should be used.
- Member States are encouraged to carry out STEPS (including Step 3) or equivalent surveys to collect nationally representative data on diabetes.

Target 8: 50% of eligible people receive drug therapy and counselling (including glycemic control) to prevent heart attacks and strokes

- This is an important target for overall NCD mortality reduction. Currently no country in the Region is collecting data for this target. However, in future, measurement of the target should be possible from STEPS surveys (including Step 3).
- Member States are encouraged to measure blood cholesterol through STEPS or equivalent surveys to ensure accuracy of risk assessment.
- Achieving this target will require reorienting and strengthening health systems to integrate essential NCD interventions within the primary health care systems, for example, the WHO Package of Essential NCD interventions for primary health care (WHO PEN).
- The indicator for this target is a coverage target and does not include quality aspects. Member States are encouraged to collect additional information to measure quality of care as needed.
Target 9: 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities

- Currently, few countries of the Region have data or existing mechanisms to collect data for this target.

- Member States should consider institutionalizing data collection mechanisms for this target with special consideration given to Service Availability and Readiness Assessment (SARA) as the gold standard method.

- Achieving this target will require developing effective national policies and enforcing those policies. In addition to the minimal list of drugs and essential technologies, Member States are encouraged to include additional items (as appropriate to the national context).