The Political Declaration of the High-level Meeting on Noncommunicable Diseases (NCDs) held in September 2011 in New York calls for concrete and comprehensive actions by Member States and the international community, and emphasizes WHO’s leading role in coordinating global action against NCDs. As a follow-up of this meeting and as per the decision of the Sixty-fourth Session of the World Health Organization (WHO) Regional Committee for South-East Asia, a regional meeting was organized from 24 to 26 April in Yangon, Myanmar. It was a platform to facilitate discussions and consensus building on priority actions of the UN Political Declaration at regional and country levels. The regional meeting also facilitated Technical Discussions on Mental Health, including Mental and Neurological disorders. It provided a forum to discuss priority actions at regional and country levels to take the mental health agenda forward. The Technical Discussions also focused on alcohol as the common risk factor for NCDs and the substantial harm from alcohol use to an individual, the family and the community.

The meeting was attended by 138 participants including 14 observers. The participants included representatives from all 11 Member States of the Region and from various agencies including the government, NGOs, WHO collaborating centres, academia and the UN. Based on the inputs received from Member States, a draft resolution on NCDs including mental health and neurological disorders was prepared. The recommendations arising out of the Technical Discussions will be submitted to the Sixty-fifth Session of the Regional Committee, to be held in Yogyakarta, Indonesia, from 5 to 7 September 2012.
Noncommunicable diseases including mental health and neurological disorders

Report of the regional meeting

Yangon, Myanmar
24–26 April 2012
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### Acronyms and abbreviations

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<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>APC</td>
<td>adult per capita</td>
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<tr>
<td>DALY</td>
<td>disability-adjusted life year</td>
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<tr>
<td>DPR Korea</td>
<td>Democratic People’s Republic of Korea</td>
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<tr>
<td>EB</td>
<td>Executive Board (of the World Health Assembly)</td>
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<tr>
<td>HIS</td>
<td>health information system</td>
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<tr>
<td>HLM</td>
<td>High-level Meeting</td>
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<tr>
<td>IEC</td>
<td>information, education and communication</td>
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<tr>
<td>IT</td>
<td>information technology</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>mhGAP</td>
<td>Mental Health Global Action Programme (of WHO)</td>
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<tr>
<td>MOH</td>
<td>ministry of health</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation Development</td>
</tr>
<tr>
<td>PEN</td>
<td>package of essential NCD (interventions)</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>SEA</td>
<td>South-East Asia</td>
</tr>
<tr>
<td>SEANET</td>
<td>South-East Asia Network for NCD Prevention and Control</td>
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<tr>
<td>SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>WHO STEPS</td>
<td>WHO STEPwise approach to Surveillance of NCD Risk Factors</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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As per the decision of the Sixty-fourth Session of the World Health Organization (WHO) Regional Committee for South-East Asia, a regional meeting was organized from 24 to 26 April in Yangon, Myanmar to hold technical discussions on the subject of “Noncommunicable diseases, including mental health and neurological disorders”. The recommendations arising out of the technical discussions will be submitted to the Sixty-fifth Session of the Regional Committee, to be held in Yogyakarta, Indonesia, from 5 to 7 September 2012.

Countries in South-East Asia (SEA) are undergoing an epidemiological transition. While a notable decline in communicable diseases is observed due to immunization and other interventions, noncommunicable diseases (NCDs) are now emerging as the most common cause of death in the majority of Member countries. Moreover, mental health and neurological disorders are a major cause of morbidity, disability and impaired quality of life among populations of the Region. NCDs together with mental and neurological disorders account for nearly half of disability-adjusted life years (DALYs) lost each year in the Region.
Until recently, NCDs were somewhat neglected, both globally and in the SEA Region. However, this changed last year when the United Nations (UN) General Assembly convened a High-level Meeting (HLM) on NCDs on 19–20 September 2011 in New York. The UN HLM on NCDs was a turning point in the battle against NCDs. The main outcome of the UN HLM was the adoption of the Political Declaration by Member States. The Political Declaration\(^1\) calls for concrete and comprehensive actions by Member States and the international community. Specifically, the Political Declaration urges Member States (a) to integrate NCD policies and programmes into the national development agenda and health-planning processes; (b) to promote multisectoral action through health-in-all policies and whole-of-government approaches; (c) to build national capacity to strengthen national policies and plans, with special emphasis on monitoring and evaluation, reducing exposure to risk factors for NCDs, promoting access to primary health-care interventions for NCDs, and; (d) to increase resources for combating NCDs and explore viable financing options.

The Political Declaration emphasizes WHO’s leading role in coordinating global action against NCDs. Specific actions required by WHO are: (a) to develop by 2012 a global monitoring framework and a set of voluntary global targets for prevention and control of NCDs; (b) to submit a report to the General Assembly at its Sixty-seventh session (in 2012) on options for strengthening and facilitating multisectoral action through effective partnerships; (c) to establish and institutionalize strong collaborative links with UN agencies, funds and programmes; (d) to prepare an updated six-year global action plan on NCDs in consultation with Member States and partners; and (e) to provide technical support to WHO’s Member States in developing national NCD plans and policies.

The UN HLM was a landmark event and was instrumental in galvanizing global support in the fight against NCDs and drawing the attention of global and national leaders to the NCD agenda. It is now important for Member countries and the international community to adhere to the commitments made in the Political Declaration. The three-day regional meeting on NCDs facilitated technical discussions on mental health including neurological disorders, as well as provided a forum to discuss priority actions at country and regional levels to follow up on the Political Declaration of the UN HLM.

His Excellency Professor Pe Thet Khin, Union Minister of Health, Myanmar warmly welcomed the participants of the regional meeting. In his speech, he highlighted that NCDs including mental health and neurological disorders represent a leading threat to human health and development, and that 80% of deaths due to NCDs occur in low- and middle-income countries. A large proportion of deaths due to NCDs are premature in these countries. In addition, they lead to catastrophic health expenditures and impoverishment, and impede poverty alleviation initiatives. He referred to the Political Declaration of the HLM of the UN General Assembly on the prevention of NCDs adopted on 19 September 2011 and highlighted the key points of the Declaration. He described the UN HLM on NCDs as a watershed event, which created a window of opportunity to galvanize global action for the prevention and control of NCDs.

The Honourable Minister elaborated recent initiatives taken by the Government of Myanmar in the area of NCD prevention and control in accordance with the 2008-2013 Global Plan of
Noncommunicable diseases including mental health and neurological disorders

Action and within the SEA Regional framework under the stewardship of the WHO Regional Office for South-East Asia (SEARO). Myanmar has recently developed a draft national policy on NCDs. After the initial successful pilot study on implementation of a package of essential NCD (PEN) interventions at the primary health-care (PHC) level, the country will implement the PEN intervention in two townships very soon. With the recent change in the political system in the country and increased expenditure on health, the country will be allocating more resources for the prevention and control of NCDs. He hoped that under the leadership of WHO/SEARO, knowledge and experience will be exchanged to help scale up activities for the prevention and control of NCDs among Member States. He wished the distinguished participants a very successful meeting and a pleasant stay in Yangon. The full text of the speech is available in Annex 1.

In his address, Dr Samlee Plianbangchang, the Regional Director, WHO/SEARO thanked all the participants for sparing their time to participate in this important meeting. He pointed out that for much of the past century, NCDs including mental health and neurological disorders have been neglected globally and it is only recently that NCDs have begun to receive due attention from Member States. The UN HLM was successful in generating a consensus that NCDs are not just a health issue but also a developmental concern. He expressed concern that the continuing high burden of NCDs despite the fact that NCDs, including mental and neurological disorders, are largely preventable by means of available “public health interventions” and “primary health-care approach”. The public health approach is cost-effective because it gives high priority to promotive and preventive care, which prevents unnecessary morbidity and reduces the severity of disease. Education and empowerment of the people should be an important long-term strategy.

A well-balanced approach is needed, which includes both promotive/preventive care on the one hand and curative/rehabilitative care on the other hand. He reiterated that dealing with NCDs is not the task of ministries of health alone. Implementation of the “health in all policies” approach should be vigorously promoted to secure the commitment of all sectors to NCD prevention and control. If successfully implemented, this will greatly expand the resource base for NCD prevention and control through a holistic approach at the national level. He referred to the Bangkok Call for Action by the Regional
Conference of Parliamentarians adopted in March 2012, which placed due emphasis on public health interventions for today’s health problems, including NCDs. He said that this Regional meeting is a platform to facilitate discussions and consensus building on priority actions of the UN Political Declaration at regional and country levels. The full text of the Regional Director’s speech is available in Annex 2.
Opening of the session

The business session of the meeting started with a warm welcome by the WHO representative to Myanmar, Dr H.S.B. Tennakoon. Dr Athula Kahandaliyanage Director, Sustainable Development and Healthy Environments, WHO/SEARO summarized the objectives and expected outcomes of the meeting.

Objectives of the meeting

The specific objectives of the meeting were:

1. To identify follow-up actions at the regional and country levels to realize the Political Declaration of the UN HLM on NCDs

2. To hold technical discussions on NCDs, including mental health and neurological disorders.

The expected outcome of the meeting was to prepare a draft resolution on NCDs including mental health and neurological disorders, which would be placed before the 65th Regional Committee of the WHO SEA Region in Indonesia in September 2012.
Organization of the meeting

The three-day meeting consisted of plenary sessions, panel discussions and group work. Topics discussed in the plenary were: an overview of NCDs including mental health and neurological disorders; strengthening multisectoral actions for the prevention and control of NCDs including country experiences; a global framework for monitoring indicators and targets for NCDs; Global NCD Plan of Action; strengthening mental health programmes through primary health care; promotion of mental well-being; and reducing harm from alcohol use. Subsequently, participants were divided into working groups for technical discussions on the above thematic areas. On the last day, a panel discussion was held to discuss how partnerships can be fostered to curb NCDs. The partners included were academia, nongovernmental organizations (NGOs), WHO collaborating centres, and international and other UN agencies. Based on the inputs received from Member States, a draft resolution on NCDs including mental health and neurological disorders was prepared and discussed in the concluding session. The final programme is given in Annex 3.

Participants of the meeting

The Regional meeting was attended by 138 participants including 14 observers. The participants included representatives from all the 11 Member countries of the Region. Various agencies were represented including governments, NGOs, WHO collaborating centres, academia and the UN. Of the 45 government nominees from Member countries, 19 (42%) were from sectors other than health, such as: education, finance/revenue, planning commission, agriculture/nutrition, legal, sports and social welfare. There was high-level participation including: the Honourable Minister of Health, Maldives; two Members of Parliament from Bhutan; Honourable Member of the Planning Commission, Nepal; Secretary of Education, Bhutan; Mayor of Padang District, West Sumatra Province, Indonesia; Secretary-General for sports, Indonesia; Joint Secretary, Ministry of Health, India; Directors General of Health Services and Central Council of Research in Unani Medicine, India; and Deputy Directors General of Health Services from Sri Lanka and Thailand. The full list of participants is given in Annex 4.

Election of office bearers

The Minister of Health and Family, His Excellency Dr Ahmed Jamsheed Mohamed of the Maldives was elected as the Chair of the meeting. Professor Tint Swe Latt, Rector University of Medicine-2 Yangon, Myanmar was elected as the Co-chair and Professor Chandrika Wijeyaratne, Sri Lanka was elected as the Rapporteur of the meeting.
Overview of noncommunicable diseases and mental health situation

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO/SEARO set the scene for the meeting with a presentation entitled, “Overview of the NCDs and mental health situation in SEAR”.

Noncommunicable diseases are the leading cause of death globally and in the SEA Region. They account for 36.1 million deaths globally. In the SEA Region, NCDs cause an estimated 7.9 million deaths each year. A matter of serious concern is that deaths due to NCDs occur at a younger age (34% of deaths are among people below the age of 60 years) in countries of the SEA Region in comparison with other Regions of WHO (Figure 1). Four major NCDs that account for 80% of deaths are diabetes, cardiovascular diseases (including stroke), chronic obstructive lung diseases and cancers. NCDs are driven by behavioural risk factors (tobacco use, harmful use of alcohol, insufficient intake of fruits and vegetables) which in turn lead to metabolic risk factors for NCDs—physical inactivity, overweight/obesity, raised blood pressure, raised blood glucose and raised blood lipids. The prevalence of risk factors in our population is unacceptably high. By eliminating the common risk factors, it is possible to reduce 80% of heart disease and stroke, 80% of diabetes and over 30% of cancers.

Figure 1: Percentage of deaths due to NCDs in persons less than 60 years of age by cause, 2008

Noncommunicable diseases are not merely health problems but also place a huge socioeconomic and developmental burden on countries of the Region due to high health-care costs, loss of productivity and premature mortality. Given the sky-rocketing costs of treatment of NCDs, public health policies and programmes should focus on health promotion and primary prevention to reduce the risk of people developing NCDs. The global strategy for prevention and control of NCDs is based on three pillars: (a) surveillance – mapping the epidemic; (b) prevention – reducing the level of exposure to risk factors; and (c) management – strengthening the health care of people with NCDs. Based on a review of the evidence, WHO has identified the most cost-effective interventions, which are shown in Table 1. Multisectoral actions are imperative for addressing the epidemic of NCDs. Partnerships are needed within the government, and with the media, civil society, academia, private sector and other stakeholders.

Table 1: List of cost-effective interventions for NCD prevention and control identified by WHO

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Public health intervention</th>
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| Tobacco use                       | • Raise taxes.  
• Protect people from tobacco smoke.  
• Warn about the dangers of tobacco use.  
• Enforce bans on tobacco advertising. |
| Harmful use of alcohol            | • Raise taxes on alcohol.  
• Restrict access to retail alcohol.  
• Enforce bans on alcohol advertising. |
| Unhealthy diet and physical inactivity | • Reduce salt intake in food.  
• Replace trans-fats with polyunsaturated fats.  
• Promote public awareness of diet and physical activity (via the mass media). |
| Cardiovascular diseases and diabetes | • Provide counselling and multidrug therapy  
• (including blood sugar control for diabetes mellitus) for people at medium to high risk of developing heart attack and stroke.  
• Treat myocardial infarction with aspirin. |
| Cancer                            | • Provide hepatitis B vaccination starting at birth to prevent liver cancer.  
• Conduct screening and treatment of precancerous lesions to prevent cervical cancer. |

Source: WHO. Global status report on NCDs, 2010
Dr Poonam Khetrapal Singh highlighted the considerable progress made in countries of the Region in the prevention and control of NCDs, including mental health and neurological disorders. NCDs were discussed during the 60th and 65th Regional Committees in 2007 and 2010, respectively, and at the 29th Health Ministers’ Meeting in 2011. To foster partnerships, biennial meetings of the South-East Asia Network for NCD Prevention and Control (SEANET) were organized in 2007, 2009 and 2011, and a regional civil society meeting on NCDs was held in Nepal in 2011. The WHO PEN intervention has been introduced in five SEAR countries. Member States are being actively supported in conducting NCD surveillance; 10 out of 11 Member countries have conducted at least one round of the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS) survey. Alluding to the UN HLM on NCDs in September 2011, Dr Singh highlighted that it was only the second time in history that a health issue was discussed by the UN General Assembly. By adopting the Political Declaration of the UN HLM, heads of state and government representatives made commitments to take concrete actions for the prevention and control of NCDs.

Moving on to mental health, Dr Singh pointed out the huge burden posed by mental and neurological disorders. Untreated mental disorders account for 13% of DALYs lost globally. Unipolar depressive disorder is the third leading cause of disease burden globally and is predicted to be the leading cause of disease burden by 2030. Despite the fact that treatment of mental disorders is inexpensive, effective and available, there is a huge treatment gap to the tune of around 90% in certain Member States of the Region. The problem is compounded by rampant stigma against patients and their families. She pointed out the link between NCDs and mental health, which share the same risk factors. For example, stroke, which is a neurological disorder, has the same risk factors as cardiovascular diseases, and alcohol use is a risk factor for both. The experience in Member States of the Region shows that by strengthening the PHC system, mental and neurological disorders can be optimally treated and treatment can be made available to more persons in need.

**Multisectoral action for prevention and control of NCDs**

The Political Declaration of the UN HLM in 2011 and the 2008 Commission on the Social Determinants of Health have clearly documented the role of
and need for multisectoral action for health, particularly in addressing equity gaps. Member States have recognized that effective NCD prevention and control require multisectoral approaches at the government level including, as appropriate, whole-of-government approaches across sectors such as health, education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance, and social and economic development. Additionally, government must lead in the formation of partnerships with civil society and the private sector.

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region moderated a panel discussion on “Strengthening multisectoral action for prevention and control of NCDs and their risk factors and underlying determinants”. Panelists were Regional Advisors from WHO/SEARO.

Dr Nyo Nyo Kyaing, Regional Advisor, Tobacco Free Initiative, pointed out that tobacco use the single most important risk factor for NCDs. She highlighted the role of different sectors in controlling tobacco use. For example, the health sector should take the lead in advocacy, advising patients to quit tobacco use, and making all health facilities 100% tobacco free. The education sector can make all educational facilities tobacco free, include the hazards of tobacco in all educational curricula, and ban the sale of tobacco products in the vicinity of schools. The media can help by creating awareness in the community on the hazards of tobacco use and measures to control tobacco use, waging a fight against the tactics and false arguments of the tobacco industry, and changing the social image of tobacco. The finance sector can raise taxes and excise on tobacco to discourage the use of tobacco. WHO has taken a leadership role in advocacy, capacity building, research and surveillance, and development of policy guidelines and legislation.

Dr Vijay Chandra, Regional Advisor Mental Health and Substance Abuse, WHO SEARO talked about strengthening multisectoral action for reducing the harmful use of alcohol. In recent years, harm from alcohol use is increasingly being recognized as a matter of public health concern. Alcohol use leads to a diverse range of harms, which affects not only the individual but also the family and community. Types of harm include medical, social, psychological and economic harm. In the past, the primary mode of control of alcohol abuse was by the society itself. Unfortunately, society is losing this control. There is widespread availability of home- and locally brewed illicit alcohol, which can
be very harmful. Illicit alcohol is not taxed and, since it is locally brewed, it is easily accessible.

Dr Kunal Bagchi, Regional Advisor Nutrition and Food Safety, said that, over the years, there has been an increase in the consumption of energy-dense diets high in saturated fat, and low in unrefined carbohydrates, and a decrease in energy expenditure due to a sedentary lifestyle. WHO’s global strategy on diet, physical activity and health emphasizes the importance of sustained and well-coordinated multisectoral responses from the agriculture, food industry, trade and education sectors, besides the health department. Additionally, community and family involvement is required on an ongoing basis. Dr Bagchi illustrated multisectoral actions in the context of salt reduction, which is a major risk factor for hypertension, heart attack and stroke. To reach the goal of reducing dietary salt, the health sector should monitor and assess salt intake, trade and commerce departments should regulate salt in processed foods, the education sector should focus on consumer education, and the food industry should label food and voluntarily reduce salt in processed food.

Dr Suvajee Good, Programme Coordinator for Health Promotion and Social Determinants, WHO/SEARO emphasized the need for primary prevention and addressing the social determinants of health. She pointed out the persistent inequities in society. Underlying social determinants of NCDs include rapid and unplanned urbanization, poverty, and illiteracy. NCDs affect the poor disproportionately. Urban populations display a higher prevalence of NCDs compared to rural populations. She stressed the need for a “health in all policies” approach. Primary prevention is key to NCD control and requires an enabling environment for adoption of healthy lifestyles by individuals.

**Country experiences in implementing multisectoral actions**

Dr Prakit Vathesatogkit from Thailand and Dr Shiba Kumar Rai from Nepal moderated a panel discussion to facilitate exchange of information on key lessons and challenges in implementing NCD actions at the country level.

Representatives from Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Maldives, Sri Lanka and Thailand shared country experiences on implementing multisectoral actions for NCD prevention and control. Based on experiences shared by Member States, the potential role of different stakeholders
in NCD prevention and control are summarized in Annex 5. Factors cited for successful multisectoral actions at the country level by Member States are listed below:

**High-level political commitment and oversight:** High-level political commitment was cited as the driving force for successful multisectoral collaborations in Sri Lanka and many other countries. In Thailand, multisectoral collaboration receives the highest political support, with the Prime Minister chairing the National Steering Committee for the Thailand Healthy Lifestyle Strategy Plan. The Committee includes multidisciplinary partners from government departments, international organizations, professional bodies, the private sector, media and civil society. Similarly, in Nepal, there is a high-level health service facilitation and coordination committee, which includes NCDs and has with membership from various Ministries such as agriculture, finance, education, health, planning, etc. In India, an inter-ministerial task force for tobacco control has been constituted at the national level under the chairpersonship of the Health Secretary to enhance coordination among various government departments.

**Evidence-based national multisectoral policies and plans:** Development of national multisectoral policies and plans with engagement of multiple stakeholders provides a sound basis for implementing multisectoral actions for NCD prevention and control. In Indonesia, the national NCD network and National Strategic Plan provides the overarching umbrella for multisectoral actions, and defines clear roles and responsibilities for all partners. In Sri Lanka and Bhutan, the national policy and strategic framework is the guiding force for multisectoral actions. Thailand’s Healthy Lifestyle Strategic Plan (2011–2020) provides the framework for multisectoral actions at the national level. It consists of five major strategies – healthy public policy, social mobilization, community building, surveillance and care system, and system capacity building.

**Community empowerment and mobilization:** In Myanmar, community leaders have been trained to adopt healthy lifestyles and to serve as change agents for NCD prevention and control. Engagement of community stakeholders made this intervention acceptable, accessible, affordable and sustainable. In Sri Lanka, a unique example of coordinated multisectoral actions at the community level is the establishment of community support centres, which serve as a “single window” point of contact of the community with services
related to the departments of health, social, legal, agriculture, sports and youth, as well as local authorities. In Bhutan, religious bodies have been mobilized to advocate for healthy lifestyles. Similarly, in Indonesia, there is good commitment and support by religious and traditional leaders, and creation of social pressure to discourage unhealthy behaviours.

**Coordination:** Effective coordination at all levels from the national level to the local level is imperative for successful implementation of multisectoral actions. In Bangladesh, multisectoral taskforce committees have been established at all levels; from the national level to the district and subdistrict levels. The coordination committees consist of various government departments, the private sector (other than tobacco), development partners, media and civil society, and professional bodies.

**Settings-based interventions:** Successful interventions in school and work settings were cited by some Member countries. In Sri Lanka, the education sector has played a critical role in promoting healthy lifestyles by including healthy lifestyles and mandatory physical activity in the school curriculum, establishing school health clubs, and instituting healthy canteen policies. In Bhutan, the education sector is supporting school-based physical activity interventions. In Myanmar, India and Nepal, the departments of education have banned junk foods in school premises. In India, the education department has directed the inclusion of health promotion in school curriculum, compulsory physical training and availability of play grounds in schools. Thailand is promoting healthier food options in schools and workplaces.

**Mainstreaming healthy lifestyles across multiple sectors:** Promotion of physical activity across different sectors has resulted in DPR Korea achieving the lowest levels of overweight and obesity in the Region. The Ministry of Sports holds mass sports activities with participation of government and ministry officials on national holidays. The Ministry of Education has included physical exercise as a part of school curriculum. Spring and autumn sports days are observed in all schools. An annual national physical capacity check-up is arranged every year to assess the physical fitness of workers. Sports days are held on the second Sunday of every month when all people in the community are encouraged to gather and do physical exercise such as “taekwondo for health”. Mass gymnastic performances are carried out every year with the participation of tens of thousands of youth.
Creating an enabling environment through legislations/regulations:
Regulation/legislation is most commonly used for tobacco control in almost all countries of the Region. These include the use of pictorial warnings on tobacco packets, ban on sale of tobacco to minors, ban on tobacco advertising, ban on smoking in public places and educational institutions, etc. Other regulatory measures include control of marketing of tobacco and unhealthy food and beverages to children, and regulations to reduce salt, sugar, and saturated and trans-fats in food products in Thailand, and a campaign against drunk driving by the police department in Nepal.

Financing/innovative fiscal measures: An example of financial incentives for encouraging healthy behaviours is seen in Bhutan, where financial institutions provide soft loans with low interest rates for purchase of sports goods. In Nepal, a health tax fund established in 1997 from the sale of alcohol and tobacco products results in the collection of US$ 5 million per year, which is used for free treatment of NCDs for the poor. In Nepal, high subsidy is given for using alternative sources of energy, e.g. smokeless stoves, biogas, solar lights and micro-hydel in rural areas.

Other examples of multisectoral actions include marketing of fresh fruits and vegetables in India and Sri Lanka, subsidized public transport to reduce air pollution in India, use of smokeless stoves and alternate energy sources to reduce indoor air pollution in Myanmar and Nepal.

In addition to successful experiences, numerous barriers were encountered in scaling up multisectoral actions at the country level. These are listed in Box 1.

**Box 1: Barriers to scaling up multisectoral actions**
- Limited capacity of the health ministry to lead multisectoral actions
- Poor health literacy among stakeholders
- Poor enforcement of laws
- Inadequate financial and human resources
- Compartmentalized working of government departments
- Lack of sufficient local evidence for the effectiveness of multisectoral interventions
- Frequent transfer of stakeholders after sensitization
- Lack of rules and guidelines for involving the private sector
- Lack of a legal and regulatory framework for mandating/promoting multisectoral actions.
For in-depth discussions and recommendations on promoting multisectoral actions for prevention and control of NCDs, a working group was constituted. It included representatives from all 11 Member States in the Region, NGOs, WHO collaborating centres, partner agencies and WHO country offices. The group work was moderated by Ms Sangay Zam, Secretary Education, Ministry of Health, Bhutan and reported by Dr Anna Ulfah Rahajoe, President, Indonesian National Noncommunicable Disease Alliance and Dr Lanka Dissanayake, National Professional Officer, WHO Sri Lanka.

**Recommendations for strengthening multisectoral actions for the prevention and control of NCDs**

**Catalyse “a whole-of-government” response**

- Promote a “health in all policies” approach, which means that all government policies (trade, environment, fiscal, agriculture, urban planning, etc.) should be vetted for health implications.
- Establish a high-level coordination and oversight committee on NCDs comprising members from different sectors within the government (e.g. health, agriculture, education, finance, planning, social affairs and welfare, sport, trade, transportation and labour). The Committee should be chaired by the head of government (e.g. Prime Minister) and should report to the Parliament.
- Incorporate NCD prevention and control into the national plan and budgeting process.
- Facilitate multisectoral governance mechanisms
- Develop a multi-stakeholder working group (comprising the private sector, NGOs, civil societies, international finance institutions/aid organizations, communities, media, etc.) to assist in the formation and implementation of national plans on NCDs.
- Develop a national multisectoral framework to foster common understanding among various sectors. The framework should include mechanisms for planning, guiding, monitoring and evaluating multisectoral actions.
- Create NCD interdepartmental ministerial groups, cross-cluster teams, health liaison groups at the top level cascading down to the provincial, district and village levels.
Recognize the “community domain (civil society, general public and private sectors)” in all health policies.

Develop guidelines and codes of conduct for engagement with NCD stakeholders to avoid conflicts of interest (do not involve private parties that manufacture products harmful to health, particularly for the development of chronic diseases).

Ensure full and transparent declarations of conflicts of interest by all stakeholders.

**Generate and sustain funds for multisectoral actions**

- Allocate sufficient public funds for NCD programmes including for multisectoral collaboration.
- Sensitize policy-makers and impose “taxes” on tobacco, alcohol and unhealthy diets.
- Use tobacco and alcohol tax revenues for NCDs and health, and tax “fast food” chains.
- Include NCD programmes in universal access schemes.
- Develop and implement joint budgets across sectors to promote multisectoral action on NCDs.

**Monitor progress in implementing multisectoral actions**

- Establish mechanisms for monitoring progress in multisectoral actions including and ensuring a smooth flow of information between different levels – top-down and bottom-up.
- Establish results-based monitoring of social audit/health impact assessment and develop a uniform progress report.
- Collect data for synthesis across countries and widely disseminate progress information to all concerned. Organize regular regional-level meetings to review progress and share experiences.

**Monitoring framework and targets for the prevention and control of NCDs**

Dr Nick Banatvala, Senior Advisor, Office of the Assistant Director General, WHO/HQ made a comprehensive presentation on the proposed global monitoring framework, including a set of voluntary global targets for the prevention and control of NCDs. Providing the background, he highlighted that
surveillance and monitoring is one of the three key pillars of the global strategy for the prevention and control of NCDs. The importance of surveillance and monitoring has been emphasized in the Political Declaration of the UN HLM, which calls upon WHO, before the end of 2012: (1) to develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through a multisectoral process, to monitor trends and assess progress made in the implementation of national strategies and plans on NCDs; (2) to prepare recommendations for a set of voluntary global targets for the prevention and control of NCDs.

The Political Declaration also urges Member States to consider the development of national targets and indicators based on national situations, building on guidance provided by WHO. The global monitoring framework incorporates three main elements, as shown in Box 2.

**Box 2: National NCD Surveillance Framework developed by WHO**

**Outcomes**
- mortality (e.g. NCD-specific mortality)
- morbidity (e.g. cancer incidence and types)

**Exposures**
- Behavioural risk factors (tobacco use, physical activity, harmful use of alcohol and unhealthy diets)
- Physiological and metabolic factors (e.g. raised blood pressure, overweight/obesity, raised blood glucose and cholesterol)
- Social determinants (e.g. educational level, household income and access to health care)

**Health systems response**
- Interventions and health systems capacity (infrastructure, policies and plans, access to health care and partnerships)


In line with the Political Declaration, WHO began the process of developing a comprehensive global monitoring framework and indicators, including a set of voluntary global targets for the prevention and control of NCDs through a series
of web-based consultations and face-to-face meetings with representatives from Member States and other stakeholders. The first discussion paper on the subject was posted for web consultation in December 2011 and included a set of 10 targets (Annex 6). Selection of indicators was based on the following criteria:

- High epidemiological and public health relevance
- Coherence with major strategies such as global strategies, the Political Declaration and the WHO surveillance framework
- Availability of evidence-based, effective and feasible public health interventions
- Evidence of achievability at the country level
- Existence of unambiguous data collection instruments and potential to set a baseline and monitor changes over time.

In addition to web-based consultations, face-to-face consultations have been held with Member States, civil society and the private sector since July 2011. Based on the feedback received from Member States, the second discussion paper was posted for web consultation in March 2012. In the second discussion paper, five targets have been proposed (premature mortality from four major NCDs – 25% relative reduction, hypertension – 25% relative reduction, tobacco – 30% relative reduction, salt intake – 30% relative reduction until 5 g/day and physical inactivity – 10% relative reduction). In addition, a set of core indicators are proposed (Table 2). The proposed targets are global, and countries are required to set national targets based on their current situation and capacity. As the set targets are relative, the actual targets will depend on the country’s baseline level of the indicators in the year 2010. It is expected that Member countries will report on the progress in 2015, 2020 and 2025.

The consultative process with Member States and NGOs will continue till the World Health Assembly in May 2012. Based on the inputs from Member States, a final draft will be placed before the Executive Board of WHO in January 2013 for finalization, to be considered in the World Health Assembly 2013.

In order to provide comprehensive regional inputs for the global monitoring framework, indicators and targets, a working group was constituted on the second day of the meeting. It comprised representatives from the 11 Member States in SEAR, NGOs, WHO collaborating centres, partner agencies and WHO country offices. The group work was moderated by Professor Hasbullah.
Noncommunicable diseases including mental health and neurological disorders

Thabrany of Indonesia and reported by Dr Guha Pradeepa (India), and Dr Mostafa Zaman (Bangladesh). After extensive discussions, the group made the following recommendations:

**Discussions and recommendations on the monitoring framework and targets for prevention and control of NCDs**

Member countries and partner agencies agreed to the overall monitoring framework and the criteria used. Member States will develop national targets in alignment with the global framework. Reporting timelines of every five years was considered appropriate for all countries. However, many concerns were raised by the participants:

**Concerns**

- There was unanimous agreement that the overall targets were too ambitious for many SEAR countries. Targets on reduction in dietary intake of salt and related indicators on reduction in the prevalence

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**Table 2: Global monitoring framework, including indicators and voluntary targets – outcomes, exposures and health systems response**

<table>
<thead>
<tr>
<th>Indicators with targets</th>
<th>Mortality between ages 30 and 70 due to CVD, cancer, diabetes, and chronic respiratory disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>25% relative reduction</td>
</tr>
<tr>
<td>Tobacco</td>
<td>30% relative reduction</td>
</tr>
<tr>
<td>Salt</td>
<td>30% relative reduction until 5g/day</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>10% relative reduction</td>
</tr>
</tbody>
</table>

Source: WHO First discussion paper on proposed framework, indicators and targets for NCD prevention and control (unpublished).
of hypertension were considered too high and unachievable in the Region.

- Setting a target to reduce harm from alcohol use was considered to be highly relevant for the SEA Region but is currently missing in the proposed list of five targets. Concern was raised that alcohol was dropped from the original list of 10 indicators based on feedback from a few countries, mainly from the developed world.

- Considering that a life-course approach is needed to deal with NCDs, there is no mention of targets for younger age groups, for example, reduction in childhood obesity.

- The proposed targets were perceived to be “aspirational” and not realistic. The proposed global targets are set based on the best-performing countries mainly from the developed world where interventions against NCDs began several decades earlier. In the SEA Region, NCD interventions are at relatively early stages and resources, both human and financial, to deal with NCDs are far less than resources in the best-performing countries.

- Participants were concerned about the ability and capacity of existing surveillance mechanisms to generate the data needed for monitoring progress in achieving the proposed targets. Currently, the baseline data for many targets are missing in many countries. The Region may need five years from now to establish a robust surveillance system to get a good baseline for the evaluation of progress in 2025.

**Actions for WHO**

- Consider lowering some targets, especially the target for salt reduction and prevalence of hypertension.

- In addition to the five proposed targets, consider five additional targets:
  1. Reducing harm from alcohol
  2. Reducing childhood obesity
  3. Increasing the availability and affordability of essential medicines and technologies
  4. Reducing indoor air pollution
  5. Reducing the prevalence of diabetes
Consider changing the indicator on “tobacco smoking” to “tobacco use”.

Build the capacity of Member States to measure and report on the proposed set of indicators.

**Actions for Member countries**

- Initiate the process for developing national indicators and targets to monitor progress towards the prevention and control of NCDs at the country level through consultation(s) with national-level stakeholders and technical support from WHO and other technical agencies.
- Establish or improve cause-specific death registries by providing in-service and pre-service training on death certification, and use of verbal autopsy techniques.
- Conduct NCD risk factor surveys based on the WHO STEPS approach at the national level for representative and comparable data on risk factors.


Global initiatives to address NCDs started in 2000, with the World Health Assembly endorsing the global strategy for the prevention and control of such diseases. The strategy comprises three elements: mapping the NCD epidemic through surveillance and monitoring; reducing population exposure to risk factors; and strengthening health systems to manage people affected by NCDs. Responding to the need of the global strategy, a Global Action Plan for 2008–2013 was formulated. The Global Action Plan (2008–2013) comprised concrete actions by Member States and WHO: (a) integrating NCD prevention into the development agenda, and into policies across all government departments; (b) establishing/strengthening national policies and programmes; (c) reducing/preventing risk factors; (d) prioritizing research on prevention and health care; (e) strengthening partnerships; and (f) monitoring NCD trends and assessing progress made at country level. It identified sets of actions for Member States, WHO Secretariat and international partners.

Dr Nick Banatwala, Senior Advisor to the office of the Assistant Director General, NCD WHO/HQ, highlighted the successes and shortcomings of the 2008–2013 Action Plan and elaborated on the rationale for updating the plan.
The key successes were increased awareness and prioritization by policymakers; recognition of the importance of multisectoral actions; development of surveillance and monitoring frameworks; tobacco control and a global strategy to reduce the harmful use of alcohol; identification of cost-effective interventions; an integrated package of interventions for primary care; prioritized research agenda and strengthened partnerships.

The limitations and constraints include insufficient political and financial commitment, misaligned national policies and plans, weak and non-integrated surveillance systems, inadequate capacity of health systems, ever-increasing urbanization, poor interagency collaboration and, finally, inadequate WHO capacity and ability to respond.

There is a need to update the global plan because of the changing political, technical and financial landscape. Politically, there is an increased commitment of Heads of State and governments, and improved collaborative partnerships. Technically, progress has been made in identifying cost-effective interventions or “best buys”, and development of a global monitoring framework with indicators and targets. Financially, with the current financial crisis, a major challenge is to ensure that countries and their partners are investing adequately in the “best buys”. There is a need for innovative financing mechanisms including global levy on tobacco products, and increasing the resource-base thorough involvement of other sectors and partners.

WHO needs to respond to the changing scenario focusing on emerging priority areas. These are:

- reducing the exposure of populations and individuals to the risk factors for NCDs;
- enabling health systems to respond more effectively and equitably to the health-care needs of people with NCDs;
- setting national targets and measuring results;
- advancing multisectoral action;
- strengthening national capacity; and
- promoting international cooperation and coordination.

To develop an updated global action plan for the prevention and control of NCDs covering the period 2013–2020, the WHO Secretariat has established
the following process and timeline, starting with regional consultations during March and July and ending with a draft plan by October 2012.

In order to provide comprehensive regional inputs to the development of the global action plan 2013–2020, a working group was constituted during the meeting. It comprised representatives from eight of the 11 Member States in SEAR (Bangladesh, Bhutan, Indonesia, India, Maldives, Myanmar, Nepal and Sri Lanka), NGOs, WHO collaborating centres, partner agencies and WHO country offices. The group work was moderated by Professor KK Talwar (India) and reported by Dr DTP Liyanage (Sri Lanka), and Dr JS Thakur (WHO, India) and Dr Rajesh Noah (India).

**Discussions and recommendations on updating the Global Action Plan (2013–2020)**

**Progress in implementation of the current plan and its strengths and weaknesses**

All the eight countries represented said that they had national plans in place for preventing and controlling NCDs. Some countries found the global action plan useful in developing their national plans, while others said that the global plan had not been critical in developing their national plans. Overall, it was felt that one of the strengths of the global plan was that it had provided a framework for countries to develop their own strategies. Progress was variable in terms of national achievement across the global plan’s six objectives.

Success stories varied from country to country. In some, governments have taken a lot of initiative to deliver on NCDs but it was clear that at the highest level, there is variation in the level of the political commitment. This showed itself in terms of allocation of resources and the implementation of multisectoral responses. Other limitations were poor capacity to implement the plan and lack of availability of external technical assistance. Overall, national plans have been insufficiently ambitious to meet the objectives of the global plan.

It was suggested that the next plan should encourage even greater political commitment at the national level and provide an environment for professional, academic and other partners to work with the ministry of health (MOH) in preventing and controlling NCDs, especially in exploring and tackling NCDs as part of poverty reduction.
Overall, the new plan should build on the existing plan. There was agreement that the overall objectives were broadly sound. The breakdown of roles and responsibilities of Member States, the Secretariat and international partners was also helpful and should continue. The new plan should encourage alignment of national and regional plans with the global plan.

**Reduction of exposure of populations and individuals to the risk factors for NCDs**

The group reviewed and endorsed the best buys in Tables 1 and 2 of the 2010 *Global Status Report on NCDs*, in terms of avoidable burden, cost-effectiveness of the interventions, and cost and feasibility of implementation. The “best buys” should form the central component of the new action plan.

The need for counselling and appropriate drug therapy for cardiovascular disease, including hypertension, was highlighted. There is a need to provide aspirin therapy to all patients with coronary heart disease. To reduce costs, generic drugs should be promoted wherever possible for all diseases. The group stressed on the importance of a settings-based approach – especially in schools and colleges – for health promotion.

**Promoting a health systems response**

The group emphasized that health systems in SEAR countries are generally weak when it comes to addressing NCDs. All the six building blocks of the health system need attention and strengthening (i.e. governance, human resources, health financing, health-care delivery, essential drugs and technology, and information systems), and should be described in the action plan. The out-of-pocket expenditure for health care, especially for NCDs, is the highest in the Region as compared to rest of the world, leading to catastrophic expenditure and pushing many to poverty. The action plan should propose approaches to reduce this.

It was recommended that building affordable health systems should be the core issue for the next action plan. The plan should highlight the need for the health system to received adequate financial allocation with equitable distribution.
The action plan should also include the identification and adoption of innovative solutions based on information technology (IT) such as mobile telephones for health promotion, long-term management, etc.

**Strengthening national capacity**

The group acknowledged that the number of trained human resources was inadequate (doctors, nurses, paramedical and health-care workers). Capacity was especially weak at the PHC level and this urgently needed strengthening. It was pointed out that too many resources were being diverted towards secondary and tertiary care, at the expense of primary care.

There is a need to integrate NCD surveillance into the wider national health information system (HIS). More capacity is needed in this area.

More capacity is also needed for building partnerships and enhancing multisectoral coordination, for example, with the finance, education and law sectors.

The group recommended that the plan should highlight the potential capacity that could come from industry and its corporate social responsibility. The plan should therefore encourage public–private partnerships, and capacity and mechanisms to strengthen such programmes. The private sector remains unregulated in many areas when it comes to NCDs, and the new plan should highlight the role and importance of regulating this important sector in the prevention and control of NCDs in Member countries.

**Promoting international cooperation and coordination, and in raising funds**

The group said that there was limited international cooperation for funding NCD programmes and lack of coordination mechanisms at the country level, especially for multisectoral action. It was agreed that the plan should emphasize that donor and international financial institution plans should now prioritize and commit funding and support for NCDs, particularly in low-resource countries. The new action plan should also highlight the convening role of WHO in bringing key stakeholders together and in providing technical support. The group said that WHO needed to be adequately resourced to undertake both these tasks.
The plan should also emphasize the need to strengthen the linkages within the UN system at the country, regional and global levels. The United Nations Development Assistance Framework (UNDAF) mechanism needs further strengthening and monitoring. The plan should also highlight the opportunities and mechanisms to share and adopt best practices among countries. Periodic evaluation of multisectoral actions/mechanisms in countries should be included in the plan.

**Monitoring progress and evaluating the new plan**

The current plan has insufficient focus on monitoring and evaluation at the national, regional and global levels, which has resulted in variable accountability. There is a need for the action plan to describe the importance and value of external evaluation. Therefore, a clear monitoring and evaluation mechanism should be included in the new plan. Monitoring progress should be aligned with the commitments made in the Political Declaration of the UN HLM.

**Mental health and neurological disorders**

**Global perspectives**

Dr Shekhar Saxena, Director, Mental Health and Substance Dependence, WHO HQ apprised participants on the needs, processes and contents of the Global Action Plan on Mental Health. The huge burden of neuropsychiatric disorders was highlighted in the *Global Burden of Disease* in 2004. WHO projections estimate that, by 2030, depression will be among the top three leading causes of DALYs lost globally. The World Economic Forum 2011 estimated that the cost of illness due to mental and neurological disorders was US$ 2.5 trillion, which could increase to US$ 6 trillion by 2030.

This huge burden of neuropsychiatric disorders is a challenge in the backdrop of limited resources, including funds, infrastructure and human resources. An indication of the low resources is the huge treatment gap in developing countries, which can be as high as 70%–85% based on global estimates.

The Mental Health Global Action Programme (mhGAP) was introduced in 2008 to scale up care for mental and neurological disorders. The objectives of the programme were to increase the commitments of governments, international organizations and other stakeholders, and to achieve significantly higher coverage with key interventions in resource-poor countries.
An action plan to address mental and neurological disorders has to be developed in 2012, as mandated by the WHO Executive Board. The possible link of the Mental Health Action Plan to other global plans including child and adolescent health, HIV/AIDS and the social determinants of health were also presented.

**Regional strategy to address mental and neurological disorders**

**Dr Vijay Chandra**, Regional Advisor, Mental Health and Substance Abuse, WHO SEARO highlighted the key aspects of the Regional strategy to address mental health and neurological disorders. There have been many developments in the field of mental health, including better medications, better understanding, better treatment and better management. However, despite these developments, a large proportion of persons, particularly in rural and remote areas, are not getting appropriate care and treatment. SEARO, working with experts in Member States, has documented the huge treatment gap in the SEAR, which can be as high as 95%, depending on the disease and geographical location. This is proof that people who need treatment are not getting it. To address this issue, SEARO has developed a strategy to train village-based health workers to identify the most common mental and neurological disorders, using a validated screening questionnaire. Once identified, patients are taken to the nearest PHC-based doctor who has been trained to provide appropriate treatment. Pilot projects, using the treatment gap for epilepsy as an example, have been extremely successful in Member States where they have been implemented (Bangladesh, Bhutan, Myanmar and Timor-Leste). Impact assessment of these pilot projects have shown that the treatment gap can be substantially reduced as shown in Table 3.

**Table 3: Impact assessment of intervention for epilepsy through the PHC system**

<table>
<thead>
<tr>
<th>No</th>
<th>Country</th>
<th>Treatment gap before intervention (%)</th>
<th>Treatment gap after intervention (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bangladesh</td>
<td>87</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Bhutan</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>Myanmar</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Timor-Leste</td>
<td>70.7</td>
<td>53.7</td>
</tr>
</tbody>
</table>
These pilot projects clearly demonstrate that people who need treatment can get it through the existing PHC system with training being the only additional investment. In addition, the programmes are sustainable as they become part of the existing government health-care delivery system. Member States where such projects have been piloted will greatly benefit from scaling up these projects. At the same time, the remaining Member States in the Region would do well to adapt these projects to suit their local needs.

**Strengthening the primary health-care system to deliver mental health care**

**Dr Nazneen Anwar** from WHO SEARO spoke on “Impact evaluation of mental health programmes”. She described evaluation and the different approaches that can be used to assess mental health programmes. There is a need to monitor programme implementation and progress, identify strengths and weaknesses, assess the achievement of objectives, cost-effectiveness and requirements for donor reporting. She illustrated the differences between impact and outcome indicators, and emphasized the importance of mid-term and end-term project evaluation for successful programme implementation and for achieving programme objectives. The impact evaluation of the mhGAP pilot project for addressing the epilepsy treatment gap in two unions of Sonargaon Upazila, Bangladesh was used as an example of successful project implementation for reducing the treatment gap of epilepsy.

**Mr Tandin Chogyal** shared the experience of strengthening the PHC system to deliver care for mental and neurological disorders in Bhutan, highlighting the sharp rise in reported cases of mental illness. The strategy included training of PHC doctors and nurses on care for mental health and neurological disorders, and development of a training manual. The services provided focused on a few common conditions such as psychosis, anxiety, depression, and alcohol and drug abuse. Complicated cases were referred to psychiatrists at the regional and national referral hospitals. Psychotropic medications were supplied through the essential drugs supply programme. Between January and December 2011, a pilot project was implemented in Punakha District with the support of WHO SEARO. The challenges identified during programme implementation were short project duration, difficulties in breaking sociocultural beliefs on treatment and care, noncompliance with treatment due to socioeconomic factors and limited funds.
**Impact indicator:** Strengthening PHC to reduce the treatment gap. In this pilot project, the treatment gap was reduced from 40% to 26%.

**Dr Md Faruq Alam** shared the Bangladesh experience of strengthening the PHC system to deliver care for mental and neurological disorders. A pilot project conducted to address this treatment gap in Sonargaon Upazila was described. The objectives of the project were to identify generalized tonic–clonic (GTC, major fits) seizures among children in the community and to treat these cases with phenobarbitone. All children (11,669) 5–14 years of age in two Unions of Sonargaon model sub-district were assessed. The treatment gap was found to be 87%.

Currently, all those requiring medication are being treated, bringing the treatment gap to 5%. The challenges faced during the pilot project were overburdened health workers, limited supply of phenobarbitone from the government in the study area (PHC level), stigma, superstitious beliefs and the non-availability of appropriate treatment facilities at the secondary level, which hampered referral of complicated cases.

Similar pilot projects will be conducted for other priority neuropsychiatric conditions such as psychosis, depression, substance abuse and developmental delay, including autism spectrum disorders. The success of the project lies in the government’s commitment to scale up this activity at the national level. Funds have been allocated in the Health, Population and Nutrition Sector Development Programme (HPNSDP) for nationwide scaling up of the project.

**Impact indicator:** Strengthening the PHC to reduce the treatment gap. In this pilot project, the treatment gap was reduced from 87% to 5%.

**Ms Sujaya Krishnan** shared India’s experience on care for mental and neurological disorders. Historically, mental hospitals were the mainstay of treatment for psychiatric illnesses. The launch of the National Mental Health Programme (1982) and the revision of the National Health Policy, which placed mental health within the general health services, changed this scenario. The District Mental Health Programme is the main intervention of the Government of India to provide community-based mental health services in the PHC setting. This programme increases awareness of mental illness, reduces stigma, provides
early detection and treatment, and generates data for planning. This programme is operational in 123 districts. Activities such as early detection and treatment at the patient’s doorstep, dispensation of essential psychotropic medicines, training of health and community workers, and preparation of information, education and communication (IEC) materials are carried out in these districts.

The acute shortage of mental health professionals, multiplicity of administrative bodies, delay in release of funds, lack of standardization, lack of monitoring mechanisms and reluctance of state governments to take over funding of the programmes are the current limitations.

To improve human resources for mental health, 11 centres of excellence in mental health specialties have been established. Postgraduate training has been strengthened by the establishment of 30 departments of psychiatry, clinical psychology, psychiatric social work and psychiatric nursing.

The District Mental Health Programme needs to be strengthened by ensuring regular flow of funds, appointing mental health professionals exclusively for this programme, training district teams on programme management, providing special training to health workers and involving community leaders and organizations in activities for increasing awareness.

**Impact indicator:** The impact of the programme should be assessed as an increase in the number of patients getting appropriate treatment.

**Dr Phunnapa Kittirattanapaiboon** presented Thailand’s experiences in strengthening the PHC system to deliver care for mental and neurological disorders. The “Framework for the mhGAP – Psychosis Programme” in Thailand, which included a baseline assessment, administration and indicators, was described. The pilot interventions were carried out in Sarapee, Nongsonghong, Wangnumkaew and Klongtom, and implemented through the PHC system in these areas. The treatment gap in the four project sites was 52.5%, 25.5%, 31.2% and 34.9%, respectively. Through training of village health volunteers and PHC staff, identification of new patients is in progress. This will result in a significant reduction of the treatment gap at all sites. Lessons learnt include issues related to stigma, training efficacy, screening skills, public education on psychosis and continuity of care.
Improving outcomes such as reducing readmissions were described. It is planned to implement the mhGAP programme for five priority mental disorders selected in six additional pilot sites. The requirements for scaling up include involvement of local administrative committees, community participation, research, policy and financial support.

**Impact indicator:** Reduction in treatment gap; reduction in readmissions.

Mr Teofilo Julio Kehic Tilman shared Timor-Leste’s experience in strengthening the PHC system to deliver care for mental and neurological disorders. He presented a study that is being carried out in 2 sub-districts: Lequidoe and Maliana. The population of the study area is 32,420, of which 324 are estimated to have epilepsy. Initially, 95 were under regular treatment and 16 were taking treatment irregularly. Following the intervention, the number of patients on regular treatment has increased to 150 and it is expected that it could further increase to 200 as the project continues. The project is expected to conclude in July 2012. The challenges faced were limited drug supply, geographical factors, external factors such as presidential and parliamentary elections being conducted during the project period, logistics and human resource issues.

**Impact indicator:** Strengthening the PHC system to reduce the treatment gap. In this pilot project, the treatment gap was reduced from 70.7% to 53.7%.

Following the presentations from countries, discussions followed on the issues of appropriate outcome indicators for programmes on care for mental and neurological disorders. The importance of monitoring programmes from their inception to improve programme outcomes, mechanisms to scale up community-level pilot projects, methods of obtaining baselines for estimating the treatment gap were the main issues discussed.

Practical aspects such as the impact of high turnover of workers and health professionals on the sustainability of programmes, and involving sectors other than the allopathic health systems for better delivery of mental health services were also discussed. The importance of customizing pilot interventions to the needs of particular communities (e.g. drop-outs from treatment), addressing stigma and other social issues were highlighted.
Recommendations

- Provide support for scaling up pilot projects in countries where they have been implemented and adapt them in other Member States.
- Include strategies to strengthen the existing PHC system to deliver care for mental and neurological disorders in the government’s health sector plan. This will ensure long-term sustainability of the programmes.
- Allocate adequate resources to ensure training of community-based health workers and PHC-based physicians in the technical aspects of delivery of care for mental and neurological disorders.
- Ensure a continuous supply of psychotropic medications by the government at the PHC level based on the WHO Essential Drugs List.
- Conduct extensive community-targeted publicity campaigns to remove stigma against persons with mental and neurological disorders.

Strategies to reduce harm from alcohol use

The session started with a presentation by Mr Karma Wangchuk on “Reducing harm form alcohol use in Bhutan”. Alcohol is a leading cause of morbidity and mortality in Bhutan. It is also a leading cause of domestic violence, divorce and road traffic accidents. Approximately 20% of food grains in the country are used to brew alcohol.

Mr Wangchuk described an ongoing community intervention project to reduce the use of and harm from alcohol in a rural area of Bhutan. The project is being implemented in five blocks (six Basic Health Units). The project period is from July 2011 to July 2012. The target is to reduce alcohol use by 50% in the project areas. The strategies being used are education to bring about changes in alcohol consumers, regulations, licensing and enforcement, and treatment.

Even before the end of the project, significant outcomes have been observed. Alcohol use has reduced by 70%, and food security has improved. People are more aware of the harm from alcohol use. It’s use is strictly prohibited in most social gatherings and it is not served to guests as before. The communities themselves have begun framing rules and related fines for alcohol consumption. Other gewogs have also begun to adapt the practices of the two pilot areas.
The practical problems faced were alcohol being intimately embedded in the people’s way of life since ancient times, and the lack of detoxification and counselling services at the district level. The draft national strategy framework for reducing harm from alcohol use is under discussion and will be placed in the Parliament. If implemented, this would effectively contribute to reducing harm from alcohol use in Bhutan.

**Impact indicator:** Reduction in alcohol use by 70%; increase in food security

Mr Pubudu Sumanasekera shared Sri Lanka’s experience of reducing harm from alcohol use in three selected locations. This project was implemented with support from WHO SEARO. Its overall objective was to empower communities to improve their well-being through addressing and minimizing the harmful use of alcohol. Implementation of the project in one of the three locations (Thlikada) in the Southern Province of Sri Lanka was discussed.

There were 1005 families living in the area, out of which 565 families had at least one person who consumed alcohol. The strategy used to enter the community was by discussing the general problems of the community and not emphasizing on alcohol use. The strategy adopted in engaging and encouraging the community to develop and implement activities and to evaluate progress was described. The technical content of the interventions included addressing the attractiveness of alcohol use, unfair privileges attached to alcohol use, understanding the real harm from alcohol use, “alcoholization” of social and cultural events, addressing the images of a user and non-user, and formulating and implementing village-level policies. For example, under “real harm”, the amount of money spent on alcohol by all the users in the community was calculated, by which both users and non-users realized the enormity of the quantum of money that flows out of the village.

Although the project period was nine months, and it has been two years since the interventions stopped, the following outcomes are still seen. Existing organizations and structures at the village have incorporated prevention of alcohol use into their agenda. Factors that are still being addressed by the community are those that increase the attractiveness of alcohol use including the media and other promotions, antisocial behaviour including violence following
alcohol use, pay day use, use of alcohol on special occasions and availability of alcohol. Serving alcohol at weddings has completely stopped.

The main reasons for the success and sustainability of community action were identified. The first was initiation of the programme with the blessings of the community. Next was patiently waiting until the community assessed and decided the objectives and activities to address the issue. Another important factor was obtaining consensus from anti-alcohol and pro-alcohol groups to achieve a common goal. Promotion of multisectoral collaboration and involvement of the community were the major contributors to the sustainability of the programme.

Impact indicator: Amount of money saved by each household from reduced use of alcohol.

Dr Usaneya Perngparn presented experiences on a pilot project on community action to reduce harm from alcohol use in Thailand. The 2007 National Household Survey showed that 10 million men and 3.2 million women out of a total population of 46.3 million between the ages of 12 and 65 years used alcohol.

For this intervention, volunteer current drinkers from 116 households were taken from 522 households of two villages in Pattana Nikom district, Lop-Buri Province, Thailand. Lop-Buri has one of the highest rates of alcohol use among the provinces.

Two baseline data surveys and three meetings in the community were conducted. The Abbot, community leaders, District Officer and his staff, General Hospital Director and community health personnel and villagers were involved. A programme to reduce harm from alcohol use was conducted in two villages of Pattana Nikam district of Lop-Buri Province of Thailand. Money boxes were distributed, in which the money saved from reducing or abstaining from alcohol use was deposited. These families were also given a form to record the amount of money deposited. Those who saved the most were given prizes by the District Officer. There was a total saving of about 60 000 baht by abstaining from drinking for six months. At the end of the intervention period, harm from alcohol use such as accidents, quarrelling and fighting in the family, and economic problems had reduced among hazardous as well as low-risk drinkers.
The success of this pilot project was due to the involvement of leading community figures. The District Office provided two thirds of the funding requirement while the rest was provided by WHO. The major challenge faced by the project team was the difficulty in arranging the group meetings and in providing individual advice to the participants. The short six-month duration of the project and the participants’ work characteristics were additional challenges faced. Besides the project activities, other sectors such as the district hospital provided medical services and monthly check-ups to the villagers during the intervention period.

**Impact indicator:** The amount of money saved per month by the households participating in the project.

Ms Orratai Waeewong presented some of the other ongoing programmes in Thailand to reduce harm from alcohol use. The strategy is to communicate through the public media and ground-level educational activities to the community about making select festivals alcohol free, e.g. the Buddhist Lent, which is celebrated from mid-July to mid-October. Similar campaigns are conducted during other festivals. The success of these programmes has led the organizers to conduct similar alcohol-free campaigns in other cultural and community activities, and to promote an alcohol control policy at the local and national levels.

**Impact indicators:** The number of people who have either reduced or quit alcohol use has increased. A substantial amount of money has been saved by families. The alcohol market has shrunk.

During the discussions, it was emphasized that community alcohol projects should take the “whole population approach” to ensure that users other than heavy users are brought under the purview of the interventions. This approach will ensure inclusion of all levels of users as well as non-users, who have different roles to play in addressing alcohol-related harm in the communities. It was suggested that alcohol, if projected as a common risk factor for NCDs, will cast a wider net and it would be easier to talk about it in communities; as a medical problem it would be less stigmatizing. The participants were also of the opinion that de-glamourizing the use and users of alcohol could be a potent approach to curb the harmful use of alcohol at the community level. Examples were cited to show that the success of community interventions
depend on community ownership in developing and implementing activities. Taking community concerns into account while initiating community behaviour change interventions was recommended.

**Recommendations**

- To make the community aware of the harm caused by alcohol use
- To promote community participation in defining the harm and in developing its own plans for reduction of harm from alcohol use.

**Further, there were extensive discussions** on the indicators and targets for addressing NCDs, which are currently under development. The group strongly recommended that the following text be added to the proceedings of the meeting:

**Draft proposal on inclusion of targets and indicators for monitoring alcohol use as a part of the overall NCD monitoring**

“The Participants of the WHO SEARO meeting entitled “Regional meeting on noncommunicable diseases including mental health and neurological disorders”, held in Yangon, Myanmar, on 24–26 April 2012 are aware of the substantial harm from alcohol use. We are aware of the wide spectrum of harm from alcohol use, which goes beyond health risks and includes economic, social and psychological harm. WHO data suggest that harmful use of alcohol is the world’s third-largest risk factor for disease and disability, and causes approximately 2.5 million deaths each year.

The participants strongly support the World Health Assembly Resolution WHA61.4 entitled, “Strategies to reduce the harmful use of alcohol”. As we proceed to implement the WHA Resolution, the need for monitoring progress becomes important. We are aware that WHO is establishing a set of indictors and targets for monitoring programmes on the reduction of NCDs. In this context, we are of the opinion that reducing harm from alcohol use should be included in the list of targets.

The participants support the following two indicators:

- Monitoring adult per capita (APC) consumption of alcohol
- Reducing the number of heavy episodes of drinking alcohol.
The participants recommend that the target for APC should be a 10% relative reduction in persons aged 15+ years by 2025 and that the target for heavy episodic drinking should be a relative reduction of 5% by 2025.”

Promotion of mental well-being

Dr Sajeeva Ranaweera from Sri Lanka spoke on the concept of mental well-being. Different types of descriptions and definitions of well-being, concept of mental well-being, quality of life, Antonovsky’s salutogenic perspective of optimal health and the concept of social capital were presented. The various determinants of mental well-being were described, some falling within the purview of the health sector, others within the purview of the social, economic and political sectors. Population-level assessment instruments on mental well-being were described, including Bhutan’s Gross National Happiness Index, Thailand’s Mental Happiness Index, the ”Better Life” Index used in the 34 countries of Organization for Economic Cooperation Development (OECD) and the private sector Gallup–Healthways well-being index in use in the United States of America and the United Kingdom.

The contents of the 2011 UN General Assembly Resolution entitled “Happiness: towards a holistic approach to development” (A/65/L.86) were discussed. This was a landmark effort to include the issue of human well-being in mainstream thinking and development plans. The work carried out to promote mental well-being by the WHO SEA Region and the European Region was highlighted. Aspects of operationalizing the concepts through innovative interventions at the community level were also discussed.

Ms Dawa Dem described a programme conducted in a school in Bhutan to promote mental well-being. The objectives of the programme were to reduce alcohol and substance use, reduce fights and quarrels, improve attendance and reduce disciplinary problems in the school. The interventions consisted of a school-based in-service programme for all members of staff, life-skills education for the students, talks, religious discourses, discussions on parenting, use of substitution classes and the use of peer helpers. The outcomes showed reductions in alcohol and substance use, number of fights and quarrels, and absenteeism. The challenges faced during implementation were time constraints, inadequate funding and lack of support from teachers.
**Impact indicator:** Reduction (compared to before project implementation) in the reported number of fights and quarrels between children during breaks and absenteeism. The exact quantum of reduction is being analysed.

**Promotion of mental well-being using traditional cultural approaches in Sri Lanka**

**Professor G.D. Sumanapala** described the traditional and cultural approaches embedded in community life in most parts of the Region since ancient times to promote mental well-being. These approaches have been initiated, developed and adapted over hundreds of years by communities, and have been influenced by variations in community life, climates, religions, etc. An ongoing programme of promotion of mental well-being using Buddhist counselling practices and other traditional approaches such as the use of astrology were described, with participation of entire communities.

During the subsequent discussions, the importance was highlighted of taking the traditions and cultures of specific populations into consideration while developing and implementing initiatives to improve mental well-being to ensure acceptability and sustainability.

**Recommendations**

- Strategies for promotion of mental well-being as applied to children and adolescents should be encouraged, as these can be a method for primordial prevention of mental illness. The actual activities to be implemented can vary depending on the local culture (e.g. spirituality in Bhutan).
- Traditional practices (such as yoga, meditation), which have been practised in the Region for centuries and are readily acceptable to the community, should play a major role in the promotion of mental well-being.

**Translating the EB 130 Resolution on mental health into an action plan**

The Executive Board of WHO in its Resolution (EB 130.R8) in January 2012 recognized the global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at
country level, and asked WHO to develop a new action plan relevant to all countries. The focus was on a comprehensive mental health plan, including prevention and promotion, which required countries to commit themselves to action.

**Dr Shekhar Saxena, WHO HQ** led the discussions on translating the EB 130 Resolution on mental health into an action plan. Comments were sought during this session from the participants on the draft EB Resolution “The global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level”.

This discussion centred on the technical programme areas to be included in the draft comprehensive mental health plan prepared by the Secretariat. The areas that have been specified are as follows:

- assessment of vulnerabilities and risks as a basis for developing the mental health action plan;
- protection, promotion and respect for the rights of persons with mental disorders, including the need to avoid stigmatization of persons with mental disorders;
- equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system;
- development of competent, sensitive and adequate human resources to provide mental health services equitably;
- promotion of equitable access to quality health care including psychosocial interventions and medication, and addressing physical health-care needs;
- enhanced initiatives, including policy, to promote mental health and prevent mental disorders;
- access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes;
- involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes;
- design and provision of mental health and psychosocial support systems
that will enable community resilience and help people to cope during humanitarian emergencies;
- participation of people with mental disorders in family and community life and civic affairs;
- mechanisms to involve the education, employment and other relevant sectors in Member States in implementing the mental health action plan;
- build upon the work already done and avoid duplication of action.

This resolution is anticipated to be adopted by the 65th World Health Assembly in May 2012, and will be followed by a process of consultation with Member States and other stakeholders. Regional meetings will be held on this and the opportunity provided by this meeting made SEAR the first Region to hold this technical consultation. A face-to-face consultation with all stakeholders will be held in Geneva on World Mental Health Day on 10 October 2012 for submission of the draft mental health plan to the EB in October 2012. The principles on which this action plan will be based are: intersectoral approach involving the education, employment and social sectors; engagement of service users and families in the design and implementation of policies, laws and services; vulnerability assessments and risks; and clear evidence and respect for human rights. It will be in alignment with and linked to other global action plans such as those for NCDs, HIV/AIDS, alcohol use, social determinants, etc.

**Partnerships for prevention and control of noncommunicable diseases**

Fostering partnerships is one of the key objectives of the global action plan on NCDs. The UN Political Declaration repeatedly refers to international collaboration and partnerships. The partners for NCD prevention and control are broad based. There are many areas where partners can contribute to the efforts and therefore their efforts need to be well coordinated. In order to explore the roles of different partners, representatives from different partner agencies were asked to make brief presentations describing their current and potential roles in NCD prevention and control. The partners varied from community-based organizations to multilateral agencies, including UN agencies.

**Nongovernmental organizations (NGOs):** A case study was presented by an NGO working in the area of diabetes control in the Maldives for the
past 12 years. With funding support from the World Diabetes Foundation, a project was designed to promote quality diabetes education and to assist diabetes educators in a variety of settings to promote healthy lifestyles for the prevention of diabetes and other NCDs, and make diabetes care accessible in all islands of the Maldives.

In each island, at least one diabetes educator has been trained. The training course is of three weeks’ duration. Five such courses have been held so far and 140 educators trained. The educators promote healthy lifestyles and help in the provision of care if required. They conduct screening of the high-risk population by measuring the blood pressure, weight and blood glucose levels. A total of 219 screening camps have been held and 475 cases of diabetes have been detected. The programme will gradually be expanded to cover other NCDs.

**Academic institutions:** There is an overwhelming disparity between the burden of NCDs and low capacity of the health systems to respond to the needs of people suffering from NCDs in Member States of SEAR. The primary role of academia should be to support and strengthen national health systems. Academia has to go beyond its traditional mandate of training and take up additional social responsibility in return for the investments made by society. Academic institutions should translate scientific evidence into messages that are relevant for day-to-day life. Today, academia cannot live in an ivory tower but must reach out to others. There should be less arrogance and greater humility among academia to seek partnerships with other stakeholders. NCDs have brought forward a new set of challenges and academia should respond accordingly. Academia should also serve as a bridge to narrow the gap between generation of evidence and its application. Academia has a lot of clout and credibility; this should be used to influence policy- and decision-making.

**WHO collaborating centres:** These have largely focused on the area of epidemiology, research and capacity building as a part of their contribution to NCD prevention and control. Using the example of the Tata Memorial Cancer Hospital, it was shown how research focused on early diagnosis of common cancers, especially of cervical cancer, has led to the development of a low-cost technology that can greatly increase the accessibility and affordability of diagnostic facilities to the unreached population. Use of telemedicine to reach the unreached was also mentioned.
The NCD Alliance includes over 2000 member and partner NCD organizations from across the world, including the International Diabetes Federation, the Union for International Cancer Control, the World Heart Federation, and the International Union Against Tuberculosis and Lung Disease. While commending the role of WHO for its strong leadership, it asked WHO to ensure that the UN Summit is seen by future generations as the turning point in our common fight against NCDs. Member organizations of the NCD Alliance committed to supporting Member States and WHO in catalysing global action, and urged Member States:

(1) To support the establishment of a global coordinating platform on NCDs, led by Member States, UN agencies, governments, civil society and the private sector. Looking to successful models such as the Partnership for Maternal, Newborn and Child Health, this platform would lead a renewed multisectoral movement for NCDs and should have the responsibility to bring together key sectors and partners to fully develop and implement a global plan for NCDs. The tide of NCDs will not be turned by continuing with the same fragmented and piecemeal country-level responses from the past – it is time to work together and make a renewed global effort.

(2) To support a comprehensive global monitoring framework and targets: The NCD Alliance fully agreed with the current global targets being considered by Member States, but they are incomplete. As this group has agreed, five targets are not enough for the most complex health challenge the world has ever faced. It asked SEAR Member States to urge all other Member States to agree to ten targets at the 2013 World Health Assembly, and to report every two years on these targets. In particular, a target is needed to ensure 80% availability of affordable, quality-assured essential NCD medicines and technologies for persons living with NCDs and for those who are dying, for whom prevention alone is not a viable option. The Alliance was happy that SEAR Member States have agreed that this target should be added to those already proposed on tobacco, salt, alcohol, physical inactivity, trans-fats, blood pressure, obesity and multidrug therapy.

(3) Put NCDs at the centre of the post-2015 development agenda: As the world begins to review the impact of the MDGs and plans
for a new framework after their expiry in 2015, we have a unique opportunity to ensure that tackling NCDs is central to future health and development planning. The Alliance therefore called on governments to ensure that NCDs are included in the outcomes of this June’s UN Conference on Sustainable Development in Rio, which will be a key process in determining the post-2015 development goals.

Dr Marinus Gotink of the United Nations Children’s Fund (UNICEF) Myanmar elaborated on the role of the UN in addressing NCD prevention and control at the country level. He mentioned that countries are passing through a demographic transition with a rise in the elderly population and NCDs. The UN HLM emphasized the role of all UN agencies, which is reflected in the UN Political Declaration. He also highlighted the importance of strengthening health systems and quality of services for universal coverage, and reducing catastrophic expenditure due to NCDs. He stressed on the role of the life-course approach and the role played by UNICEF, which will provide additional benefits for developmental defects, including neural tube defects, if interventions are undertaken in the pre-conception period. He mentioned the scaling up of nutrition initiatives, and that UNDAF can play an important role in NCDs.

**Closing remarks**

In her concluding remarks, Dr Poonam Khetrapal Singh observed that this meeting had been very productive. It facilitated sharing of experiences among Member countries, and led to the development of a draft resolution for the 65th Regional Committee. The need for multisectoral action was repeatedly emphasized; this requires the highest political commitment at the country level. She encouraged countries to consider holding national-level consultations with multiple stakeholders to engage with and sensitize other sectors to the role they can play in ensuring that health issues are taken into consideration in all public policies.

With regard to monitoring indicators and targets, she said that very valuable feedback had been received from the meeting participants. It is important that Member States of this Region have an opportunity to contribute their inputs to the global framework. She also stressed the importance of setting national targets at the country level through a consultative process. It was the first time that a joint meeting on NCDs and mental health had been held due to the need
articulated by Member States. She highlighted the progress achieved since 2007, when the Regional Framework on NCD prevention and control was developed, to the past year, when the Jakarta Call for Action was adopted by the Health Ministers’ meeting. Dr Singh said that this series of activities has helped to get NCDs into the political agenda. She thanked the Minister of Health from the Maldives, the special invitees and the participants.

Dr Renu Garg proposed a formal vote of thanks, expressing her gratitude to the Ministry of Health, Myanmar for hosting the meeting, to the Chair, Co-Chair and session moderators, as well as to all the participants for their sincere participation throughout the meeting. The Chair thanked the participants for the in-depth and fruitful discussions and expressed his appreciation to SEARO for the successful conduct of the meeting.
Noncommunicable diseases including mental health and neurological disorders

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.17, WHA56.1, WHA57.17, WHA60.23 and WHA 64.11; Executive Board resolutions 130.R8 and its own resolutions SEA/RC52/R7, SEA/RC53/R10 and SEA/RC60/R4 relating to the prevention and control of noncommunicable diseases including mental and neurological disorders;

Acknowledging the Political Declaration of the High-level Meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and noncommunicable diseases control, and the Rio Political Declaration on Social Determinants of Health;

Recognizing that noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and mental and neurological disorders, are the leading cause of premature death and disability and that the burden is likely to increase in the South-East Asia Region due to ageing of the population, globalization, changes in dietary patterns, unplanned urbanization and other social determinants;
Noting with concern that the rapidly increasing health care costs associated with treatment of NCDs including mental and neurological disorders disproportionately affect the poor, impoverish families and overburden the public health care system;

Recognizing the substantial stigma against mental and neurological disorders;

Recognizing the substantial harm from alcohol use that goes beyond health risks and includes social, psychological and economic risks;

Realizing that effective and affordable interventions are available to modify the common risk factors of NCDs, such as unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol;

Recognizing the role of the “life course” approach that emphasizes the critical importance of health promotion and disease prevention strategies to minimize the risk of NCDs at each stage of life;

Appreciating that policies in sectors other than health have a major bearing on risk factors and environmental and social determinants of NCDs, and reiterating that there is a pressing need to strengthen multisectoral collaboration at all levels;

Acknowledging the need for development of standard indicators and targets to monitor the progress towards prevention and control of NCDs and their risk factors at global, regional and national levels, and taking note of the proposed WHO framework for monitoring indicators and voluntary targets,

Urges the Member States:

(a) to integrate NCD policies and programmes into national health planning processes and the global and national development agenda, and by 2013, to strengthen national multisectoral policies and plans for prevention and control of NCDs including mental and neurological disorders;

(b) to address NCD risk factors using the “life course” and an evidence-based approach beginning in pre-pregnancy period and continuing through childhood and adulthood including the elderly with the emphasis on public health interventions;
(c) to accelerate implementation of the WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol with the emphasis on implementation of “best buys”; 

(d) to develop national targets and indicators based on guidance provided by WHO, keeping in view national capacity, and strengthen national surveillance systems to measure key indicators in order to track progress towards NCD prevention and control;

(e) to develop comprehensive policies and strategies that address the promotion of mental health, prevention of mental and neurological disorders and early identification, care, support, treatment and recovery of persons with mental and neurological disorders;

(f) to adequately increase innovative and sustainable domestic financing for health promotion, primary prevention, and strengthen health systems for early diagnoses and management of NCDs including mental and neurological disorders, particularly at the primary care level while ensuring equitable access to affordable essential medicines and technologies; and

**Requests the Regional Director:**

(a) to work closely with Member States and partner agencies to address the regional and national burden of NCDs including mental and neurological disorders and to ensure optimum communication and advocacy messages in support of multisectoral actions for NCD prevention and control through existing fora (e.g. WHO Governing Bodies, UN General Assembly, WHO Regional Committees, UN regional bodies);

(b) to provide technical guidance and support to Member States for developing and strengthening national health systems and multisectoral plans and policies for prevention and control of NCDs, including mental health and neurological disorders; and

(c) to support Member States in the development of national frameworks including indicators and targets for monitoring progress towards prevention and control of noncommunicable diseases, including mental and neurological disorders.
Honourable Regional Director, WHO South-East Asia Region, Dr Samlee Plianbangchang, distinguished participants, honorable guests and partners, ladies and gentlemen,

**Mingalabar,**

I am privileged to have an opportunity to address on today's inaugural ceremony of the Regional Meeting on Noncommunicable Diseases including mental health and neurological disorders.

I warmly welcome you all to this auspicious occasion and would like to thank all participants and partners for your interest and time in attending this Regional Meeting.

Today, noncommunicable diseases (NCDs), mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes represent a leading threat to human health and development. These four diseases are the world's biggest killers, causing an estimated 35 million deaths each year – 60% of all deaths globally – with 80% in low- and middle-income countries.

NCDs are the biggest causes of death globally and large proportions of the deaths are premature. NCDs lead to catastrophic health expenditure and impoverishment, and hence NCDs are a threat to development and impede poverty reduction initiatives. These diseases are preventable. Up to 80% of heart disease, stroke, and type 2 diabetes and over a third of cancers could be prevented by eliminating shared risk factors, mainly tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.
Ladies and gentlemen,

More attention has now been paid globally to noncommunicable diseases. Last year, Heads and Representatives of States and Governments assembled at the United Nations from 19 to 20 September to address the prevention and control of noncommunicable diseases worldwide, with a particular focus on developmental and other challenges, and social and economic impacts, particularly for developing countries.

Resolution 66/2 on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases was adopted by the General Assembly on 19 September 2011.

The Political Declaration,

- Notes with profound concern a challenge of epidemic proportions caused by NCDs and its socioeconomic and developmental impacts
- Calls for responding to the challenge with a whole-of-government and a whole-of-society effort
- Commits to reducing risk factors and creating health-promoting environments
- Calls for strengthening of national policies and health systems
- Calls for international cooperation including collaborative partnerships in the prevention and control of noncommunicable diseases
- Calls for activities to support and facilitate noncommunicable disease-related research and its translation to enhance the knowledge base for ongoing national, regional and global action.

It also calls upon WHO, before the end of 2012, to:

- Develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through multisectoral processes, to monitor trends and to assess progress made in the implementation of national strategies and plans on NCDs;
- Prepare recommendations for a set of voluntary global targets for the prevention and control of NCDs.
The Political Declaration also urges member States to consider the development of national targets and indicators, based on national situations, building on guidance provided by WHO.

The High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases is a watershed event and creates a window of opportunity to galvanize global action for the prevention and control of NCDs.

Ladies and gentlemen,

We are proud to be a host country for this Regional Meeting on noncommunicable diseases including mental health and neurological disorders. We would like to thank WHO/SEARO for giving us an opportunity to host the Regional meeting.

The specific objectives of the meeting are:

1. To identify follow-up actions at the regional and country levels to realize the Political Declaration of the UN High-level meeting on noncommunicable diseases

2. To hold technical discussion on noncommunicable diseases including mental health and neurological disorders.

Myanmar, as one of the Member States of the WHO South-East Asia Region has been engaging actively in the combat against these preventable noncommunicable diseases in accordance with the “2008–2013 Plan of action for the global strategy for the prevention and control of noncommunicable diseases” and also within the "South-East Asia Regional framework for the prevention and control of NCDs". At this point, I would like to take the opportunity to commend the leadership of the Regional Director, Dr Samlee Plianbangchang in addressing and tackling noncommunicable diseases in the Region.

Myanmar has recently developed a draft national policy on noncommunicable diseases. We have also held a workshop on “Package for essential noncommunicable diseases (PEN) intervention” at the primary health care level. We are going to implement the PEN intervention in two townships very soon. With a recent change in the political system and increased budget for
health expenditure, we will be allocating more resources for the prevention and control of noncommunicable diseases for the country.

I believe within the next two days, under the leadership of WHO SEAR, delegates will be able to exchange knowledge and experiences in the prevention and control of noncommunicable diseases among each other. That will certainly lead to scaling up of activities for prevention and control of noncommunicable diseases in the Region.

In spite of a short period of stay in the country and the tight schedule of the meeting, I would like to advise the delegates to manage to explore Yangon and, at least, to pay visit to the glorious Shwe Dagon Pagoda, holy place for Buddhists and cultural heritage of Myanmar.

Since we have just celebrated the auspicious Myanmar New Year, I wish all of you a Happy New Year and wish you all the success at the meeting. May I also wish you all a happy, healthy and successful year ahead. Have a nice stay in Yangon!

Thank you.
Excellency, Professor Pe Thet Khin, Union Minister of Health, the Government of Myanmar, Excellencies, Dr U Ko Ko, WHO Regional Director Emeritus, distinguished participants, honourable guests, ladies and gentlemen;

With great pleasure, I warmly welcome you all to the Regional Meeting on NCDs, including mental health and neurological disorders. I thank all participants for sparing their valuable time to attend this important meeting. I gratefully thank His Excellency, Professor Dr Pe Thet Khin for his gracious presence to inaugurate the meeting.

Excellencies, distinguished participants, for much of the past century, NCDs, including mental health and neurological disorders have been neglected, globally as well as in the South-East Asia Region. It is only recently that NCDs have begun to receive due attention from Member States.

Last year marked a turning point in the battle against NCDs when a high-level meeting on NCDs was convened by the United Nations General Assembly or the UNGA in New York City. This high-level meeting was successful in generating a consensus that NCDs are not only a “health issue” but also a “development concern”. NCDs adversely affect social and economic progress, nationally and globally. The meeting was also able to draw the attention of world leaders to the urgent need to prevent and control NCDs. The UNGA adopted a “Political Declaration” calling for multisectoral commitment of Member States and other stakeholders and partners in the prevention and control of NCDs through concrete and comprehensive global actions.
Ladies and gentlemen, NCDs contribute to about eight million deaths every year in SEAR. The great concern is that one third of these deaths are premature, and that these preventable deaths occur before the age of 60 years in the economically productive age groups. The burden of NCDs is increased by several factors, such as a rapidly ageing population, unplanned urbanization and accelerated by progressive increase in unhealthy lifestyles.

At the same time, millions of people worldwide are affected by “mental disorders”. According to WHO estimates, these disorders accounted for 13% of the 2004 global disease burden. The good news, however, is that NCDs, including mental disorders, are largely preventable, by means of available “public health interventions” and a “PHC approach”. Through these interventions and approaches, the underlying risks and determinants of NCDs are primarily tackled.

Distinguished participants, I would like to reiterate that dealing with NCDs is not the task of ministries of health alone. It needs multisectoral and multidisciplinary cooperation and collaboration. Education and empowerment of people in the community is an important strategy towards long-term achievements in NCD prevention and control. In order to prevent and control NCDs, a well-balanced development between promotive/preventive care on the one side and curative/rehabilitative care on the other is needed.

In the process of tackling NCDs, we need to keep in mind that the number of NCD cases that need treatment and rehabilitation is huge. The majority of these cases require long-term or even lifelong care. A lot of medicines and medical devices are needed and specialized services are required in most cases. All of these would entail a high cost of care for NCD patients. Care provided right in the community should be an important part of health services provided for the chronically NCD-affected people. Community-based services, if properly organized and managed, will significantly contribute to a reduction in the cost of care.

Public health interventions and PHC approaches are cost-effective because these interventions and approaches accord priority attention to promotive and preventive care. Promotive and preventive care can prevent unnecessary morbidity and reduce the severity of disease. Consequently, the quality of life of NCD-affected people will be enhanced and their social and economic
dependence will be reduced. NCDs, as we can see, may represent only the tip of the iceberg. What lies below the surface may be far greater.

A public health strategy with a community-based approach, along with appropriate multisectoral research, will bring the invisible portion of NCDs to our attention, since some NCDs are preceded or triggered by infectious diseases. Therefore, integrated research should be pursued to ensure early detection and timely treatment of certain NCDs.

Ladies and gentlemen, different sectors should all come forward to develop appropriate national policies for tackling NCDs. The implementation of “health in all policies” or “healthy public policies” should be vigorously promoted to secure the commitment of all sectors to NCD prevention and control. All sectors have important roles to play either collectively or individually. A “health in all policies” or “healthy public policies” approach requires continued advocacy for all stakeholders at all levels. “Health in all policies” or “healthy public policies”, if successfully implemented, will greatly expand the resource base for NCD prevention and control, through a holistic approach at the national level.

Last month in Bangkok, we had a regional conference of parliamentarians, where the Bangkok Call for Action was adopted. The Bangkok Call placed due emphasis on public health interventions for dealing with today’s emerging health challenges, including NCDs. I am happy to note that some honourable parliamentarians who attended the conference in Bangkok are also present here today.

Also, critically important, comprehensive care of NCD patients needs a well-coordinated system of public health and medical interventions. These interventions should work in tandem, whereby patients can be efficiently referred back and forth between primary care in the community and specialized care in medical institutions. Medical institutions also have an important role to play in training and supervising community-based health workers or CBHWs, and in ensuring the quality of health care at community level.

Ladies and gentlemen, several Member States in the Region have started developing national plans for follow up of the UN Political Declaration. In order to support Member States, WHO is pursuing the development of a global monitoring framework, to regularly assess progress in implementation of the UN
Political Declaration. WHO has undertaken the development of policy options for multisectoral actions through partnerships at all levels. WHO is exercising a coordinating role within the UN system in addressing NCDs. And to provide more effective support to countries, WHO is expanding its technical competence and resources through its action plan on NCDs.

This Regional meeting is a platform to facilitate discussions and consensus building on priority actions on the UN Political Declaration at regional and country levels. This is also an opportunity to share countries’ past experiences in NCD prevention and control. I look forward to the recommendations from the meeting which will be taken forward in implementing the UN Political Declaration individually or collectively among stakeholders. Let us combine our wisdom and efforts in our attempt to fight these emerging scourges of mankind.

Finally, ladies and gentlemen, I wish the meeting all success. And I wish you all a pleasant stay in Yangon. Thank you.
# Annex 3

## Agenda of the meeting

### Regional Meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, Yangon, Myanmar, 24–26 April 2012

**Programme**

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<tr>
<td><strong>08:00–09:00</strong></td>
<td><strong>Registration</strong></td>
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</table>
| **09:00–09:30** | • Welcome by Dr H.S.B. Tennakoon, WHO Representative to Myanmar  
• Opening of Business Session – Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region  
• Meeting objectives and expected outcomes – Dr Athula Kahandaliyanage, Director Sustainable Development & Healthy Environments, WHO South-East Asia Region  
• Introduction of Participants – Dr Renu Garg, Regional Advisor, Noncommunicable Diseases, WHO/SEARO  
• Nomination of Chairperson, Co-Chairperson and Rapporteur – Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region  
• Administrative Announcements – Dr Renu Garg, Regional Advisor, Noncommunicable Diseases, WHO/SEARO |
| **09:30–10:00** | **Setting the scene:**  
Chairperson and Co-Chairperson of the Meeting  
Prevention and control of noncommunicable diseases including mental health and neurological disorders — an overview  
Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region |
| **10:00–11:15** | **Strengthening multisectoral actions for prevention and control of noncommunicable diseases**  
**Moderator:** Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region  
**Panelists** (Regional Advisors from WHO-South-East Asia Region)  
• Tobacco control – Dr Nyo Nyo Kyaing, RA-TFI  
• Reducing harmful use of alcohol – Dr Vijay Chandra, RA-MHS  
• Promoting healthy diet and physical activity – Dr Kunal Bagchi, RA-NFS  
• Primary prevention of NCDs and addressing social determinants – Dr Suvajee Good, Programme Coordinator, HPE  
**Discussion** |
| 11:30–13:00 | **Options and mechanisms for multisectoral actions for prevention and control of noncommunicable diseases — Country experiences**  
**Moderators:** Dr Prakit Vathesatogkit, Thailand and Professor Dr S.K Rai, Nepal  
**Panelists**  
1. Professor Tint Swe Latt, Myanmar  
2. Mr Wangchuk Dukpa, Bhutan  
3. Dr M Zaman, Bangladesh  
4. Dr Nopporn Cheanklin, Thailand  
5. Dr Babu Ram Marasini, Nepal  
6. Dr H. Suir Sam, Indonesia  
7. Dr T.L.C Somatunga, Sri Lanka  
8. Ms Sujaya Krishnan, India  
**Discussion** |
| --- | --- |
| 14:00–15:00 | **Inauguration of the Meeting**  
• Inaugural address by H.E. Professor Pe Thet Khin, Union Minister of Health, Myanmar  
• Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region  
• Group photograph |
| 15:30–17:00 | **Monitoring indicators and targets for prevention and control of noncommunicable diseases**  
**Moderator:** Professor Tint Swe Latt, Myanmar  
**Proposed framework, indicators and targets for noncommunicable disease prevention and control:** Dr Nick Banatvala, Senior Advisor, Noncommunicable Diseases, WHO/HQ  
**Interventions by Member States**  
**Discussion** |
| 18:30 | **Reception by** Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region |

**Day 2, Wednesday, 25 April 2012**

| 09:00–09:15 | **Recap of Day 1:** Dr Renu Garg, Regional Advisor, Noncommunicable Diseases, WHO/SEARO |
| 09:15–10:45 | **Mental health and harmful use of alcohol**  
**Moderator:** Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO/SEARO  
**Therein**  
**Mental health : Global Action Plan and EB Resolution**  
Dr Shekhar Saxena, Director Department of Mental Health and Substance Dependence, WHO/HQ  
**Regional strategy to address mental health and neurological disorders**  
Dr Vijay Chandra, Regional Advisor, Mental Health and Substance Abuse, WHO/SEARO  
**Discussion** |
<table>
<thead>
<tr>
<th>Time</th>
<th>Parallel sessions on noncommunicable diseases and mental health</th>
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<tbody>
<tr>
<td>11:00–17:00</td>
<td><strong>NCD group</strong></td>
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<tr>
<td>11:00–12:30</td>
<td>Global NCD Action Plan 2013–2020</td>
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<tr>
<td></td>
<td><strong>Moderator:</strong> Professor Hajera Mahtab, Bangladesh</td>
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<tr>
<td></td>
<td><strong>Presentation:</strong> Developing an updated action plan for the global NCD strategy for 2013–2020</td>
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<tr>
<td></td>
<td>Dr Nick Banatvala, Senior Advisor NCD, WHO/HQ</td>
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<td>Interventions by Member States</td>
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<td></td>
<td><strong>Discussion</strong></td>
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<tr>
<td>13:30–15:15</td>
<td>Group work</td>
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<td></td>
<td><strong>Group 1:</strong> Strengthening multisectoral actions for prevention and control of noncommunicable diseases</td>
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<tr>
<td></td>
<td><strong>Group 2:</strong> Indicators and targets for monitoring progress towards prevention and control of NCDs</td>
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<td></td>
<td><strong>Group 3:</strong> Updating the Global NCD Action Plan 2013–2020</td>
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<tr>
<td>15:30–17:00</td>
<td>Group work (continued)</td>
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<tr>
<td></td>
<td><strong>Promotion of mental well-being</strong></td>
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<td></td>
<td><strong>Concept of mental well-being</strong></td>
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<td></td>
<td>Dr Sajeeva Ranaweera, Sri Lanka</td>
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<td></td>
<td><strong>Country presentations:</strong></td>
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<tr>
<td></td>
<td>1. Bhutan: Mr Karma Wangchuk and Mr Choden</td>
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<td></td>
<td>2. Thailand: Dr Usaneya Perngparn and Ms Orratai Waewong</td>
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<td></td>
<td>3. Sri Lanka: Dr Pubudu Sumanasekara</td>
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<td></td>
<td><strong>Discussion</strong></td>
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<tr>
<td>17:30</td>
<td>Sightseeing tour organized by the Ministry of Health, Myanmar</td>
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**Day 3, Thursday, 26 April, 2012**

<table>
<thead>
<tr>
<th>Time</th>
<th>Recap of Day 2: Dr Athula Kahandaliyanage, Director</th>
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<tbody>
<tr>
<td>09:00–09:10</td>
<td>Department of Sustainable Development and Healthy Environments, WHO South-East Asia Region</td>
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</table>
09:10–10:45

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<thead>
<tr>
<th><strong>Group Presentations</strong></th>
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<tbody>
<tr>
<td><strong>Moderators:</strong> Dr Jagdish Prasad, India and Dr Athula Kahandaliyanage, WHO South-East Asia Region</td>
</tr>
<tr>
<td><strong>Group 1:</strong> Strengthening multisectoral actions for NCD prevention and control</td>
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<tr>
<td><strong>Discussion</strong></td>
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<tr>
<td><strong>Group 2:</strong> Monitoring indicators and targets for NCD prevention and control</td>
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<td><strong>Discussion</strong></td>
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<tr>
<td><strong>Group 3:</strong> Updating the Global Plan of Action on NCDs 2013–2020</td>
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<td><strong>Discussion</strong></td>
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<tr>
<td><strong>Group 4:</strong> Process and contents of the mental health action plan: views of SEAR countries</td>
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<tr>
<td><strong>Discussion</strong></td>
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11:00–12:30

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<tr>
<th><strong>Panel discussion: Fostering partnerships to curb noncommunicable diseases</strong></th>
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<tr>
<td><strong>Moderators:</strong></td>
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<tr>
<td>Professor Tint Swe Latt, Myanmar and Dr Tashi Wangdi, Bhutan</td>
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<tr>
<td><strong>Interventions by partners</strong></td>
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<tr>
<td><strong>Role of NGOs in community capacity building — experience from Maldives</strong></td>
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<tr>
<td>Ms Aishath Shiruhana, Maldives</td>
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<tr>
<td><strong>Role of academia in NCD prevention and control</strong></td>
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<tr>
<td>Dr Arjun Karki, Nepal</td>
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<tr>
<td><strong>Role of WHO collaborating centres</strong></td>
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<td>Dr Surendra Shastri, India</td>
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<td><strong>Role of civil society</strong></td>
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<td>Dr E Ulysses Dorotheo, NCD Alliance, Philippines</td>
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<td><strong>Intervention by Department for International Development, UK</strong></td>
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<tr>
<td>Dr Julia Kemp, DFID, Myanmar</td>
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<tr>
<td><strong>Role of UN in addressing NCD prevention and control at country level</strong></td>
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<tr>
<td>Dr Marinus Gotink, UNICEF, Myanmar</td>
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<tr>
<td><strong>Discussion</strong></td>
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12:30–13:30

<table>
<thead>
<tr>
<th><strong>Concluding session</strong></th>
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<tbody>
<tr>
<td><strong>Chairperson and Co-Chairperson of the Meeting</strong></td>
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<tr>
<td><strong>Draft Resolution on Noncommunicable Diseases including mental health and neurological disorders for the sixty-fifth Regional Committee</strong></td>
</tr>
<tr>
<td>Rapporteur of the Meeting</td>
</tr>
<tr>
<td><strong>Closing Remarks</strong></td>
</tr>
<tr>
<td>Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region</td>
</tr>
</tbody>
</table>
Annex 4
List of participants

Regional Meeting on Noncommunicable Diseases, including Mental Health and Neurological Disorders, Yangon, Myanmar, 24–26 April 2012

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   Ameenee Magu  
   Malé  
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Noncommunicable diseases including mental health and neurological disorders

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Noncommunicable diseases including mental health and neurological disorders

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### Annex 5

**Roles of different sectors in NCD prevention and control**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Roles identified by Member States</th>
</tr>
</thead>
</table>
| Health                               | • Technical leadership and coordination  
• Oversight /monitoring and evaluation  
• Health systems strengthening                                                   |
| Professional medical associations    | • Guideline development  
• Capacity building  
• Generating evidence                                                               |
| Law/legislation/enforcement/security | • Formulation and enforcement of appropriate NCD-related legislations                                                                                           |
| Education                            | • Inclusion of knowledge on NCDs in school curriculum  
• Healthy school settings (make them tobacco free, provide healthy food choices)                                                             |
| Communication ministry/media         | • Awareness generation, advocacy  
• Support fight against tobacco/alcohol and other industrial lobbies  
• Regulation of marketing of foods to children, tobacco/alcohol                                                                 |
| Finance                              | • Allocation of sufficient resources  
• Imposition of taxation for alcohol /tobacco /junk food  
• Use of financial subsidies for promoting “good” behaviour, for example – healthy eating, physical activity                                      |
| Environment                          | • Ecologically safe developmental policies  
• Measures for indoor and outdoor pollution control                                                                                                             |
| Agriculture                          | • Remove subsidy for tobacco cultivation, promote alternate cropping,  
• Promote fruit and vegetable production and marketing                                                                                                          |
| Industry                             | • Manufacture health-promoting foods and products  
• Adopt a “healthy workplace” approach  
• Include NCDS as a part of corporate social responsibility                                                                             |
<table>
<thead>
<tr>
<th>Sector</th>
<th>Roles identified by Member States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban planning and transport</td>
<td>• Provision of appropriate facilities for physical activity (walking, cycling)</td>
</tr>
<tr>
<td>Community/civil society</td>
<td>• Awareness generation • Advocacy • Watchdog role in implementation of laws</td>
</tr>
<tr>
<td>Parliamentarians/policy-makers</td>
<td>• Leadership and vision • Policy development</td>
</tr>
<tr>
<td>Commerce/trade</td>
<td>• Regulation of tobacco, alcohol and food industries and their marketing • Curb unfair trade practices</td>
</tr>
<tr>
<td>International agencies including the UN</td>
<td>• International treaties/pacts • Technical assistance and guideline development</td>
</tr>
<tr>
<td>Religious and other community leaders</td>
<td>• Build healthy norms of social behaviours • Act as change agents</td>
</tr>
<tr>
<td>Private health sector</td>
<td>• Service provision within the guidelines</td>
</tr>
</tbody>
</table>
### Annex 6
**List of targets proposed in the first WHO discussion paper**

<table>
<thead>
<tr>
<th>No.</th>
<th>Outcome targets</th>
<th>Indicator</th>
<th>Data source(s)</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Mortality from NCDs</strong>&lt;br&gt;25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease</td>
<td>Unconditional probability of dying between the ages of 30 and 70 years from cardiovascular disease, cancer, diabetes, or chronic respiratory disease</td>
<td>Civil registration system, with medical certification of cause of death, or survey with verbal autopsy</td>
<td>*</td>
</tr>
<tr>
<td>2</td>
<td><strong>Diabetes</strong>&lt;br&gt;10% relative reduction in the prevalence of diabetes</td>
<td>Age-standardized prevalence of diabetes among persons aged 25+ years</td>
<td>National survey (with measurement)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Tobacco smoking</strong>&lt;br&gt;40% relative reduction in the prevalence of current tobacco smoking</td>
<td>Age-standardized prevalence of current tobacco smoking among persons aged 15+ years</td>
<td>National survey</td>
<td>*</td>
</tr>
<tr>
<td>4</td>
<td><strong>Alcohol</strong>&lt;br&gt;10% relative reduction among persons aged 15+ years of alcohol per capita consumption (APC)</td>
<td>Per capita consumption of litres of pure alcohol among persons aged 15+ years</td>
<td>Official statistics and reporting systems for production, import, export, and sales or taxation data; and national survey</td>
<td>*</td>
</tr>
<tr>
<td>5</td>
<td><strong>Dietary salt intake</strong>&lt;br&gt;Mean population intake of salt less than 5 g per day</td>
<td>Age-standardized mean population intake of salt per day</td>
<td>National survey (with measurement)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td><strong>Noncommunicable diseases including mental health and neurological disorders</strong></td>
<td></td>
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</tbody>
</table>
| 6 | **Blood pressure/hypertension**  
25% relative reduction in prevalence of raised blood pressure | Age-standardized prevalence of raised blood pressure among persons aged 25+ years | National survey (with measurement) |
| 7 | **Obesity**  
No increase in obesity prevalence | Age-standardized prevalence of obesity among persons aged 25+ years; | National survey (with measurement) |
| 8 | **Prevention of heart attack and stroke**  
80% coverage of multidrug therapy (including glycaemic control) for people aged 30+ years with a 10-year risk of heart attack or stroke ≥30%, or existing cardiovascular disease | Percentage of estimated people aged 30+ years with a 10-year risk of heart attack or stroke ≥30%, or existing cardiovascular disease who are currently on multiple drug therapy (including glycaemic control). | National survey (with measurement) |
| 9 | **Cervical cancer screening**  
80% of women between the ages of 30-49 years screened for cervical cancer at least once | Percentage of women between the ages of 30-49 years screened for cervical cancer at least once | National survey; health facility data |
| 10 | **Elimination of industrially produced trans-fats from the food supply**  
Elimination of industrially produced trans-fats (PHVO) from the food supply | Adoption of national policies that eliminate partially hydrogenated vegetable oils (PHVO) in the food supply | Policy review |
The Political Declaration of the High-level Meeting on Noncommunicable Diseases (NCDs) held in September 2011 in New York calls for concrete and comprehensive actions by Member States and the international community, and emphasizes WHO’s leading role in coordinating global action against NCDs. As a follow-up of this meeting and as per the decision of the Sixty-fourth Session of the World Health Organization (WHO) Regional Committee for South-East Asia, a regional meeting was organized from 24 to 26 April in Yangon, Myanmar. It was a platform to facilitate discussions and consensus building on priority actions of the UN Political Declaration at regional and country levels. The regional meeting also facilitated Technical Discussions on Mental Health, including Mental and Neurological disorders. It provided a forum to discuss priority actions at regional and country levels to take the mental health agenda forward. The Technical Discussions also focused on alcohol as the common risk factor for NCDs and the substantial harm from alcohol use to an individual, the family and the community.

The meeting was attended by 138 participants including 14 observers. The participants included representatives from all 11 Member States of the Region and from various agencies including the government, NGOs, WHO collaborating centres, academia and the UN. Based on the inputs received from Member States, a draft resolution on NCDs including mental health and neurological disorders was prepared. The recommendations arising out of the Technical Discussions will be submitted to the Sixty-fifth Session of the Regional Committee, to be held in Yogyakarta, Indonesia, from 5 to 7 September 2012.