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Noncommunicable diseases and mental health

Noncommunicable diseases: developing comprehensive commitment

1. The challenges posed by chronic, noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, chronic lung diseases and diabetes, are increasingly being addressed by Member countries. In 2007, the Regional Committee adopted a resolution[1] endorsing the Regional Framework for Prevention and Control of NCDs[2] and urging Member States to formulate and strengthen national policies, strategies and programmes for integrated prevention and control of NCDs.

Strengthening capacity

2. To support national efforts in formulating comprehensive NCD policies, plans and programmes, and to promote implementation of evidence-based and cost-effective interventions, the Regional Office initiated a project on Capacity Strengthening for Policy-Makers and NCD Programme Managers. Training materials developed under this project were pilot-tested in Nepal. Using this training package, and with WHO support, Bhutan, Maldives, Nepal, Sri Lanka and Thailand organized national capacity-strengthening workshops. Detailed guidelines for coordinators and resource persons conducting NCD capacity strengthening workshops at national and sub-national level were developed by the Regional Office.

[1] Resolution SEA/RC60/R4 on Scaling up Prevention and Control of Chronic Noncommunicable Diseases in the South-East Asia Region

[2] see: www.searo.who.int/LinkFiles/Health_Promotion_&_Education_RegFrmonNCD.pdf

Formulating and implementing policy and strategy

3. With WHO technical support and guidance, significant progress in implementing existing national NCD policies, plans and programmes was noted in Bangladesh, India, Indonesia and Thailand. Other countries are in various stages of formulating new national NCD policy and strategy, including Bhutan (formulating its first ever national policy and strategy on NCD prevention and control), Nepal and Sri Lanka (in the process of formulating new national policies), and Maldives (completed formulation of a new strategic plan for 2008–2010). The ministries of health of Bangladesh, Indonesia and Sri Lanka made important structural changes within their ministries, strengthening technical units or departments at national level to coordinate integrated NCD programmes.

4. WHO provided technical support for the following:

- For cardiovascular diseases, diabetes and stroke: the launching, by the Ministry of Health of India in January 2008, of a pilot programme for the prevention and control of cardiovascular diseases, diabetes and stroke in six districts.
- For chronic obstructive pulmonary disease and asthma: the establishment of a new WHO Collaborating Centre in Chandigarh, India, to conduct collaborative research and strengthen capacity for prevention and management of chronic obstructive pulmonary disease and asthma.
- For oral health: initiating[3] the formulation of a Regional strategy on oral health, with the objectives of facilitating restructuring of the oral health system; encouraging Member countries to develop or strengthen their national oral health plans; facilitating oral health promotion and prevention programmes; and ensuring access to equitable, quality oral health care.

Surveying of risk factors

5. Since the introduction of the WHO STEPwise approach to surveillance of NCD risk factors[4] in the Region in 2001, most Member countries have gathered standardized information on the levels of major risk factors in their populations. Further technical assistance was provided to Bhutan, India, Maldives, Nepal and Sri Lanka for planning, implementing and managing

[3] With the support of the governments, Regional Network for NCD Prevention and Control (SEANET-NCD), and the WHO Collaborating Centre for Promoting Community-based Oral Health, Chiang Mai, Thailand

[4] See: www.who.int/chp/steps/en/index.html

data from the surveys. Results of the Regional surveys so far conducted, which were shared with the Regional Committee in 2007, will guide countries in further planning of health promotion and primary prevention of NCDs.

6. To facilitate risk factor surveillance activities, a new institution was designated as WHO Collaborating Centre for Noncommunicable Diseases Prevention and Control.[5] This Centre will also sustain the Regional NCD Risk Factor InfoBase and support Regional networking including developing and hosting a website of the Regional NCD Network (SEANET-NCD).

Challenges

- Reducing the level of exposure of populations in the Region to NCD risk factors.
- Promoting multisectoral, multidisciplinary and multilevel partnerships.
- Strengthening the capacity of health systems to develop, implement, monitor and evaluate national plans and programmes for integrated prevention and control of NCDs.

Mental health: aiming for collective action

7. Mental health can be improved through the collective action of society. Improving it requires not only specific activities in the health field, but also coordinated policies and programmes of governments and business sectors. Priority attention was therefore given to four areas.

Promoting mental health

8. Owing to the many social and cultural determinants of mental well-being, strategies for mental health promotion have been formulated in terms of specific socio cultural context. The Regional Office earlier developed technical materials on mental health promotion.[6,7,8] These were adapted and have been used in Bhutan, several states of India, Indonesia and Myanmar. To promote mental health, experts from Member countries agreed that traditional methods, such as yoga and meditation, played an important role.

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[5] WHO Collaborating Centre for NCD Prevention and Control, Chennai, India

[6] *Training manual for community-based physicians on treatment of generalized tonic-clinic seizures (major fits)*. New Delhi, SEARO, 2004 (document SEA-MENT-132, rev 1) (at: www.searo.who.int/LinkFiles/Technical_documents_Ment-132.pdf)

[7] *Training manual for community-based health workers on identification and care of generalized tonic-clinic seizures (major fits)*. New Delhi, SEARO, 2004 (document SEA-MENT-133, rev 1) (at: www.searo.who.int/LinkFiles/Technical_documents_Ment-133.pdf)

[8] *Epilepsy: a manual for physicians*. New Delhi, SEARO, 2004 (document SEA-MENT-134) (at: www.searo.who.int/LinkFiles/Technical_documents_Ment-134.pdf)

Traditional and culturally accepted methods are increasingly being used in mental health promotion in Member countries.

Strengthening of primary health-care centres

9. Studies from countries in the Region have reported the treatment gap (proportion of the total number of patients who have not received a required treatment for selected neuropsychiatric conditions) to be as high as 95%. To address this gap, the Regional Office has a strategy[9] for training village-based workers to identify the most common and disabling neuropsychiatric conditions. Based on this identification, patients are referred to the nearest general practitioner for appropriate treatment.

10. This strategy has also been successfully implemented in all atolls in Maldives. With the proper identification, referral and treatment of all patients with epilepsy, the Government of Maldives has now strengthened the community mental health system by training community health coordinators and developing a draft national mental health policy.

11. Similar training of community health workers has also been conducted in DPR Korea and Myanmar. Since the programmes were developed with the participation of Member countries, they are culturally appropriate and acceptable to the community, and hence sustainable.

Training in mental health related to disasters

12. The training manuals on psychological care of tsunami-affected populations,[10,11] developed by the Regional Office after the tsunami disaster of 2004, were translated, adapted and used after cyclones Sidr in Bangladesh and Nargis in Myanmar. Extensive training of master trainers on implementation of psychological care has now been conducted in three

[9] See: *Development of strategies for community-based neuropsychiatric services*. New Delhi, SEARO, 2002 (document SEA-MENT-128) (at: www.searo.who.int/LinkFiles/Meeting_reports_Development_of_Strategies_for_Community_Based_Neuropsychiatric_Services.pdf)

[10] *Psychosocial care of tsunami-affected populations. Manual for community level workers*. New Delhi, SEARO, 2005 (document SEA-MENT-135) (at: www.searo.who.int/LinkFiles/List_of_Guidelines_for_Health_Emergency_community_level-workers.pdf)

[11] *Psychosocial care of tsunami-affected populations. Manual for trainers of community level workers*. New Delhi, SEARO, 2005 (document SEA-MENT-136) (at: www.searo.who.int/LinkFiles/List_of_Guidelines_for_Health_Emergency_trainers_community-workers.pdf)

Member countries (Bangladesh, Maldives, Myanmar) using the adapted materials.

Reducing harm from alcohol use

13. Harm from alcohol use is a major concern in several Member countries of the Region. The Regional Office has conducted community-based surveys of patterns of alcohol use, and of harm from alcohol use, in India (Tamil Nadu), Myanmar and Sri Lanka. At this stage, the evidence is being compiled.

Challenges

- Consideration of culturally accepted traditional methods of mental health promotion, such as yoga and meditation.
- Implementing the strategy for training village-based workers as a national movement.
- Ensuring availability of appropriate drugs for treatment of neuro-psychiatric conditions in the field.
- Strengthening the mental health and psychosocial aspects of disaster preparedness in Member countries.
- Developing culturally appropriate evidence-based strategies to reduce harm from alcohol use.

Health promotion and education: nurturing a multisectoral approach

14. The work in the area is guided by commitments related to the Bangkok Charter for Health Promotion (2005) and to resolutions of the Regional Committee[12] and World Health Assembly.[13] The overall strategy is to nurture and sustain a cross-sectoral approach focusing on disease-specific issues, and different population groups and settings. The *Regional Strategy for Health Promotion for South-East Asia*[14] was published in 2008; it calls for multidisciplinary and multisectoral integration of health promotion into (i) disease or issue-specific interventions; (ii) population-based interventions; and (iii) settings-based interventions.

[12] SEA/RC59.R4 (2006) on Regional Strategy for Health Promotion
[13] WHA60.24 (2007) on Health Promotion in a Globalized World
[14] (document SEA/HE/194)

15. Main activities supported by WHO included:

- Tobacco and alcohol: parliamentarians from countries of the Region endorsed a Call for Action[15] making recommendations to WHO and Member countries related to the development of effective strategies for control of tobacco and alcohol. This Call promotes advocacy for health in national development and has helped bring about national consensus on important health issues, particularly legislative and policy actions for promoting health (see also page 121).
- Alternative financing: a five-country (India, Indonesia, Nepal, Sri Lanka, Thailand) study on innovative financing of health promotion[16] was conducted in order to compile a Regional profile. The results of the study are being finalized and will offer local experts the opportunity to contribute towards health-financing policy and decision-making at the national level.
- Social determinants of health: in order to analyse health inequities and the impact of social determinants on health outcomes, a six-country (India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand) health equity study was supported based on analysis of demographic and health survey data. A Regional profile was compiled following a Regional consultation;[17] it will assist policy-makers in addressing issues related to the social determinants of health.
- School health promotion: eight Member countries (Bhutan, India, Indonesia, DPR Korea, Maldives, Sri Lanka, Thailand, Timor-Leste) each conducted a case study on the implementation of school health promotion, highlighting the successes, challenges, and possible solutions; the case studies are being compiled as a SEARO publication. Additionally, nine Member countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand) participated in data collection and analysis training under the Global School Health Survey (GSHS).[18] This provided an opportunity for countries to generate data on behaviour among their school-age populations (13–15 years) for use during the development of school health programmes and policy.

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[15] Policy Options for Reducing Harm from Alcohol Use.Regional Conference of Parliamentarians on Legislative and Policy Actions for Promoting Health in the Countries of the WHO South-East Asia Region. Bali, Indonesia, October 2007 (www.searo.who.int/LinkFiles/Alcohol_and_Substance_abuse_PC_WorkingPaper.pdf)

[16] Alternative Financing of Health Promotion: Policy Options and Management

[17] *Social determinants of health – report of a regional consultation*, October 2007 (document SEA-HE-190)

[18] Conducted by WHO and the US Centers for Disease Control

- Social and behavioural research: the Regional Office initiated social and behavioural research to collect evidence and explain human behaviour in complex settings. A study was conducted in Indonesia on the socio-cultural and behavioural factors associated with transmission of avian influenza from poultry to humans. A study in Sri Lanka was supported to identify the factors which contribute to malnutrition; the findings have been applied to the strengthening of interventions for behaviour change in the community. WHO provided technical support in the design and conduct of the studies.
- Urbanization: collaboration with the WHO Kobe Centre, Japan, on promoting healthy urbanization continues under the Bangalore Healthy Urbanization Project (BHUP).[19] The purpose of the project is to determine the impact of social determinants of health on exposed populations in urban settings for 2006–2007. Technical support was provided to establish a coordination and management mechanism through a Public Health Promotion Board and a Health Promotion Policy, to assure multisectoral participation and assist in institutionalization of the project. A 20-minute video was produced to highlight implementation of the BHUP. WHO provided technical support in situation analysis, and in implementation of the interventions.
- Active and healthy ageing: great emphasis is placed on understanding demographic characteristics and trends, analysis of social and economic determinants, and policies and programme interventions using a life-course approach. In addition to the strategic directions agreed during a Regional consultation (see Box 2.1),[20] WHO initiated 10 case studies on active and healthy ageing,

Box 2.1: Key strategic directions for implementing active and healthy ageing

- Health promotion based on a life-course approach across all sectors
- Strengthening of health systems in order to perform a stewardship role in active and healthy ageing
- Addressing the social and economic determinants of ageing.

[19] *Report of the Bangalore Health Urbanization Project 2006–2007* (collaborative effort of WHO-Kobe Centre, WHO India, SEARO, and partners, December 2007)
[20] Regional Consultation on Healthy Ageing, December 2007

focusing on health system strengthening, social and economic determinants, and health promotion to document the various factors that affect ageing.

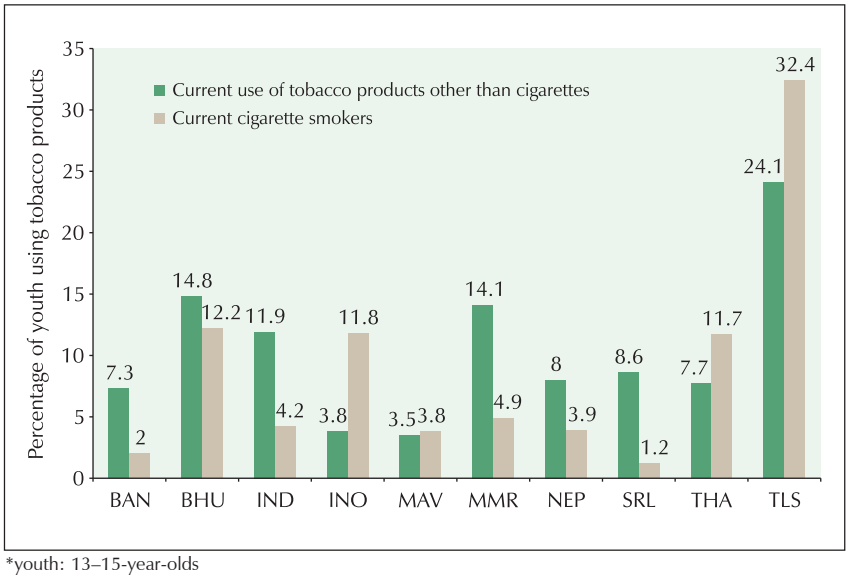
Challenges

- Capacity building for health promotion infrastructure.
- Innovative financing mechanisms for health promotion.
- Gathering evidence on the impact of health promotion interventions.

Tobacco control: expanding knowledge and awareness of the epidemic

16. Tobacco use kills 1.2 million people annually in the Region, out of 5.4 million deaths globally. There are some unique characteristics of tobacco use in the Region, such as smokeless and indigenous tobacco products, which require unique responses. See Figure 2.1 for the current picture of use of tobacco products among the youth of the Region.

Figure 2.1: Current cigarette smoking and current use of tobacco products other than cigarettes among the youth* of selected Member countries, 2006–2007



*youth: 13–15-year-olds
Source: Global Youth Tobacco Survey (GYTS)

Strengthening national resources

17. WHO's efforts to help countries build national capacity in tobacco control under the Bloomberg Global Initiative to Reduce Tobacco Use (BGI) have intensified.[21] Four countries – Bangladesh, India, Indonesia, and Thailand – received direct support from BGI for staff and core activities. The staff support received at the Regional Office contributed to greater and intensified technical support to all Member countries. SEARO is also supporting the Member countries, as well as NGOs, to apply for grants through the Bloomberg Grant Mechanism. In addition to the US$ 3.1 million provided for staff and core activities in the four Bloomberg focus countries and the Regional Office, approximately US$ 15 million for the Region has also been received through the Bloomberg Grant Mechanism, most of which is for the four Bloomberg focus countries.

Strengthening tobacco surveillance

18. Tobacco surveillance is a key area of work, and the BGI provided a unique opportunity to implement the Global Adult Tobacco Survey (GATS), using the standard protocol. Three of the four BGI-supported countries have started field work for the GATS, which will be completed by the end of 2008. WHO technically supports this activity and analysis of the data. The results will help the countries strengthen tobacco surveillance, and will be useful for monitoring the tobacco epidemic to target interventions.

19. Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal and Sri Lanka have also undertaken various surveys with WHO support, such as a youth tobacco survey, school personnel survey, and health-professional student survey.[22]

20. As per the recommendations of a regional surveillance workshop (Regional Workshop on Tobacco Surveillance – Linking Data to Action, Nepal, February 2007), a regional strategy for utilization of tobacco surveillance data was developed to provide guidance on the use of data for developing and implementing evidence-based programmes and activities.

Advocating for tobacco control

21. Advocacy for tobacco control is a crucial area of work. A large-scale advocacy campaign based on the 2007 theme of World No Tobacco Day (WNTD) – Smoke-free Environments – was undertaken throughout the year. Member countries were also supported to intensify their advocacy campaigns

[21] An initiative launched in 2006 by Mr Michael Bloomberg, Mayor of New York City, to strengthen capacity for tobacco control

[22] see: www.searo.who.int/EN/Section1174/Section2469.htm

with the 2008 WNTD theme – Tobacco-free Youth. A number of documents[23,24,25,26,27] were produced and disseminated among countries and stakeholders both as advocacy tools and to guide countries in revising and strengthening their tobacco control programmes. The mechanism for information exchange and sharing was also strengthened.

Focusing on multisectoral collaboration

22. Tobacco control being a cross-cutting area, countries of the Region have been focusing on multisectoral collaboration in their efforts to control tobacco in Member countries. In Bangladesh, India, Myanmar and Thailand, tobacco issues have been incorporated into the school curriculum in collaboration with the ministries of education.

23. The Region was the first WHO region to initiate close collaboration with the TB control programme. A pilot project on TB and tobacco was implemented in Nepal. By incorporating tobacco control measures and working together, the TB control programme will be strengthened, contributing to reduced morbidity and mortality.

Enforcing legislation

24. Issues such as the large number of smokeless tobacco products and the economic and employment aspects of tobacco are unique to the Region. Five countries (Bangladesh, India, Myanmar, Sri Lanka, Thailand) have comprehensive tobacco control legislation, and other countries are in the process of developing theirs.

25. However, enforcement of tobacco control measures and legislation needs to be strengthened in the Region to ensure effective tobacco control.

Challenges

- Development of appropriate tobacco control measures, including comprehensive national tobacco control legislation in line with the WHO Framework Convention on Tobacco Control (FCTC).
- Public education for sustained tobacco control, and multisectoral collaboration, with a particular focus on the raising of taxes on tobacco products.

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[23] *Annual report on the progress of implementation of the BGI*, 2007
[24] *Regional communication strategy for tobacco control*, 2008
[25] *Regional tobacco surveillance report*, 2007
[26] *BGI newsletter*, Vol. 1, Issue 1, April 2008
[27] *Profile on tobacco and youth in the South-East Asia Region*. New Delhi, SEARO, 2008

- Implementing the six-point MPOWER package (see Box 2.2) as advocated in the first WHO report on the tobacco epidemic.[28]

Box 2.2: MPOWER package

- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertisements, promotions and sponsorships
- **R**aise taxes on tobacco

By developing and implementing the MPOWER package, deaths in the Region from tobacco use can be reduced.

Injuries, violence and disabilities: focusing on prevention

26. Available data substantiate the fact that up to one third of the global burden of injuries is accounted for by the Region.[29] Road traffic injuries and violence are the leading causes of injury, and drowning is the leading cause of mortality in children less than 15 years of age in some Member countries. Motorcycle-related injuries account for a large proportion of road traffic injuries in the Region. This is due to the remarkably large percentage of motorcycles among all registered vehicles in Member countries (50%–75%) compared to developed countries (1%–4%).

Reviewing national programmes

27. Eight Member countries have formulated national plans and implementing mechanisms for preventing injuries. Most of these plans are based on the Regional Strategic Plan for Injury Prevention,[30] which guides Member countries to collect information, formulate/implement policies for injury prevention, strengthen emergency care, mobilize resources, and include injury prevention in their public health agendas.

[28] *WHO Report on the global tobacco epidemic, 2008 – the MPOWER package*. Geneva, WHO, 2008 (www.who.int/tobacco/mpower/en/)
[29] *The world health report 2004 - changing history* (at: www.who.int/whr/2004/en/)
[30] *Strategic plan for injury prevention and control in South-East Asia*. New Delhi, SEARO, 2002 (document SEA-Accident-8) (www.searo.who.int/en/Section1174/Section1461/Section1717_7365.htm)

28. The national programmes on violence and injury prevention and their linkages to disability prevention were reviewed in collaboration with all country programme managers.[31] WHO and Member countries are working very closely to strengthen country capacity in implementing policies and strategies for injury prevention, establish centralized national responsibility for injury prevention, and report minimum essential data sets on injuries.

Strengthening the generation of evidence

29. Work to strengthen the capacities of Member countries in generating evidence and reporting injuries continued, based on the injury surveillance and information system. Technical support to establish this surveillance system was provided to Bhutan, DPR Korea, India, Indonesia, Nepal, and Sri Lanka; these countries are trying to find a way to incorporate injury reporting into their existing health information systems. Timor-Leste is being supported in a situation analysis on injuries. Thailand was supported to develop a data collection form and software for ensuring that data are useful for analysis.

Member countries actively participated in the UN Road Safety Week Campaign.

Training in injury prevention

30. A Regional workshop on injury epidemiology, prevention and care was held for trainers, to adapt and use the TEACH-VIP[32] modular training curriculum on injury prevention and control. A workshop on introducing injury prevention into the curriculum of medical and nursing schools in the Region is planned in July 2008.

Collating national data on road safety

31. As a follow-up to the *World report on road traffic injury prevention* launched in 2004,[33] and the UN Road Safety Week Campaign of 2007,[34] WHO has been

[31] Regional Meeting of National Managers of Injury Prevention and Care, September 2007, Thailand

[32] *Training education and advancing collaboration in health on violence and injury prevention, (TEACH-VIP)* at: www.who.int/violence_injury_prevention/capacitybuilding

[33] Geneva, World Health Organization, 2004, at: www.who.int/violence_injury_prevention/publications/road_traffic/world_report/en

[34] See: www.who.int/roadsafety/en/

collaborating with the Bloomberg Philanthropies in developing the *Global status report on road safety*[35] to support Member countries of the Region in collating national data and advocating necessary actions for road safety.

Identifying standards of care for hearing disability and for eliminating avoidable blindness

32. WHO provided the epidemiological framework and support for developing a situation review and update on deafness, hearing loss and intervention programmes,[36] and drafted a Regional strategic framework, VISION 2020, for prevention of avoidable blindness.[37] This framework includes targets and a timeline for implementation of VISION 2020 in Member countries.[38]

Challenges

- Improvement of the information system on injury and violence.
- Establishing units in ministries of health to implement and coordinate injury prevention and care.
- Measures to reduce the severity of, and deaths and disability due to, injuries.
- Prevention of disabilities and enhancement of community rehabilitation and services.

[35] See: www.who.int/violence_injury_prevention/road_traffic/global_status_report/en/

[36] *Situation review and update on deafness, hearing loss and intervention programmes – proposed plans of hearing impairment in countries of the South-East Asia Region*. New Delhi, SEARO, 2007 (document SEA-Deafness-10)

[37] *VISION 2020: the right to sight for 2008–2015*. Report of the Expert Group Meeting – VISION 2020, New Delhi, December 2007

[38] See: www.searo.who.int/en/Section980/Section1162/Section1167/Section1171_4755.htm)