Noncommunicable diseases and social determinants of health

Noncommunicable diseases (NCDs)

1. Noncommunicable diseases (NCDs) of chronic character such as cardiovascular disease, diabetes, cancers and chronic lung diseases account for an estimated 54% of the 14.7 million annual deaths and nearly half of the total disease burden occurring in the South-East Asia Region. This increasing burden of NCDs is the outcome of three main processes: ongoing demographic change, unhealthy behaviours by growing segments of socioeconomically disadvantaged urban and rural dwellers, and the failure of health systems to protect the health of the people and deliver basic health services in an equitable way.
2. Contrary to long-held beliefs, the poor are now extensively and disproportionately exposed to the health-harming impacts of man-made socioeconomic, psychosocial, cultural, political and physical environments. Tobacco use, harmful use of alcohol, inadequate consumption of fruits and vegetables and preferential use of less expensive foods rich in saturated and partially hydrogenated fats and salt have become increasingly common among the disadvantaged, vulnerable and marginalized. Effective, efficient, workable, low-cost public health solutions to the NCD problem in developing countries are known, but largely underutilized.

3. The major focus of WHO efforts with regard to NCDs during the biennium was to assist Member States in strengthening their national capacity for formulation, implementation and evaluation of policies, plans and programmes for the integrated prevention and control of NCDs. The SEA regional package of NCD capacity-strengthening materials was revised, updated and expanded, and extensively used at national workshops conducted with WHO assistance in Bangladesh, DPR Korea, Myanmar and Sri Lanka. The Regional Office also developed a comprehensive set of materials to train managers and facilitators of national and subnational NCD capacity-strengthening programmes. WHO also mounted a training for NCD programme workforce from nine Member States on planning and conducting national NCD capacity-strengthening activities.

NCDs can be combatted with low-cost public health solutions.
4. Direct technical assistance was provided to Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal and Sri Lanka in formulating, implementing and evaluating national NCD policies, action plans and programmes. Bhutan and Sri Lanka were supported in implementing evidence-based interventions for the prevention and control of NCDs at the primary care level; a WHO package of essential NCD interventions (PEN) was introduced at training workshops. Subsequently, the feasibility of a broad application of the package was pilot-tested in select districts of both countries. Community-based intervention projects were supported in India, Indonesia and Thailand.

5. NCD risk factor surveys in Bangladesh, Bhutan, DPR Korea, India, Maldives, Myanmar and Nepal were supported at various stages, including planning, implementation, data analysis and results dissemination. A set of indicators for reporting core NCD mortality, morbidity and risk factors data was developed.

6. The Regional Office continued to provide secretariat support to strengthen and promote the SEA Network—SEANET-NCD—focusing on partnership building and capacity strengthening for resource mobilization. Two institutions involved in NCD control joined the network of regional WHO collaborating centres, and the process of designating three other centres was advanced.

7. To address oral diseases, a regional consultation was organized in 2008 to discuss the challenges in oral health promotion and integrated disease prevention. The strategies worked out at this meeting were used in strengthening national oral health policies and programmes in the Region.

8. NCDs present a growing health and economic challenge to the Region. There is mounting evidence on the progressive socioeconomic divide in terms of exposure to NCD-causing factors and access to basic health services by people at risk and those with established NCDs. Efforts are needed to develop and implement workable, low-cost solutions to the NCD problem and to recognize the urgent need to invest in prevention and control measures. The persistent gap in allocation of human and financial resources needs to be bridged, and the capacity of the health workforce and partners outside the health sector to implement public health-oriented NCD prevention needs to be increased.
Mental health and substance abuse

9. Activities during the biennium in this area have focused on four issues:

   (1) Strengthening the existing primary care system in Member States to deliver essential mental health care;
   (2) promotion of mental well-being in the community;
   (3) reducing harm from alcohol use in the community; and
   (4) a cluster of other projects, including adolescent mental health, suicide prevention, reducing harm from psychoactive substance use, addressing learning and behavioural disorders among children, community-based rehabilitation of the intellectually impaired, and psychosocial and mental health needs of disaster-affected communities.

10. The Regional Office has developed a strategy to deliver essential mental health care to all persons, including those in rural and remote areas, who need such care. The optimum method of delivering such care is strengthening the existing primary care system. In order to do this, village-based health workers are being trained to identify the most common and disabling neuropsychiatric conditions. Based on information from community-based studies in Member States, epilepsy, psychosis and depression are the most common and disabling conditions. Materials have been developed to train community-based health workers to identify these conditions, and train community-based general physicians to treat them using approved medications. The publications are Training Manual for Community-Based Health Workers on Identification and Care of Generalized Tonic-Clonic Seizures (Major Fits); Training Manual for Community-Based Physicians on Treatment of Generalized Tonic-Clonic Seizures (Major Fits) (using Phenobarbital). This strategy has been successfully applied for epilepsy in Maldives, Myanmar, Nepal and select states of India. The programme has reduced the treatment gap from 95 per cent to less than 10 per cent.

11. The concept of promotion of mental well-being is based on “primordial prevention”, which attempts to prevent the occurrence of risk factors in the community. Instead of treating the consequences of stress through counseling or medication, it is more beneficial to prevent its occurrence in the first place. Traditional practices used in Member States (for example Bhutan, India, Myanmar, Nepal, Sri Lanka and
Thailand) for centuries are being promoted, such as yoga, meditation and Vipasana. An intersectoral workshop on the promotion of mental well-being was conducted in Colombo, Sri Lanka, in October 2009. Delegates discussed community-based programmes and advocated that existing programmes be evaluated for their impact.

12. Harm from alcohol use is a major concern in several countries and is linked to rapidly increasing consumption of alcohol, particularly in urban slums and rural and remote areas. Of particular concern is the use of home-brewed and illicit alcohol and country liquor. Alcohol is inextricably linked to poverty and gender-based violence. All Member States have contributed to the WHO document “Strategies to Reduce the Harmful Use of Alcohol: Draft Global Strategy”. The draft strategy covers 10 policy options; of particular importance are community action and reducing the public health impact of illicit and informally produced alcohol. Community action is the best method of controlling harm from alcohol, particularly from illicit and informally produced alcohol, which is widely available in the Region. Pricing and control of availability can also help. Community action to reduce harm from alcohol is being tested in India, Sri Lanka and Thailand.

13. To address adolescent mental health, the life-skills approach is being used in Bhutan, India, Indonesia, Myanmar, Sri Lanka and Thailand. Suicide prevention is being addressed through safe storage of pesticides (Sri Lanka, and Tamil Nadu in India). The Regional Office is also addressing learning and behavioural disorders among children through advocacy programmes in all countries of the Region. Community-based rehabilitation of the intellectually impaired (India, Indonesia and Maldives); and the psychosocial and mental health needs of disaster-affected communities (all Member States) have also been supported.

14. Challenges remain in this area, such as scaling up programmes and strengthening the health system to deliver essential mental health care by training community-based health workers, as well as through advocacy with governments. The concept of promotion of mental well-being needs to be developed as a public health strategy through the testing of community-based projects and assessment of their impact and benefit for the community. Further testing of programmes on reducing harm from alcohol use in the community also needs to be done, with the adaptation and scaling up of successful models.
Tobacco free initiative (TFI)

15. Tobacco use kills over 1.2 million people annually in South-East Asia. Control of the tobacco epidemic in the Region is complex due to widespread availability and use of smokeless and other cheaper indigenous smoking tobacco products such as bidi and cheroots, and the inequality of taxation on different tobacco products. Although five countries in the Region have comprehensive tobacco control legislation in place, and other countries are in the process of developing the same, inadequate enforcement of tobacco control measures has been a general problem in the Region.

16. Efforts have been made to implement the MPOWER policy package as well as the guidelines developed by the Conference of Parties for effective implementation of the WHO Framework Convention on Tobacco Control (FCTC). Tobacco control efforts are also being supported mainly in four Bloomberg Initiative (BI) focus countries in the Region. The knowledge and skills of national counterparts have been enhanced through intercountry and national awareness building and training workshops. Countries of the Region have been supported in strengthening tobacco control legislation through intercountry workshops, enhancing the capacity for drafting and amending legislation.

Member States have strengthened tobacco controlled advocacy.
17. The Regional Office has made sustained efforts to link the impact of tobacco control on poverty alleviation and the achievement of MDGs through consultative meetings of UN agencies and partners. Policy-makers and legislators were briefed about the economic benefits of tobacco control, and tobacco tax assessments were completed in two countries. Intercountry workshops have been held on the protocol on illicit trade in tobacco products to enable Member States to participate in negotiations on the protocol. A national capacity assessment on tobacco control was conducted in Thailand. Advocacy was conducted through the publication of tobacco control profiles for Myanmar and Sri Lanka and a Regional Communication Strategy and other advocacy documents to advance implementation of the FCTC.

18. A large-scale advocacy campaign based on the 2008 theme of World No Tobacco Day (WNTD) ("Tobacco-free Youth") and the 2009 theme ("Tobacco health warnings") was undertaken. As part of these campaigns, a number of documents and factsheets were produced and disseminated among countries and stakeholders, both as advocacy tools and to guide countries in revising and strengthening their tobacco control programmes.

19. The Regional Office also made efforts to promote multisectoral collaboration within countries. Bangladesh, India, Myanmar and Thailand have incorporated tobacco control into the school curriculum in collaboration with their ministries of education. South-East Asia is the first among the WHO regions to initiate collaboration with the TB control programme by integrating the PAL (Practical Approach to Lung Diseases) approach in the TB control programme, including the completion of a pilot project on TB and tobacco in Nepal. Two other Member States were also supported in this area.

20. Significant progress was achieved in the area of tobacco surveillance. All components of the tobacco surveillance system were implemented in the Region. The South-East Asia Region is the only one that completed and released the Report of the Global Adult Tobacco Survey (GATS) in Bangladesh and Thailand under the Bloomberg Initiative.
Figure 2.1: Key findings of GATS in Bangladesh and Thailand in terms of MPOWER indicators, 2009

Source: Global Adult Tobacco Surveys (2009), Bangladesh and Thailand.

**MPOWER Policy 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 advertising, promotion and sponsorship
- **R**aise taxes on tobacco

21. These surveys helped Member States to assess trends in the tobacco epidemic and to revise policies and programmes, as well as to meet obligations under certain specific provisions of the FCTC. The Regional Office also initiated an integrated surveillance approach to tobacco surveillance through STEPS (WHO STEPwise approach to noncommunicable disease risk factor surveillance). This approach has already been adopted in Myanmar and Nepal. To support tobacco cessation services in the Region, a cessation manual for doctors, dentists and nurses was developed, and a Regional Tobacco Cessation Training Workshop for training of trainers was organized in which 9 Member States participated.

22. While enforcement of existing tobacco control measures will continue to be an important issue, strengthening tobacco control legislation and
existing measures in line with the Framework Convention also poses a challenge for the Region. In addition, serious efforts and advocacy will be required to ratify the protocol on illicit trade in tobacco products. It will be important to integrate tobacco surveillance with surveillance of other risk factors and to make it part of the health information system, in order to avoid duplication of efforts and resources.

**Disability, injury prevention and rehabilitation**

23. The SEA Regional Office has advocated with and supported countries to increase political, financial and technical commitment on injury prevention and building of institutional capacity. An injury prevention cell has been established in the Ministry of Health, Maldives, which brings the total number of Member States in the Region having an injury unit in their MoH to four including Indonesia, Sri Lanka and Thailand.

24. An Intercountry Workshop for Trainers on Injury Epidemiology, Prevention and Care was organized in Khon Kaen, Thailand in 2008; subsequently, such training was carried out at the national level in Thailand and also India, and injury prevention and care activities in several other countries received impetus. A second initiative, an Intercountry Workshop for Injury Surveillance System conducted...
in Bandos, Maldives in 2009, aimed to strengthen country capacity in generating injury surveillance reports and disseminating the information across sectors. Bhutan, India, Myanmar, Nepal and Sri Lanka have piloted the injury surveillance system. Injury surveillance reports of Thailand were translated for sharing with the international public health community.

25. Member States, together with the Regional Office, developed the Status Report on Road Safety to identify both the gaps and the key priorities for intervention, as well as to stimulate road safety activity at the national level. During the biennium, the National Road Traffic Safety Policy and Strategy was endorsed in Bangladesh and Maldives.

26. The Profile of Child Injuries in Selected Member States of the Asia-Pacific Region was produced, as well as a fact sheet on child injury prevention in the Region. Drowning among children has become a priority agenda item in Thailand, and the intervention programme has been expanded for the entire nation.

27. Special briefing seminars and conferences were organized to raise awareness of the Convention on the Rights of People with Disabilities. An information booklet for policy-makers on the roles and responsibilities of the health sector with regard to the Convention—the first of its kind globally—was developed. A disability access audit was conducted at the Regional Office premises and the recommendations approved for action. Staff recruitment policies and the WHO-SEARO website are being made more accessible for persons with disabilities. To ensure coordination and inclusiveness of people in WHO technical programmes, disability mapping was conducted.

28. The First Asia-Pacific Congress on Community-based Rehabilitation (CBR) was organized in 2009 by the WHO Regional Office, WHO headquarters, the Asia-Pacific Development Centre on Disability (APCD), the Government of Thailand and several international agencies to highlight the evidence of innovative activities and the need for research in CBR. Many people with disabilities also attended the congress and made presentations.

Blindness and deafness

29. A comprehensive situation analysis on VISION 2020 of the SEA Region and a framework for developing an action plan for a comprehensive eye health programme for blindness prevention was developed. Bangladesh, Myanmar and Nepal were supported in implementing national blindness prevention. India has been supported
in developing information, education and communication (IEC) materials on ocular emergency and diabetic retinopathy. Thailand has an established multisectoral partnership structure for blindness prevention. Technical coordination and support to assess the blindness situation and information, including strengthening of the National Blindness Prevention Committee, has been initiated and is currently ongoing.

30. A draft Five-Year Plan for the Prevention of Deafness and Alleviation of Hearing Impairment for the SEA Region 2010-2014 has been developed in collaboration with the Sound Hearing Society. Assessment of the epidemiology of hearing loss in all Member States and a regional symposium on “infant hearing screening” was conducted in 2009. India was supported in human resources development and in implementation of the model for the school programme to prevent deafness and alleviate hearing loss.

31. Injury and disability prevention and rehabilitation share similar challenges, such as limited information, budget and human resources, especially in epidemiology and primary prevention. Development of multisectoral collaboration and a strategic approach to problem-solving and resource mobilization are crucial.

Health promotion and education

32. Health promotion and education (HPE) in the Region are carried out mainly through policy advocacy and multisectoral training. Capacity-building initiatives for health promotion and education require the

Sustainable health promotion mechanisms are being implemented in the Region.
involvement of both health and non-health professions, as well as strengthening of infrastructure. The role of local academic institutions is critical to health promotion and education.

33. HPE activities implemented in countries of the SEA Region during the reporting period focused on strengthening health promotion practice, building capacity and formulating multisectoral and multidisciplinary task forces, mainstreaming health promotion in national policies and activities, and establishing sustainable mechanisms for implementation of health promotion. The *Regional Strategy for Health Promotion for South-East Asia* was developed and published to provide a strategic guideline and framework for countries to build a critical mass of human resources for health promotion, drawn from health and non-health disciplines.

34. Training of health and non-health professionals in health promotion practices was conducted in Bhutan, India and Timor-Leste. SEARO developed two training packages and organized trainings of trainers for community health workers, school health coordinators, academics and staff of related ministries in the three countries. HPE provided the training through partnerships with academic institutions, namely the National Institute of Public and Social Medicine, Bangladesh; the Royal Institute of Health Science, Bhutan; the National Institute of Health and Family Welfare, India; and the Institute of Health Sciences, Timor-Leste.

*School health promotion is a key aspect of the regional health promotion strategy.*
35. School health promotion is a key aspect of the regional strategy using a setting-based approach. Global School Health Survey (GSHS) training, data collection, analysis and reporting were supported in India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. The GSHS results provided important evidence for formulating strategic planning and interventions for implementation of the school health promotion programme. Through a series of workshops, three further guidelines were developed: Guidelines for Oral Health Promotion in Schools, Guidelines for Water, Sanitation and Hygiene in Schools, and Guidelines for Monitoring and Evaluation of the School Health Promotion Programme.

36. Technical support was provided to Bangladesh, India, Maldives and Sri Lanka to develop national health promotion policies. Intercountry consultations on health promotion financing and addressing equity gaps were organized. A five-country study on the status of health promotion financing and innovative financing was conducted in India, Indonesia, Nepal, Sri Lanka and Thailand. A regional consultation on options for financing health promotion in 2009 reviewed the study findings and provided strategic directions in this area for the Region. Health equity analysis was conducted in six countries using Demographic and Health Survey (DHS) data, and the impact of social determinants on health outcomes was identified.

37. The Regional Consultation on Social Determinants of Health: Addressing Health Inequities held in Colombo led to the “Colombo Call for Action”, which recognized the existence of inequities in health in SEA Region countries and provided guidance on tackling them through political commitment—putting “closing the gap in a generation” on the national agenda and mainstreaming health equity in all policies.

38. Regional strategies will need to be brought in line with the “Nairobi Call to Action for Closing the Implementation Gap in Health Promotion”, adopted in 2009. The strengthening of health promotion practices and skills in countries of the Region will need continued support, and could be facilitated by the establishment of an SEA Region Social Science Network on Social Determinants of Health. Monitoring and evaluation of health promotion activities across issues, population groups and settings is also a continuing need.