Establishing Noncommunicable Disease Risk Factor InfoBases in the SEA Region

Report of the Planning Workshop
Pattaya, Thailand, 17-19 November 2004

WHO Project: ICP NCD 001 (II)

World Health Organization
Regional Office for South-East Asia
New Delhi
June 2005
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1. INTRODUCTION

1.1 Background

Member States of the SEA Region are undergoing an epidemiological transition. As a manifestation of this, noncommunicable diseases (NCDs) such as cardiovascular diseases, cancers, chronic pulmonary diseases and diabetes mellitus are assuming alarming proportions. They account for 51% of all deaths and 44% of the disease burden. The epidemiological transition is being propelled by demographic and socioeconomic transformation occurring in the countries of the Region. This has resulted in the adoption of undesirable changes in lifestyles including unhealthy eating practices, tobacco and alcohol consumption and physical inactivity.

In spite of the growing evidence of a rapid increase in NCDs, they are not perceived as a major public health problem and do not get priority in the Region. There is inadequate political commitment and resource allocation for prevention and control of NCDs. In order to gather available evidence and generate more information with the aim of strengthening the evidence base for advocacy for NCD prevention and control, it is essential to set up appropriate surveillance mechanisms in the countries.

1.2 Regional Strategy for NCD Surveillance

A strategy for NCD surveillance in the SEA Region was developed at the Intercountry Workshop on Establishing South-East Asia Regional Network for Noncommunicable Disease Surveillance held in Colombo, Sri Lanka in October 2002.

The objectives of the strategy are:

(1) To support Member States in the development of a strategic plan for NCD surveillance.

(2) To strengthen the capacity of Member States in the implementation of NCD surveillance at the national level.
(3) To improve availability, accessibility and validity of core information on major NCDs and their risk factors at national and regional levels.

(4) To promote the development and utilization of standardized tools and methods to facilitate tracking time trends and making intercountry comparisons.

(5) To augment the capacity of the Countries for data management and encourage utilization of information.

(6) To promote intercountry collaboration in developing national NCD surveillance systems and facilitate sharing of information between Member States.

The strategy has specified targets till 2010. Establishment of a national NCD InfoBase is in keeping with this strategy. During the Meeting of the High Level Task Force on the Supplementary Intercountry Programme for 2004-2005, nine countries of the Region were targeted for establishment of the InfoBases.

2. OBJECTIVES OF THE WORKSHOP

2.1 General Objective

To strengthen public health information systems in the collection, sharing and utilization of NCD and their risk factors surveillance data.

2.2 Specific Objectives

(1) To present and discuss with national NCD InfoBase focal points the structure and management of NCD risk factor InfoBase, and

(2) To develop a plan of action for deploying national NCD InfoBases in nine countries of the Region and for sustaining linkages between InfoBases at national and regional levels.

3. ORGANIZATION OF THE WORKSHOP

The workshop was inaugurated by Dr William L Aldis, WHO Representative to Thailand, on behalf of Dr Samlee Plianbangchang, Regional Director,
WHO South-East Asia Region. The text of the Regional Director’s address is at Annex 1.

The workshop was attended by 18 participants from the countries of the Region as well as one participant from Vietnam. In addition, staff from WHO Headquarters, the Eastern Mediterranean Regional Office, the South-East Asia Regional Office and the WHO country offices in Bangladesh, Indonesia, and Maldives participated in the workshop (see List of the Participants at Annex 2).

The programme of the workshop is at Annex 3.

4. **NCD SURVEILLANCE IN THE SOUTH-EAST ASIA REGION**

Dr Jerzy Leowski, Regional Adviser, Noncommunicable Diseases, SEARO, introduced the Regional NCD Surveillance Programme to the participants. He pointed out the increasing trends in the burden of NCDs in the Region and that common, modifiable risk factors are responsible for the ongoing epidemics of NCDs in the Region. There is sufficient evidence for causal link between these risk factors and NCDs and on availability of cost-effective population-based and individual intervention to initiate action. The World Health Report 2002 estimated that 42.5% of all deaths in the SEA Region were attributable to selected NCD risk factors. There is a need to strengthen surveillance activities on risk factors in the Region so as to improve availability, accessibility, validity and utilization of data for programme development, monitoring and evaluation. In pursuance of this objective, a Regional NCD Surveillance Network was established with WHO support in 2002. The participating countries are: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand. Eight countries of the Region are also in different stages of conducting the NCD risk factor surveys using the standardized WHO methodology. WHO Regional Office is providing necessary support in terms of training, maintaining an equipment pool and providing technical advice on methodological and statistical issues. The Region has also established a Regional NCD InfoBase in order to provide a sustainable mechanism for storage and utilization of surveillance data. This has been put on the regional website and provides free access to different users. It is proposed to transfer the InfoBase to countries.
Dr Ruth Bonita, Director Surveillance, WHO/HQ, focused on how to use surveillance data for developing NCD policies and programmes. One of the challenges is the lack of good quality, comparable country-level data on NCD risk factors to inform health policy-makers. WHO Global InfoBase and the WHO STEPwise framework for surveillance and prevention provide new tools to address this challenge. She also underscored the difference between research and surveillance. Surveillance of NCDs and risk factors is essential for guiding policy development and public health priorities, allocation of health care resources, tracking levels and trends in health status and developing and evaluating prevention programmes. She used the example of the United Kingdom wherein surveillance data were used to explain the decline in deaths due to coronary heart disease (CHD). This makes a powerful case for investing in risk factor interventions to policy-makers. She also showed how surveillance data from China can explain the increase in deaths due to CHD. Patterns of risk factors are changing fast in many parts of the world and countries need good quality comparable data to plan action. Surveillance is therefore a “public good” and makes for a wise and cost-effective investment by countries. There is a strong case for an integrated and sustainable surveillance mechanism that includes NCDs and their risk factors in its fold.

5. **AVAILABILITY OF NCD RISK FACTOR DATA IN THE COUNTRIES OF SEA REGION**

5.1 **Bangladesh**

A concerted NCD surveillance system is yet to be developed and the current information comes mainly from sporadic surveys. Reporting of hospital data is incomplete and population-based data come mainly from individual or institutional research. Data on smoking, obesity, blood pressure, diabetes and hypercholesterolemia were presented from such studies. A National Action Plan for Surveillance of Major NCDs has been drafted. The process of training of all the relevant stakeholders and establishment of a network of institutes is under way.
5.2 Bhutan

Bhutan suffers from a double burden of disease as is true for other countries of the Region. A national-level survey on tobacco consumption, conducted in 2001, showed that 3% of the population smoked. Information on other risk factors is mainly hospital-based and few community-based studies have been done in recent past. A health management information system exists from basic health unit (BHU) to the Planning and Policy Division of the Ministry of Health and includes some NCDs. Government is cognizant of the emerging problem of NCDs and the need for a comprehensive multisectoral approach for dealing with them.

5.3 DPR Korea

The Department of Prevention and Treatment, Ministry of Public Health, gathers hospital-based information on NCDs. Mortality from cardiovascular diseases has increased from 12.1% in 1960 to 47% in 1991 despite a decline in total mortality. Information on hypertension was presented. Analytical studies done in the country also provide evidence of association between smoking, hypertension and obesity with cardiovascular diseases.

5.4 India

In India many national initiatives coordinated by the national health system address the challenges of NCDs. A well-established hospital and population-based cancer registry system exists in the country and provides regular good quality data on cancers. Many large-scale surveys have been carried out in the country on tobacco use, nutritional status, diabetes, cardiovascular diseases etc. WHO standardized NCD risk factor surveys have been carried out in five centres. They provide very good quality data on all major risk factors. A hospital-based system for collection of information on morbidity and mortality due to NCDs has been initiated recently. An NCD Cell is being created in the Ministry of Health to coordinate activities. Surveillance of NCD risk factors at the state level is being taken up under the Integrated Disease Surveillance Programme launched in the country.
5.5 **Indonesia**

Information on cause of death comes from the national household health surveys and provides evidence for the increasing share of NCDs in total deaths. Under the Healthy Indonesia 2010 campaign, periodic health surveys and routine reporting systems include information on NCDs and their risk factors. There is still no “one stop” source for all the information related to NCDs. Under the decentralized system, districts are the units for planning and administration. Still, the information available through surveys provides information at provincial rather than district level. The National Institute of Health Research and Development (NIHRD) is the coordinating institution for NCD surveillance activities. It has a well developed information system.

5.6 **Maldives**

The data on causes of death through the national vital registration system show a rapid increase in mortality due to cardiovascular diseases - an increase from 18.1% in 1995 to 41.8% in 2003. Hospital-based information is available from the Indira Gandhi Memorial Hospital and shows a high load of NCD-related mortality, morbidity and disability. Tobacco surveys have been carried out in 1997 and 2001 and the results show a decline in tobacco use among both men and women. A NCD risk factor survey using standardized WHO approach is currently under way. Information from available sources would be used for the development of preventive strategies in the next 10-year Health Master Plan 2005-2015.

5.7 **Myanmar**

An integrated Health Management Information System (HMIS) was established in 1995 and includes community-based as well as institutional-based information. It covers priority communicable and noncommunicable diseases and provides information on mortality and morbidity. HMIS data are regularly compiled at different levels (townships, states, divisions and central) and monthly and annual reports are published and shared with health administrators, managers, planners and policy-makers. NCD risk factor data come from special surveys conducted by individuals and institutions with no
regularity. Such surveys in the past have been done on smoking, hypertension and obesity.

5.8 Sri Lanka

There are multiple sources of information on NCDs and their risk factors under the national HMIS. The hospital-based system provides information on morbidity and mortality due to NCDs. Demographic health surveys provide information on alcohol and tobacco consumption. Nutrition surveys provide information on nutritional status and food consumption patterns. A NCD risk factor survey using standardized WHO approach has been completed recently. There is no specific system or process for compiling data on NCDs. As a result, there is not much dissemination of the data and accessibility of the data is limited.

5.9 Thailand

The existing surveillance systems related to NCDs include vital registration system, cancer registry, national health examination survey and behavioural risk factor survey. Provinces are the unit of authority in the country and information needs to be provided at this level for appropriate action. The National Health Examination Survey III was conducted in 2004 and the data are being analysed. There is a “one stop” source for information on NCDs at the NCD Information Centre within the Ministry of Public Health. This centre would disseminate the results to all the stakeholders including policymakers.

6. WHO NCD INFOBASE

6.1 Global NCD InfoBase

Dr Kate Strong introduced the WHO Global InfoBase to the participants. The WHO NCD InfoBase has been developed by the NCD Surveillance Team as a tool to improve the quality and availability of country-level risk factor data. The NCD InfoBase assembles country-level risk factor data, stratified by age and sex. It collects population-based prevalence and risk factors data and uses a standard format that provides a single source for chronic disease surveillance.
data that are transparent, accessible and also presents all the information necessary to make data usable for further analysis.

The risk factors included are: (1) tobacco use; (2) alcohol consumption; (3) low fruit/vegetable intake; (4) physical inactivity; (5) obesity; (6) high blood pressure; (7) high cholesterol and (8) diabetes.

InfoBase users have the opportunity to access all of the information currently available on NCD risk factors and select the data that meets their needs. In order to include the available data in the InfoBase, the following minimal information is required:

- Valid source/reference (the source is stored as a hard copy at the location of data entry);
- Survey year, survey area, survey methods and design, and survey population, and
- Explicit data definitions.

These requirements are mainly aimed at providing the user with sufficient information to make a judicious choice about the appropriateness of the data use for the particular purpose.

Surveillance of Risk Factor (SuRF) report 1 was published in April 2003. It provided the most recent nationally representative NCD risk factor data for each country. SuRF report 2 which is under preparation, would provide comparable estimates for risk factors for all countries after harmonization of data and would also provide a profile of risk factor trends.

The InfoBase focuses on primary sources from population-based studies. However, for disease-specific modules, hospital-based data would also be included.

### 6.2 Regional NCD InfoBase

Dr Leowski introduced the Regional NCD InfoBase to the participants. Establishment of sustainable databases for NCDs and their risk factors is among the targets for 2010 identified under the Regional Strategy for NCD Surveillance. The Regional NCD Risk Factors InfoBase is an entry point for
establishing national NCD InfoBases in the countries. It is imperative that the Global InfoBase expands outwards in order to promote utilization, ownership of InfoBase and address country-specific needs.

Dr K. Anand, Short Term Professional (NCD), WHO/SEARO explained to the participants the rationale and process of establishment of the Regional NCD Risk Factor InfoBase. He emphasized that InfoBase serves different functions at different levels and at the national level it would be a useful tool for planning, monitoring and evaluation of NCD prevention and control programmes. InfoBase is a tool for improving data utilization by policymakers and programme managers in order to fill the knowledge action gap. Thus the maximum utility of the InfoBase would be at the national level. WHO would provide technical support in deploying the NCD InfoBase at the country level. The development of the regional NCD InfoBase was a step in the decentralization of the InfoBase. The tool developed by WHO headquarters was made available to the Regional Office and training of the regional InfoBase team was conducted through videoconferencing in August 2003. Subsequent to this, more data sources were entered into the InfoBase. Data verification and synchronization was done in collaboration with WHO headquarters. The Regional NCD InfoBase was established in March 2004 and was put on the SEARO Website in April 2004. The sources included in the regional InfoBase increased from 31 to 178. These additional sources were identified through the national NCD data focal points. The Regional Office is planning to transfer the InfoBase to the national level and the process has already been initiated with the identification of the national NCD InfoBase focal points. The necessary guidelines and training resources have been prepared and would be taken up for discussion in the meeting. He also pointed out that 75% of data sources are from adhoc surveys by individuals and institutions and these have limitations for use in surveillance. He also shared with the participants problems in the identification and retrieval of data sources faced during the establishment of the regional NCD InfoBase and hoped that these would be addressed to a large extent if the InfoBase is transferred to the national level and a sense of ownership is developed by the countries.

Mr Vishal Arora, Data Entry Focal Point, WHO/SEARO, introduced the structure of the InfoBase to the participants. He took the participants through each level of the InfoBase describing the type of information to be entered
into the InfoBase. This was followed by a practice session. One data source was taken as an example and was used to demonstrate how to enter data into the InfoBase. Following this, the participants were provided with another data source and asked to enter the data into the InfoBase under the supervision of WHO InfoBase team members. This session provided the participants with the understanding of the computer and manpower needs for deployment of InfoBase at the national level.

Dr Ruth Bonita and Dr Kate Strong, in a joint presentation, emphasized the need for quality assurance at all levels of the InfoBase for credibility. They also described the classification of levels of evidence related to population of health and how these have been used to harmonize data in the InfoBase for the SuRF report 2.

6.3 **WHO Support in Establishing NCD InfoBase in Member States**

In order to facilitate the process of deployment of InfoBase at the national level, the Regional Office had prepared three documents, viz,

- Draft Regional Guidelines for Establishing NCD InfoBase
- Draft Training manual for NCD InfoBase Manager
- Draft Regional NCD InfoBase Training Module

These three documents were discussed by the participants and feedback provided. The need for a training manual and module was appreciated by the participants and they felt that it covers most of the issues adequately. The participants felt that the training module may further highlight the issues relating to presenting InfoBase data to policy-makers. The draft guidelines for establishing NCD InfoBase was extensively discussed and many suggestions for revision were made. The three documents would be finalized taking into account the suggestions and comments made by the participants.

6.4 **Country Plans of Action for NCD InfoBase Deployment**

The participants prepared and presented a tentative work plan for deployment of the NCD InfoBase at the national level. These are summarized in Tables 1 and 2.
### Table 1. Deployment of InfoBase at national level – Summary organizational issues

<table>
<thead>
<tr>
<th>Country</th>
<th>InfoBase focal point</th>
<th>InfoBase team (Tentative)</th>
<th>Placement of InfoBase</th>
<th>Links planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Director Disease Control</td>
<td>Programme Managers CVD, Cancer, DM, Tobacco + Others</td>
<td>Directorate General of Health Services (Dept of Disease Control)</td>
<td>MIS; NCD Surveillance FP; NCD Prevention FP; WRO; SEARO</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Director, Department of Public Health</td>
<td>1 Member from Research Planning &amp; HMIS</td>
<td>Ministry of Health in Department of Public Health</td>
<td>HMIS; Research and Epidemiology Unit; Planning and Policy Division; WHO Offices</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>Vice Director, Department of Treatment and Prevention</td>
<td>Members of NCD Programme</td>
<td>Prevention and Treatment Department of MoPH</td>
<td>HMIS; National Research Organizations; NCD Surveillance FP; NCD Prevention FP; WRO, SEARO</td>
</tr>
<tr>
<td>India</td>
<td>Additional Secretary (Health)</td>
<td>Deputy Director-General (Med); Senior Deputy Director-General (ICMR); CMO, NCD Division</td>
<td>Ministry of Health and Family Welfare - NCD Cell</td>
<td>HMIS; National Research Org; NCD Surveillance and Prevention FP; WRO, SEARO</td>
</tr>
<tr>
<td>Indonesia</td>
<td></td>
<td>Core team from NIHRD Policy-makers</td>
<td>National Institute of Health Research Development - MoH</td>
<td>DG MC; DG PH; DG Drug Service; CHP; Bureau of Planning; Centre Information Data System</td>
</tr>
<tr>
<td>Maldives</td>
<td>Deputy Director, MoH</td>
<td>NCD Programme Managers; Physicians; Data Entry Operators</td>
<td>Health Information and Research Unit; Department of Public Health</td>
<td>HMIS; Health Information and Research Unit; Statistics Sec; NCD Prevention FP; WRO; SEARO; NGOs</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Director Medical Care</td>
<td>Directors: Health Planning Research, Public Health; Assistant Director - Computer</td>
<td>Department of Health</td>
<td>MHIS; National Research organization; NCD Surveillance FP; NCD Prevention FP; WRO; SEARO</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Director – Health Information</td>
<td>Director - NCD; Assistant Epidemiologist; MO Information</td>
<td>Health Information Centre</td>
<td>Health Secretariat; WRO; SEARO</td>
</tr>
<tr>
<td>Thailand</td>
<td>NCD Information Centre</td>
<td>Disease Control Department, MoPH</td>
<td></td>
<td>HMIS; National Research Org; NCD Surveillance and Prevention FP; WRO; SEARO</td>
</tr>
</tbody>
</table>

CMO – Chief Medical Officer, CVD – Cardiovascular Diseases, FP – Focal Point, HMIS – Health Management Information System, ICMR – Indian Council of Medical Research, MoH – Ministry of Health, MoPH – Ministry of Public Health, SEARO – Regional Office for South-East Asia, WRO – Office of WHO Representative
### Table 2. Resource and support requirements

<table>
<thead>
<tr>
<th>Country</th>
<th>Computer and internet availability</th>
<th>Training requirements</th>
<th>Accessibility</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Computer – part time; Internet – dial up</td>
<td>Orientation of team members; training for data entry</td>
<td>Free access to all; CDR, hard copies, Web access</td>
<td>Hospital-based studies to be kept in national InfoBase</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Computer upgrade required</td>
<td>Orientation of team members; data entry training</td>
<td>Within MoH, donor agencies; internal network and hard copies</td>
<td>Adaptation of S/W as per country requirements</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>No computer or internet</td>
<td>Training at Regional Office; translation of documents</td>
<td>Free access; CDR, restricted Web access</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>No computer for InfoBase; internet available</td>
<td>Training for staff deployed for data entry, verification, retrieval and analysis</td>
<td>Free to all using LAN and internet</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>Computer available, may need upgrading; slow internet access</td>
<td>Training for InfoBase team; software use; data adjustment; workshop at regional or national level</td>
<td>Within MoH, research institutions, governmental offices, NGOs and universities using restricted web access</td>
<td>Support from RSSG, periodic consultation, communication through email</td>
</tr>
<tr>
<td>Maldives</td>
<td>Part-time computer with ISDN line</td>
<td>Training for data entry, basic epidemiology &amp; statistics;</td>
<td>Within MoH, DPH, IGMH, donors and partners using CDRs, LAN and restricted web</td>
<td>In-country training, data handling</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Computer with dial up connection</td>
<td>Training of computer skills</td>
<td>Within MoH and wider circle of identified users using CDRs, LAN and restricted web</td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Computer and internet access</td>
<td>Training for S/W, database maintenance, data transformation</td>
<td>LAN and Web access</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>Computers with ISDN line</td>
<td>Training required; translation into Thai language</td>
<td>Free web access to all</td>
<td>RO / HQ to perform data entry process</td>
</tr>
</tbody>
</table>
7. CONCLUSIONS

(1) Noncommunicable Diseases (NCDs) are a major public health problem in the countries of the SEA Region.

(2) The availability, accessibility, validity and utilization of information on NCDs and their risk factors for policy and programme development, monitoring and evaluation need to be strengthened in the countries.

(3) There is a need to build stronger links between NCD information and policy making process involving stakeholders from all sectors.

(4) WHO NCD InfoBase is a useful tool for sharing information on NCD risk factors. It promotes and facilitates evidence-based approach to policy making.

(5) Sustaining InfoBases at regional and national levels is a matter of concern.

(6) The primary users of the InfoBase would be policy-makers and NCD programme managers at the ministry of health level.

(7) The purpose of the InfoBase is to support advocacy, planning, monitoring and evaluation of NCD prevention and control programmes.

(8) The development of the InfoBase should be based on principles of:
   ➢ sharing aggregate data at all levels - national, regional and global;
   ➢ transparency in the process of evolution by involving all levels;
   ➢ autonomy and flexibility at the country level so to utilize InfoBase to address country-specific needs;
   ➢ ownership of data and national NCD InfoBases by Member States;
   ➢ quality assurance at all levels.

8. RECOMMENDATIONS

8.1 Recommendations for Member Countries

Member countries should:

(1) Strengthen capacity to generate information for NCD surveillance purposes.

(2) Further evolve national mechanisms for NCD surveillance (including establishing linkage between national surveillance data collection mechanisms and national health information systems).
(3) Consider deployment of the NCD InfoBase at the national level.

(4) Adopt a multisectoral approach during deployment of the InfoBase by providing broad linkages and accessibility to all potential users.

8.2 Recommendations for WHO

WHO should:

(1) Assist Member States in strengthening capacity for developing sustainable NCD surveillance mechanism.

(2) Develop and share standards and norms including technical guidelines for strengthening NCD surveillance systems.

(3) On request, facilitate the development of national NCD InfoBase through appropriate technical assistance.
Annex 1

TEXT OF ADDRESS BY DR SAMLEE PLIANBANGCHANG, REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

Noncommunicable diseases including cardiovascular diseases, cancers, chronic lung diseases and diabetes mellitus are assuming alarming proportions and becoming the leading causes of mortality, morbidity and disability in the WHO South-East Asia Region. They accounted for 51 per cent of deaths and 44 per cent of the disease burden in 2002. There is evidence that disease rates from these conditions are increasing in the Region.

The World Health Report 2002 reiterated evidence on the preventability of NCDs by risk factor reduction and through health promotion. The report revealed that five of the top ten global risk factors to health are obesity, high blood pressure, high cholesterol, alcohol consumption and tobacco use - all major risk factors for NCDs.

At the same time, results of community-based NCD prevention projects and national NCD control programmes clearly demonstrate that even modest risk factor reduction through adoption of healthy lifestyles bring about a huge public health benefit. Despite such evidence, effective public health action has not been undertaken so far to control the epidemic of NCDs. It is an appropriate time, therefore, to strengthen regional efforts to address this important public health priority.

Recognizing the global challenges posed by NCDs and the opportunities for their effective prevention, WHO developed a Global Strategy for the Prevention and Control of NCDs in 2000. In continuation of such efforts and to stimulate global response and provide a framework for action, the Global Strategy on Diet, Physical Activity and Health was adopted by the World Health Assembly in 2004.

Surveillance of NCDs and their risk factors is an essential element in planning and evaluating health programmes. In order to strengthen capacity for NCD surveillance in the Region, a regional strategy was adopted in 2003. Among other initiatives, it envisages establishing sustainable databases for NCDs and their risk factors at regional and country levels.
Accordingly, a Regional NCD Risk Factor InfoBase was developed in 2004. It makes existing information easily accessible at one place and promotes utilization of available data for advocacy, programme development and research. The current efforts of the NCD intercountry programme in the Region aim at fulfilling the need to provide an appropriate data management tool for sharing epidemiological evidence on major NCDs and their risk factors at the country level. In this context, the establishment of a national NCD InfoBase is being supported in nine countries of the Region. National NCD InfoBase focal points and teams have been identified recently in the participating countries.

I am pleased to welcome representatives of these national InfoBase teams and colleagues from all levels of WHO at this important intercountry workshop. As you are aware, the workshop aims at developing a consensus on the structure and management of NCD InfoBases and developing a plan of action for deploying them at the country level. The excellent support extended by the Ministry of Public Health, Thailand, in organizing this meeting is greatly appreciated.

Finally, I would like to wish you all success in your deliberations and a pleasant stay in Pattaya. Thank you.
## Annex 2

### LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position/Division</th>
<th>Institution/Department</th>
<th>City/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dr Sayed Badrun-Nahar</td>
<td>Director (Diseases Control)</td>
<td>Directorate General of Health Services</td>
<td>Dhaka, Mohakhali</td>
</tr>
<tr>
<td></td>
<td>Mr Md Khaled Hussain</td>
<td>Sr. Assistant Secretary (WHO-2)</td>
<td>Ministry of Health and Family Welfare</td>
<td>Dhaka</td>
</tr>
<tr>
<td>India</td>
<td>Mrs P. Jyoti Rao</td>
<td>Additional Secretary (Health)</td>
<td>Ministry of Health and Family Welfare</td>
<td>New Delhi</td>
</tr>
<tr>
<td></td>
<td>Dr S. Badrinath</td>
<td>Deputy Director-General (M)</td>
<td>Directorate General of Health Services</td>
<td>New Delhi</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Dr Lusianawaty Tana</td>
<td>National Focal Point for NCD InfoBase</td>
<td>NIHRO, Ministry of Health</td>
<td>Jakarta</td>
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Regional Adviser, NCD
Dr K. Anand
Short-term Professional, NCD
Mr Vishal Arora
Data Entry Focal Point, NCD
Annex 3

PROGRAMME

Wednesday, 17 November 2004

0830 – 0900 hrs  Inaugural Session
0900 – 1000 hrs  Regional NCD Surveillance Programme – Dr Jerzy Leowski
1015 – 1100 hrs  Utilization of NCD risk factor data – Dr Ruth Bonita
1100 – 1200 hrs  WHO Global InfoBase and Surf Report – Dr K. Strong
1300 – 1700 hrs  Country presentations on availability and accessibility of NCD risk factor data

Thursday, 18 November 2004

0830 – 0900 hrs  Regional NCD Risk Factor InfoBase - Introduction - Dr Jerzy Leowski
0900 – 0930 hrs  Establishment of regional NCD risk factor InfoBase - Dr K. Anand
0930 – 1000 hrs  Structure of regional NCD InfoBase - Mr Vishal Arora
1015 – 1100 hrs  Identifying and retrieving sources of Information on NCDs and NCD risk factors – Dr K. Anand & Dr Kate Strong
1100 – 1200 hrs  Data entry and verification – Mr Vishal Arora and Ms J. Lippe
1300 – 1500 hrs  Practical exercise – Data entry and report generation – Mr Vishal Arora and Ms J. Lippe
1515 – 1630 hrs  Group discussion on deployment of NCD InfoBase at national level
1630 – 1700 hrs  Group Work - Preparation of action plan for deployment of national InfoBase

Friday, 19 November 2004

0830 – 1000 hrs  Presentation of Draft action plan for deployment of InfoBase by Member states
1015 – 1100 hrs  Role of national InfoBase focal points and teams (General discussion moderated by Dr Jerzy Leowski)
1100 – 1130 hrs Assessing quality and validity of epidemiological data – Dr Ruth Bonita
1130 – 1200 hrs Quality assurance and harmonization of data – Dr Kate Strong
1300 – 1400 hrs Discussion on SEAR training resources for NCD InfoBase
1400 – 1500 hrs General Discussions on:
• Requirements for WHO technical assistance
• Sustaining regional and national InfoBases
• Future plans
1515 – 1700 hrs Conclusions and Recommendations
1700 hrs Closing