Report of the

Mega Country Health Promotion Network Meeting on Diet, Physical Activity and Tobacco

convened in Geneva, Switzerland
11-13 December 2002

by the Department of
Noncommunicable Disease Prevention and Health Promotion
NONCOMMUNICABLE DISEASES AND MENTAL HEALTH

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EXECUTIVE SUMMARY

WHO convened a meeting of the Mega Country Health Promotion Network on Diet, Physical Activity and Tobacco at WHO headquarters in Geneva, Switzerland, on 11-13 December 2002. The meeting was called to build on the recommendations of the previous meeting, also held at WHO headquarters, in December 2001, which clearly demonstrated the alarming degree to which global trends relating to unhealthy diet, physical activity and tobacco use affect all Mega countries. This meeting concentrated on diet, physical activity and tobacco, and reviewed the situation and policy responses in Mega countries.

The overall goal of the meeting was the strengthening of the Network as a meaningful collaborative initiative for promoting NCD prevention and encouraging better health. The 60 participants, from the countries concerned and from WHO regions and headquarters, based their discussions on the World Health Report 2002 (WHR), with its emphasis on the prevalence and trends of major NCD risks, tobacco use and control, diet and nutrition and physical activity.

In an overview of the importance of tobacco, diet and physical activity in the prevention and control of chronic disease, Dr Derek Yach, Executive Director of WHO's Cluster of Noncommunicable Disease Prevention and Mental Health (NMH), highlighted the importance of WHR 2000 and pointed out some important but less obvious issues and statistics presented in the WHR.

In an address on global risks from NCDs and the prevalence and trends of those risks, as presented in the WHR, Dr Colin Mathers, from the Evidence and Information for Policy Office at WHO headquarters, stressed that just a few risk factors contribute to a wide range of illnesses and deaths. Those that have a major impact on health are tobacco use, sedentary lifestyles and unhealthy diet - risk factors that every concerned individual can be persuaded to change for the better.

Dr Vera L. Costa e Silva, Project Manager for WHO's Tobacco Free Initiative (TFI), described WHO's activities in the field of tobacco control, and Dr Ruth BONITA, Director of Cross Cluster Surveillance (CCS), introduced the issue of risk factor data use in Mega countries.

Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion (NPH) at WHO, presented the WHR messages on diet, physical activity and WHO's response. He described in detail the preparations being made for the WHO Global Strategy on Diet, Physical Activity and Health. The simple messages to be put across are that everyone’s health can be improved by not smoking, by eating less fat, sugar and salt, and by doing more physical activity.

Dr Ruitai Shao, Medical Officer in WHO’s NPH, spoke on the need to upgrade the Mega Country Network so as to respond more effectively to the challenges, increase national capacity and link up with other country initiatives. National capacity building was recognized as a core component by both the Ottawa Charter for Health Promotion and the Global Strategy for NCD Prevention and Control.
Following exhaustive discussion of the issues raised in the plenary and among five working groups, the participants drew up a comprehensive set of recommendations aimed at strengthening the Mega Country Health Promotion Network. These included:

- Identify a central, national Institute for the technical cooperative work and a permanent focal point within each Mega country who serves as official representative of the Ministry of Health.
- Establish intersectoral mechanism within each Mega country to support Mega country involvement, including the potential role of NGOs.
- Consider establishing a small steering group, or secretariat, composed of selected Mega country focal points and WHO HQ staff to guide the direction and work plan for the Mega Country Network.
- Prepare a country-specific report on the status of key NCD risk factors, policies and programmes in cooperation with each Mega country.
- Improve communications within the Mega Country Network through websites, both country- and WHO-based, video-conferencing (WHO), print material and newsletters.
- Provide explicit programme and policy guidelines and direction to Member States; identify and promote specific health promotion demonstration projects and increase the priority given to NCDs, especially through building the evidence base on effectiveness.
- Identify and/or establish key WHO Collaborating Centres to specifically support the work of the Mega Country Network.
- Integrate diet and physical activity programmes, particularly in low resource countries, into poverty reduction, maternal and child health, sustainable development and other existing programmes.

**INTRODUCTION**

The WHO Mega Country Health Promotion Network was born out of the recognition that a grouping of the world’s most populous countries would have tremendous potential to influence and improve the health of the whole world. Eleven countries which have populations of 100 million or more together constitute over 60% of the global population. They are Bangladesh, Brazil, China, India, Indonesia, Japan, Mexico, Nigeria, Pakistan, the Russian Federation and the United States of America.

These diverse countries stand at different levels of development and are experiencing different trends in the shifting patterns of disease and death. Among the trends that have an impact on the global health are:

- Rapid changes in lifestyles
- Population growth and demographic changes
- Increasing urbanization and changing types of work
- Development and proliferation of communication channels
- Global trade and marketing.
These changing circumstances have major health consequences that are too large to be satisfactorily addressed by individual countries acting alone. By working together, Mega countries can raise a powerful voice in support of the global health policy agenda and help to bring about positive outcomes.

Formed in March 1998, the Mega Country Health Promotion Network has as its primary goals:

- To improve the information base for health promotion and disease prevention by sharing successful promotion policies and programmes, and related surveys and evaluations;
- To develop health promoting strategies in four areas:
  - **Healthy lifestyles**, in particular tobacco use, diet and nutrition and physical activity
  - **Healthy life course**, giving priority to women, children, adolescents and the ageing population
  - **Supportive environments**, looking especially at good sanitation, safe water and malaria and insect vector control
  - **Supportive settings**, especially schools, cities, workplaces and communities;
- To mobilize resources from existing, redistributed and non-traditional sources and to increase the status of health as a priority;
- To increase intersectoral collaboration across governmental and nongovernmental agencies, and across the public and private sectors, so as to improve health;
- To address issues of scale that Mega countries share in common, such as reorienting and redistributing resources in large bureaucracies, building the capacity of national partners, reaching large populations through the media and using high technology to provide distance education and training.

**COURSE OF THE MEETING**

The WHO Mega Country Health Promotion Network met at WHO headquarters in Geneva, Switzerland, on 11-13 December 2002 to discuss how global trends relating to unhealthy diet, physical inactivity and tobacco use affect all Mega countries. Professor Igor S. Glasunov, Head of the Department of Policy and Strategy Development at the National Centre of Preventive Medicine in Moscow, was elected as Chair of the meeting. Dr Bela Shah, Senior Deputy Director General in the Division of Noncommunicable Diseases, Indian Council for Medical Research, and Dr Kong Ling-Zhi, Director, Division of NCD Prevention and Control in the Department of Disease Control, Ministry of Health of China, were elected as Vice Chairs. The chosen rapporteurs were Dr Michael Eriksen, Georgia State University, USA, Dr Sania Nishtar, Heartfile, Pakistan, and Dr Annette Akinsete, Federal Ministry of Health, Nigeria.

Discussions focused on the *World Health Report 2002 (WHR)* and its emphasis on the prevalence and trends of major NCD risks, tobacco use and control, diet and nutrition, and physical activity. In particular, the 60 participants from the 11 countries concerned and from WHO regions and headquarters, sought ways of strengthening the Network as a meaningful collaborative initiative for promoting NCD prevention and encouraging better health.
Dr Derek Yach, Executive Director, WHO Cluster of Noncommunicable Disease Prevention and Mental Health (NMH), presented an overview of the importance of tobacco, diet and physical activity in the prevention and control of chronic diseases, and highlighted some of the important issues and statistics presented in the WHR. He drove home the message that just a few risks explain many causes of death and disease, namely tobacco use, sedentary lifestyles and unhealthy diet. He quoted the Director-General of WHO, Dr Gro Harlem Brundtland, who had told the 55th World Health Assembly in May 2002: "The world is living dangerously - either because it has little choice or because it is making the wrong choices". Along this line, Dr Yach suggested that "we should aim to make healthy choices the easier choices".

One of the striking facts he highlighted was that cardiovascular diseases (CVD) in the Mega countries account for 59.3% of all CVD deaths in the world - 9.64 million out of a global total of 16.26 million. And in many developed countries, women at age 50 today have nearly 50 years of life expectancy in front of them; there is therefore all the more need to pay particular attention to NCD prevention among this population.

In an address on global risks from NCDs and the prevalence and trends of those risks, as presented in the WHR, Dr Colin Mathers, from the Cluster of Evidence and Information for Policy at WHO headquarters, stressed that a few risk factors contribute to a wide range of illnesses and deaths. Those that have a major impact on health are tobacco use, sedentary lifestyle and unhealthy diet - risk factors that every individual can be persuaded to change for the better. He also noted in relation to blood pressure that even individuals who are technically below the traditional danger levels may also be at risk.

Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion (NPH) at WHO, presented the WHR messages on diet and physical activity, and WHO's response. He described in detail the preparations being made for the WHO Global Strategy on Diet, Physical Activity and Health. The simple messages to be put across as integral parts of the Global Strategy are that everyone’s health can be improved by not smoking, by eating less saturated fat, sugar and salt, and by taking regular exercise. Unfavourable, rapid changes in diet and physical activity are major driving forces behind the growing NCD epidemic.

He pointed out that today the NCDs contribute to 60% of all deaths and 43% of the global burden of disease. But projections show that, by 2020, deaths from NCDs will account for 73% of all deaths and for 60% of the disease burden. Together with the smoking habit, diet and physical activity are of overwhelming importance for the global disease burden and for the potential public health gain.

Diet and physical activity have a major influence on many leading NCDs, both alone and in combination. Diet strongly affects blood cholesterol, blood pressure, body weight and other major CVD determinants. Diet also influences the risk of several cancers, diabetes, hypertension, obesity etc. Key aspects in the diet are, in addition to the energy intake, the quality of fat and the quantity of salt and sugar.
Physical inactivity alone increases all causes of mortality. It can double the risk of dying from CVDs and stroke. It causes nearly two million deaths worldwide every year, doubles the risk of developing CVDs, Type II diabetes and obesity. And it increases the risk of colon and breast cancer, hypertension, lipid disorders, osteoporosis, stress, anxiety and depression.

Dr Ruitai Shao of WHO’s NPH, said the Mega Country Network needed to be upgraded so as to respond more effectively to the challenges, increase national capacity and link up with other country initiatives. National capacity building was recognized as a core component by the Ottawa Charter for health promotion and by the Global Strategy for NCD prevention and control. It will require study of the trends in NCDs and common risk factors, global initiatives and the many actions initiated by UN, WHO and other international development organizations. Among these are the report of the Commission on Macroeconomics and Health (CMH), WHO’s Country Cooperation Strategy (CCS) and the Country Focus Initiatives (CFI).

The Mega Country Health Promotion Network, together with the regional networks and the Global Forum for NCD Prevention and Control, will all play an important role in improving national capacity. Dr Shao quoted from the Bangkok Declaration of March 2002, which underlined that prevention and health promotion are cheap and cost-effective in comparison to clinical services, but they urgently need resources, expertise and political commitment.

Participants raised questions about the need to find additional support for country-level analysis and assistance in programme interventions. Especially in the field of surveillance, data coordination among the 11 countries should offer good opportunities to solve problems together, through WHO data systems as well as through such regional systems as CINDI. Country representatives asked whether additional analysis can be done among the networks to solve problems, and whether comparative analyses among countries are already in the pipeline. It was seen as an added advantage of the Mega country network that it is more diverse than most existing networks since it includes developed and developing countries, with high and low mortality rates. Some countries have resources and experiences that can enrich other countries, while lifestyle changes over time can more readily be compared.

The meeting divided into five working groups to deal separately with nutrition and diet; physical activity; tobacco; the WHO Global NCD Infobase; and national capacity (advocacy and Mega country collaboration). Following exhaustive discussion of the issues raised in the plenary and among the working groups, the participants drew up a comprehensive set of recommendations aimed at strengthening the Mega Country Health Promotion Network. These included:

- Identify a central, national institute for the technical cooperative work and a permanent focal point within each Mega country who serves as official representative of the Ministry of Health;
- Establishing an intersectoral mechanism within each Mega Country to support country involvement, including the potential role of NGOs;
- Urging WHO to establish a small steering group, or secretariat, composed of selected Mega country focal points and WHO HQ staff to guide the direction and work plan for the Network;
• Preparing a country specific report on the status of key NCD risk factors, policies and programmes in cooperation with each Mega country;
• Improving communications within the Network through websites, both country- and WHO-based, video-conferencing (WHO), printed material and newsletters;
• Identifying and promoting specific health promotion demonstration projects, and increasing the priority given to NCDs, especially by building the effective evidence base;
• Recruiting key WHO Collaborating Centres to support the work of the Network, and organizing both a policy and technical meeting of the leadership of the Mega country delegations at the next World Health Assembly in May 2003;
• Providing specific recommendations, particularly for low resource countries, for integrating diet and physical activity programmes into poverty reduction, maternal and child health, and other existing programmes.

The full list of recommendations appears below.

NUTRITION AND DIET

In discussions on diet and nutrition, Brazil suggested that it would be useful to learn from the tobacco experience. Promotion of better nutrition needs to have a sound science base as well as a global strategy. Also needed for diet and nutrition issues are:

• A focus on social marketing to counter today’s sophisticated marketing;
• Measures to control advertising, labelling and health claims;
• Building capacity among health professionals, education professionals, the media and consumer groups, and
• Facilitating social mobilization.

In this context, Dr Yach suggested that easy, practical and visible successes were needed. These could come from encouraging increased consumption of fruit and vegetables as well as nuts and whole grains; from promoting physical activity; and from encouraging the maintenance of a normal body weight.

But there are also complex policy and action issues. These will include developing long-term sustainable intersectoral solutions to promote physical activity and healthy diets; improving the availability and affordability of health foods globally; reviewing the information environments to ensure that children and adults are fully informed consumers; and developing market solutions to promote less fatty, salty and sugary foods.

WHO itself can help to organize and coordinate efforts at the country level, as well as advancing the global effort. It has already commissioned an investigation of some impediments to good nutrition which appear under the guise of trade barriers.

Practical issues that need to be looked at include marketing, the Codex Alimentarius, subsidies and tariffs, issues of production and shipping, and the effect of policies on availability and cost. A striking example was given that, if UK schools provided an apple in every school lunch, this would consume 40% of the UK’s entire apple supply. Participants felt there is a great need for innovative research and demonstration
programmes, and countries will need to experiment with innovative approaches and evaluate the outcomes.

**Brazil**’s experience with legislation has included progress - after lengthy negotiations - in getting trading partners to label foodstuffs, including the listing of trans-fatty acids.

**Pakistan**’s experience with diet and nutrition proved quite different from that of tobacco control; so much has already been accomplished with tobacco control, and the level of awareness of the health hazards is much higher for tobacco than it is for better diet and greater physical activity. There are also cultural barriers in Muslim countries, particularly in respect to women and physical activity, and these call for different types of strategies.

**Bangladesh** noted that there is a need to define what is meant by optimal physical activity. Major changes in physical activity are occurring in the developing countries, often involving the elimination of current patterns of strenuous physical activity. The role of under-nutrition should also be considered insofar as it affects chronic disease in the developing world.

**Mexico** observed that existing poverty reduction programmes emphasize eating “more,” not necessarily eating “better.” It is important for other partners (such as poverty reduction programmes) not to deliver different messages. Other speakers suggested the theme of “Healthy Eating” could address the problems of both under- and over-nutrition.

**China** reinforced the importance of working with other partners and organizations that may have an impact on the availability of healthy food choices. One example is that of fast food outlets, currently meeting public approval in many countries. Supermarkets are also proliferating around the world, and some chains are showing interest in varying their products and getting involved in nutrition campaigns.

**Russia** emphasized the role of Mega countries and raised three points. Firstly, rather than contrasting tobacco and diet, Russia suggested a more integrated policy approach that looks at multiple risk factors, including diet and tobacco. Secondly, the Mega countries need to address regional issues within each country, and to work simultaneously at intra-country and federal level. Finally, there is a need to go quickly beyond outcome indicators and develop process indicators.

It was generally felt that nutrition and diet strategies will be more complex than those for tobacco. Everyone needs to eat, and there are additional issues of under- and over-nutrition and changing dietary recommendations, whereas none of these problems exist for tobacco use, which is bad without exception.

As regards regulation, WHO suggested that the application of legislative and regulatory strategies will be up to national authorities, rather than WHO. It is likely that WHO will take a more positive approach in encouraging healthy behaviours through a “Health Promotion” theme, since there are many positive food and exercise behaviours that can be practised, and systems and environments can be designed to reinforce these desired behaviours.

The WHO Secretariat differentiated between the Expert Report and the Global Strategy. The Expert Report will be a WHO/FAO expert technical document, whereas the Global
Strategy will be the outcome of the input received through consultation, and will be drafted and presented for consideration at the 57th World Health Assembly in May 2004.

**Nutrition and Diet Working Group**

Ms Amalia Waxman, NPH, requested feedback on the draft questionnaire to assist the member states as they prepare for the Regional Consultations. The final questionnaire will be distributed to all Regional Offices which will use it according to their needs and plans. Its purpose is not for surveillance but rather to identify existing interventions and policies, and thus pave the way to prepare for the Regional Consultation meetings. Questions arose as to whether programmes should be research, demonstration or ongoing projects, or all three. It needs to be specified that all programmes should be directed at the relationship between diet, nutrition and physical activity, and chronic disease promotion. The Secretariat suggested that the questionnaire should report on the most prominent or most successful programmes, rather than offering a full inventory.

It was proposed that, rather than asking whether or not there are specific policies, it might be better to ask for examples of policies that have had a positive impact on disease prevention or health promotion, or where nutrition has been a factor in influencing agriculture policy. This could also be true for public-private partnerships, where it would be best to highlight positive collaborations.

**PHYSICAL ACTIVITY**

Mr Hamadi Benaziza, NPH, stressed the positive contribution that physical activity can make to everyone's health, and the way in which Move for Health, the theme of World Health Day 2002, had been taken up around the world.

Some speakers suggested that physical activity might not necessarily benefit from an integrated approach and that it may require separate attention and indeed may provide a fresh perspective to health promotion. Pakistan made the point that integration needs to be separated at the policy level and the programme level. At the policy level, it is legitimate to pay separate attention to each programme component; at the programme level, resources dictate the extent to which vertical programmes can be offered and, typically in low-resource countries, there needs to be integration into existing programmes, particularly poverty reduction efforts. WHO should therefore explicitly recommend integration at the programme level.

Mexico noted, however, that integration needs to be done scientifically and practically. For example, it may not be appropriate to encourage physical activity among certain populations that already need to walk for hours to obtain social services. The WHO Secretariat observed that there are natural opportunities for integration of physical activity and nutrition because of the importance of energy balance, but that the integration of risk factors is more complex.

Brazil described plans to make Agito Sao Paolo a national programme. Turning a local programme into a national one presents a huge challenge, but it can be accomplished. One success resulted from asking the public the most acceptable ways of increasing their
physical activity; dancing was identified as an acceptable and popular way of engaging in physical activity - whether in a ballroom or the bathroom.

Among the barriers to physical activity were air pollution, as in Mexico City and the big cities of India, and safety concerns in many urban areas. Lack of appropriate space may be a problem. Brazil and China mentioned working with urban planners to incorporate policies to limit traffic, crime or pollution problems. China and India noted the special needs of rural areas, where there is less awareness of the value of physical activity. Nigeria emphasized the importance of school programmes for both nutrition and physical activity.

Regarding the physical activity evidence base, the US noted the availability of six evidence-based interventions that have been identified and form part of the US Community Guide to Preventive Services. These may be applicable to other Mega countries.

**Physical Activity Working Group**

This working group commended the Move for Health campaign, and favoured the continuation of Move for Health Days on an annual basis. The slogan Move for Health has “brand value” and the concept should not be expanded beyond physical activity, but it would be appropriate to have different annual subtitles or themes. To integrate other risk factors into the theme would be confusing. The programme needs to be inclusive so as to get the maximum number of stakeholders and focal points from various sectors involved. It is essential to identify potentially interested parties, such as transport and urban planning departments, banks, insurance companies, environmental groups, local leaders, sport leaders and the sport industry for funding and overall involvement in promoting physical activity and the Move for Health Day.

The message for the Move for Health Day should be simple, attractive, focused, clear and to the point. It should deal primarily with physical activity issues (policy, environment, domains, settings, population groups, interventions etc), and will serve as an entry point to tackle other health and social issues related to physical activity and healthy lifestyle. Messages on Move for Health should be inserted into each country’s various important health, sport and socio-political days.

There is need for a website or web-board on physical activity/Move for Health to facilitate the exchange of information. It is important for planning to take into account local culture and traditional sports.

WHO leadership was deemed to be crucial to this concept as it lends credibility and authenticity to the exercise, and will help to bring about acceptance at country level. Also, the Working Group felt it was imperative to have a central coordinating function. WHO will provide technical support on each year’s theme, facilitate networking and contribute to the mobilization of extrabudgetary resources for the event. There should be clear-cut guidelines on how to use the Move for Health logo.

The Move for Health programme should be given long-term direction in terms of the five- to ten-year Global Strategy, with short- and long-term objectives clearly outlined. Every effort should be made to highlight the other NCD-related risks such as diet and tobacco, but also other diseases and conditions against which physical activity confers protection.
**TOBACCO**

Dr Vera L. Costa e Silva, Project Manager for WHO's Tobacco Free Initiative (TFI), introduced the discussion on Tobacco. In respect of the Tobacco Free Initiative, participants at the meeting agreed that the basic framework for national capacity required a national office, a national plan and a multi-sectoral task force. The strategy should be to decentralize so as to reach remote areas, and to work in synergy with other health issues. A careful watch should be kept on the tobacco industry, and it will be important to involve the civil society and to invest in training and human resources. In addition, it is vital to be creative and search for new approaches to the tobacco problem.

Specific challenges for tobacco control associated with Mega countries include:

- **Intra-country variation:** This has implications for national averages, and what they really mean. The problem should be explicitly put on the Mega country agenda, particularly for the attention of the surveillance sub-committee;
- **Independence of local jurisdictions in relation to federal law;**
- **The difficulty of implementing programmes in large countries.**

Additional issues that were raised included the lack of financing available for tobacco control, the powerful influence of the tobacco industry, and the question of partnership with governments. How can Mega Countries share experiences and successes among one another? In view of the economic impact of tobacco control on tobacco-related jobs and government revenue, the World Bank report on the costs of tobacco use calls for wider study. Dr Yach displayed a pie-chart showing that the 11 Mega countries contribute 61.7% of the global total of 1.2 million deaths each year from lung cancer.

Bangladesh raised the issue of harmonizing tax rates in neighbouring countries so as to eliminate cross-border sales of tobacco. This illustrates the importance of transnational action for effective global tobacco control, whether through the Framework Convention on Tobacco Control (FCTC) or from regional cooperation.

**Tobacco Working Group**

The Tobacco Working Group considered how to make tobacco control a higher priority on the national agenda, not just on the public health agenda, since in many countries tobacco control is already a public health priority but cannot compete with other government interests. There is a need to provide economic evidence to convince non-health ministries.

WHO has a role to play in raising the profile of tobacco control. Countries listen to WHO and can use its imperative. Consequently, WHO and other international organizations need to speak out as well on tobacco control. The UN system must speak with one voice on this issue.

Mega countries should analyse their style of government to determine whether priority should be placed at the national or local level, or through some combination of those. Thus, in countries like Canada and Australia, there are strong federal efforts, partly related to the nature of their governments. In the United States, most of the progress has been made at the state and local level, rather than through federal policy.
While financial resources for effective tobacco control programmes are limited, community action and mobilization can be very effective, but they need to be used in such a way as to focus attention on the problem and mobilize the community. The real challenge is to succeed in implementing what we know works. Community leaders must serve as activists and obtain attention from the media. Pakistan emphasized the value of emotional or personal appeals in getting people involved in tobacco control.

While it is necessary to develop strategies to counter the tobacco industry campaigns, the specific strategy chosen, be it litigation, legislation, regulation, media advocacy or civil disobedience, should always be consistent with the culture and tradition of the country.

The group asked: What is unique about Mega countries and tobacco control? The responses revealed a wide spectrum of experiences. Thus Nigeria cannot get the attention of government or the financial resources that are available, and this problem is compounded by Nigeria's partnership with BAT (British American Tobacco Corporation). At the country level nobody is focused on NCD or tobacco control.

China considers tobacco as a social issue, much broader than just a health problem, since tobacco affects jobs, tax revenues and so on. WHO should organize professional expertise to carry out case analysis on the total impact of tobacco production and control, and make suggestions to governments. It was suggested that this work be done at the provincial level as well as at the federal level, in order to take into account the complete picture. China also reiterated the power of the Mega countries working together and sharing approaches, media material and so forth. They must speak with one voice on what is acceptable and provide mutual support and solidarity in actions against the tobacco industry. If one country says “No” to a tobacco company initiative, it would be helpful if all Mega countries say the same and support the action of each Mega country.

Pakistan noted that the very size of the Mega countries attracts the interest of the tobacco industry, as well as adding complexity through the heterogeneity of a large population.

Countries don’t need to spend so much time on learning about the problem; what they need to know are the solutions. Winston Churchill was quoted as saying: “Don’t talk to me about problems. They speak for themselves. Talk to me about solutions”. It was agreed that the tangible outcome of the meeting will be the sharing of experiences and approaches, legislation, plans and strategies.

**WHO GLOBAL NCD INFOBASE**

Knowledge of behavioural risk factors and risk conditions is an inherent aspect of understanding NCDs. However, the capacity to understand or know about those factors is obviously quite different from the capacity and skill needed to gather risk data through a system of surveillance. Valid data should be a high priority for the development of NCD prevention and health promotion policies and programmes. To varying degrees of coverage and detail, Mega countries are undertaking surveillance of selected NCD risk factors to obtain good data on behavioural risk factors and their determinants - for planning of policies and activities, and for monitoring the development. Many applications of risk factor surveillance currently occur as components of community-based demonstration projects focusing on NCDs, specific risk factors (including smoking) or school health.
This plenary session which was introduced by Dr Ruth BONITA, Director of the Cross Cluster Surveillance Initiative (CCS), agreed that, ideally, risk factor surveillance should be:

- Flexible enough to generate national, state and municipal or local estimates;
- Able to generate valid information taking into account the cultural nuances of each nation and its diversity;
- Integrated into the government's health system and sustained so as to permit tracking of trends over time;
- Capable of generating practical information that can be used to inform policy development and programme intervention.

The session and the following working group dealt with the availability, quality and use of existing risk factor information in the Mega countries.

**Risk Factor Data Base Working Group**

This working group reported on available data in the Mega countries. The data for tobacco are probably the best, but are certainly not perfect, while data on fruit and vegetable consumption and physical activity are most in need of development. The group also provided Mega country representatives with an opportunity to review and comment on preliminary data currently contained in the WHO Global NCD Infobase, as follows:

**Bangladesh**
Concern was expressed over the tobacco use data as they come from a private (not government) source. HQ will provide the Bangladesh representative with the data source and he will, in due course, provide national tobacco use data.

**Brazil**
The report from Brazil shows only certain small area surveys have been included in the Infobase, but there are actually many different small area surveys to chose from. These other studies will need to be included. Additionally, there are national data for leisure time physical inactivity and for fruit and vegetable intake. These will be provided by the representative.

**China**
The data displayed in the NCD Infobase are from the Tianjin Survey, as this is the most recent information. A new national survey is now in the field and results will be in early this year. The surveillance team would like to include these data if it is possible to obtain a copy of the results before publication.

**India**
There are now better studies on obesity, hypertension and cholesterol. These studies have been provided to WHO for inclusion in the Infobase.

**Indonesia**
The Indonesian data are not the most up to date. Additional data will be provided by the representative.

**Japan**
The most recent data come from the National Nutrition Survey and are now in the Infobase. Some concern was expressed over the accuracy of the sample sizes recorded from the survey and these are being checked and changed.
Mexico
Since 1987, the Centre for National Surveys has been conducting surveys in Mexico. The Centre recently published a Year 2000 survey on nutrition and provided a copy of a CD-ROM that contains information on this survey and more. Fifteen databases can be accessed on the web page: www.insp.mx.

Nigeria
The Infobase displays data from the Nigerian National Prevalence Survey of NCDs. A new survey is being conducted this year (2003) and it is hoped that updates will be added to the Infobase.

Pakistan
The Pakistan data from the 1990-1994 National Survey need to be finalized for inclusion in the Infobase. Most of the data currently displayed for Pakistan are not accurate and will need to be confirmed.

Russian Federation
Only the MONICA survey data are provided for the Russian Federation. While these figures are good, the data are older than the representative would like. Additional data include a telephone-based survey of health and risk factors for Moscow residents. Data from the CINDI Health Monitor conducted in 10 Russian provinces will come later.

USA
The National Health and Nutrition Surveys (NHANES) are represented in the Infobase. However, the Infobase is missing key data from surveillance systems such as the Behavioral Risk Factor Surveillance System (BRFSS). Data from such sources will be incorporated into the Infobase, and it will be checked to ensure that the data are accurately displayed.

The participants in the working group agreed to update current data and provide additional available data in the standard format for entry into the WHO Global NCD Infobase. Additional suggestions regarding harmonization of the data to allow comparisons between the Mega countries are as follows:

- Focus on what data should be collected routinely and how this data should be used in policy and programme development;
- Contribute to the STEPS framework by promoting standard data collections for diet and physical inactivity as well as other NCD risk factors such as tobacco use, obesity and blood pressure;
- Measure the mean population distribution of risk where possible (e.g., using the values of mean systolic blood pressure, mean BMI, mean total cholesterol and mean blood glucose);
- Focus on shifting the risk of the entire country populations to the left of the distribution curve, thus reducing risk for the greatest number of people, and
- Focus on feasible surveillance of behaviours and risk factors, their determinants and related process factors for monitoring progress in national and community based NCD prevention and health promotion programmes.
NATIONAL CAPACITY, ADVOCACY, MEGA COUNTRY COLLABORATION, FUTURE ACTIVITIES

Dr Marshall Kreuter provided an overview of his project to assess the current status of health promotion in Mega countries. In the context of national capacity for diet and physical activity, evaluation skills are in greatest need of upgrading. A report is expected to be completed shortly, and will contain specific recommendations for WHO.

As he noted in his First Draft Summary Report on the Network, dated 12/5/02, assessments of skills at national, state and provincial levels showed evaluation to be clearly the most notable and consistent deficiency reported. That report also underlined the benefits of participating in the Mega Country Network. The four consistent themes emerging from respondents were:

- The opportunity to share experiences with others facing similar challenges;
- The global partnership with other large nations and WHO adds credibility and increases the ability to influence the national health agenda;
- Access to innovations undertaken by other nations;
- Being a part of a mutually supportive environment.

Although a few respondents were unsure whether the benefits of participating in the Mega Country Network outweigh the costs, there is clear evidence that participation in the Network does, to varying degrees, stimulate transnational cooperation. The potential benefits of effective collaboration are substantial. In particular, collaborators can share priorities of common interest, interaction among collaborators in turn establishes trust, and resources can be made available to support cooperative efforts. The major barriers to transnational cooperation continue to be lack of available time, the cost and, in some instances, the lack of a clear connection between the needs of the country and the purpose of the Network.

Dr Kreuter suggested that WHO should consider (with input from the participating nations) reframing a compelling vision of how the Network can, worldwide, contribute tangibly to lowering the burden of disease and improving the quality of life. Such a vision statement should be crafted in such a way as to address the scepticism currently held by some participants.

Dr Shao reviewed the forces that shape NCD Prevention and Health Promotion and the current extent of work at WHO to determine how the Network may best be structured to achieve the full potential of a grouping of the world’s largest countries. While WHO has expressed readiness to upgrade its commitment to the Network, developing that potential is not just a matter for WHO headquarters but requires the active commitment of the Mega countries themselves. The next steps will include information sharing (websites), concerted action through the FCTC and other bodies, training, strategies for dealing with common problems and, possibly, collaborative research or demonstrative projects.

WHO aspires to move the Mega Country Network from a relatively passive group that meets annually to a dynamic group that conducts work between meetings and advances the
collective progress in NCD prevention. The countries and WHO need to work together to secure the necessary resources. While it is unlikely that WHO will be funding Mega country projects, collaborative approaches are more likely to obtain support from ministries or foundations within countries.

India noted that NCDs need to be consistently reflected in the report to ensure that the messages reach the right people, and also that the country differences among the Mega countries should be acknowledged; it is important for Mega countries to learn from each other as well as to develop the Mega country and NCD capacity within their own borders.

A range of future activities were discussed. They included questions on how to strengthen the practical collaboration, to identify focal points and key agencies, to promote communication, training and advocacy. The different lines of future activities, as well as future meetings, were discussed.

The participants agreed that the next Network meeting should take place in Melbourne, Australia, in April 2004, in association with the 18th IUHPE World Conference on Health Promotion and Education.

RECOMMENDATIONS FROM THE MEGA COUNTRY HEALTH PROMOTION MEETING, 11 -13 DECEMBER 2002

Strengthening Mega Country Health Promotion Network by action of Mega countries and WHO - recommendations included:

- Identifying a central, national Institute for the technical cooperative work and a permanent focal point within each Mega country who serves as official representative of the Ministry of Health.
- Establishing and institutionalizing an intersectoral mechanism within each Mega country to support Mega country involvement, including the potential role of NGOs.
- Ensuring close links with the regional integrated NCD prevention networks and the Global Forum for NCD Prevention and Control.
- Considering to establish a small steering group, or secretariat, composed of selected Mega country focal points and WHO HQ staff to guide the direction and work plan for the Mega Country Network.
- Preparing a country-specific report on the status of key NCD risk factors, policies and programmes in cooperation with each Mega country.
- Working with existing training programmes (schools, visitors programmes, etc.) to meet the various needs of Mega Country Network members.
- Improving communications within the Mega Country Network through websites, both country- and WHO-based, video-conferencing (WHO), print material and newsletters.
Addressing current national and global issues:

- Providing explicit programme and policy guidelines and direction to Member States, identifying and promoting specific health promotion demonstration projects, and increasing the priority given to NCDs, especially through building the evidence base on effectiveness.

- Identifying and/or establishing key WHO Collaborating Centres to specifically support the work of the Mega Country Network.

- Organizing a meeting of the members of the Mega country delegations at the next World Health Assembly in May 2003 to secure political and possibly financial support for the Mega Country Network.

- Mega countries should actively prepare and participate in the process for developing a Global Strategy on Diet, Physical Activity and Health.

- Diet and physical activity programmes, particularly in low resource countries, should be integrated into poverty reduction, maternal and child health, sustainable development and other existing programmes.

- The next annual meeting of the Mega Country Network should be convened in connection with the forthcoming World Health Promotion and Education Conference in Melbourne, Australia, in April 2004. Consideration should be given to holding other future meetings in Mega country sites.

- A concrete action plan should be developed, including resource mobilization, for activation of the Mega Country Health Promotion Network before the World Health Assembly in May 2003.

- Countries should review/explore WHO country budgets regarding support for action plans.

- Critique should be made of data in the existing Mega Country Infobase, with the provision of updates, if necessary.

- Assisting in pre-testing the IPAQ instrument with the goal of creating standard measurement tools that can allow for comparisons and facilitate evaluation of different approaches.

- Finalizing and utilizing the overview of health promotion capacity in Mega countries - the “Kreuter Report.”

- Mega countries should provide support for the adoption of a strong FCTC and prepare for national implementation of the treaty obligations.

- Ensuring good organization and effective implementation of practical collaborative programmes, such as Move for Health (physical activity), Quit & Win (tobacco), and the Global fruit and vegetable promotion project "5 A Day", in each Mega Country.

- Enhancing collaboration with school health initiatives and surveillance activities.

- Ensuring that chronic disease and health promotion issues are priorities within WHO Country Cooperation Strategies (CCS).
Annex A

Agenda

Wednesday, 11 December 2002

The Joint Opening Plenary Session will begin at 09:00 in Salle C - 5th floor

08:30-09:00 Registration [at the entrance of Salle C]

09:00-09:15 Welcome and opening remarks and election of the officers
  > Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion (NPH), World Health Organization

09:15-10:00 Setting the scene
  > Dr Derek Yach, Executive Director, Noncommunicable Diseases and Mental Health (NMH), World Health Organization

10:00-10:30 World Health Report (WHR) 2002: Global risks to NCDs, prevalence and trends of major NCD risks
  > Dr Colin Mathers

10:30-11:00 Coffee break

11:00-12:30 Discussion

12:30-14:00 Lunch break

14:00-14:45 Tobacco: WHR message and response in countries (FCTC, national policies)

14:45-15:30 Discussion

15:30-16:00 Coffee break

16:00-17:30 Working groups:
  (1) Tobacco Control
  (2) Risk factor data and Mega Countries

18:00-19:30 Reception
Thursday, 12 December 2002

09:00-09:30 Diet and physical activity: WHR message and response in countries
WHO Global Strategy on Diet, Physical Activity and Health (Panel on country responses concerning diet)
> Dr Pekka Puska

09:30-10:30 Discussion

10:30-11:00 Coffee break

11:00-11:45 Discussion (Panel on Country responses concerning Physical Activity)

11:45-12:30 Discussions

12:30-14:00 Lunch break

14:00-15:30 Working groups:
(3) Diet; National policy responses
(4) Physical activity, Move for Health

15:30-16:00 Coffee break

16:00-17:30 Working group 3 continues
Plenary: National capacity, advocacy, Mega Country collaboration

Friday, 13 December 2002

09:00-09:45 Upgrading the Mega Country Network to effectively respond to the challenges, increase in national capacity and links with other country initiatives
> Dr Ruitai Shao

09:45-10:30 Discussion

10:30-11:00 Coffee break

11:00-12:30 Working group reports

12:30-14:00 Lunch break

14:00-15:30 Structured discussion on practical outcomes and future work, including communication, advocacy, training and resource mobilization issues

15:30:16:00 Coffee break

16:00-17:00 Conclusions, next steps, future meetings

17:00 Closure of the meeting.
Annex B

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Dr Derek Yach
Executive Director
Noncommunicable Diseases and Mental Health:

Key messages:
- a few risks explain many causes of death and disease
- mega-countries account for over 60% of people at risk world-wide for NCDs
- governments and WHO must lead in defining effective action

"The world is living dangerously
- either because it has little choice
- or because it is making wrong choices"

Immersed in a sea of risk
Leading 10 risk factors as causes of disease burden

Developing countries

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Local Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
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<tr>
<td>Unsafe sex</td>
<td>Blood pressure</td>
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<td>Tobacco</td>
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<tr>
<td>Tobacco</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Mental health</td>
</tr>
<tr>
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<td>Tobacco</td>
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<tr>
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<td>Tobacco</td>
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Developed countries

<table>
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<td>High blood pressure</td>
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<tr>
<td>Smoking</td>
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<tr>
<td>Low fruit and vegetable intake</td>
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<tr>
<td>High BMI</td>
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<td>Physical activity</td>
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<tr>
<td>Iron deficiency</td>
<td>Tobacco</td>
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<tr>
<td>Zn deficiency</td>
<td>Tobacco</td>
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<tr>
<td>37% &amp; Diabetes</td>
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World Attributable Mortality by Undernutrition and Diet-related Risks and Physical Inactivity (600s)
WHO Regions
Cardiovascular Diseases, deaths by age, 2000

<table>
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<tr>
<th>Region</th>
<th>20%</th>
<th>50%</th>
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<tr>
<td>AFR (1.9 m)</td>
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<td>AMR (2.0 m)</td>
<td>44%</td>
<td>64%</td>
<td>83%</td>
</tr>
<tr>
<td>EME (1.9 m)</td>
<td>44%</td>
<td>64%</td>
<td>83%</td>
</tr>
<tr>
<td>EUR (5.0 m)</td>
<td>43%</td>
<td>64%</td>
<td>83%</td>
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<tr>
<td>SEAR (3.8 m)</td>
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<td>83%</td>
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<tr>
<td>WPR (3.7 m)</td>
<td>44%</td>
<td>64%</td>
<td>83%</td>
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</tbody>
</table>

World Health Organization

Death/Provable Cancer in MEGA and All Other Countries

Annex C.1

Diabetes Prevalence in MEGA and All Other Countries

1999 Disease or Injury
1. Acute lower respiratory infections
2. HIV/AIDS
3. Perinatal conditions
4. Diarrheal diseases
5. Lower respiratory infections
6. Stroke
7. Childhood diseases
8. Diabetes
9. Tuberculosis
10. HIV
11. Perinatal conditions
12. Other infections
13. Congenital anomalies
14. Diastolic hypertension
15. Trachea, bronchus and lung cancers

World Health Organization

Priorities for WHO, and industry implications

A Transition in WHO-Private Sector Interaction

- FROM: Private-public partnerships like GAVI, MMV, IAVI, DG’s Pharmaceutical Roundtable to address key issues of access and lack of supplies.
- TO: Multi-stakeholder involvement beyond products, commodities and finances to joint initiatives in which we each amplify our public health actions in communities.
TOBACCO COMPANY ACTIVITIES REVEALED IN WHO INQUIRY

"WHO... the leading enemy"

"Attack WHO... discredit key individuals"

"CONTAIN, NEUTRALIZE, REORIENT WHO"

Contribution of the WHO FCTC to Global Tobacco Control Efforts

- The FCTC will develop binding and comprehensive global standards on tobacco.

- The treaty can incorporate mechanisms to monitor conduct of nations and hold them accountable to global public.

- The treaty can include provisions to strengthen capacity of countries to implement tobacco control.

WHO's continuing collaboration within the UN Interagency Task Force

- Creates a global forum to highlight tobacco control issues.

- Promotes multilateral coordination and domestic action.

- Facilitates development of national coalitions.

- Mobilizes NGOs, media and civil society.
THE GLOBAL REALITY

- Noncommunicable diseases contribute 60% of deaths and 43% of the global burden of disease. Already 79% of these NCDs are occurring in developing countries.
- Half of these are attributable to cardiovascular diseases.
- By 2020 these deaths will account for 73% deaths and 60% of the disease burden.

WHR 2002:

- 10 of the top risks explain high proportion of the premature deaths and disease burden in the world.
- 7 of them (including alcohol) are strongly dependent on diet and physical activity!
- DIET, PHYSICAL ACTIVITY, (together with tobacco) are of overwhelming importance for disease burden and for potential public health gain.
**NCDs ARE TO A GREAT EXTENT PREVENTABLE DISEASES**
- Medical evidence for prevention exists
- Population-based prevention is the most cost-effective and the only affordable option for major public health improvement in NCD rates
- Major changes in population rates can take place in a surprisingly short time

**PREVENTION TARGETS COMMON LIFESTYLE RELATED RISK FACTORS**
- Unhealthy nutrition
- Physical inactivity
- Tobacco use
- Modifiable

**PREVENTION TARGETS MAIN RISK FACTORS**
- **Key Risk Factors:** Unhealthy diet (salt, quality of fat,...), physical inactivity, tobacco and alcohol drinking.
- The behavioral factors lead to high blood pressure & hypertension, blood glucose intolerance & diabetes, elevated blood cholesterol & hypercholesterolemia, anemia, overweight and obesity.
- Simple changes in these lifestyles can powerfully prevent chronic diseases and promote health.

**NUTRITION**
- Major role in development of CVDs and other NCDs
- Dietary habits and nutrition in transition in the developing world

**Diet and risk of NCD**
- Up to 80% of cases of coronary heart disease and up to 90% of type 2 diabetes could be avoided through changing lifestyle factors
- About one third of cancers could be prevented by eating healthily, maintaining normal weight and being physically active throughout the life span

**Prevention Works**
- Age-adjusted mortality rates of coronary heart disease in North Karelia and the whole of Finland among males aged 35-64 years from 1969 to 2001
Physical Inactivity

An Important Global Public Health Issue

- Increases all causes of mortality. It can double the risk of dying from cardiovascular diseases and stroke
- Causes nearly 2 million deaths globally every year
- Doubles the risk of developing cardiovascular diseases, Type 2 Diabetes (90% cases), obesity
- It substantially increases the risks of colon cancer (40-50%) and breast cancer, hypertension (50%), lipid disorders, osteoporosis, stress, anxiety and depression
- PA enhances functional capacity and independent living in older persons

PHYSICAL ACTIVITY

- Powerful health determinant
- Prevention and health enhancement
- Disease treatment
- Declining physical activity in many parts of the world

Various levels of physical activity and their benefits

"We have effective means to reduce these risks (of ill-health). The critical question is: How do we implement these measures on a wide scale and ensure better health outcomes?"
Global Strategy on Diet, Physical Activity and Health: Our Mandate

- WHA 54.8 discussion paper on health promotion (2001)
- WHA 55.23 resolution on Diet, physical activity and health: calls for preparation of global strategy (2002)

"High blood pressure and high blood cholesterol, strongly linked to cardiovascular and cerebrovascular diseases, are also closely related to excessive consumption of fatty, sugary and salty foods. They become even more dangerous when combined with deadly forces of tobacco and excessive alcohol consumption. Obesity, a result of unhealthy consumption, is itself a serious health risk."

HEALTHY DIET and PHYSICAL ACTIVITY are

For the individual:
- effective way to prevent diseases and promote health

For the society:
- a cost effective and sustainable way to improve public health

Global Study on Nutrition Transition and NCD

- Proposed 12-country long-term study

Four main goals:
- To document the prevalence and distribution of known nutrition-related risk factors for NCD in a variety of urban settings from the developing world
- To expand knowledge of the associations and interactions between dietary/activity/body composition patterns and NCD
- To identify modifiable community-level & individual-level determinants of nutrition-related risk factors for NCD
- To enhance the capacity for data collection, processing, analysis

World Health Assembly requests the Director-General to develop a global strategy on diet, physical activity and health within the framework of renewed WHO strategy for the prevention and control of non-communicable diseases and, in consultation with Member States, and with the bodies of the United Nations system and professional organizations concerned, to give priority to providing support to Member States for establishment of corresponding national policies and programmes.
Regional Consultations

Objective I

- Provide recommendations and feedback to the draft of the Global Strategy on Diet, Physical Activity and Health

Objective II

- Contribute to regional work in the field of diet, physical activity and health through:
  - A review of the extent of the NCD problems related to diet and physical inactivity in the region;
  - Sharing of experiences of various strategies, policies and programmes that are being implemented in countries in the regions

WHO Regional Consultations

The consultations will...

- Review the extent and the causes of the health problems associated with diet, physical inactivity and chronic diseases
- Evaluate various prevention strategies, policies and programmes being implemented in countries in the Region;
- Recommend practical and feasible actions for addressing the problems related to diet, physical activity and health while taking national, social, cultural and economic realities into consideration

WHO Regional Consultations

Dates and Meeting Places

- AFRO: 16-20 March 2003, Harare, Zimbabwe
- AMRO: 22-24 April 2003, San José, Costa Rica
- EMRO: 27-29 April 2003, Teheran, Iran
- EURO: 27-29 March 2003, to be confirmed
- SEARO: 13-15 March 2003, New Delhi, India
- WPRO: to be confirmed, Kuala Lumpur

WHO Regional Consultations

Participants

- Ministries of health;
- Ministries of agriculture;
- Ministries of trade, sports and recreation, education, urban planning and transport;
- A broad intersectoral representation is desirable

We are also reaching out to other stakeholders:

- Private sector: meetings took place and we are preparing for a DG-CEO roundtable in May 2003
- NGOs: Meetings held and communication initiated - a formal meeting will be held in May 2003 before the WHA
- UN: a formal meeting with UN agencies and intergovernmental organizations will be held in June 2003
"In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, the private sector and foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference."

Annex C. 2
NATIONAL CAPACITY BUILDING
FOR NCD PREVENTION AND HEALTH PROMOTION

Dr Ruitai Shao
NONCOMMUNICABLE DISEASE PREVENTION
AND HEALTH PROMOTION
WORLD HEALTH ORGANIZATION

BACKGROUND
ISSUES
TRANSITIONS:
BURDEN OF DISEASES AND RISKS TO HEALTH
MANDATED: CHARTER, RESOLUTIONS, STRATEGIES
GLOBAL ACTIONS
WHO ACTIONS
CMH REPORT AND FOLLOW UP ACTIVITIES
- COUNTRY COOPERATION STRATEGIES AND
COUNTRY FOCUS INITIATIVE

ISSUES
TRANITIONS:
DEMOGRAPHIC TRANSITION
EPIDEMIOLOGICAL TRANSITION
NUTRITIONAL TRANSITION
BEHAVIOURAL CHANGE
GLOBALIZATION
BURDEN OF DISEASES
RISKS TO HEALTH
HEALTH DETERMINANTS

CHARTER, RESOLUTIONS AND STRATEGIES
FOR HEALTH PROMOTION AND NCD PREVENTION

HEALTH PROMOTION: FROM OTTAWA CHARTER TO MEXICO
MINISTERIAL STATEMENT
Build healthy public policy. Create supportive environments. Strengthen community action. Develop personal skills. Reorient health services. Sustainabilty of local, national and international actions in health
WHA RESOLUTIONS FOR NCD PREVENTION
AND HEALTH PROMOTION
- Resolutions on NCD Prevention and Control (WHA 51.8, 1998)
- WHA 53.11, 2000
- WHA Report on Health Promotion (WHA 54.8, 2001)
- WHA Report on Diet, PA and Health (WHA 55.16, 2002)
- WHA Resolution (WHA 55.22, 2002)

CHARTER, RESOLUTIONS AND STRATEGIES
FOR HEALTH PROMOTION AND NCD PREVENTION
Key points
COMMITMENT TO HEALTH PROMOTION
AND NCD PREVENTION AND CONTROL
GLOBAL ALLIANCE
COOPERATION, COORDINATION, NETWORKING, PARTNERSHIP
EVIDENCE OF EFFECTIVENESS OF INTERVENTION
CAPACITY BUILDING
HOLISTIC INTEGRATED APPROACH
TECHNICAL ASSISTANCE

GLOBAL ACTIONS
for development and health
- World Summit on Sustainable Development (WSSD)
  - United Nations: Johannesburg Summit 2002
- The Second World Assembly on Ageing
  - United Nations: Madrid 8-12 April 2002
- Global Fund: HIV/AIDS, TB and Malaria
incorporating health into development agenda

- **INTEGRATE HEALTH INTO DEVELOPMENT AGENDA**
  THE REPORT OF COMMISSION ON MACROECONOMICS AND HEALTH AND FOLLOW UP ACTIVITIES
- **IMPROVE WHO PERFORMANCE AT COUNTRY LEVEL**
  - COUNTRY COOPERATION STRATEGY (CCS), FOCUS INITIATIVE (CFI) AND FOLLOW UP ACTIVITIES
- **HEALTH PROMOTION POLICY AND PRIORITIES**
  - YOUNG PEOPLE, HEALTH SYSTEM AND HEALTH SERVICE

Following WSSD, effective investments in health are seen as good opportunities for promoting sustainable development.

**Summary of Key Findings and Recommendations**

- Health underpins economic development and effort for poverty reduction
- A few health conditions account for most of the avoidable mortality in low and middle-income countries
- Cost-effective actions are available to address risks, to reduce death and improve health
- The price tag per person per year for essential interventions is relatively low (LEDI), benefits in terms of lives saved and economic returns are dramatic
- Current levels of investment are far less than those needed to reap rewards of scaling-up health initiatives
- Millions of lives could be saved, and billions of dollars worth of development could result from increased spending
- Investments in people's health are vital pre-condition for economic development
- Developing countries should aim to raise domestic budgetary spending on health by an additional 1% of GDP as of 2007, rising to 2% per cent by 2015
- Assistance from OECD nations should increase from current levels of 0.5 billion per year to 27 billion per year by 2017 and to 93 billion per year by 2015
- This amount would correspond to 0.1 percent of OECD countries' GDP

The CCS: an expression of WHO's corporate strategy at country level

- broader approach to health in the context of human development and poverty reduction
- greater role in establishing consensus on health policy, strategies.
- organisational culture that encourages strategic thinking, creative networking, innovation and influence

The country cooperation strategy (CCS) within WHO's corporate framework

<table>
<thead>
<tr>
<th>INTERNATIONAL DEVELOPMENT GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH FOR ALL</td>
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</table>

- WHO goals Regional and Sub-Regional
- Members, Representatives and Stakeholders

- WHO Programme Budget

WHO Programme Budget

- Membership
- Regional Offices
- UN and Other Agencies

The implication of the CMH Report and its follow up activities, and CCS, CFI to NCD Prevention and Health Promotion

- The Potential of Health and Development
- Health promotion and Integrated NCD prevention and control are important components of health and development
- Links CMH report and its follow up activities, CCS and CFI with Health Promotion, Integrated NCD prevention and control
- Works with CMH, CCS and CFI teams to incorporate the KP and NCD prevention into development and health agenda and set high priorities at country level
INCORPORATE NCD AND HP INTO DEVELOPMENT AND HEALTH AGENDA

To incorporate NCD prevention and health promotion into development and health agenda.

GAPS
- VAST SCIENTIFIC KNOWLEDGE BUT NOT ENOUGH SUFFICIENT POLICY DEVELOPMENT AND ACTION
- PREVENTION AND CLINIC SERVICE INFRASTRUCTURE
- LIMITED RESOURCES AND ACTUAL NEEDS IN NCD PREVENTION AND HEALTH PROMOTION

CAPACITY BUILDING:
WHAT NATIONAL CAPACITY NEEDED FOR NCD PREVENTION AND HEALTH PROMOTION?
- DEVELOP NATIONAL PLANS
- MANAGE THE INTEGRATED NCD PREVENTION AND HEALTH PROMOTION PROGRAMME
- FACILITATE COMPREHENSIVE POLICY DEVELOPMENT
- FOSTER COMMUNICATION, ADVOCACY
- PROMOTE RESOURCE MOBILIZATION
- ENSURE INFORMATION DISSEMINATION

WHO ACTIVITIES
- INTEGRATION OF NCD INTO NATIONAL HEALTH POLICIES AND STRATEGIES
- BURDEN OF DISEASES, ANNUAL, WHO AND OTHERS
- STRATEGIES AND RESOLUTIONS FOR HEALTH PROMOTION AND NCD PREVENTION AND FCTC
- MEC, DCC, AND CPH
- NETWORKING
- MEGACOUNTRY HEALTH PROMOTION NETWORK
- REGIONAL NETWORKS AND GLOBAL FORUM ON NCD PREVENTION
- TRAINING PROGRAMMES
- INFLEXIONAL NETWORKING
- NORTH CARELIA PROJECT: INTERNATIONAL VISITORS PROGRAMMES
- GLOBAL FORUM: INTEGRATING INTERNATIONAL VISITORS PROGRAMMES

MEGA COUNTRY HEALTH PROMOTION NETWORK
- Initiative from MEC countries
- Ministerial support
- Work started with school health and health behaviour surveillance

REGIONAL NETWORKS FOR INTEGRATED NCD PREVENTION AND CONTROL
<table>
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<th>RO/Network</th>
<th>INITIATED</th>
<th>Countries involved</th>
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<td>EURO/CINDI</td>
<td>1982</td>
<td>29(51)</td>
</tr>
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<td>AM/OCARMEN</td>
<td>1996</td>
<td>7(35)</td>
</tr>
<tr>
<td>EMRO/EMAN</td>
<td>2001</td>
<td>6(22)</td>
</tr>
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<td>AFRO/ANDI</td>
<td>2001</td>
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</tr>
<tr>
<td>APO/MOANA</td>
<td></td>
<td>Network is being established (427)</td>
</tr>
<tr>
<td>SEARO</td>
<td></td>
<td>Network is being established (5(10))</td>
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GLOBAL FORUM ON NCD PREVENTION AND CONTROL

- LINKS REGIONAL NETWORKS, WHO REGIONAL OFFICES, WHO HEADQUARTERS AND MAJOR GLOBAL PARTNERS (NGOs, COLLABORATION CENTERS, AGENCIES).
- SHARES EXPERIENCES.
- DISCUSSES JOINT AND GLOBAL ACTIONS.

GLOBAL FORUM ON NCD PREVENTION AND CONTROL

The second meeting on Nov 4-6th, 2002 in Shanghai

- Review the progress of the regional network development
- Toward comprehensive policy development for NCD prevention and control:
  - Surveillance, monitoring, evaluation
  - Risk factor interventions and strategies
  - Health service work
- Advocacy, capacity building and health promotion
- Research on effectiveness of community based NCD programmes
- Future Collaboration

COOPERATION, COLLABORATION AND PARTNERSHIP

- WHO COLLABORATING CENTRES
  - MANY WHO COLLABORATING CENTRES ESTABLISHED
- COOPERATION OF NPHIs
  - MEETING OF DIRECTOR GENERALS OF NATIONAL PUBLIC HEALTH INSTITUTES 15-18 OCT. 2003 IN BELLAGIO, ITALY
- COOPERATION RESEARCH PROGRAMMES
  - GLOBAL PROGRAMME ON HEALTH PROMOTION EFFECTIVENESS (GPHPE)
  - WHO STUDY ON THE EFFECTIVENESS OF COMMUNITY BASED PROGRAMMES FOR NCD PREVENTION AND CONTROL

NATIONAL CAPACITY BUILDING: INSTITUTIONAL CAPACITY

ORGANIZATIONAL AND PROFESSIONAL

- IMPROVE ADMINISTRATIVE MANAGEMENT
- FACILITATE INSTITUTES DEVELOPMENT
  - National Public Health Institutes Development
  - Structure and network
  - International, within country cooperation
- PROMOTE PROFESSIONAL DEVELOPMENT
  - ESTABLISH TRAINING PROGRAMMES, EXAMPLES:
    - CINDI winter school
    - Other Regional Network Training Programmes
  - Global Forum, Rotating International Visitors Programmes
- EDUCATION
- THE ROLE OF NGOs
TOWARD COMPREHENSIVE HEALTH POLICY DEVELOPMENT

- Policy for NCD prevention and health promotion:
  - Agreement or consensus among relevant partners on issues to be addressed and on approaches or strategies to deal with them.
- Policy framework:
  - Create the healthy public health environment
  - NCD and health promotion as top priority
  - Establish mechanisms for coordination and cooperation
  - Change of health system and health service to meet the needs
  - Integrated approach (public health, population approach)

INFLUENCE AND CHANGE PUBLIC POLICY

- Advocacy is pursued of influencing outcomes - including public policy and resource allocation decisions within political, economic, and social systems and institutions - that directly affect people's lives.
- Advocacy consists of organized efforts and actions based on the reality of "what is."
  - Highlight critical issues that have been ignored and submerged
  - Influence public attitudes
  - Enact and implement laws and public policies
- Strengthening the national capacity will contribute to influencing and changing public policy for NCD prevention and health promotion.

COORDINATING NCD PREVENTION ACTIVITIES IN BRAZIL

- To constitute a national commission:
  - Involve multiple organizations
  - Formalize policy guidelines
- To establish the principles of the policy:
  - Coordination of all activity for NCD development of an institutional culture
  - Linkage of population and individual-based activities
- To coordinate the activities for NCD prevention

DEMONSTRATION AREAS FOR NCD PREVENTION IN CHINA

HOW TO RAISE RESOURCES: BANGKOK STATEMENT

Prevention and health promotion is cheap and cost effective in comparison to clinical curative services, but needs some resources, expertise, and political commitment.

RESOURCE MOBILIZATION

- TOBACCO TAX
- ALCOHOL TAX
- SOFT DRINK TAX
- SOCIAL SECURITY FUND
QUESTIONS ON
COLLABORATION IN THE FUTURE

- FOCAL POINTS: PERSONS, INSTITUTES
- FORMS OF COLLABORATION
- RESOURCE, ADVOCACY, COMMUNICATION

THANK YOU
Appendix

Capacity Assessment Report

Mega Country Health Promotion Network

Revised January 28, 2003

Prepared by Marshall Kreuter, Ph.D.
Acknowledgments

The author of this report is grateful for the time, effort, and courtesies extended by the 17 health professionals from the 11 countries that make up the Mega Country Health Promotion Network. (See Appendix B)

This report reflects their insights, concerns and suggestions. Each representative is dedicated to improving the health and quality of life of those in the countries they serve. Collectively, they hold the view that the Mega Country Health Promotion Network has the potential to accelerate global health improvement, but they acknowledge that it is an ambitious and complex undertaking. They believe that it will require sustained, joint efforts by WHO and member countries, along with equal doses of science (evidence), passion, and respect for the uniqueness of the member nations. The “Options for Action” included in this report are based on their views and suggestions.

Special appreciation goes to Dr. Pekka Puska and his team in the Department of Noncommunicable Disease Prevention and Health Promotion for providing the leadership, coordination and insightful editorial suggestions that made the project possible.

Marshall W. Kreuter
Atlanta, Georgia USA
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Introduction

Purpose

The purpose of this assessment was to assess, from the perspective of member countries: (1) the health promotion capacity among the countries participating in the WHO Mega Country Health Promotion Network, and (2) their perception of actions needed to enhance the attainment of the goals of the Network.

Protocol

1. A formal request was sent from the Division of Non Communicable Disease Prevention and Health Promotion at WHO to WRs in WHO Regional Offices serving countries in the WHO Mega Country Health Promotion Network. The request solicited their support in contacting two representatives from each participating country who would be willing to respond to a questionnaire designed to elicit their perspectives about the health promotion capacity of their respective countries.

2. Given the logistical complexities and language difficulties in gathering the information deemed necessary to prepare the report, three methods of data collection were employed: a) telephone interviews (2 countries), b) written responses/comments to the questionnaire via e-mail (2 countries), c) face to face interviews during the December 10-12 Mega Country Meeting in Geneva (7 countries). In all three methods, a common set of questions was used. (See Annex A.) The telephone interviews were audio taped with permission of participants.

3. The information generated from the questionnaires and interviews was analyzed and grouped into four general categories or “themes.” These themes served as the basis for the findings and options for action.
Assumptions

Prior to all interviews, participants were informed of the following assumptions.

1. The primary focus of this inquiry on the actions and capacities of the 11 countries in the Mega Country Health Promotion Network specifically as their health promotion efforts were carried out in the context of addressing the reduction of three major chronic disease risk factors: tobacco, nutrition, and physical activity.

2. For many, it is difficult to distinguish the differences between Health Promotion, Health Education, and Health Communication. During the discussions, time was not spent teasing out the independent, unique merits of each discipline. Rather, it was understood that all three disciplines share considerable common ground and that health promotion represents a reasonably comprehensive umbrella under which respondents could frame their comments. Health Promotion was operationally defined as follows: “The process of enabling people to increase their control over, and to improve, their health.”

3. “Health promotion capacity” was operationally defined as having two distinct, but complementary, components: (1) the presence of health program planning, implementation, and evaluation skills, and (2) the organizational structures, resources and commitment needed to support the implementation of those skills. Both of these dimensions were addressed in this review process.

Characteristics of Respondents

Seventeen respondents from 11 Mega countries participated in the interview/questionnaire response process. (See Annex B). For each country, at least one respondent was a senior level staff member within the national ministry of health. Collectively, they held national leadership roles in: NCD prevention and control, national food and nutrition policy, health promotion, and preventive medicine. Other national leaders who provided input from the participating countries represented non-governmental sectors (health foundations and academic research centers).

Only four of the Mega Country representatives interviewed had been engaged in previous meetings of the Mega Country Health Promotion Network. This rather small
point highlights an issue that, if not addressed, may have a significant impact on the future of the network. As is the case for any collaborative effort, the success of the Mega Country Health Promotion Network will be in large part dependent upon the extent to which its members: (1) are aware of and endorse the Network’s mission and goals, (2) understand each other’s strengths and needs, (3) see the value of a global collaborative effort, and (4) trust one another. These fundamental characteristics of cohesion are difficult to attain and sustain when there is discontinuity in participation of network members.

Findings

The remainder of this report provides the findings based on an aggregate review of participants’ responses to the interview/questionnaire process. The responses clustered around these four general themes: (the numbers in parenthesis connote the relevant questionnaire item(s) for that theme)

- Theme 1 - National Level Support (1, 2, 3, 7, 13)
- Theme 2 - National and State/Provincial Capacity for Health Promotion (4, 5, 9, 10, 13)
- Theme 3 - Transnational Cooperation (6, 11, 12, 13)
- Theme 4 - Health Promotion Success Stories (8, 13)

Findings for each theme are organized into three parts. The first provides a narrative of the central issues raised by respondents related to that theme. The second consists of brief bullet points summarizing salient points raised in the theme. The third part is a “Options for Action” box. The box lists future actions that WHO’s Division of Non-communicable Disease Prevention and Health Promotion might consider as they continue their efforts to strengthen the Mega Country Health Promotion Network.

The report concludes with a master table summarizing all of the “Options for Action” including those generated by the final question asked of the respondents: “What specific actions should WHO take to enhance the probability that the goals of the Mega Country Health Promotion Network will be reached?
Theme 1: National Level Support

Narrative Findings

Responses to this question varied considerably. Some perceived support (governmental) for health promotion to be “unequivocally supportive” while others viewed it to be “generally non-supportive.” The variability seemed to be associated with several factors.

Leadership and National Policy

The first factor is associated with those appointed to leadership roles in the Ministries and Departments of Health. Obviously, leaders who understand and value the principles of health promotion are more likely to be supportive of health promotion of those programs, including those that focus on NCDs. Respondents indicated that high level leaders who do not embrace health promotion (1) do not understand what it is, nor what it and can accomplish, (2) tend to perceive health promotion as lacking scientific evidence and, therefore, substance, or (3) view it as an activity that “everybody” and “anybody” could and should do.

Another factor influencing national support for health promotion is current national health priorities. Countries with policies that included national goals and priorities aimed at non-communicable diseases were more supportive of health promotion. The opposite was true among those nations where communicable and infectious diseases remain the major threats to health and quality of life. Leaders in those countries, and those they serve, see and experience the burden of infectious and communicable diseases on a daily basis. Consequently, they are hard pressed to shift limited health resources away from those immediate problems.

However, all but one respondent from those latter countries expressed the following sentiment:

“As their political and health leaders were given evidence about trends with respect to non-communicable disease risk factors (including a projection of future health burdens in the context of the health transition), their rhetoric about health promotion and NCD programs became more supportive.”

In fact, respondents were consistent in their belief that, over the past 5 years, resistance to supporting health promotion and NCD programs was diminishing. They attributed this gradual change to a combination of better evidence of the impact of health promotion and a concerted effort to communicate the benefits of health promotion to leaders and political decision-makers.
Economic support

Economic support for health promotion and NCD prevention remains problematic in every Mega Country. The problem is relative. For example, in Nigeria and Pakistan, few government health resources are allocated for health promotion and NCD prevention. In both countries however, their health ministries have established relationships with heart health foundations and those collaborations are apparently establishing important groundwork for future progress.

Respondents from Brazil see opportunities for economic support though a national health policy that provides incentives for cost effective health initiatives. A tripartite commission, consisting of representatives from the federal, state, and municipal levels determines criteria that will be used for establishing these incentives and they are currently considering such criteria for NCD prevention and health promotion.

In the USA, where budgetary resources have been less of a problem, approximately 80% of support for chronic disease prevention and health promotion in the states and territories comes from grants and cooperative agreements from their national level public health focal point: Centers for Disease Control and Prevention (CDC). Currently, very large amounts of national public health resources are being directed to address a problem that didn’t exist three years ago: bio-terrorism. Recent declines in the global and US economies have led to severe budget cuts in all of the US states. The changes in health policy priorities, combined with economic downturn, pose a serious challenge that goes beyond US borders. For three decades, CDC has made global health a priority and has invested resources, including staff, to address health problems faced by nations all over the world. This national level shift in resources could threaten that important priority and, consequently, indirectly affect aspects of the Mega country network.

Low Cost

In the context of resources, several respondents made comments to the effect that “you don’t need a lot of money to make a difference in health promotion and NCD prevention.” There are certainly numerous examples to support the validity of that sentiment. However, descriptions of these successful cases suggest that they tend to be led or managed by tireless leaders and volunteers whose passion for the problem accounts for a good portion of success. Thus, “low cost” successes are more likely to emerge in places that have the existing capacity (and the will) to make something happen. The description of the Russian Federation/WHO/U.S.A. training course in the Transnational Collaboration (Examples of Collaboration) section of this report provides an example of this process.

The “Low Cost” Caveat

The “low cost” message is generally perceived to be positive because it communicates the idea that nations needn’t invest large resources in health promotion and NCD
prevention to obtain improvements in health. However, the “low cost” message has a potential downside. For example, it is true that the participatory dimension of health promotion (involvement of lay people and volunteers) is one of its unique benefits. It is not far fetched to imagine that decision-makers would interpret this dimension of “practicality” to mean that health promotion and NCD prevention would require only modest investments in professional staff, surveillance, or other resources associated with scientific development. Left unchecked, such a view could have the effect of de-valuing health promotion and weakening its position in the face of budget shortfalls. Care should be taken in how the notion of “low cost” is communicated to national decision-makers.

Summary

- Administrative support for NCD prevention and health promotion at the national level varies across the Mega countries.
- Budgetary support also varies but it is perceived to be insufficient in most countries.
- In countries where communicable diseases account for most of the health burden, national leaders are hesitant or unable to invest limited resources in competing priorities like NCD prevention.
- There is evidence that efforts to enlighten leaders about the benefits of health promotion have resulted in heightened awareness among health decision makers.
- Although NCD prevention and health promotion is not a priority in all countries, some of those countries (with comparable budget problems) have been able to make more progress than others. This pattern supports the notion that the Mega countries have different levels of “readiness” to move forward and make progress in this area.
OPTIONS FOR ACTION

Develop two documents. One that provides documentation of the specific kind of information and/or strategies shown to be effective in gaining national and political support for NCD prevention and control, and for health promotion. The other, using examples from the Mega Countries, would be a brief anthology of “health promotion programs that work” – examples of health promotion efforts that have yielded measurable health benefits.

Implement a dissemination plan to make the two documents above available throughout the Mega Country Network (and other countries as requested) in a practical, user friendly format.

Using the projected estimates from the health transition, develop a clear WHO statement on “costs” and “benefits” of implementing integrated health promotion and NCD prevention strategies among the Mega countries.

For Mega countries where communicable diseases remain the highest priority, develop protocols (models) illustrating how health promotion can be integrated into, and improve the outcomes of, communicable disease prevention and control programs. In this context, health promotion would serve as an effective segue to the development of non-communicable disease prevention and control programs.
Theme 2: National and State/Provincial Level Capacity for Health Promotion Skills

Narrative Findings

Capacity was operationally defined as the extent to which national and state staff were skilled in five areas of health promotion: (1) understanding NCDs and relevant risk factors, (2) community assessment, (3) program planning, (4) the application of strategies and tactics, and (5) evaluation.

Health Promotion Skills

All but two respondents indicated that pertinent national staff members were either “extremely competent” or “competent” in their understanding of NCDs and relevant risk factors. The majority (7 of 11) felt that their national staff members were competent in their community assessment skills. On the criteria “program planning” and the “application of strategies and tactics,” six countries were judged as competent; and five were perceived to be in need of substantial improvement. On the matter of evaluation skills, all respondents reported the need to substantially improve the evaluation capacities in their respective countries.

The state/provincial level assessment for these same skills yielded a less satisfactory profile. With the exception of three countries, all respondents indicated that the state/provincial level competence for all five areas was in need of some degree of improvement. At both the national and state/provincial levels, “evaluation” was the skill that respondents felt was most consistently deficient.

The majority of respondents expressed their need to be clear that by indicating the need for technical improvement at the sub-national level, they did not want to diminish the intent and level of effort currently being made. Without prompting, several expressed considerable pride in the work and commitment of their colleagues in states/provinces and localities, indicating that they have been and will continue to eager participants in relevant training programs.

Risk Factor Surveillance

Surveillance of behavioral risk factors and risk conditions is an inherent aspect of the category “understanding NCDs and their relevant risk factors.” However, the capacity to understand or know about those factors is obviously quite different from the capacity and
skill need to gather risk data through a system of ongoing, periodic surveillance. All respondents were in agreement that data generated from valid surveillance systems should be a high priority for the development of NCD and health promotion policies and programs.

Respondents from the following Mega countries indicated that they were (to varying degrees of coverage and detail) undertaking surveillance of selected NCD risk factors: Bangladesh, Brazil, China, Indonesia, Japan, Mexico, Nigeria, Russian Federation and the United States. Interviews indicated that many applications of risk factor surveillance occurred as components of community-based demonstration projects focusing on NCDs, specific risk factors (smoking) or school health.

The risk factor surveillance priorities for Mega country representatives are captured in the following composite statement.

“I (we) want a risk factor surveillance capacity that

- Is flexible enough to generate national, state, and municipal or local estimates;
- Generates valid information taking into account the cultural nuances of our nation(s) and the diversity therein;
- Is sustained (integrated into the government’s health system) to permit tracking of trends over time;
- Generates practical information that can be used to inform policy development and program intervention.”

While acknowledging the value of behavioral risk factor surveillance, several respondents felt that additional emphasis needed to be placed on mechanisms to assess and monitor critical social determinants including indicators of income (poverty), education, housing, crime, and social cohesion.

**Clarifying the Role of STEPS**

Several of the participants were interviewed at the December Mega Country meeting in Geneva after hearing presentations about the WHO STEPwise approach to Risk Factor Surveillance (STEPS). Those interviewed indicated that they were generally supportive of what they heard about STEPS and were in agreement that efforts should be made, wherever possible, to use standardized questions and protocols. However, they were unclear how STEPS was connected to risk factor on-going risk factor surveillance activities supported by WHO. Some envisioned that STEPS might result in: (1) an added burden from having to generate reports for the purpose of global surveillance, and
Generally, respondents indicated that their first priority is to strengthen their risk factor surveillance capacities within their respective countries. The extent to which STEPS is perceived to contribute to, or deter from, that priority will influence its acceptance among the network members.

Training/Personnel Development

In virtually all countries, the respondents noted that one of the key functions of their national level program was to provide technical support to build the health promotion capacities in states and municipalities. Technical support and training is often provided through official national/state/local public health networks. For example, tied to their national health goals for the year 2010 (Indonesia Sehat 2010) the Indonesian Directorate of Health Promotion has implemented a national health promotion training initiative that is being carried out in localities throughout the Republic of Indonesia. In varying degrees of scope and detail, similar health promotion and NCD staff development strategies were mentioned by respondents from Japan, Brazil, Mexico, China, Russia, and the U.S.A. At this time in Pakistan and Nigeria, non-governmental heart health foundations constitute a major vehicle for enhancing NCD skills. (Also see discussion of Russia/CINDI/WHO/USA joint training on epidemiology in “Transnational Cooperation” section of this report.)

In-country Networks

All respondents indicated that public health networks within their respective countries often serve as a major channel though which capacity-building efforts occur. For example, throughout towns and villages in Brazil, 16,000 family health teams consisting of a physician, nurse and local health workers, constitute a major avenue for enhancing the skills required for the delivery of effective primary care services (including health promotion). Pakistan has a network of local level “lady health workers,” and Bangladesh has a similar network of indigenous health workers. These networks constitute effective “channels” through which health promotion training can reach local level practitioners.

In the United States, the Centers for Disease Control and Prevention (CDC) at the national level provides both economic and technical support to state health agencies for a wide-variety of prevention programs of which health promotion is an integral part. A survey is currently underway in the U.S. to ascertain how the CDC might enhance its efforts to strengthen health promotion capacity at the state level.

While the relationship between national and state/provincial health ministries constitutes an important means for the enhancement of health promotion capacity, it is only one of several existing mechanisms. Respondents cited other mechanisms including: universities with public health training programs, professional societies and associations,
accessing national and global research literature (increasingly through the Internet), national and regional professional health promotion meetings, technical workshops, and electronic distance learning programs. Although these mechanisms vary in number, quality, and accessibility across the Mega countries, the extent to which they exist (and are used) may be viewed as a nation’s health promotion capacity building “system.”

Summary

• There is considerable variability in the NCD health promotion “skills” capacity among national and state/provincial staff across the Mega countries.

• In the majority of Mega countries, competency levels in the states/provinces are problematic and in need of improvement.

• Because there are numerous factors that explain variability in health promotion competence within and across nations, any serious effort to strengthen that capacity must be tailored to address the skills and competencies deemed to be priorities by a given nation or state.

• At all levels and in all nations, respondents perceived evaluation to be the skill in greatest need of improvement. This observation is of utmost importance because countries will be called upon to implement interventions to mitigate risk factors and social determinants for which there is currently little evidence of their effectiveness (e.g., obesity, physical activity, poverty). Interventions carried out “in the field” to influence these factors demand the application of sound evaluation strategies.

• Among respondents, strengthening the capacity of in-country risk factor surveillance is essential for the effective development of all health promotion policies and programs, especially those with a focus on NCD prevention and control.

• More emphasis needs to be placed on the detection and tracking of relevant social determinants.

• Although uneven, risk factor surveillance capacities are slowly being strengthened across the Mega Country Network. Efforts to accelerate that improvement merit priority consideration.

• All Mega countries have existing formal and informal “systems” that have the potential to help to strengthen health promotion capacities. While some are quite active, others remain latent. Once identified and activated
in each country, these systems could constitute effective channels for training and capacity building.
Theme 3: Transnational Cooperation

General Support and Value

Within the Mega Country Health Promotion Network “transnational” cooperation is defined as “any sharing of health promotion resources, programs, research, personnel exchanges and training, or technical support.” Respondents were asked to indicate the extent to which they interacted with health promotion leaders like themselves from the other participating Mega countries. They were given three general response options: “extensive contact” (routinely engaged in cooperative actions), “occasional contact” (periodic contact, perhaps associated with a specific health issue), and “never” (no contact beyond professional meetings).
Because the notion of “cooperation” was framed specifically in the context Mega County Health Promotion Network, respondents found this question difficult to answer. That is, all of the respondents had varying degrees of contact and cooperation with other nations, most of which were not connected with the network per se. Thus, for the majority of those interviewed, collaboration “within the network” was, to a certain extent, a matter of semantics.

**Benefits**

Nevertheless, at a general level, all respondents acknowledged the value of transnational cooperation – it is perceived as an inherently good thing. And, most respondents did indicate that they could envision both short and long term benefits from participation in the Mega Country Health Promotion Network. Short term benefits include: (1) sharing ideas with colleagues from other large nations who are facing similar health promotion and NCD prevention challenges, and (2) using the network membership as a means to add credibility to health promotion endeavors in the eyes of national leaders. Some countries reported that they have already experienced these benefits. In the long term, as the network matures, it will in a better position to leverage support from philanthropies and other non-governmental sectors for tackling common issues of global concern: e.g., the role of poverty and health.

Participants identified four, specific benefits they had experienced as a result of their being a part of the Mega Country Health Promotion Network. Those included: (1) the opportunity to share experiences with others faced with similar challenges, (2) the global partnership with other large nations and WHO adds credibility and increases their ability to influence the national health agenda, (3) access to innovations undertaken by other nations, and (4) being a part of a mutually supportive environment. Several participants “envisioned” that members of the Mega Country Network could combine their collective influence to foster global policies benefiting multiple countries. It was suggested that such collective policy endorsement might begin in a given region.

**Practical Concerns**

It is important to note that a few respondents indicated that they had not yet been able to make a clear connection between the needs of the country and the purpose of the network. Those respondents attributed this lack of clarity to what they called “an absence of meaningful and clear communication” about the network between meetings. It was not clear whether this meant communication with WHO headquarters, other network members, or both. (Two respondents identified the last minute change in the December meeting agenda a sign of that lack of clarity.)

Some expressed doubts as to whether or not continued participation in the network would in fact yield benefits that would exceed the cost of participation. One of those “costs” – is the sense that an investment in the Mega country network would by necessity mean diverting time and staff resources away from more immediate local priorities. One respondent made reference to an interesting political “cost.”
“Our country has been actively and successfully engaged with health promotion collaborations with other nations in our region. We are concerned that that being a member of the Mega Country Health Promotion Network might cause us to be perceived as being “elitist.”

Examples of Collaboration

Those able to provide examples of collaboration with other Mega countries indicated that it did serve as a stimulus, prompting more interaction and collaboration with other member countries in the network. Their stated intention to sustain their collaboration was associated two factors: (1) common interest or challenges, and (2) establishing a sense of mutual trust with their counterparts. Respondents provided several concrete examples of transnational cooperation leading to tangible outcomes.

The respondent from China indicated that in prior meetings, it became clear that India and Indonesia were also facing serious challenges in addressing increasing rates of diabetes in their respective countries. That contact has apparently contributed to an exchange of ideas and methods and a subsequent increase in collaboration between those three countries.

Technical support from the Office on Smoking and Health at CDC in the U.S. (in cooperation with the WHO Tobacco Free Initiative Program) to other members of the Mega Country network helped establish the development of risk factor and tobacco surveillance systems.

Interviews with representatives from the Russian Federation and the U.S.A. revealed that a comparatively modest collaboration turned out to have extraordinary potential for enhancing the health promotion and NCD capacities throughout the Mega country network. A training course called “Evidenced based Chronic Disease Prevention” offered by the School of Public Health in St. Louis, Missouri, U.S.A was very well received by practitioners in that country. Supported by funds from the CDC and the Soros Foundation in Moscow, faculty from St. Louis University SPH, CDC, WHO, and the National Center of Preventive Medicine (Russian Federation), revised and translated the course into Russian to be used as a “training of trainers” course. The course has been widely disseminated throughout the Russian Federation and (with support from WHO EURO and the CINDI network) further dissemination is planned. Imbedded in this example are important lessons: (1) collaboration around a common goal, (2) responding to needs or demands expressed by the population, (3) use of an approach known to be effective, (4) seeking support from multiple sources, and (5) tailoring the approach to local needs. [To view examples of the training curriculum in English and Russian, see this website: http://www.pitt.edu/~super1/national/ebcdp.htm]

Summary

- Generally, respondents acknowledge the value of transnational cooperation. However, a few members were unsure whether the benefits
of participating in the Mega Country Health Promotion Network out weigh the “costs.”

• There is clearly evidence that participation in the Mega Country Network does, to varying degrees, stimulate transnational cooperation.

• The potential benefits of effective collaboration within the network are substantial.

• Productive cooperation appears to be associated with several factors: (1) collaborators share priorities of common interest, (2) interaction among collaborators establishes trust, and (3) resources are made available to support cooperative efforts.

• Lack of time, cost, and a lack of a clear connection between the needs of the country and the purpose of the network constitute the major barriers to transnational cooperation.

**OPTIONS FOR ACTION**

Mega country participants, and other leaders in their respective countries, would benefit from a more compelling rationale for their commitment to the Mega Country Network. WHO should consider (with input from the participating nations) reframing a compelling vision of how the network can, globally, tangibly contribute to lowering the burden of disease and improving quality of life. Such a vision should be explicit in pointing out that global health improvement is a function of the collective improvement of the individual network participants and the other nations in their regions. This vision statement should transparent and crafted to address the skepticism currently held by some participants.

Working with the Mega countries and the WHO Regional Offices, develop a network communications plan to be “phased in” over time. This network would be designed to facilitate communication between and among WHO headquarters, the WHO Regional Offices, and the member countries. The system could be used to transmit and share data, pose problems and request feedback, augment training, and provide technical support. When countries engage in International collaboration and exchanges between meetings, they provide evidence for the
**Theme 4: Health Promotion Success Stories**

**Narrative Findings**

Participants had no difficulty identifying health promotion “success stories” within their respective countries and, in most cases, they offered two or three. Given the time limitation, those descriptions were general, and provided only minimal detail. In the Russian Federation, “Quit and Win” tobacco cessation campaigns that yielded quit rates ranging from 15-30% after 12 months. Brazil cited several examples including a successful tobacco control program and a breast feeding program that is now a world model. Indonesia cited its successful national nutrition network and it national health promotion strategy tied to its “Healthy People 2010” initiative. Japan highlighted the allocation of resources from its national ministry of health to support NCD prevention and health promotion demonstrations at the provincial level. These successful demonstrations have been shared with other (non-Mega) countries. This act of sharing has contributed to strengthening Japan’s collaboration with other countries in its WHO region.

Nigeria highlighted its successful health promotion efforts in: (1) a program promoting breast feeding during the first six months of life, (2) childhood immunization, and family planning. In India, improved risk factor surveillance has led to improved studies and better science related to obesity, cholesterol and physical inactivity. Mexico pointed to successful community-based diabetes control programs at the state level.

In Pakistan, the Heartfile Foundation, in collaboration in with the Ministry of Health, has launched a three-tier community-wide cardiovascular disease prevention and health promotion program. The first tier reaches out to different segments of the Pakistani population using print media campaigns targeted to the urban and rural literate population. The second tier activates the state owned electronic media to reach those not reached by print media. The final tier focuses on the uneducated, rural population by nurturing existing networks and developing new ones to reach those at the grass roots level. (Although in a more formative stage of development, a similar collaboration between a heart health foundation and the Ministry of Health is ongoing in Nigeria.)

Notable success stories in the USA include: (1) dramatic reductions in tobacco consumption in many states with specific examples in California, Massachusetts, and Florida, (2) the national hypertension control program leading to marked declines in stroke mortality, and (3) programs leading to a decrease in alcohol-related auto injuries and mortality.

In China, the World Bank provided support to enhance selected health capacities in 7 cities and one province in China. Focusing on a combination of health problems including NCDs, HIV/AIDS, and injury prevention, World Bank consultants worked with local Chinese health professionals to strengthen their approach to surveillance, policymaking, and human resource development. Over the five-year span of the project, this led to measurable improvements in health outcomes in the 7 cities and one
province. Based on this experience, the Chinese Ministry of Health launched model NCD programs in 30 provinces.

Summary

- Respondents had little difficulty calling to mind specific, credible examples of NCD/health promotion success stories at the national, state/provincial, and local levels.

- It is interesting to note that, in most instances, these “stories” came from either personal experience, published accounts reported in academic journals or formal technical reports or a combination of both. Since decision-makers do not use these channels to obtain information, we should not be surprised that they remain, for the most part, uninformed about the credible evidence demonstrating that investments in NCD prevention and health promotion can yield substantial benefits.

- The collaboration between governmental and non-governmental organizations (e.g., foundations, advocacy groups, etc.) seems to be an effective mean of adding visibility and resource support to health promotion efforts, especially in the context of non-communicable disease research and programs.
OPTIONS FOR ACTION

Consideration should be given to undertaking country specific efforts to capture these success stories. The summaries should include documentation of progress/outcomes as well as detailed descriptions of the strategies and tactics that led to those outcomes. (Reinforces option cited under National Level Support)

The “effects” portion of these success stories should be translated into “user friendly” format so that political leaders and the mass media can easily identify the benefits and value of investments in well-planned health promotion/disease prevention efforts.

Detailed descriptions of successful inter and intra-organizational collaboration (e.g., Heartfile and the Ministry of Health in Pakistan) should be documented and included as examples of “success stories.”

These success stories, including descriptions of methodology, should be incorporated as standard part of the communications plan described in the previous section.
## Summary of Possible Actions

<table>
<thead>
<tr>
<th>Possible Action</th>
<th>Rationale</th>
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<tr>
<td>Determine what specific processes and actions are effective in gaining understanding of, and national and political support for, NCD prevention and health promotion. Disseminate this information throughout the Mega Country Network (and other countries as requested), in a practical, user friendly format.</td>
<td>Heighten global awareness of, and support for, NCD prevention and health promotion as a key strategy to mitigate current trends in global burden of disease.</td>
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<td>Using the projected estimates from the health transition, develop a clear WHO statement on “costs” and “benefits” of implementing integrated health promotion and NCD prevention strategies among the Mega Countries.</td>
<td>Provides scientific rationale supporting the need for a Mega Country Health Promotion strategy.</td>
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<td>For Mega countries where communicable diseases remain the highest priority, develop protocols (models) illustrating how health promotion and NCD prevention can be integrated into existing communicable disease prevention and control programs.</td>
<td>NCD prevention and health promotion strategies can be complementary to public health practices addressing communicable diseases.</td>
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<td>Support a country by country health promotion capacity building plan that includes an up-to-date inventory of existing of potential capacity building resources and delineates the focus and reach (regional coverage) of each resource.</td>
<td>Such plans will provide a national template for engaging multiple sectors around a common mission of health improvement, and will expand the effects of the network deeper into the member nations.</td>
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<tr>
<td>Possible Action*</td>
<td>Rationale</td>
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<td>Health promotion capacity building plans should be: (1) grounded in established standards of effective health promotion practice and (2) tailored to address the conditions, circumstances, and resources unique to that country.</td>
<td>Plans should be evidence based and sensitive to national needs and traditions.</td>
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<td>With input from experts from the network countries, develop practical guidelines, protocols, and tools for evaluating the impact of health promotion and NCD programs. The protocols and tools should be flexible enough to be adapted to address the wide range of differences in factors to be evaluated between and within nations.</td>
<td>Program evaluation competence is essential not only to provide ongoing feedback to assess program progress and make necessary corrections, but also contribute to our knowledge of what strategies and tactics are most effective in attaining health improvement goals.</td>
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<td>Create, within the existing WHO infrastructure, a focal point for Mega County “program evaluation.”</td>
<td>This focal point would serve to oversee the development and on-going upgrading of evaluation protocols and tools and provide technical support for the periodic meta-analysis of evaluations around programs addressing common health promotion and NCD issues.</td>
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<td>WHO should (with input from the participating nations) reframe a compelling vision of how the network can, globally, tangibly contribute to lowering the burden of disease and improving quality of life. Such a vision should be explicit in pointing out that global health improvement is a function of the collective improvement of the individual network participants and the other nations in their regions. This vision statement should transparent and crafted to address the skepticism currently held by some participants.</td>
<td>Mega Country participants, and other leaders in their respective countries, would benefit from a more compelling rationale for their commitment to the Mega Country Network. Respondents indicated that the rhetoric in the current goals of the network is not compelling.</td>
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<td>Possible Action*</td>
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<td>Working with the Mega countries and the WHO Regional Offices, develop a network communications plan to be “phased in” over time. This network would be designed to facilitate communication between and among WHO headquarters, the WHO Regional Offices, and the member countries.</td>
<td>Such a system is needed to transmit and share data, pose problems and request feedback, augment training, and provide technical support.</td>
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<td>Develop a standard format that will enable member nations to capture their health promotion success stories, including detailed descriptions of the strategies and tactics that led to the successful outcomes.</td>
<td>Well documented “success stories,” many of which are going undetected, constitute a major means of enhancing the knowledge base for practitioners and enlightening leaders and the public about the tangible benefits that result from effective NCD prevention and health promotion.</td>
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<td>Establish a Mega Country Secretariat to coordinate relevant WHO resources in support of the Mega Country Health Promotion Network.*</td>
<td>Respondents indicated the need for strong, visible leadership and a focal point for communication.</td>
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<td>Develop a Mega Country policy framework. This policy should include a formula to assure that each participating country designate a senior delegate to represent their country. The primary duties of this delegate will be: (1) to assure maximum feasible participation of relevant organizations and sectors in Mega Country activities within that country, and (2) represent the country at the annual Mega Country meetings.*</td>
<td>Participants envision that consistency in major meeting attendance would enhance continuity among member nations and strengthen ties among them.</td>
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<td>Possible Action*</td>
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<td>Consider holding annual meetings in designated Mega Countries. Some portion of</td>
<td>Enhance global visibility and credibility of the network.</td>
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<td>the agenda would focus on issues and challenges faced by that country. Criteria</td>
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<td>for hosting such meetings should include participation of high level national</td>
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<td>leaders from the host country.*</td>
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<td>Promote/coordinate visits by a small team of selected experts from selected</td>
<td>Has dual utility as an effective mechanism for technical support and a</td>
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<td>Mega Countries to provide technical assistance to a partner nation. (E.g.,</td>
<td>practical means of promoting collaboration.</td>
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<td>expanding on the model used by the Russian Federation for “Evidenced Based</td>
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<td>Chronic Disease Prevention,” or the U.S.A for risk factor surveillance)</td>
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* At the end of each interview, participants were asked: “What specific actions should WHO take to enhance the probability that the goals of the Mega Country Health Promotion Network will be reached? Some of those responses were incorporated into the “Possible Actions” boxes. Those that were not, are included in this table and marked with an asterisk.
ANNEX A

MEGA COUNTRY HEALTH PROMOTION NETWORK: SELF STUDY QUESTIONNAIRE

Background/Process

The questions below served as probes for the telephone and face-to-face interviews. The same questions, formatted with appropriate space for response were used to gather input from two countries (Russia and Brazil) via e-mail. It should be noted that the e-mail input from those two countries was complemented by face-to-face discussions at the Mega Country Health Promotion Network meeting held in Geneva, on December 10-12, 2002.

During the face-to-face interviews, most probes were followed up for purposes of clarification and/or examples.

Assumptions

All participants were informed that the primary focus of this inquiry was on the actions and capacities of the 11 countries in the Mega Country Health Promotion Network specifically in the context of the reduction of three major chronic disease risk factors: tobacco, nutrition, and physical activity as a means to address NCD prevention.

They were also advised that time would not be spent on distinguishing the differences between Health Promotion, Health Education, and Health Communication. It was assumed that all three share considerable common ground and fit under the comprehensive umbrella of health promotion as defined by WHO: “The process of enabling people to increase their control over, and to improve, their health.”

The Questions/Probes

In addition to their respective titles and responsibilities, participants from the 11 Mega countries were asked the following questions:
1. What is your perception of the national level leadership support given to health promotion aimed at the prevention of non-communicable diseases (including school health)?

2. How would you assess (in terms of adequacy) the economic or budgetary support for health promotion staff and programs?

3. If possible, can you distinguish between the support given by Ministry (department) of Public Health and support given by political leaders?

4. How would you characterize the current health promotion capacity for addressing chronic disease risk factors among staff at the national level? Respondents were asked to consider these five skills as indicators in their estimations of capacity: (1) Understanding NCDs and relevant risk factors, (2) Community assessment, (3) Program planning, (4) Application of strategies and tactics, and (5) Evaluation.

5. How would you characterize the current health promotion capacity for addressing chronic disease risk factors among staff at the state/provincial level?

6. If “transnational” cooperation is defined as “any sharing of health promotion resources, programs, research, personnel exchanges and training, or technical support” – please characterize your interaction with leaders like yourself from each of the 10 other Mega Countries. (Respondents were given three levels of contact to consider: (1) Extensive, e.g., routine cooperation, (2) Occasional, e.g., periodic contact, perhaps associated with a specific health issue, and (3) Never, e.g., no contact beyond professional meetings.

7. What are the priority health problems (e.g. diseases, risk factors, social/economic/environmental determinants) being addressed by health promotion programs in your country? Follow up query: on what basis were they deemed priorities?

8. What do you consider to be the health promotion “success stories” in your country?

9. What would you say are the strengths of health promotion in your country?

10. What aspects of health promotion that you would like to see strengthened in your country?

11. What are the “benefits” of being a participant in the Mega Country Health Promotion Network?
12. What would you say are “costs” of being a participant in the Mega Country Health Promotion Network?

13. What specific actions should WHO take to enhance the probability that the goals of the Mega Country Health Promotion Network will be reached? (As a frame of reference, participants were given the following published goals of the Mega Country Health Promotion Network: (1) Improve the information base for health promotion, (2) Develop health promoting strategies (healthy lifestyles, health life course for women, children, adolescents, and the aging), (3) Supportive environments, (4) Supportive settings
## ANNEX B

### MEGA COUNTRY REPRESENTATIVES WHO PARTICIPATED IN THE SURVEY/INTERVIEW PROCESS

<table>
<thead>
<tr>
<th>Country</th>
<th>Participant</th>
<th>Title</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>Mr. M. A. Hannan</td>
<td>Joint Sect'y Ministry of Health and Welfare</td>
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<tr>
<td></td>
<td>Dr. Mahmudur Rahman</td>
<td>Dir. National Institute of Preventive and Social Med.</td>
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<tr>
<td>Brazil</td>
<td>Dr. Denise Coitinho</td>
<td>Dir. Food and Nutrition Policy, Ministry of Health</td>
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<tr>
<td></td>
<td>Dr. Eliabetta Recine</td>
<td>Tech. Coordinator, Food and Nutrition Policy</td>
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<tr>
<td>China</td>
<td>Dr. Kong Ling-zhi</td>
<td>Drir. NCD Prevention and Control, Ministry of Health</td>
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<tr>
<td>India</td>
<td>Dr. Bela Shah</td>
<td>Senior Deputy Director General, Division of Noncommunicable Diseases, Indian Council for Medical Research</td>
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<tr>
<td>Country</td>
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<td>Indonesia</td>
<td>Mr. Dachroni</td>
<td>Director of Health Promotion</td>
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<td></td>
<td>Mr Kresnawan</td>
<td>Head, Food Consumption, Community Nutrition</td>
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<td>Ministry of Health</td>
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<td>Japan</td>
<td>Dr. Tomoko Takamiya</td>
<td>Deputy Dir. Office of Life-Style Related Disease Control</td>
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<td></td>
<td>Dr. Hidemi Takimoto</td>
<td>Office of International Collaboration, National Institute of Health and Nutrition</td>
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<td>Ministry of Health</td>
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<td>Mexico</td>
<td>Dr. Gustavo Oliaz Fernandez</td>
<td>National Institute of Public Health</td>
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<td>Nigeria</td>
<td>Dr. Kingsley Akinroye</td>
<td>Vice President, Nigerian Heart Association</td>
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<td>Dr. Annette Akinsete</td>
<td>National Coordinator, NCD Control Program, Federal Ministry of Health</td>
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<td>Pakistan</td>
<td>Dr. Sanita Nishtar</td>
<td>President, Heartfile (National Heart Foundation of Pakistan)</td>
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<td>Mr. Muhammad Din</td>
<td>Deputy Secretary, Ministry of Health</td>
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<td>Russian Federation</td>
<td>Prof. Igor Glasunov</td>
<td>Head, Dept. of Policy and Strategy Development</td>
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<td>Nat’l Center for Preventive Medicine</td>
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<tr>
<td>United States of America</td>
<td>Dr. David McQueen</td>
<td>Associate Director Global Health, Nat’l Center for Chronic Disease Prevention and Health Promotion, CDC</td>
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