I am pleased to be here attending a meeting on a topic that has been a priority in this office for more than 15 years. When I was Regional Adviser NCD in this office, a great deal of emphasis was placed on the role of PHC in NCD prevention and control. UNRWA was a pioneer in this region and integration of diabetes into the UNRWA health centres started almost 20 years ago. the Director of health then was Robert Cook who had the vision to introduce the concept of chronic diseases in PHC based on the croatian model. I had the privilege of supporting Dr Cook in organising and participating in the first evaluation of this project more than 15 years ago. I did this together with our late colleague Hilary King. A few years later we did a second evaluation focusing also on hypertension when Dr Abdelmoumen, was the Director of Health.

So I am delighted to be here again with a revival of interest in this area which I think is central to NCD prevention. I cannot imagine how you can make a difference in addressing NCDs without integrating their prevention and management into PHC. Take the prevalence of diabetes or high blood pressure and try to estimate the proportion of people affected with these conditions who can be managed by secondary or tertiary care levels; only a small minority. The vast majority will have to be seen by primary care professionals. Obviously the kind of care they get depends on the development of the PHC and the strength of the health system and its capacity to provide chronic care. It depends also on how the health professionals, doctors and nurses are trained and equipped to deal with these conditions. The reality today is that a considerable proportion of people with NCDs have no access to the minimum standards of care, either
because of weak health systems or in inequities to access to quality health care, or lack of priority given to these conditions. Detection rates are low, people present with complications leading to high morbidity, enormous suffering of patients and families, disabilities and premature death. So integration into PHC is basic approach in NCD prevention and control. It is needed for better surveillance, for more effective prevention, and for better management and for addressing inequalities in access to care and in health outcomes.

We should also be pleased that this initiative is coinciding with a solid commitment by WHO and most MS in the renewal of PHC. The strategic emphasis on strengthening health systems based on PHC is now firmly placed among the priorities of the DG. The World Health report will focus on PHC. PHC will be discussed in all regional committees in September and October and again during the EB in January and WHA in May. Towards the end of the year, there will be a global consultation on the PHC and NCDs held in Geneva. The interest in PHC is based on the priority given to it by the GS. So let me begin by introducing the strategy and its implementation plan which has recently been endorsed with a great interest by member States during the last WHA two months ago.

**Deaths by cause in the world**

The health problems caused by NCDs are today leading to premature death of more than 35 million people every year because of heart disease, stroke, cancer, chronic lung disease and other chronic health problems. You can see here that out of 58 million deaths estimated to have taken place annually, more than 30% are caused by various forms of heart disease, about 16% by cancer and another 16% by other chronic diseases.
Noncommunicable Diseases

- Responsible for 60% of all deaths, 80% are in low- and middle-income countries.

- Major noncommunicable diseases:
  - Heart Disease and strokes
  - Cancer
  - Chronic lung disease
  - Diabetes

- Shared preventable risk factors:
  - Tobacco use
  - Unhealthy diet
  - Physical inactivity
  - Harmful use of alcohol

We in WHO use the term "noncommunicable diseases" to describe these conditions. Some use the term chronic diseases and for each term there are pros and cons. The important point is that their magnitude is enormous, they cause 60% of all global deaths. 80% of these deaths take place in low and middle income countries. As you saw from the previous slide, cardiovascular disease, strokes, cancer, chronic lung disease and diabetes represent the overwhelming proportion of the burden and mortality caused by noncommunicable diseases. These four groups of diseases are caused by shared preventable risk factors related to lifestyles, mainly smoking, unhealthy diet and physical inactivity and lack of physical exercise as well as the harmful use of alcohol.

Reducing risk

- Unhealthy diet causes approximately 5.3 million deaths a year
- Physical inactivity causes approximately 1.9 million deaths a year
- Tobacco use causes 5.4 million people a year

The causes of the main chronic disease epidemics are well established and well known. I have mentioned the most important modifiable risk factors:

- unhealthy diet and excessive energy intake;
- physical inactivity;
- tobacco use.
About one billion people worldwide (one third of adults) currently smoke

Half of all long-term smokers will be killed by tobacco, and half of these will lose 20–25 years

5.4 million deaths each year

Death toll estimated to reach 8.3 million by 2030

Tobacco is the single greatest preventable cause of death in the world today. One billion people currently use tobacco. This is about one quarter of all adults. Tobacco kills half the people who use it long term. WHO estimates that it presently kills more than 5 million people every year. And if current trends continue, it will kill more than 8 million per year by the year 2030. The vast majority of these preventable premature deaths will be in low and middle income countries.

Today, tobacco is an important risk factor in the causation of the eight leading causes of death in the world. The shaded areas represent estimates of the share of tobacco in mortality from these conditions.
What is of major concern is that we are witnessing a rapidly rising trend in the prevalence of these health problems and a progressive increase in death and disabilities caused by them across the world. As far as mortality is concerned, our estimates indicate that there will be an overall 17% increase in the number of deaths caused by these conditions over the ten year period from 2006 and 2015. Another important message is that although already 80% of these deaths are occurring in low and middle income countries, available evidence suggests that the increasing trend in these countries will continue and that the highest increase in the coming years will be seen in the African region (27%), followed by the Eastern Mediterranean (25%) and Southeast Asia regions (21%). So heart disease, stroke, cancer, diabetes and chronic lung disease are already manifesting their greatest burden in low and middle income countries. In addition we have evidence to show that in many populations the poor and marginalised are the most severely hit by these problems: I am stressing this point because NCDs were very much neglected at the PHC level in many low land middle income countries partly because of a misconception that they are more seen as diseases of affluent societies.


<table>
<thead>
<tr>
<th>Geographic Region (WHO classification)</th>
<th>Total deaths (2005)</th>
<th>NCD deaths (2005)</th>
<th>NCD deaths as a % of total deaths</th>
<th>Projected NCD deaths 2015</th>
<th>Projected total deaths 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO Total</td>
<td>17,390.7</td>
<td>12,410.0</td>
<td>71.4%</td>
<td>20,572.0</td>
<td>15,692.0</td>
</tr>
<tr>
<td>Africa</td>
<td>534.8</td>
<td>388.5</td>
<td>72.4%</td>
<td>666.6</td>
<td>500.0</td>
</tr>
<tr>
<td>Americas</td>
<td>834.6</td>
<td>688.5</td>
<td>82.8%</td>
<td>997.7</td>
<td>737.0</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>126.6</td>
<td>108.0</td>
<td>84.9%</td>
<td>157.7</td>
<td>118.0</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>145.7</td>
<td>120.0</td>
<td>82.4%</td>
<td>177.4</td>
<td>131.0</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>108.0</td>
<td>89.0</td>
<td>82.1%</td>
<td>130.0</td>
<td>97.0</td>
</tr>
</tbody>
</table>

(WHO, 2005)

Noncommunicable diseases >

International donors

US$2.9 billion

Official Development Aid (ODA) to the health sector in 2002

0.1%

Allocated to noncommunicable diseases and mental health

Increased health support by donors is mostly directed towards HIV/AIDS, not noncommunicable diseases

Noncommunicable diseases >

World Health Organization

Noncommunicable diseases >
The Need for Action…

Why?

Effective interventions exist for primary prevention: Examples...
- Raising tobacco taxes and prices
- Salt reduction
- Improving availability and affordability of healthy food
- Improving transportation policies and environmental designs
- Raising alcohol taxes and prices

Cost-effective interventions exist for secondary and tertiary prevention:
- Cardiovascular disease can be prevented by targeting high risk people
- 75% of recurrent heart attacks and strokes can be prevented by 4 medicines
- Treating diabetes
- Early detection and cancer

Cost-effective interventions are available to prevent up to 85% of cardiovascular disease and diabetes and 40% of cancer, and to control noncommunicable diseases at primary health care level.

There is clearly a need for urgent action. But the focus should be on evidence based, cost effective affordable action.

The global response to address Noncommunicable Diseases

So what is the world doing to address the leading causes of death and disease burden?

The journey for a concrete and sound strategy started in the year 2000 when the World Health Assembly, which is governing body of WHO and the annual meeting of the Health Ministers and representatives of the 193 member states of WHO discussed and endorsed the global strategy for the prevention and control
of noncommunicable diseases. The global strategy provided for the first time clear vision and sound strategic directions to countries and to WHO for addressing the determinants, risk factors and the existing burden of NCDs. Two years later, another very important milestone, the Assembly endorsed the Framework Convention for Tobacco Control, the first international public health treaty developed and endorsed by member states. It now has 158 parties. A year later in 2004, the Assembly endorsed the global strategy on diet, physical activity and health and more recently in 2007 WHO and countries together initiated the work to translate the global strategy endorsed in 2000 into an action plan which has recently been endorsed by the Assembly in May of this year. Part of the interventions covered by the action plan is the set of policy interventions, called MPOWER to address tobacco use and I will come back to this a few minutes later.

The Global Strategy on Diet Physical Activity and Health (DPAS)

The Global Strategy on Diet Physical Activity and Health has been endorsed by the World Health Assembly in May 2004.
Diet and Physical Activity Strategy

Develop, strengthen, implement global, regional, national policies, plans to improve diets and increase physical activity that are sustainable, comprehensive and actively engage all sectors improve diets and increase physical activity.

WHO EMRO Plan for prevention and control of diet and physical activity related NCDs

Workshop 25th March, Dubai, UAE

Develop multisectoral approach for the prevention and control of NCD’s

Development of a set of recommendations on marketing of foods and nonalcoholic beverages to children
The Implementation Plan of the Global Strategy for the Prevention and Control of Noncommunicable Diseases

Process:
- 2007 – Drafting of the plan based on the strategic directions endorsed in 2000
- January 2008 – Discussions at WHO’s Executive Board
- February/March 2008 – Informal consultations with Member States, International Partners and the business community
- April 2008 – Final draft Action Plan was published on the internet (www.who.int/gb)

The plan for the global strategy was the outcome of intensive work initiated in 2007 and involved extensive input from Member States, international NGOs and stakeholders as well as the business community. It involved discussions at the EB and the WHA and in several consultations with member states and stakeholders.

Global NCD Action Plan

Global Strategy for the Prevention and Control of Noncommunicable Diseases

- Based on a careful review of evidence and international experience (1989-2000)
- Endorsed by the World Health Assembly in 2000
- Addresses action required by Member States, WHO, and international partners
Lessons Learned

- NCDs are preventable through interventions against the common risk factors and their determinants
- Strategies to reduce exposure to established risk factors should be combined with strategies to prevent the emergence of risk factors
- To have an impact, interventions should be of appropriate intensity and sustained over extended periods of time
- Success requires community participation, supportive policy decisions, legislation, intersectoral action and health care reforms
- More health gains are achieved by influencing public policies in other sectors like trade, education, agriculture, food production, urban development and taxation than by changes in health policy alone.

Purpose of the Global Strategy

• To map the emerging epidemics of noncommunicable diseases and analyse their social, economic, behavioural and political determinants
• To reduce the level of exposure of individuals and populations to the common modifiable risk factors
• To strengthen health care for people with noncommunicable diseases by improving access to essential standards of care and developing guidelines for cost-effective interventions

The WHA considers these diseases as one of the key health challenges in the 21st century, threatening socioeconomic development as well as the life and health of millions of people. The strategy therefore has three aims.

Key Components of the Global Strategy

- Surveillance: to quantify and track NCDs and their risk factors and determinants to provide the foundation for advocacy, national policy and global action
- Promotion of health across the life course and prevention of risk factors are the most feasible approaches for many member states
- Improving access to, and quality of, health care, focusing on cost-effective and equitable interventions for people with chronic diseases
Six Key Objectives of the Plan

- The Plan sets out
  - 6 objectives
  - Three sets of actions and intervention under each objective for member states, WHO and international partners, to be implemented over the six-year period: 2008–2013,
  - and performance indicators

The plan translates the broad directions recommended by the global strategy into six objectives with three sets of action under each objective directed to MS, WHO and international partners. It provides also examples of indicators that will be used to track and monitor progress in implementing the plan.

Proposed actions under the Plan

- Member States
- WHO Secretariat
  - WHO Headquarters
  - WHO Regional Office for Africa (AFRO)
  - WHO Regional Office for the Americas (AMRO)
  - WHO Regional Office for the Eastern Mediterranean (EMRO)
  - WHO Regional Office for Europe (EURO)
  - WHO Regional Office for South-East Asia (SEARO)
  - WHO Regional Office for the Western Pacific (WPRO)
- International partners

Objectives of the Plan: 2008-2013

1. Raise the priority accorded to noncommunicable disease in development work at global and national levels, and to integrate prevention into policies across all government departments.
2. Establish and strengthen national policies and plans for the prevention and control of noncommunicable diseases.
3. Promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol.
4. Promote research for the prevention and control of noncommunicable diseases.
5. Promote partnerships for the prevention and control of noncommunicable diseases.
6. Monitor noncommunicable diseases and their determinants and evaluate progress at the national, regional and global levels.

As I said before, these are the six objectives of the plan.

There is increasing recognition of the negative impact these disease have on overall development and the strategy involves work to ensure that prevention programmes become an integral part of the global and national development
agendas. These are the six objectives of the plan. Objective 1 also aims to highlight that fact that prevention initiatives including tobacco control is an all government approach. This is not a problem that can be managed by the health sector alone, it is a responsibility that should be equally shared by all sectors in government and by the international community.

**Objective 1**

To raise the priority accorded to NCDs in development work at global and national levels, and to integrate prevention into policies across all government departments.

- Actions include, among others,
  - Incorporate the prevention and control of NCDs in poverty-reduction strategies and in relevant social and economic policies (action for Member States)
  - Develop and disseminate tools to assess the impact of policies on the determinants, risk factors and consequences of NCDs; and provide models of effective, evidence-based policy-making (action for Secretariat)

Under the same objective, there are evidence-based interventions at the link with poverty reduction strategies and socio-economic policies. The work on the economics of these health problems particularly tobacco use is being strengthened.

**Objective 2**

To establish and strengthen national policies and plans for the prevention and control of NCDs

- Actions include, among others,
  - Developing a national multisectoral framework for the prevention and control of NCDs
  - Integrating prevention and control of NCDs into the national health development plan
  - Reorientating and strengthening of health systems to address inequalities in access and quality of health care

Much of the work done over the next 6 years will focus on assisting countries to build their national prevention programmes specially in developing the right policies and implementing multisectoral plans and in strengthening their health systems to address inequalities and to deal more effectively with chronic conditions.
Reorient and strengthen health systems...

- Ensure that provision of health care for chronic diseases is dealt with in the context of overall health system strengthening in both public and private sectors and has the elements necessary for effective care for chronic conditions...
- Use evidence based guidelines, establish standards of health care and integrate management into PHC
- Strengthen human resources capacity with special focus on PHC
- Take action to support self management and care
- Develop mechanisms of sustainable health financing to reduce inequalities in accessing health care

Objective 3
To promote interventions to reduce the main shared modifiable risk factors for NCDs

- Actions for:
  - Tobacco control
  - Promoting healthy diet
  - Promoting physical activity
  - Reducing the harmful use of alcohol

In Objective 3, which focuses on reduction of risk factors, the emphasis will be on the major risk factors listed here.

Objective 3: Tobacco Control

- Actions for Member States
  Implementing six cost-effective policy interventions (the MPOWER package), which builds on the measures for reducing demand contained in the WHO FCTC:
  - Monitor tobacco use and tobacco-prevention policies
  - Protect people from tobacco smoke in public places and workplaces
  - Offer help to people who want to stop using tobacco
  - Warn people about the dangers of tobacco
  - Enforce bans on tobacco advertising, promotion and sponsorship
  - Raise tobacco taxes and prices

For tobacco: the guidance for all countries comes from the work of the Framework Convention for Tobacco Control. Based on the Convention and as an entry point to full implementation, WHO recommends that all countries implement with a high level of coverage six policy interventions:

These are interventions proven to reduce tobacco use.
Objective 4
To promote research for the prevention and control of Noncommunicable Diseases

- Actions include, among others,
  - Develop a research agenda with priority given to research areas directly relevant to the prevention agenda (action for Secretariat)
  - Support, and work jointly on, priority research areas at the global, regional and subregional levels (action for international partners)
  - Research will focus particularly on socioeconomic determinants, lifestyle and behavioral modification, community-based interventions, equity, reorientation of health systems and primary health care, together with research that explores models of care that are applicable to resource-poor settings.

The fourth objective is to develop a prioritised research agenda with emphasis on the generation of further evidence needed for prevention and for national programmes specially for low and middle income countries.

Objective 5
To promote partnerships for the prevention and control of Noncommunicable Diseases

- Actions include, among others,
  - Establish effective partnerships for the prevention and control of NCDs, and develop collaborative networks, involving key stakeholders, as appropriate (action for Member States)
  - Establish an advisory group in 2008 in order to provide strategic and technical input and conduct external reviews of the progress made by WHO and its partners in the prevention and control of NCDs (action for Secretariat)
  - Collaborate closely with and provide support to Member States and the Secretariat in implementing the various components of the global strategy for the prevention and control of NCDs (action for international partners)

And obviously such an ambitious agenda is impossible to implement by one agency or even by member states alone. It requires very strong partnerships with other stakeholders in the international community, international organizations and NGOs, civil society and the private sector.

Objective 6
To monitor NCDs and their determinants, and evaluate progress at the national, regional and global levels

- Actions include, among others,
  - Strengthen surveillance systems and standardized data collection on risk factors, disease incidence and mortality by cause, using existing WHO tools (action for Member States)
  - Develop and maintain an information system to collect, analyze and disseminate information on trends in mortality, disease burden, risk factors, policies, plans and programmes (action for Secretariat)
And finally, monitoring the trends of these conditions and their determinants and risk factors including tobacco at the global and national levels is a basic component of the global strategy. Such monitoring provides the foundation for advocacy, policy development and global action. Monitoring is not going to be limited to tracking data on magnitude and trends of NCDs and their risk factors but will also evaluate the progress made by each country in implementing the strategy and in addressing the increasing burden of these diseases.

Monitoring Indicators

- The indicators developed in the action plan are examples of measurements that WHO will use in monitoring and reporting on the global status of the prevention and control of NCDs.
- Baseline values are available in WHO for many of the indicators; however, where baselines are not currently available, mechanisms will be established in 2008 and 2009 to collect relevant data.
- 27 indicators related to the implementation of the strategy and reduction of the different risk factors.

There is a need for measurable process and output indicators to permit accurate monitoring and evaluation of actions taken and their impact. Already 27 indicators have been included in the plan but more work is being done in 2008 and 2009 to set realistic targets and refine indicators that will be the basis of the first global report on noncommunicable diseases hopefully developed in 2010.

Examples of indicators

- Indicators related to tobacco use
  - Number of countries that have excise tax rates of at least 50% of the retail price of a pack of the most commonly-used cigarettes
  - Number of countries with complete smoke-free legislation covering all types of places and institutions, as defined in the WHO Report on the Global Tobacco Epidemic, 2008
  - Number of countries with bans on tobacco advertising, promotion and sponsorship, as defined in the WHO Report on the Global Tobacco Epidemic, 2008
  - Number of countries that have incorporated smoking cessation support (including counselling and/or behavioural therapies) into primary health care, as defined in the WHO Report on the Global Tobacco Epidemic, 2008
  - Prevalence of tobacco use among adults aged 25–64 years

These are some examples of indicators used to monitor tobacco use. As I said, WHO is currently refining these indicators to develop the basis of a global information system to monitor our progress in addressing the noncommunicable disease and tobacco epidemic.

In conclusion, the world now has to deal more effectively with the leading causes of death and disease burden. These are conditions that are causing tens of millions of deaths every year, leading to enormous loss in terms of lost productivity and health care costs, contributing to poverty and progressively impeding sustainable development. We have the right vision and sound strategy
to address them now. For tobacco, we have clear scientific evidence not only for the devastating effect of smoking but also the evidence on the serious hazards of exposure to smoke, second hand smoke. The only proven way of protecting people from the harmful effects of exposure to tobacco smoke is a completely smoke free environment. This is being done in many countries, including some developing ones. I hope that you will agree with me that what the UN stands for should make it among the first institution to move in this direction and should motivate all to work for a smoke free UN.

Thank you.