World Health Organization

REGIONAL OFFICE FOR Europe

Consultation on the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases

Copenhagen, Denmark, 17-18 March 2011

Report of the meeting

ABSTRACT

During 17-18 March 2011, 79 participants including NCD technical counterparts from 36 Member States, 1 intergovernmental organization, 7 observers and the WHO secretariat met to develop a five-year operational plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases, and to contribute to the development of a European position on NCDs and development in advance of the Global Ministerial Conference and the United Nations High Level Meeting. There was also opportunity to discuss a practical set of actions that can be taken by Member States, by WHO and by partners to address the epidemic, and to review the responses to noncommunicable diseases already taken across the European Region.

Keywords

CHRONIC DISEASE - PREVENTION AND CONTROL
STRATEGIC PLANNING
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Introduction

Opening session

A consultation of WHO European Member States was held on the 17th and 18th March 2011 in Copenhagen, Denmark, hosted by the WHO Regional Office for Europe. It brought together national technical focal points for noncommunicable disease (NCD) and other stakeholders to develop a five-year operational plan for the implementation of the European Strategy for the Prevention and Control of NCD ('European NCD Strategy').

Dr Jose Martin Moreno, Director, Programme Management, WHO Regional Office for Europe welcomed participants to the meeting on behalf of the Regional Director. He paid tribute to Dr Gudjon Magnusson, former Director, Health Programmes, for the leadership that he had shown in developing the European NCD Strategy, endorsed by Member States in 2006. He outlined developments since then and the broader context, with the concurrent development of a WHO European health policy, Health2020, the First Global Ministerial Conference on Healthy Lifestyles and NCD Control and a forthcoming United Nations General Assembly High-level meeting on NCD in September 2011. Given this time of global opportunity, he asked participants to look to their own responsibilities and to consider what they might deliver five years hence.

Objectives and scope of the meeting

Dr Gauden Galea, Director, Division of NCD and Health Promotion, invited participants to introduce themselves. There were 79 participants in attendance, including representatives of 36 Member States and 1 intergovernmental organization, 7 observers from nongovernmental organizations, 4 WHO Temporary Advisors and the WHO Secretariat (Annex 2). The main objectives of the meeting were: to review the responses to noncommunicable diseases across the European Region; to agree on a practical set of actions that can be taken by Member States, by WHO and by partners to address the epidemic in the next five years to 2016; and, to contribute to the development of a European position on NCDs and development in advance of the Global Ministerial Conference and the United Nations High-level Meeting.

Background and context of the consultation

Dr Robert Bertollini, Chief Scientist, WHO Regional Office for Europe greeted participants and introduced the speakers that followed.

Dr Agis Tsouros, Head, Policy and Cross-cutting Programmes and Regional Director's Special Projects, presented the concepts and principles for the European health policy, Health2020. This policy framework is intended as an overarching 'umbrella' framework with the objective of interconnecting various elements of WHO work in a coherent, integrated way. The vision of Health2020 is to enable people to reach their full potential for health and well-being. It is intended to be challenging and practical, evidence-based and value-based. A participative process had been set up for its development which would engage a wide range of partners and aimed to be a vehicle to generate debate within countries. In developing the policy, a number of questions needed to be addressed including which interventions would have the greatest effect

and which opportunities held the greatest promise. He went on to list the issues that matter to maximize impact such as health being a responsibility of the whole of government, and the need to invest in health promotion and disease prevention. These would give the European NCD Strategy and its Action Plan for implementation a better chance to be implemented.

Professor Karl Andersen, Landspital University Hospital, Iceland and on behalf of the European Chronic Disease Alliance, gave an overview of the burden of NCD in Europe and the best strategies for tackling them. While great progress has been made in some areas such as reduction in tobacco prevalence, there are some worrying trends, particularly obesity and diabetes. He drew attention to the three-fold difference in standardised death rates for NCDs across Europe which largely comprises differences in deaths from cardiovascular diseases. Where large reductions in deaths from coronary heart disease (CHD) have been achieved, modelling estimates this to be mainly due to an improvement in risk factors with only a small proportion attributable to treatment. Taking the example of Iceland, its 80% decline in CHD over 1981-2006 was mainly achieved by relatively modest population-level reductions in cholesterol and blood pressure, as well as a halving in tobacco prevalence. Nevertheless, the worsening of some risk factors (obesity and diabetes) threatened to counteract the benefits seen from these other achievements. He presented the advantages and disadvantages of population-level and high-risk prevention strategies, concluding that both are needed but with greater emphasis at the population-level. Finally, he gave examples of strategies in countries for reducing salt, *trans*-fats and saturated fats and smoking prevalence as likely to bring the greatest impact on CHD and to save costs.

Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases

Dr Gauden Galea, introduced the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases ('NCD Action Plan'). He explained that it is being developed alongside Health2020 with its focus on systemic risks and societal responses, and the health system and public health policy paper which challenged the health system to collaborate intrasectorally and make better links between its separate strands of work. He drew attention to three things for consideration with respect to NCD: the role of social networks in 'transmission' of noncommunicable diseases and their risk factors; the many 'populations' within a population, some particularly vulnerable, which makes a 'population-level' prevention strategy even more complex; and the efforts of industry to influence health policy through lobbying and other activities which are ignored at our peril. Recognising the comprehensive, integrated approach of the European NCD Strategy, the NCD Action Plan seeks to focus on a few priorities that could be achievable over five years. As there was a danger of not achieving anything when committing to everything, he was proposing a short list of areas for focus that could have significant benefit for Europe by the end of five years.

He then asked members of the Division of Noncommunicable Diseases and Health Promotion to introduce their work and how it relates to that of the NCD Action Plan.

Dr Valentina Baltag, Technical Officer, Adolescent Health, introduced the work of the Maternal Health, Child and Adolescent Health and Sexual and Reproductive Health programmes. The NCD Action Plan had made them reflect on the links between their programme areas and NCDs and how they might do things differently. Risk factors accumulate throughout the life course including intrauterine. Birth weight is a predictive factor for NCDs in later life and they have been recently focusing on the birth weight registration. NCDs, for example maternal obesity and diabetes, can affect pregnancy outcomes; the course of pregnancy

affects the likelihood of NCD in the future for example weight gain and pregnancy-induced hypertension can lead to a greater risk of NCDs in later life. Health promotion and disease prevention can be integrated into antenatal care. Child and Adolescent Health programmes often focus on diarrhoea and sexual health; this now gives an entry point to look at NCD.

Ms Rula Khoury representing the Tobacco Control programme informed the meeting that the Framework Convention for Tobacco Control has been ratified in 46 countries and the European Union. Regarding Alliances, the FCTC represents a powerful tool, with civil society a key actor. Within surveillance, a key focus has been data harmonization; four standardized survey tools are available with a range of options. They also collect national estimates on tobacco prevalence from countries which they can standardize for comparability. In relation to social determinants of health, there has been a recent M-POWER report on women and tobacco. Implementing the FCTC requires a whole of government approach. As to health systems, a recent global survey of health professionals found that very few had been trained in effective interventions to combat smoking; they can offer a model to do this.

Dr Joao Rodrigues da Silva Breda, Programme Manager, Nutrition, Physical Activity and Obesity, said that 1 in 4 children in Europe is overweight or obese and lower socio-economic groups are more affected. Four in ten European citizens aren't doing sufficient physical activity each week. There have been various declarations and policies at the European level including the Food and Nutrition Action Plan and the Obesity Charter and many European countries have put in place their own policies; for example, 36 Member States have new developments in monitoring and surveillance. His programme had specific contributions to make for each of the five areas of the NCD Action Plan and, regarding the proposed priority areas for focus, they had particular experience on the issues of marketing to children and with a salt action network.

Dr Lars Moller presented the work of the Alcohol and Illicit Drugs programme. Europe has the highest alcohol consumption of any WHO Region. There are huge differences in drinking patterns and consumption within the Region, with increasing consumption in eastern Europe. Europe was the first WHO Region to have an action plan, first starting in 1992. They have been working with the European Commission on reducing consumption and harm. There is a new alcohol information system and a recent alcohol status report for Europe.

Dr Matt Muijens, Programme Manager, Mental Health, said that the link between NCD and mental health is very strong. Those with intellectual disabilities can lack access to decent healthcare and, although frequently high risk, may get no care for NCD. The burden of disease is very high for those with mental health problems and those with significant co-morbidities die younger. Behavioural risk factors may be higher, for example smoking prevalence is high amongst people with anxiety. There is a powerful social gradient for stress and cardiovascular disease. Mental health is not a core feature of the NCD Action Plan as it will have its own strategy in 2012.

Finally, **Dr Dinesh Sethi**, Technical officer, Violence and Injury Prevention, spoke of the overlap in risk factors for NCD and injuries such as alcohol and poverty. The life course approach is closely linked to risky behaviours in adolescence that impact on both NCDs and injuries. Transport policy links closely to other agendas such as climate change which is relevant to public health. Common approaches are needed which involve intersectoral working and strengthened health systems.

Country experience, strengths and needs in NCD control

Participants divided into five small groups, working in parallel on the same topic. The aim was to gather country experience, strengths and needs in NCD control, particularly with regards to the priority actions proposed. The objectives of the exercise were: to gain an overview of where countries' main strengths and needs are; to find out whether countries have other areas in NCD control that they are proud of and wish to share; to help WHO find out if there are countries that have experience that could be used at a later date in a case study.

Feedback

In the afternoon, **Dr Sheela Reddy, United Kingdom** chaired the session at which workgroups fed back from their discussions.

Dr Alban Ylli, Albania, presented on behalf of workgroup A1 which comprised representatives from Belgium, Albania, Romania, Croatia, Norway, Portugal, The FYR Macedonia and Turkey. He summarised first the general strengths. Each country has some policies and plans focusing on specific aspects of NCD, for example tobacco, cancer; some countries have broader NCD strategies (Belgium, Macedonia, Romania). In each country there are dedicated resources and structures for information systems including NCD-related data yet, although there is a lot of data, it may not be valid or used. Fiscal policies on tobacco and alcohol are present in all the countries; these may be related to health care financing in some countries (Norway, Romania). All countries are organising NCD related information campaigns for general population or school populations. Some services for early detection and secondary prevention exist in all countries; in a few cases, these are advanced and systematic.

Moving then to common needs, the development of integrated plans for NCD posed a problem. Countries need a more participatory approach in building them; where they exist, the plans need to focus more on primary prevention and to have more resources dedicated to primary health care. Secondly, there is a need for standardisation of indicators for NCD, in collaboration with all existing international organisations. These should be not only to measure burden but also to monitor programmes. More leadership and more resources are needed from ministries of health in support of intersectoral approaches – other ministries may appear passive and uninterested. New technology could be used in improving health literacy but needs to be adapted to cultural context and educational level. Finally, NCD services within health system need to be more integrated and with appropriate involvement of primary health care.

Dr Liis Rooväli, Estonia presented feedback from workgroup A2 which comprised representatives from Bosnia and Herzegovina, Bulgaria, Estonia, Poland, Slovakia and Spain. All countries had a national health plan or small, separate strategies, for example on cancer or obesity, although there may be issues with implementation. In some countries, these overall and issue-specific strategies were linked, in others not. Almost no country had data by socio-economic categories and there was no system for morbidity data and disease registries. She proposed that WHO make analysis of which indicators are needed and establish guidance on how to collect and monitor. Regarding fiscal policy, the majority had implemented tobacco laws although they might perceive potential ethical issues in relation to using funds from taxing tobacco to finance public health activities. Almost all countries had some initiatives to support physical activity such as cycling paths. They needed to strengthen their links with communities for policy-making. Regarding secondary prevention, almost all had cervical and breast screening, some colorectal screening. Primary health care needs strengthening and more to deal with

prevention. Overall, their proposal was that the NCD Action Plan be more concrete on what to do, with options and tools to implement.

On the use of tobacco taxes for funding public health activities, the WHO Secretariat responded that it is possible for consumption to reduce and revenue to increase at the same time.

One participant asked if WHO and the EU might target finance ministries with these arguments to assist the Ministries of Health. **Dr Stefano Vettorazzi, European Commission**, responded that whether or not to target funds is up to Member States, the EU does not have power in this area.

Dr Theodora Stavrou, Greece presented feedback from workgroup A3 which comprised representatives from Bosnia and Herzegovina, Finland, Greece, Lithuania, Serbia, Switzerland and United Kingdom. She described a mixed group in which some had comprehensive national strategies or plans which were well implemented, whereas others had these only on paper. They need better integration of the comprehensive national health strategies with the separate risk factor strategies, and with related policies like accident prevention. Improvement was required to health information systems. It would be useful if WHO and the EU used common indicators and distinguished the key indicators so that good quality data could be collected using common methodology through nationally organized efforts. Fiscal policies were mainly in the area of tobacco, not salt reduction. Healthier alternatives were available for food products but were an expensive choice. Regarding health literacy, they found it difficult to change behaviours; clear and consistent messages are required. Evidence-based information which meets the growing demand from the population is needed which could also provide guidance to people who suffer from NCDs in order to manage their conditions. More guidance from the European level on cardiovascular risk assessment would be valued as well as WHO guidelines on what to screen, how to screen and when. They thought it would be helpful if WHO emphasised the importance of funding allocated to preventive services. Finally, they supported alliance with NGOs, professional organizations and industry when appropriate but not for tobacco.

Other members of the work group commented. The integration effort also referred to that between clinicians of different fields, for example, cardiologists and oncologists etc. Another suggested that systems needed to be set up for monitoring the new programme. **Dr Stefano Vettorazzi, European Commission**, clarified that the European Commission has been asked to follow up on the Council Conclusions "Innovative approaches for chronic diseases in public health and healthcare systems" of December 2010 with a reflection process and paper by 2012.

Dr Mariella Borg-Buontempo, Malta, presented feedback from workgroup A4 which comprised representatives from Austria, Belgium, Hungary, Israel, Latvia, Malta and Slovenia. Most countries in the group have a national plan although some are at planning stage, some being revised. Most do regular surveys and can disaggregate data. There is an important need for collaboration across sectors, particularly given the long-term time frame required. In taking a 'health in all policies approach' discussion should take place at an earlier stage to avoid problems later with implementing fiscal and marketing measures. All government sectors should be included and co-ordination is needed. Most of the countries have health literacy, health promotion and community empowerment but these are underdeveloped and need strengthening. More coordination and communication between stakeholders is needed. This is a long term challenge so being pragmatic and realistic, it is necessary to identify achievable short term goals to show some successes while also starting more longer term goals.

Another member of the work group added that, on the question of prioritising the action areas, it can be very hard for professionals to compromise and recognise that it is not possible to do it all now. In deciding where to begin, she recommended aiming at areas where most consensus and then go for stricter measures. It was also commented that when engaging politicians, the opposition should not be forgotten, otherwise a change in government might lead to significant changes in policy.

Dr Jeyhun Mammadov, Azerbaijan presented feedback from workgroup A5 which comprised representatives from Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Netherlands, Republic of Moldova, Tajikistan, Turkmenistan, Uzbekistan. They had had an intensive discussion. Most countries had national programs on specific diseases or risk factors such as CVD, diabetes, healthy life promotion, tobacco control, salt iodization, mental health. These could serve as a good foundation to expand into an NCD comprehensive plan although few had such broader, integrated NCD strategies in place. Political will to take action existed in some countries but for a number there was weak implementation of current NCD-related legislation such as for tobacco and alcohol control. There is a need to build capacity of the health sector to influence politicians and other sectors, including on fiscal and marketing issues such as taxation. More attention to nutrition issues is also needed, especially to reduction of salt consumption. NCD situational analyses had been conducted in a number of countries but there was a need to improve information systems to better monitor or track NCD related issues and use this information as a baseline for planning. Some countries experienced staff shortages in rural areas and in primary health care. Further needs expressed were to improve community involvement and to develop quality standards for chronic diseases management. WHO support was considered as critical in agenda setting.

One participant asked for clarification as both salt iodization and salt reduction had been discussed. **Dr Joao Rodrigues da Silva Breda, Programme Manager, Nutrition, Phyiscal Activitiy and Obesity** explained that iodine deficiency issues had been recognised as an urgent issue for some Member States. It is not incompatiable to have concurrent programmes for salt iodization and salt reduction.

Discussion

In the discussion that followed the completion of feedback, there were contributions from 3 countries (Estonia, Lithuania, United Kingdom), as well as WHO Secretariat.

There appeared to be consensus to take a comprehensive, integrated approach, while at the same time to do a few things together to make a difference. The concept of integration, with its many dimensions, needs emphasis particularly given the common risk factors and their multiplicative effect.

The European NCD Strategy and NCD Action Plan appear to use different frameworks, and these do not match the Global NCD Action Plan, therefore, it would be useful map these against each other to more clearly show the links. It would be helpful to see more clearly how elements were derived and to be quite clear how the prioritising has been done.

In selecting specific actions, there is value in choosing ones that do not lose the common elements that bind the disease-specific groups together, for example focusing on salt reduction may be of interest to a cardiovascular NGO, less so for a cancer NGO whereas tobacco control would be of interest to both.

Action areas of the NCD Action Plan

Following the coffee break, the meeting then broke into five parallel sessions. The draft NCD Action Plan has five main action areas, each of which has a list of possible actions. The intention of this session was to take a close look at each of the action areas (one per work group) and consider where countries might place their priorities and how they might measure progress in these. The specific objectives of the session were: to review one specific action area, gathering general comments on its approach and content; to discuss the key actions to be taken by Member States and WHO in the next five years, and which 2-3 would have priority; to consider what targets might be set for this action area, and for suggested priority actions in particular; to consider how progress in this action area, and for these priority actions in particular could be measured; to consider how suggestions for the area reflect the concept and principles of Health2020. Within each group, one or more 'seeds' had been planted to to initiate discussion on the topic for 5 minutes opening at the start of the working group.

Dr Vlasta Hrabek-Zerjavic, Croatia chaired the morning plenary, starting by thanking the hosts for the reception given the previous evening. She reiterated that the purpose of the morning was to receive feedback from the parallel sessions and to agree a way forward on the NCD Action Plan.

B1: Building Alliances and networks and fostering citizen participation

Feedback

Dr Alban Ylli, Albania, presented back from **Workgroup B1:** ***Building Alliances and networks and fostering citizen participation***, which had chaired been by Dr Pol Gerits, Belgium. The countries participating in the group were: Albania, Belgium, Portugal, Romania and the FYR Macedonia. The 'seeds' were Professor Stig Pramming and Professor Vilius Grabauskas, Lithuania and the WHO staff participating were: Dr Nedret Emiroglu, Executive Manager, Division of Communicable Diseases, Health Security and Environment and Dr Dinesh Sethi, Technical Officer, Violence and Injury Prevention.

The discussion was not focused on countries but instead on the need for working together, building alliances. They had discussed which stakeholders needed to be involved and their role, what tasks needed to be carried out and the efficacy of the networks, as well as feasibility and sustainability issues regarding networks. They had described two levels of networking, one at the European regional level which attracted international bodies and NGOs, the other at the national level. For both levels of networks, tasks over the five years would be: to become more coordinated and systematic and thus more effective in advocacy activities; to agree a common platform by different parties in the network (common principles, common language); to build capacity amongst NHOs (professionals' and citizens' groups); to agree new ideas and solutions; and to gain more involvement from the media. They remarked that financial sustainaibility was a critical success factor for both levels of network.

Discussion

In the discussion that followed, there were contributions from 5 countries (Albania, Croatia, Israel, Spain, United Kingdom), 3 observers, 2 WHO Temporary Advisors, as well as the chair and WHO Secretariat.

There was substantial discussion on the the issue of working with industry and their inclusion within alliances for NCD prevention and control. Ways of interacting with industry without getting resources or advice from them were discussed. Some recounted their difficulties while others spoke more positively of their experiences; in both situations, setting limitations in the relationship with concrete pledges and specific goals was considered helpful. There was some debate over whether some industries such as sports, insurance, were genuinely interested in healthy lifestyles and shared goals with public health. It was noted that there can be a difference in the areas where the private sector is willing to participate. So, for example, the food industry might be willing to act in areas such as health information, which are less effective, whereas public health was more interested in other areas such as salt, saturated fat, marketing. Self-regulation of the tobacco and alcohol industries has not worked and there are examples such as marketing to children where high responsibility might be expected to be shown by the private sector but it is not happening. Participants were reminded that industry is a fully legal member of society and important as a stakeholder. It was possible to learn from them and test ideas but it required a different approach. They could be offered a role in public health actions under certain ethical rules which could be acknowledged. Recognising that there is wide scope for interaction with the private sector but with limits, WHO Secretariat proposed an initial set of guidelines for the relationship which can be further developed to support the Action Plan. This could be used in terms of potential conflicts of interest and to ensure the private sector gained no competitive advantage nor influenced norms.

The need for an appropriate regional network mirrored by national networks where appropriate was noted. Examples were shared of alliances with health professionals and patient organisations within countries and international. A focus on co-morbidites and common factors was felt to be more efficient than separate alliances with disease-specific groups. The importance of talking with doctors and working with them to improve practices was emphasised.

Specific suggestions were made regarding the text of this area in the NCD Action Plan. The roles and tasks of WHO should be divided from those of the Member States, otherwise there is overlap with each other that could lead to further debates. Regarding supranational cooperation, the OECD and European Union should be included and there needs to be clarity on who is doing what so that not everyone was trying to do everything. The media should be very visible and the social media should not be forgotten, particularly when approaching the younger generation.

B2: Strengthening surveillance, monitoring and evaluation

Feedback

Dr Liis Rooväli, Estonia, presented back from Workgroup B2: *Strengthening surveillance, monitoring and evaluation*, which had been chaired by Jasminka Vuckovic, Bosnia and Herzegovina. The countries participating in the group were all from the European Union: Bulgaria; Spain; Finland; Poland; Estonia; Bosnia and Herzegovina. The 'seeds' were Professor Kari Kuulasmaa, Finland, and Professor Maximilian de Courten, European Chronic Disease Alliance and the WHO staff participating were: Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, Trudy Wijnhoven, Technical Officer, Nutrition, Physical Activity and Obesity, Ms Rula Nabil Khoury, Regional Surveillance Officer, Tobacco Control and Dr Manfred Huber, Coordinator, Health Ageing, Disability and Long-term care.

There were big differences in monitoring systems between countries. All had mortality data, hospitalised morbidity data and cancer registries. Some additionally had regional or institutional disease-specific registries for myocardial infarction, diabetes mellitus or stroke, some of which were project-based. All carried out health information surveys, usually every 3-5 years, on risk

factors some of which could be disaggregated by socio-economic status. All participated in the Health Behaviour in School-aged Children surveys and the European School Survey Project on Alcohol and Other Drugs (ESPAD), some do health examination surveys, some have nutrition surveys and others ad hoc studies. In general, there are sufficient resources to carry out regular surveys. Other countries had access to health insurance data with personal identifiers and prescription data. Some have monitoring systems for national strategies and action plans. Estonia has carried out a national burden of disease study using the WHO CHOICE model which has enabled attribution of disease burden to risk factors and proven a powerful tool.

The group is convinced of the importance of the monitoring/evaluation process, seeing two aspects: a general evaluation of health risks and NCDs, and an evaluation of the five-year NCD Action Plan. They consider the evaluation part of the document to be very weak and note that whereas research was part of the European NCD Action Plan, it seems to be missing from the NCD Action Plan. They believe that research and producing evidence is needed; this might comprise evaluation of effect and cost-effectiveness of interventions, attribution of results of concrete actions to outcomes, and working out what would be the most effective way to use or cut funds. They noted that it is easy to make cuts in a country where there is no evidence but if the evidence is not collected then they felt they were not helping themselves. They underlined the importance of a general monitoring system to follow progress though recognised that this needs to be sophisticated for a comprehensive integrated approach. They recommended that WHO develop a concrete document or convened a coordinating body to develop an approach on how and what to monitor. This should use a combination of different data sources and methodologies, feasible at different income-levels of countries and identifying a few really concrete, realistic indicators to collect in a standardised way, as well as target groups to be addressed. Taking a long-term perspective, monitoring/evaluation of NCDs and risk factors has to be integrated into general health information system to support linkage and sustainability and to follow longer impact of work on NCDs. They recommended that WHO coordinate and cooperate with other international organizations to support monitoring and evaluation at the country level and international comparability and benchmarking.

Their final comments on improvement of the document were: to strengthen the evaluation part so it is not only included in the section's title; to make the action points more concrete and specific to help countries to implement; to address the relevant information needs of the policy makers and stakeholders; and, to strengthen the part of sharing good practices.

Discussion

In the discussion that followed, there were contributions from 8 countries (Romania, Belgium, Israel, Turkey, The FYR Macedonia, Kakakhstan, Finland, Slovenia), 2 observers and 1 WHO Temporary Advisor, as well as the chair and WHO Secretariat. The discussion covered both this section and some general comments on the NCD Action Plan.

Advice was to be consistent with actions, indicators, monitoring and evaluation approaches for the other WHO risk factor-specific action plans. There was caution against relying just on randomized controlled trials for evidence as these only included a small fraction of people with a condition. Account should also be taken of 'natural experiments' which show the effects of interventions on the general population. In general, there was perceived to be sufficient evidence to start to take action without needing to wait for more. In strengthening the evaluation part of the section, it should avoid becoming disconnected from specific action, and a treatise on evaluation rather than practical. It should look at identifying a number of actions and identifying

indicators to go with that. The difference between evaluation of prevention interventions and other types of interventions was remarked upon. The need for upward /outcome /progress indicators was suggested, as were measures to reflect intersectoral cooperation for each and every sector.

It was re-emphasised that there were two aspects to the group discussions, one the evaluation approach for the NCD Action plan which is short-term, and the other, the development of health information systems which is more long-term. There is a value in having specific targets for the former because these can spur politicians to action, as in the tobacco field. It may take time to develop targets and decide what type so these may need to be decided at a later stage; it would be also difficult to do until it was known which actions remain in the rest of the document and how their progress should be best evaluated, for example to take account of alliances and co-morbidities. An Expert Committee could be convened to assist with this. A scorecard system could be used to compare progress against a series of action points. Indicators could be standardised if there were specific actions to recognise the diversity in countries and indiciators sensitive to that diversity.

From the comments, there seemed to two views on the style of the NCD Action Plan overall: one suggesting to take the approach of the Global Action Plan with its broad, aspirational goals, the other suggesting a more specific approach to point out who does what, with what resources and to whom activities should be reported over what period. There was a suggestion that the latter approach might help to strengthen primary prevention efforts in countries. The consensus seemed to be to take an approach inbetween the two options which was sensitive to different levels of development so that there were different solutions for different countries. A step-wise approach depending on country resources was proposed as an organising principle for the Action Plan.

B3: Addressing social determinants of NCDs

Feedback

Dr Theodora Stavrou, Greece, presented back from ***Workgroup B3: Addressing social determinants of NCDs*** which had been chaired by Dr Sheela Reddy. The countries participatiing in the group were: Belgium, Bosnia and Herzegovina, Croatia, Greece, Hungary, Kyrgyzstan, Serbia, Slovakia, Slovenia, Turkey. The 'seeds' were Dr Jozica Zakotnik and Mr Erik Blas, and the WHO staff participating were: and Dr Agis Tsouros and Dr Manfred Huber.

In many ways, she felt their discussions linked to those of the previous two groups. Overall, there was agreement of the need to address social determinants: there is a lot of talk about inequalities without doing anything about them. Data collection is important but there is enough evidence already accumulated to act. Perhaps, as with previous groups' discussions, a stepwise approach might be considered. They had agreed with the need to collect data that is disaggregated. This also means going beyond existing databases as data is not routinely available on people who do not seek care. They had discussed interesting efforts to influence government that equity is important. There a need for better communication with the public and for the use of mass media to highlight inequity. Health professionals need to be trained to recognize the importance of social determinants. They had shared successful examples of local government involvement. They had noted how difficult it is to change behaviour in socially disadvantaged groups. They had found the notion of "proportionate universalism" from the UK Marmot social determinants report to be helpful, that is, focusing efforts on disadvantaged groups while retaining a universal framework of service.

They recommended that the NCD Action Plan could be more specific on actions. Priority actions would be that policy implementation should be monitored and evaluated and NCD surveillance data is improved by disaggregating by age, sex and social strata. Capacity building would be required for this new approach. While they recognised the importance of early life interventions, they also felt there to be a continuum throughout life and considered it difficult to set priorities and separate parts of the life course. They had discussed equity impact assessment and thought it would be useful to have tools; only the United Kingdom seemd to have experience of this. On the issue of targets, it seemed that only the United Kingdom again had a national set of indicators. They asked what they measure (Input, Progress, Outcome).

Discussion

In the discussion that followed, there were contributions from 4 countries (Belgium, Slovenia, Turkey, United Kingdom), 3 observers, 1WHO Temporary Advisors, as well as the chair and WHO Secretariat.

This area was considered an important but challenging issue. Practice advice was offered such as focusing on a few important determinants such as gender and education and getting started, rather than becoming overwhelmed and inactive. Attention was drawn to the good work that already exists at the subnational level, for example healthy cities, which can provide useful examples for the national level. Public health professionals, and others, were thought to need support with good examples, tools and capacity-building on how to approach governments and deal with other sectors. Apparently, at the European Commission there exists a working group on health equality which is developing a tool for equity impact assessments.

Data can be powerful and add strategic value. Yet there can be a disconnect between NCD experts, who are already aware of what the data shows, and the non-experts who are relatively unaware. Because of the gap, there is a lack of urgency amongst policy-makers and still the belief persists that it is a matter of individual choice rather than public health action that is required. Reliable data is needed as is a need to understand more on an humanistic basis and gather information through different methodologies, for example focus groups. It was suggested that WHO have a responsibility to help make the connections between experts and policy-makers and to ensure that data is accessible and communicated in different formats to different audiences through different media.

There was support for strengthening the area of social determinants further in the action plan, to be more specific on actions and the importance of related sectors, and a suggestion to merge this and the health promotion parts of the document. There was support for taking a step-wise approach as had been proposed in discussions for the Surveillance section, with both short-term and long-term actions. Given the breadth of the topic, the NCD Action Plan cannot address everything but can instead say what specifically an NCD programme can do to address social determinants. More could be done within the health sector for example, such as having gender-responsive services with universal access, addressing certain groups and reporting on inequities.

B4: Promoting health and preventing disease

Feedback

Dr Mariella Borg-Buontempo, Malta, presented back from ***Workgroup B4: Promoting health and preventing disease*** which had been chaired by Dr Ruth Weinstein, Israel. The countries

participating in the group included Israel, Malta and Latvia. The 'seed' was Dr Sylvie Stachenko and the WHO staff participating were: Lars Møller and Joao Rodrigues da Silva Breda.

Again there were similarities between their discussions and those of other groups. Their impression was that the essence of 'integration' seems to be missing within this action area and they proposed more emphasis on it, encompassing both intersectoral and intrasectoral components. They also found the prevention component to be not very evident within this action area and to need strengthening, clarifying the responsibilities of those outside heath system. They thought that health literacy was working at different levels (clients, health professionals, politicians) and so proposed that it be removed from the priority actions framework, and put horizontally as an overarching component with integration being achieved through this. Similarly, they thought that social determinants should be overarching as a horizontal component across all areas together with health literacy as presently it is only limited to disaggregation within surveillance systems. The group recognised that equity was not included within the context of prioritising, however they felt the need to be mindful of it. They found evidence to be lacking on community programmes and community empowerment and that tracking real outcomes was problematic.Different scenarios require different levels of evidence at which to act and rather than being paralysed waiting for evidence, the best available evidence could be used instead, monitoring continuously in order to learn and adjust. Evidence shows that things must not be done in isolation – multicomponent programmes are the most effective.

In terms of more specific comments, they thought that the section might benefit in the following ways:

- Although mental health is not included as a main condition in the NCD Action Plan, a comment should be included later on in this part of the document
- Paragraphs 72, 73 and 74 are extremely general and Paragraph 72 needs to be made more concrete
- Additional, complementary products might be a targeted advocacy paper on the priority areas and a policy toolkit developed by looking at evidence from other countries and how good practice is spread
- Inclusion (or link to) more concrete actions taken from the four current risk-factor-specific action plans in tobacco (FCTC), alcohol, obesity and food and nutrition
- Highlighting specific priority actions by specifying and separating out: marketing to children and young adults; transport and urban planning; fiscal and marketing aspects for salt, tobacco, alcohol and transfat
- Inclusion of action targets
- Expanding the fiscal recommendations explicitly to include incentives for prevention, such as those to primary care physicians

Discussion

In the discussion that followed, there were contributions from 2 countries (Israel, United Kingdom), 1 observer and 3 WHO Temporary Advisors, as well as the chair and WHO Secetariat.

The need for better alignment of this section with that on 'health in all policies' and social determinants was re-emphasised; it seemed difficult to split the health promotion section from the social determinants section. There could be further opportunity to spell out even further what is most effective in prevention, such as a population approach. An additional comment to the feedback was that, while a focus on *trans*-fats might seem easier to start with, it is important not to lose sight of the need to reduce saturated fats.

There was some further debate of Paragraph 74. A better balance between individual and community approaches, and thus the bullets contained within the paragraph, is needed. The expression 'health literacy might be replaced (or supplemented) by 'skills development' to add clarity and link back to the Ottawa Charter. Health literacy is very focused around people and public; if a 'health in all policies' approach were to be successful, then health literacy needs to be thought about in a broader way.

B5: Orienting health services towards prevention and chronic care

Feedback

Dr Jeyhun Mammadov, Azerbaijan, presented back from ***Workgroup B5: Orienting health services towards prevention and chronic care*** which had been chaired by Dr Eric Koster, the Netherlands. The countries participatiing in the group were: Azerbaijan; Belarus; Georgia; Iceland; Kazakhstan; Netherlands; Tajikistan; Turkey; Turkmenistan; Uzbekistan. The 'seeds' were: Karl Andersen and Ertuğrul Goktas and the WHO staff were: Dr Hans Kluge, Director, Division of Health Systems and Public Health and Dr Valentina Baltag, Technical Officer, Adolescent Health.

There was a broad consensus within the group on the need for a more coordinated and integrated disease management model; the need to manage co-morbidities in one and the same patient calls for more patient-centred approaches, with shared responsibilities of staff in the clinical pathways for an individual patient outcome - financial incentives can help achieve this. There is also the need for better balance between secondary/tertiary care and primary prevention. This requires arguments or data to convince politicians, for example, sharing successful lessons from different countries or elsewhere within the country that prevention programs save money and reduce health inequality. It also needs action taken across Government sectors given that much action is outside the Ministry of Health and a shift in thinking among both politicians and population. The group recognised that there are high expectations from individuals to have access to high technology medicine, which can be expensive but is not always most effective, and this is compounded by pressure from private industry.

The group saw as priorities the need to study lessons learned and use a patient oriented model, to practice an integrated approach to tackle diseases together, and to establish healthcare surveillance to measure impact of health interventions.The latter should include how patients/families are satisfied and what patients feel about their health. They saw WHO as playing a good role in documenting and disseminating lessons learned and good practices.

Regarding specific textual changes, they had comments on two paragraphs:

- Paragraph 81, bullet 4: on the issue of implementing population-based, organized screening programme, they asked that this reflect country context given that the evidence-base and cost-effectiveness, sensitivity and specificity, depends on prevalence in the population, and that health care workers & health system need to be prepared to manage patients diagnosed through screening.
- Paragraph 83, bullet 2: the considered the word "universal" as not applicable, suggesting instead: "a universal access through appropriate health financing models, adapted to country-specific context"

Discussion

In the discussion that followed, there were contributions from 5 countries (Netherlands, Serbia, Slovenia, Spain, the FYR Macedonia), 1 observer , as well as the chair and WHO Secretariat.

There was some discussion on the issue of financial incentives for health professionals to carry out prevention. Some found this difficult to understand or implement, others thought it a good idea and had experience to share. It was explained that although many people have co-morbidities, traditional tools are oriented around the management of individual diseases. Provider payment mechanisms do not have disease-oriented outcomes but stimulate across a group of professions and can lead to a more patient-centred model.

Better connections could be made between this section and others (areas 2, 3, 4) so that social determinants, prevention and care are better linked. One example given was that many primary health settings have focal points for health promotion and these health professionals could contribute to community empowerment.

There is an opportunity to emphasise the potential role of public health institutes and centres, and to advocate for their strengthening. These have the role of coordinators and evaluators, placing NCD at a higher priority level on the agenda or in activities or intersectorally. South-east Europe has a number of good examples of networks of national and regional public health institutes. Additionally, health professionals needing to train and reorient to update their competencies was mentioned.

Finally, it was suggested that this section mention that for the high risk and those already ill, non-medical treatment of chronic diseases was also beneficial.

Preparing for the Global Ministerial Conference and UN high-level meeting

Overview of the preparatory process

In this session, Dr Galea shared the process for the UN General Assembly high-level meeting on NCD that takes place 19-20 September 2011 in New York. He clarified that this is not technically a 'summit' nor a 'special session' within the General Assembly but a 'high-level' meeting; as such it can run for two days. A successful meeting would need the involvement of Ministries of Foreign Affairs, nevertheless, he recognised that there is not always a relationship between Ministries of Health and Ministries of Foreign Affairs. Leading up to the event, six regional consultations have been organized: that for the WHO Western Pacific Region took place the day before, the one for the WHO African Region is due the following month. The one for the WHO European Region took place during November 2010. The report of the Oslo meeting has been circulated to countries for comment. There has been extensive feedback and the report would be published shortly. There has also been a web-based consultation about the same report to get ideas of what a wider group is thinking. Two further informal consultations have taken place with non-governmental organizations and the private sector and the outcomes are published on the WHO headquarters dedicated website[1]. These will be supplemented by a UN agencies consultation as well as an interactive hearing of NGOs and the private sector for which registration will close on 15 April. The outcome documents from the consultations will feed into

[1] http://www.who.int/nmh/events/un_ncd_summit2011/en [accessed 29 March 2011]

a draft outcome statement for the high-level meeting which is being prepared by two appointed co-facilitators from Luxembourg and Jamaica. There will be ample time to positively influence the document through Member States's own preparations for the meeting.

In parallel, have been the preparations for the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control that will be hosted jointly by WHO and the Russian Federation and take place during 28-29 April 2011 in Moscow. Although it is a meeting in its own right, it also presents an opportunity for Ministers of Health to make a clear statement on NCDs in the run up to the New York meeting which will have a MoFA-dominated agenda. Prior to this Conference, there will be a multi-stakeholder forum to bring together the private sector and civil society on 27 April. In parallel on the same day will be a meeting of European Member States. There has been a rich debate in Europe with some reluctant to support on the NCD / development agenda. This day will be an opportunity to brief countries in their preparations for New York.

NCDs and development

Professor David Stuckler, Harvard School of Public Health, presented the links between NCDs and development. He explained how turmoil in markets or macroeconomic policies in Europe can have health consequences on the other side of the globe, and in turn have repercussions for health back in Europe. NCDs or chronic diseases have been deplored as the 'neglected epidemic'; two-thirds of countries have no budget or capacity for tackling NCDs and there is no significant relationship between aid and burden of disease. He referred to a 'scandal of ignorance' with people unaware of the problem, the global community having little support, and donors reluctant to ask for budget for issues outside the MDGs.

The UN high-level meeting is only the second disease-specific meeting of its kind; the first one on HIV/AIDs proved a turning point and there are similar hopes for this one. Given the danger of trying to do everything and achieving nothing, the Lancet NCD group is about to release a paper setting priorities for the highest yield, lowest cost interventions. These include tobacco control and reducing salt intake. While focusing on four main diseases, these seek an approach that is inclusive of other diseases for example through strengthening health systems and surveillance. This reinforces the NCD Action Plan and provides opportunities for Europe in taking a whole of government approach and a focus on inequalities and social determinants.

Discussion

In the discussion that followed, there were contributions from 6 countries (Switzerland, United Kingdom, Bosnia and Herzegovina, Slovenia, the FYR Macedonia, Lithuania) and 1 WHO Temporary Advisor, as well as WHO Secretariat.

Countries had a series of questions, wanting to know as soon as possible what would be the role and expectations of Ministers in Moscow, the nature of the outcome document, if there would be duplication between the Moscow and New York meetings, and how best to advise for the UN meeting. There was a strong message from the group that they needed to see the programme for Moscow. They would value a briefing paper for the meeting which provided them with some strong messages and arguments for Ministries of Health and other sectors to think about solutions to the problem. Only a handful of country representatives were already involved in the

process for the Moscow Conference. There was also reference to the Executive Board resolution on NCD due to be discussed in May and inclusion of NCDs in MDGs.

In response, the WHO Secretariat explained that the outcome document is a function of the UN not WHO and a draft will be made available sufficiently in advance to allow country consultations. The Regional Director is anxious to see a good ministerial representation from the WHO European Region in Moscow. There are opportunities for ministers to have roles in Moscow if they register and their interests are made known. Unfortunately, the programme is not yet available. The outcome of the Moscow Conference will be a Conference Declaration. The Moscow Conference is an opportunity to set parameters for global discourse. The Moscow Conference will be largely representatives of Ministries of Health whereas the New York meeting will involve those from MoFAs.

A draft resolution for Executive Board had been originally presented in January and would return in May.

Next steps

Country focal points were asked to get involved in the preparatory processes within their own countries. It would be useful to have a briefing paper to assist in preparations which: explains the process for the UN modalities paper; summarises the arguments on NCDs and development; consolidates the links with MDGs and social determinants; clarifies the importance of social justice and equity; outlines solutions relevant for high-, middle- and low-income countries; debates on how strongly to make the links with mental health and injuries.

Closing session

Dr Jose Martin Moreno fed back from the meeting of the steering group for the Global Ministerial meeting that had been taking place by videoconference in parallel with the preceding session. He was able to share a broad structure of the programme which had just been received.

Speaking on behalf of participants, **Dr Jasminka Vucković**, Senior Specialist for Primary Health Care and Public Health, Ministry of Health and Social Welfare, Bosnia and Herzegovina, thanked WHO for organising the meeting. It had been a chance to talk about an issue of importance for the countries. There had been excellent presentations and good work in groups. She recognised that countries had good strategies but problems implementing them. Given the economic climate, another issue would be how to finance all these activities. An additional theme was surveillance, monitoring and evaluation. Having heard so many rapporteurs today on action areas, she recognised the importance of evaluation of these areas and the importance of identifying a common set of indicators. There was now a chance to put NCDs as the top issue of the world.

Ms Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe, welcomed participants to the Regional Office and apologised for being unable to attend the opening session. She had just been key note speaker at a meeting organised by The Economist on the future of health care in Europe and NCDs had come up. It is a challenge to convince politicians of the need to invest in prevention, which has a medium- to long-term outcome, when hospitals present them with a more immediate problem. High-level political commitment is needed. She asked participants to ensure that their Ministers come to the Moscow Conference. Insufficient representation by the WHO European Region would be unfortunate. Secondly, she spoke of the complexity of NCDs. It is not possible to address the epidemic effectively without going down to

the root causes and determinants. This needs a whole of government approach with Ministries of Health in the driving seat. It needs the attention and support of the Prime Minister. What is needed now is action. Turning to the Action Plan, she supported a stepwise approach and to have a monitoring and evaluation system in place. She was pleased with the outcome of the meeting which had benefited from the rich input and experience of countries. Finally, she thanked everyone for their presence and to the WHO Secretariat and those who had worked behind the scenes to make the meeting a success.

Conclusions

Countries are at different stages in responding to the challenge of NCDs. While most countries have some policies and plans in place to focus on specific aspects, risk factors or diseases, fewer have broader NCD strategies. Where issue-specific strategies exist these may not be linked or implemented and the development of integrated plans poses a problem. There may be dedicated resources and information systems in place but data may not be valid or used and it may not be by socio-economic category. Standardised indicators are needed that allow within and between country comparison, and which can be used to monitor programmes not just measure burden. Fiscal policies are present in most countries for tobacco and alcohol control, less so for other risk factors. Breast and cervical cancer screening programmes exist in most countries and some have colorectal screening. Some services for early detection and secondary prevention exist in many countries but these may be advanced and systematic in only a few. More guidance from cardiovascular risk assessment would be valued as well as guidelines on what to screen, how to screen and when. Further support is needed in improving health literacy, in supporting intersectoral approaches and community empowerment, and in appropriate involvement of primary care, also in prevention.

There had been strong endorsement of the European NCD strategy with its comprehensive, integrated approaches and the NCD Action Plan needs to reflect those principles. There is consensus for a focused Action Plan in the form of an action-oriented business plan supported by a regional network. This presents the opportunity to do a few things together to make a difference.

The Action Plan needs to be mapped against the European NCD Strategy so that it is clear how the documents relate. The rationale for selection of specific areas for the NCD Action Plan should be made clear. There is interest in setting targets to be achieved by 2016 but these may not be set effectively in the next few weeks.

In style, there needs to be a balance in approach between that of the Global Action Plan with its broad, aspirational goals, and the alternative a more specific approach which points out who does what, with what resources and to whom activities should be reported over what period. The NCD Action Plan needs to be sensitive to different levels of development so that there are different solutions for different countries; a step-wise approach depending on country resources can serve as an organising principle for the Action Plan to help achieve this.

The concepts and approach to social determinants of health was considered important enough to merit integration across the document rather than to be confined to one section alone.

In general, there is support for having a few priority actions, although the nature of these may be adjusted in the light of comments received. These will have a stronger focus in the next version of the draft NCD Action Plan which will structure around them.

A number products to support the implementation of the Action Plan have been proposed, including identification of indicators to measure progress and guidelines for appropriate interaction with the private sector.

In terms of next steps, there is a short timescale now for producing the final draft NCD Action Plan for the Standing Committee of the Regional Committee. Countries will be given an opportunity to comment on the next draft of the document but with a tight deadline; comments will be requested largely on structure, not text.

In addition to the general conclusions regarding the NCD Action Plan, a number of specific suggestions were made for improving the sections of the document. These are to be found in Annex 3.

Annex 1

PROVISIONAL PROGRAMME

Thursday, 17 March 2011

08.15 – 09.00	Registration	
09.00 – 09.45	Opening session	
	• Opening • Health2020 Introduction • Round of introductions	Dr J. Martin Moreno Dr A. Tsouros
	• CVD Burden and Responses: The Evidence for Action	Professor S. Capewell and Professor K. Andersen
09:45 – 10:20	**Plenary 1:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases	Dr G. Galea
	• Overview of Action Plan • Scope and purpose of the meeting • Current programmes on NCD and related conditions	Programme Managers, Noncommunicable Diseases and Health Promotion Division
10.20 – 10.45	*Break*	
10.45 – 12.30	**Work groups A:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases	
	• Discussion in groups to discuss strengths and needs of countries for tackling NCDs, and how well the draft Action Plan addresses needs.	
12.30 – 13.45	*Lunch*	

13.45 – 15.00	**Plenary 2:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases • Feedback from work groups A • Introduction to task for work groups B
15.00 – 15.30	*Break*
15.30 – 17.30	**Work groups B:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases • Discussion in groups of action areas of Action Plan
17.30	*Close of the day*
17:30	*Reception – WHO Cafeteria*

Friday, 18 March 2011

09.00 – 10.30	**Plenary 3:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases • Review of Day 1 & introduction to Day 2 • Feedback from work groups B • Discussion
10.30 – 11.00	*Break*
11.00 – 12.45	**Plenary 3 (continued):** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases • Feedback from work groups B • Discussion
12.45 – 14.00	*Lunch*
14.00 – 15.00	**Plenary 4:** Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases • Summary of feedback • Discussion • Conclusions & next steps
15.00-15.30	*Break*
15.30-16.45	**Plenary 5:** Preparatory process for the High-level Meeting of the United Nations General Assembly

on the Prevention and Control of NCDs

- Overview of preparatory process
- WHO European Regional Statement on Noncommunicable Diseases
- Discussion
- Conclusions & next steps

16.45 – 17.00 Closing session

17.00 *Close of the meeting*

Annex 2

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Annex 3

SUGGESTIONS FOR IMPROVEMENT

B1: Building Alliances and networks and fostering citizen participation

- WHO Secretariat requested to develop a set of guidelines for the relationship with industry /private sector to be used in terms of potential conflicts of interest and to ensure the private sector gains no competitive advantage nor influences norms.
- The section should refer to two levels of networking, one at the European regional level which attracted international bodies and NGOs, the other at the national level. WHO can facilitate the development of national networks that mirror a regional network, with a focus on co-morbidities and common factors, including engagement of health professionals.
- Proposed tasks for such networks over the five years would be: to become more coordinated and systematic and thus more effective in advocacy activities; to agree a common platform by different parties in the network (common principles, common language); to build capacity amongst NGOs (professionals' and citizens' groups); to agree new ideas and solutions; and to gain more involvement from the media.
- The roles and tasks of WHO should be divided from those of the Member States, otherwise there is overlap with each other that could lead to further debates.
- Regarding supranational cooperation, clarity should be sought on who is doing what so that not everyone was trying to do everything.
- Stronger reference should be made to including the media.

B2: Strengthening surveillance, monitoring and evaluation

- The section needs to address two aspects, a general evaluation of health risks and NCDs, and an evaluation of the five-year NCD Action Plan.
- The evaluation part of the document needs to be strengthened so it is not only included in the title but it should avoid becoming disconnected from specific action, and remain practical. It should identify a number of actions and explore targets with indicators.
- There needs to be stronger inclusion of research and the need to develop evidence, for example from evaluation of impact and cost-effectiveness of interventions. Reference to evidence should take a broader perspective than just randomized controlled trials and acknowledge that there is perceived to be sufficient evidence to already start to take action.
- There needs to be advice to countries on a general monitoring system to follow progress for a comprehensive integrated approach.
- Actions, indicators, monitoring and evaluation approaches should be consistent with the other WHO risk factor-specific action plans.
- A concrete document and /or Expert coordinating body could be convened to help develop an approach on how and what to monitor using a combination of different data sources and methodologies, feasible at different income-levels of countries.
- The section needs to recognise that monitoring/evaluation of NCDs and risk factors has to be integrated into the general health information system to support linkage and sustainability and to follow longer impact of work on NCDs.

- WHO should coordinate and cooperate with other international organizations to support standardisation international comparability of indicators, recognising the diversity in countries.

B3: Addressing social determinants of NCDs

- Strengthen the area of social determinants further in the action plan, as an overarching horizontal component and possibly merge this and the health promotion parts of the document.
- Broaden the range of actions on social determinants; at present these seem to be laregly limited to disaggregation within surveillance systems.
- There needs to be further clarity on what specifically an NCD programme can do to address social determinants.
- Be more specific on practical actions that countries can take. to be more specific on actions and the importance of related sectors,
- Priority actions would be that policy implementation should be monitored and evaluated and NCD surveillance data is improved by by disaggregating by age, sex and social strata, although mechanisms and capacity building may need to be needed to support this.
- While recognising the importance of early life interventions, it is also difficult to set priorities and separate parts of the life course.
- The notion of "proportionate universalism" from the UK Marmot social determinants report was considered helpful and might be included or referred to.
- Good examples, tools and capacity-building are requested for example for equity impact assessment and on how to approach governments and deal with other sectors.
- On the issue of targets, a set of indicators would need development as few countries have experience with this.
- WHO requested to help make the connections between experts and policy-makers and to ensure that data is accessible and communicated in different formats to different audiences through different media.

B4: Promoting health and preventing disease

- There needs to be more emphasis on 'integration' within this action area, the essence of which encompasses both intersectoral and intrasectoral components.
- The prevention component needs to be more evident within this action area, clarifying the responsibilities of those outside the health system.
- Health literacy works at different levels and could be removed from the priority actions framework, and put horizontally as an overarching component with integration being achieved through this.
- Explictly recognise that there is sufficient evidence to act and that best available evidence should be used, monitoring continuously in order to learn and adjust.
- Recognise that multicomponent programmes are the most effective.
- Although mental health is not included as a main condition in the NCD Action Plan, a comment should be included later on in this part of the document.
- Paragraphs 72, 73 and 74 are extremely general and Paragraph 72 needs to be made more concrete.
- Within Paragraph 74, a better balance between individual and community approaches, and thus the bullets contained within the paragraph, is needed.
- The expression 'health literacy might be replaced (or supplemented) by 'skills development' to add clarity and link back to the Ottawa Charter. Health literacy is very

focused around people and public; if a 'health in all policies' approach were to be successful, then health literacy needs to be thought about in a broader way.

- Additional, complementary products might be a targeted advocacy paper on the priority areas and a policy toolkit developed by looking at evidence from other countries and how good practice is spread.
- Inclusion (or link to) more concrete actions taken from the four current risk factor-specific action plans in tobacco (FCTC), alcohol, obesity and food and nutrition.
- Highlight specific priority actions by specifying and separating out: marketing to children and young adults; transport and urban planning; fiscal and marketing aspects for salt, tobacco, alcohol and transfat.
- Include action targets.
- Expanding the fiscal recommendations explicitly to include incentives for prevention, such as those to primary care physicians
- Better align this section with that on 'health in all policies' and social determinants; it seemed difficult to split the health promotion section from the social determinants section.
- Spell out even further what is most effective in prevention, such as a population approach.
- When emphasising action on *trans*-fats, do not lose sight of the need to reduce saturated fats.

B5: Orienting health services towards prevention and chronic care

- There was a broad consensus within the group on the need for a more coordinated and integrated disease management model; the need to manage co-morbidities in one and the same patient calls for more patient-centred approaches, with shared responsibilities of staff in the clinical pathways for an individual patient outcome.
- Clarify the added value of financial incentives in helping to achieve a more patient-centred approach and prevention in primary health care.
- Aim for better balance between secondary/tertiary care and primary prevention, including arguments or data to convince politicians if necessary and sharing examples that prevention programs save money and reduce health inequality.
- Priorities are to study lessons learned and use a patient oriented model, to practice an integrated approach to tackle diseases together, and to establish a healthcare surveillance system to measure impact of health interventions.The latter should include how patients/families are satisfied and what patients feel about their health.
- WHO have a role in documenting and disseminating lessons learned and good practices.
- Paragraph 81, bullet 4: on the issue of implementing population-based, organized screening programme, this should reflect country context given that the evidence-base and cost-effectiveness, sensitivity and specificity, depends on prevalence in the population, and that health care workers & health system need to be prepared to manage patients diagnosed through screening.
- Paragraph 83, bullet 2: suggest instead of the word "universal" to use instead: "a universal access through appropriate health financing models, adapted to country-specific context".
- Make better connections between this section and others (areas 2, 3, 4) so that social determinants, prevention and care are better linked.
- Emphasise the potential role of public health institutes and centres, and to advocate for their strengthening.

- Mention that for the high risk and those already ill, non-medical treatment of chronic diseases was also beneficial.