MEETING REPORT

Malaysia

Myanmar

Singapore

Philippines

Brunei Darussalam

Technical Consultation On Indicators For Non-Communicable Diseases And Situational Analysis On Cancer Data For The ASEAN Region

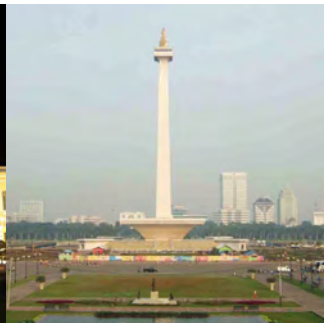
Cambodia

Thailand

Laos

Vietnam

Indonesia



KUALA LUMPUR, MALAYSIA

21-23 NOVEMBER 2011

Ministry of Health Malaysia

ASEAN Secretariat

MEETING REPORT

Technical Consultation On Indicators For Non-Communicable Diseases And Situational Analysis On Cancer Data For The ASEAN Region

KUALA LUMPUR, MALAYSIA
21-23 NOVEMBER 2011

Ministry of Health Malaysia

ASEAN Secretariat

NOTE

The views expressed in this report are those of the participants of the Technical Consultation on Indicators for Non-Communicable Diseases and Situational Analysis on Cancer Data for the ASEAN Region and do not necessarily reflect the current policies of Ministries of Health of ASEAN Member States.

This report has been prepared by the Disease Control Division, Ministry of Health Malaysia for the Ministries of Health of the ten ASEAN Member States, and for those who participated in the Technical Consultation on Indicators for Non-Communicable Diseases and Situational Analysis on Cancer Data for the ASEAN Region, which was held in Kuala Lumpur, Malaysia from 21 to 23 November 2011.

EXECUTIVE SUMMARY

The Ministry of Health, Malaysia in collaboration with the ASEAN Secretariat organised a Technical Consultation on Indicators for Non-Communicable Diseases and Situational Analysis on Cancer Data for the ASEAN Region. This meeting was held in Kuala Lumpur, Malaysia from 21 to 23 November 2011. 14 ASEAN NCD Focal Points and/or their representatives from six ASEAN Member States, one representative from the WHO Western Pacific Regional Office in Manila, Philippines one representative from the ASEAN Secretariat in Jakarta, Indonesia and four secretariat members attended this meeting.

The objectives of this meeting were:

i. To identify suitable and practical indicators NCD risk factors (both process and outcome indicators) for the ASEAN Region;

ii. To recommend time-bound targets to monitor progress for NCD prevention and control in the ASEAN Region;

iii. To develop a viable mechanism for Networking and increasing capacity for collaboration in utilising Cancer Registries in the ASEAN Region;

iv. To finalise the (a) Terms of Reference for Ad-hoc ASEAN Task Force on Non-Communicable Diseases (ATFNCD); and (b) ASEAN Workplan on Non-Communicable Diseases (2011-2015).

Background information were provided through three plenary papers on the following topics: (i) Towards time bound targets for NCD prevention and control in ASEAN; (ii) Country Update: Singapore Cancer Registry; and (iii) ASEAN Cooperation on Health: Non-Communicable Diseases".

Three groups sessions were held to address the issues related to identifying NCD indicators and time-bound targets, national NCD surveillance systems and cancer registries. The output of the discussions were: (i) the main NCD indicators and time-bound targets for the ASEAN region; (ii) recommendations for moving forward in establishing or strengthening national NCD surveillance systems; and (iii) establishing and strengthening cancer registries.

A special plenary session was also held to finalise the Terms of Reference for Ad-hoc ASEAN Task Force on Non-Communicable Diseases (ATFNCD); and (b) ASEAN Workplan on Non-Communicable Diseases (2011-2015).

The outputs of this meeting will be presented by all ASEAN NCD Focal Points to the heads of their respective Ministries of Health for consideration as well as for further input and action. It is envisaged that the Terms of Reference for the Ad-hoc ATFNCD, the ASEAN Workplan on NCD, and the NCD Indicators and time-bound targets will be endorsed in the upcoming Senior Officials Meeting on Health and Development (SOMHD) in March 2012.

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Kuala Lumpur, Malaysia
21-23 November 2011

1. Introduction

1.1. Background

Based on the ASEAN Strategic Framework on Health Development (2010-2015), one of the areas that have yet to be implemented and overseen by an existing ASEAN health subsidiary body is the initiatives under Non-Communicable Diseases (NCDs).

Philippines took the lead in organising the Workshop on the Drafting of the ASEAN Workplan for Non-Communicable Diseases which was held in Tagaytay City, Philippines from 31 March to 1 April 2011. The Workshop was attended by delegates from seven ASEAN Member States i.e. Brunei Darussalam, Cambodia, Philippines, Singapore, Indonesia, Thailand & Malaysia. Representatives from the ASEAN Secretariat, ASEAN Focal Point on Tobacco Control (AFPTC) and WHO Western Pacific Regional Office (WPRO) were also in the attendance to provide technical assistance. Two documents were produced at the end of this meeting:

i. Draft Terms of Reference of the ASEAN Task Force on Non-Communicable Diseases (ATFNCD);

ii. Draft ASEAN Workplan on Non-Communicable Diseases (2011-2015).

The ASEAN Workplan on NCD was agreed by consensus, with division of work to each AMS for all ten (10) main activities. The main objective of the Wokplan was to further strengthen NCD prevention and control in the ASEAN region, in line with the mandates and resolutions of the WHO.

At the 6th Senior Offcials Meeting on Health SOMHD held on 25 - 27 July 2011 in Myanmar, the Meeting recommended the establishment of the "Ad-hoc ASEAN Task Force on NCD" to implement the above workplan. The Meeting also requested all Member States to nominate focal points on NCD, to be submitted to ASEAN Secretariat by 31 August 2011. The ATFNCD will first have to consider and finalise the Term of References and Workplan to be submitted for SOMHD's approval.

Malaysia was requested to be the lead country for **two main activities** under the ASEAN Workplan for NCD:

i. Developing key indicators on Healthy Lifestyle and NCD for ASEAN (co-lead with Brunei Darussalam);

ii. Situational analysis and Networking on Cancer data and Registry Information System in the ASEAN region (co-lead with Singapore).

1.2. Objectives

The main objectives of this Meeting are as follows:

i. To identify suitable and practical indicators NCD risk factors (both process and outcome indicators) for the ASEAN Region;

ii. To recommend time-bound targets to monitor progress for NCD prevention and control in the ASEAN Region;

iii. To develop a viable mechanism for Networking and increasing capacity for collaboration in utilising Cancer Registries in the ASEAN Region;

iv. To finalise the (a) Terms of Reference for Ad-hoc ASEAN Task Force on Non-Communicable Diseases (ATFNCD); and (b) ASEAN Workplan on Non-Communicable Diseases (2011-2015).

1.3. Participants

Nine ASEAN NCD Focal Points and/or their representatives from six ASEAN Member States (Brunei Darussalam, Indonesia, Malaysia, Myanmar, Philippines and Singapore) participated in this meeting. One NCD Technical Officer from WHO WPRO in Manila and one representative from the ASEAN Secretariat in Jakarta facilitated discussions during this meeting as well. The meeting secretariat comprised of officers from the NCD Section, Disease Control Division, Ministry of Health (MOH) Malaysia. **(Appendix A)**

2. Proceedings

2.1. Agenda and Programme of the Meeting

The three-day meeting consisted of plenary presentations and group discussion sessions. The objectives of the plenary presentations were to share current recommendations and experiences on NCD indicators and cancer registries in the ASEAN region. Strategies on how to move forward in strengthening National NCD Surveillance Systems and cancer registries in the ASEAN region were also discussed. Please see **Appendix B** for the meeting agenda.

2.2. Introduction to the Meeting

Dr Feisul Idzwan Mustapha (Malaysia) welcomed the participants. Dr Zainal Ariffin Omar, Deputy Director (NCD), Disease Control Division, MOH Malaysia provided the opening remarks, highlighting the increasing global attention towards strengthening NCD prevention and control, and the opportunity for the ASEAN community to mount an effective regional response. Dr Feisul subsequently presented the background and scope of the meeting and explained the agenda and programme.

2.3. Setting the Agenda

Three plenary presentations described the context of the meeting and provided guidance for the group work and discussions. The key contents of the papers were as follows:

(1) Dr Cherian Varghese, WHO WPRO NCD Technical Officer, presented "Towards time bound targets for NCD prevention and control in ASEAN". This paper provided an overview of the global and WHO response towards to NCD prevention and control, with emphasis on NCD surveillance, as well as cancer registries. A copy of the powerpoint is included in **Appendix C**.

(2) Dr Chow Khuan Yew, Health Promotion Board, Singapore, presented "Country Update: Singapore Cancer Registry". This paper provided the background, latest updates and challenges that Singapore has faced in establishing and running its Cancer Registry. A copy of the powerpoint is included in **Appendix D**.

(3) Dr Ferdinal Fernando, ASEAN Secretariat, presented "ASEAN Cooperation on Health: Non-Communicable Diseases". This paper provided background information as well as the future direction for regional cooperation for NCD in ASEAN. A copy of the powerpoint is included in **Appendix E**.

Issues and concerns identified in the discussions were further deliberated during the group sessions.

2.4. Group Sessions

The group sessions were divided into three main activities: (1) Situational analysis on NCD surveillance & Identifying NCD indicators and time-bound targets for the ASEAN region; (2) National NCD Surveillance Systems; and (3) Cancer registries.

For all group sessions, the meeting participants unanimously elected Prof. Tint Swe Latt (Myanmar) as chairperson, and Dr Norhayati Md. Kassim (Brunei Darussalam) as rapporteur. Dr Cherian Varghese (WHO WPRO) acted as facilitator for group session one and two, while Dr Chow Khuan Yew (Singapore) acted as facilitator for group session three.

2.4.1. <u>Group Session One:</u> Identifying NCD indicators and time-bound targets for the ASEAN region

For each of the six ASEAN Member States represented in this meeting, a situational analysis was conducted on existing NCD surveillance that covers i.e. (i) NCD risk factors surveys; (ii) morbidity data and (iii) mortality data. The results of this group work are detailed in **Appendix F**.

A major reference used during the discussion was the "Targets to Monitor Progress in Reducing the Burden of Noncommunicable Diseases: Recommendations from a WHO Technical Working Group on Noncommunicable Disease". **(Appendix G)** Based on the draft WHO global targets, the group identified ten (10) main indicators and ASEAN targets which were divided into three main categories i.e. (i) outcome targets; (ii) exposure targets; and (iii) health systems targets. The results of this group work are detailed in **Appendix H**.

2.4.2. <u>Group Session Two:</u> National NCD Surveillance Systems

A major reference used during the discussion was the "WHO Discussion Paper: Monitoring NCDs and Their Risk Factors: A Framework for Surveillance". **(Appendix I)** The meeting participants deliberated on feasible recommendations on both developing and strengthening National NCD surveillance systems for the ASEAN region. This is essential to enable each country to effectively monitor progress for NCD prevention and control programs and activities in the ASEAN Region, particularly for the NCD indicators agreed upon in Group Session Two. The results of this group work are detailed in **Appendix J**.

2.4.3. Group Session Three: Cancer registries

Discussions centred upon the current status of existing cancer registries in ASEAN Member States and current challenges faced in its implementation. For ASEAN Member States without cancer registries e.g. Myanmar and Brunei Darussalam, options for moving forward was considered, taking into account current obstacles and issues. While for countries with existing cancer registries, steps for further improvement in terms of quality and coverage were discussed. The results of this group work are detailed in **Appendix K**.

2.5. Special Plenary Session for the ASEAN NCD Task Force

The main objective of this plenary session was to finalise the Terms of Reference for Ad-hoc ASEAN Task Force on Non-Communicable Diseases (ATFNCD); and (b) ASEAN Workplan on Non-Communicable Diseases (2011-2015). For this session, the meeting participants unanimously nominated Dr Zainal Ariffin Omar (Malaysia) as the chairman, while Dr Ferdinal Fernando (ASEAN Secretariat) acted both as facilitator and rapporteur for this session.

Discussions on the Terms of Reference were based on the existing Terms of Reference of the ASEAN Focal Points on Tobacco Control (AFPTC). The finalised outputs of this plenary session are detailed in **Appendix L** (Terms of Reference for the Ad-hoc ATFNCD) and **Appendix M** (ASEAN Workplan on NCD).

3. Conclusions and Recommendations

3.1. General Conclusions

The Technical Consultation on Indicators for Non-Communicable Diseases and Situational Analysis on Cancer Data for the ASEAN Region was held successfully, and the objectives were met. The discussions, observations and outcome of all of the group work and recommendations will be presented by all ASEAN NCD Focal Points to the heads of their respective Ministries of Health for consideration as well as for further input and action.

It is envisaged that the Terms of Reference for the Ad-hoc ATFNCD, the ASEAN Workplan on NCD, and the NCD Indicators and time-bound targets will be endorsed in the upcoming SOMHD in March 2012.

3.2. Recommendations

(1) National NCD Surveillance system is an essential component in strengthening the NCD prevention and control program in all countries. ASEAN Member States will need to establish and strengthen NCD surveillance in the coming years to effectively monitor progress towards achieving the NCD time-bound targets.

(2) An effective response towards NCD prevention and control not only involves the response at a country level, but requires a response at the regional level as well. This is because exposure to NCD risk factors crosses country borders i.e. import and export of unhealthy food and drinks, smuggling of illicit tobacco and marketing of foods and non-alcoholic drinks to children over the internet and satellite TV channels. ASEAN Member States share many socio-cultural characteristics and existing cooperation creates a unique opportunity to mount an effective regional response towards decreasing exposure of the population.

Appendix A

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

List of Participants, Facilitators, Observers and Secretariat

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Appendix B

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Meeting Agenda

Day 1, Monday 21 Nov 2011	Programme
8.30 – 9.00 am	Registration
9:00 – 10.00 am	Opening Session
	Welcoming remarks by Dr Feisul Idzwan Mustapha, Ministry of Health, Malaysia
	Opening Address by Dr Zainal Ariffin Omar, Deputy Director (NCD), Disease Control Division, Ministry of Health, Malaysia
	Backgroup, scope and objective of Meeting
	Introduction of Participants and Facilitators
10.00 – 10.30 am	*Coffee break*
10.30 – 11.30 am	Towards time bound targets for NCD prevention and control in ASEAN, by Dr Cherian Varghese
11.30 – 12.00 pm	Country Update: Singapore Cancer Registry by Dr Chow Khuan Yew
12.00 – 12.30 pm	ASEAN Cooperation on Health: Non-Communicable Diseases (NCD), by Dr Ferdinal Fernando
12.30 – 2.00 pm	*Lunch break*
2:00 – 3.15 pm	Group Session One: Identifying NCD indicators and time-bound targets for the ASEAN region
3.15 – 3.30 pm	*Coffee break*
3.30 -5.00 pm	Continue Group Session One
	Presentation and discussion
8.00 pm	Welcoming Dinner hosted by MOH Malaysia
	End of Day 1

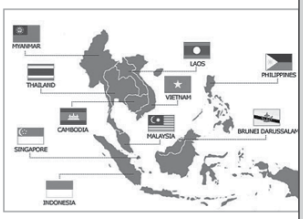
Day 2, Tuesday 22 Nov 2011	Programme
9:00 – 10:45 am	Group Session Two: National NCD Surveillance Systems
	Presentation & discussion
	Coffee break
11.00 – 1.00 pm	Group Session Three: Cancer registries
	Presentation and discussion
1.00 – 2.30 pm	*Lunch break*
2.30 – 3.45 pm	Finalising the Terms of Reference for Ad-hoc ASEAN Task Force on Non-Communicable Diseases (ATFNCD)
3.45 – 4.00 pm	*Coffee break*
4.00 – 4.45 pm	Finalising the ASEAN Workplan on Non-Communicable Diseases (2011-2015)
4.45 – 5.15 pm	Next steps by ASEAN Secretariat
	Next steps by MOH Malaysia
	Closing ceremony
	End of Day 2
Day 3, Wednesday 23 Nov 2011	**Programme**
9:00 – 12.00 pm	Informal discussions on further action among ASEAN Member States
	End of Meeting

Appendix C

MEETING REPORT

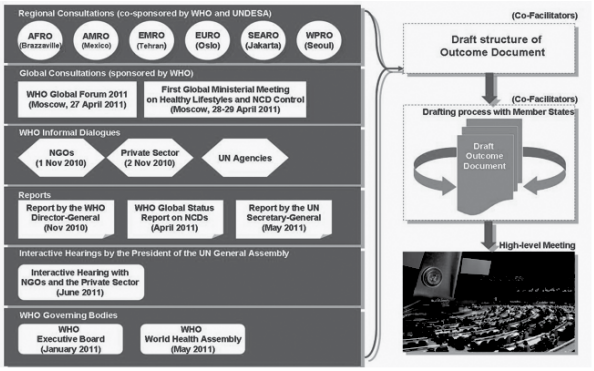
Kuala Lumpur, Malaysia
21-23 November 2011

Towards time bound targets for NCD prevention and control in ASEAN.



Dr. Cherian Varghese MD., Ph.D
Technical Officer (NHP)

WHO's role in the preparatory process leading towards the UN High-level Meeting on NCDs (New York, 19-20 September 2011)



Time bound commitments of the UN GA HLM Political Declaration (1)

- Promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of NCD
- Building on continuing efforts to develop before the end of 2012, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings (WHO)
- Building on the work already under way, to prepare recommendations for a set of voluntary global targets for the prevention and control of NCD, before the end of 2012 (WHO)

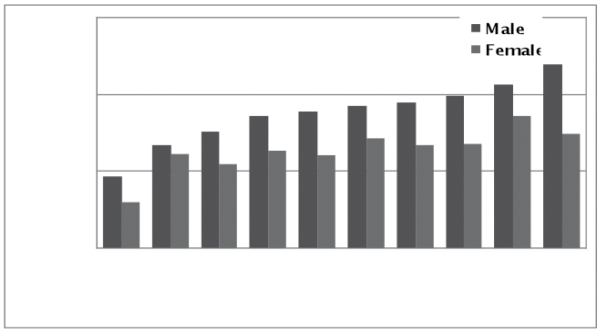
Time bound commitments of the UN GA HLM Political Declaration (2)

- To submit options for strengthening and facilitating multisectoral action for the prevention and control of NCD through effective partnership by the end of 2012 to the General Assembly (SG)
- To present to the General Assembly at the sixty-eighth session a report on the progress achieved in realizing the commitments made in this Political Declaration, including on the progress of multisectoral action, and the impact on the achievement of the internationally agreed development goals (SG)

Regional committee Resolution on NCD

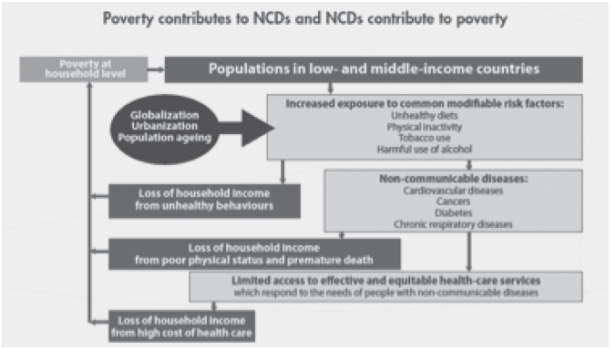
- Urges Member States to fulfil urgently commitments in the UN GA HLM Political Declaration
- Request the Regional Director to
  - Develop strategies for resource mobilization and provide technical assistance and capacity building for NCD prevention and control
  - To develop mechanisms for sustained engagement with partners
  - To develop by 2013, a regional action plan for 2014-2018 with time bound targets and indicators
  - To report periodically to the Regional Committee on the progress achieved.

Age-standardized death rate (per 100,000) from NCD, ASEAN, 2008

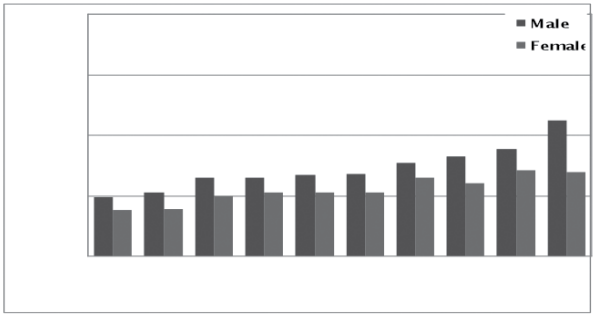


*Country data not available. Estimate based on a combination of country life tables, cause of death models, regional cause of death patterns, and WHO and UNAIDS program estimates for some major causes (not including chronic diseases).
Source: WHO Global Status Report on Noncommunicable Diseases 2010

NCDs contribute to poverty and poverty increases the risk of developing NCDs



Percentage of all NCD Deaths under age 60, ASEAN, 2008



*Country data not available. Estimate based on a combination of country life tables, cause of death models, regional cause of death patterns, and WHO and UNAIDS program estimates for some major causes (not including chronic diseases).
Source: WHO Global Status Report on Noncommunicable Diseases 2010

Existence of Unit, Branch, or Dept. in Ministry of Health with responsibility for NCDs, Country Capacity Survey, ASEAN, 2010

Country	NCD unit
Brunei	No
Cambodia	Yes
Indonesia	Yes
Lao PDR	Yes
Malaysia	Yes
Myanmar	Yes
Philippines	Yes
Singapore	Yes
Thailand	Yes
Viet Nam	Yes

Source: WHO Global Health Observatory http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=2396

Existence of operational policy/strategy/action plan, Country Capacity Survey, ASEAN, 2010

Country	CVD	Cancer	CRD	DM	Alcohol	Unhealthy diet and/or overweight / obesity	Insufficient physical activity	Tobacco
Brunei	No	No	Yes	No	Yes	Yes	No	Yes
Cambodia	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Indonesia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lao PDR	DK	DK	DK	DK	DK	DK	DK	No
Malaysia	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Myanmar	Yes	Yes	Yes	DK	DK	Yes	DK	Yes
Philippines	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Singapore	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thailand	Yes	Yes	Yes	DK	Yes	Yes	Yes	Yes
Viet Nam	Yes	Yes	Yes	Yes	No	No	No	Yes

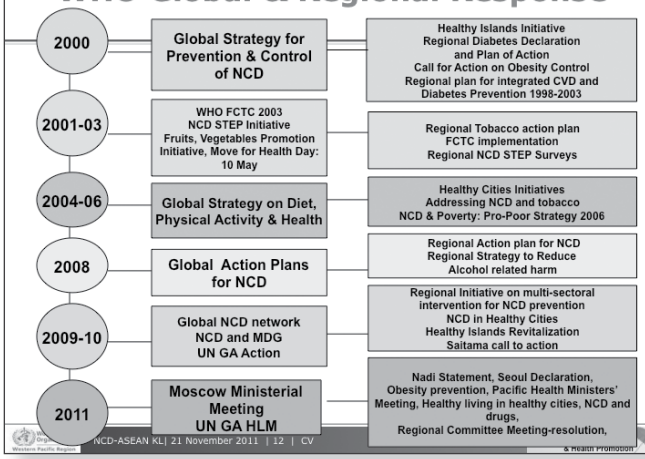
Source: WHO Global Health Observatory http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=2396

Existence of risk factor surveillance*, Country Capacity Survey, ASEAN, 2010

Country	Existence
Brunei	No
Cambodia	Yes
Indonesia	Yes
Lao PDR	Yes
Malaysia	Yes
Myanmar	Yes
Philippines	Yes
Singapore	Yes
Thailand	Yes
Viet Nam	Yes

*Harmful alcohol use, diet, physical inactivity, and tobacco use
Source: WHO Global Health Observatory http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=2396

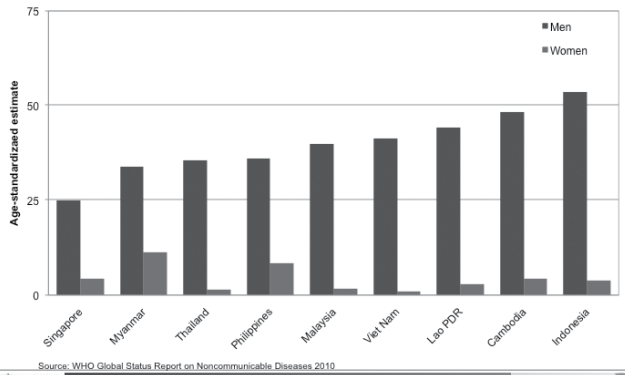
WHO Global & Regional Response



NCD prevention and control

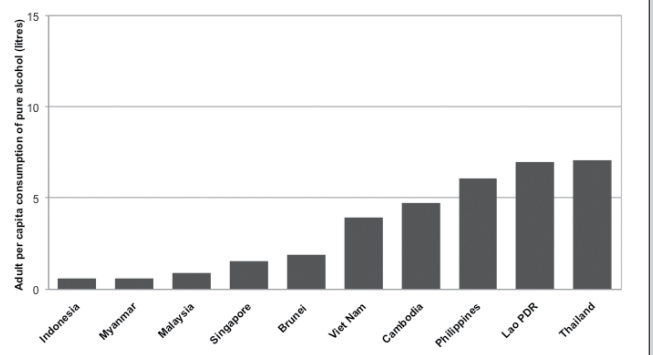
1. National multi-sectoral policy and plan within the national health and development plan
2. Population based, multi-sectoral actions for risk reduction
3. Health system strengthening for NCD prevention and management
4. Surveillance, monitoring and reporting
5. Sustainable partnerships and advocacy

Age-standardized prevalence of daily tobacco smoking in adults aged 15+ years, comparable country estimates, ASEAN, 2008



Source: WHO Global Status Report on Noncommunicable Diseases 2010

Total adult (15+ years) per capita consumption of pure alcohol (litres) for both sexes, ASEAN, 2008

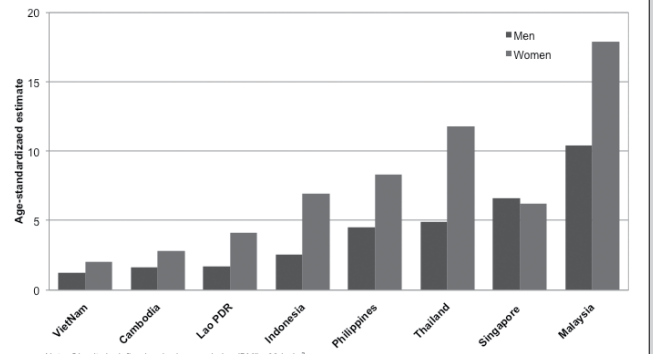


Source: WHO Global Status Report on Noncommunicable Diseases 2010

2. Population Based Multisectoral Actions for NCD Risk Reduction
Control of Tobacco and Harmful use of Alcohol

- 10 % reduction in tobacco use by 2014
- Tobacco taxation and Health Promotion Foundations
- Plain packaging- a pathbreaking approach
- Scaling up strategies to reduce harmful use of Alcohol

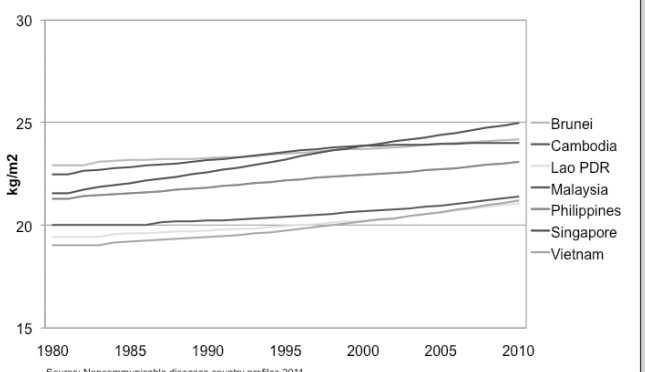
Age-standardized prevalence of obesity in adults aged 20+ years, comparables estimates, ASEAN, 2008



Note: Obesity is defined as body mass index (BMI) ≥30 kg/m²

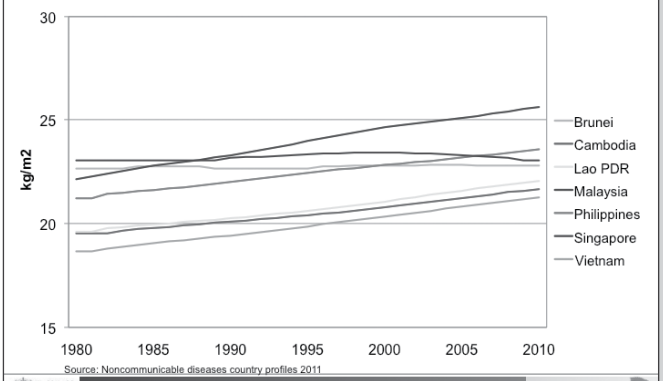
Source: WHO Global Status Report on Noncommunicable Diseases 2010

Mean Body Mass Index, Males 20+ years, ASEAN, 1980-2010



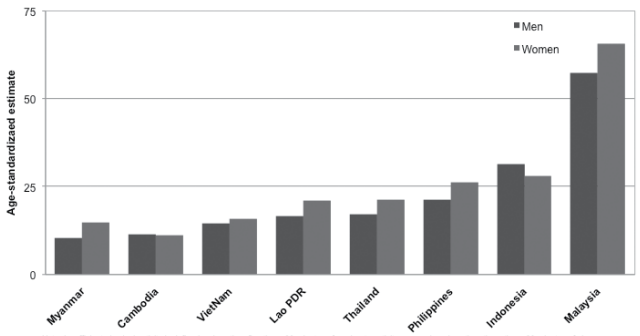
Source: Noncommunicable diseases country profiles 2011

Mean Body Mass Index, Females 20+ years, ASEAN, 1980-2010



Source: Noncommunicable diseases country profiles 2011

Age-standardized prevalence of insufficient physical activity in adults aged 15+ years, comparable country estimates, ASEAN, 2008

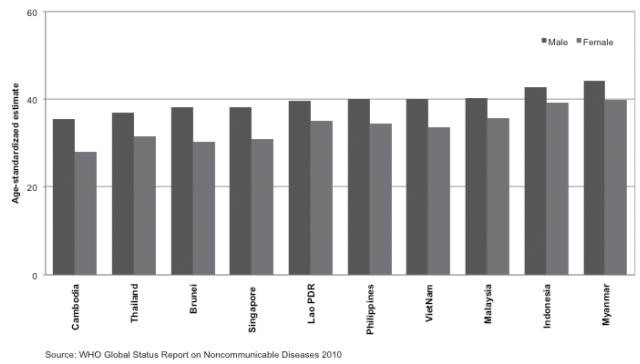


Note: Insufficient physical activity is defined as less than five times 30 minutes of moderate activity per week, or less than three times 20 minutes of vigorous activity per week, or equivalent.

Source: WHO Global Status Report on Noncommunicable Diseases 2010

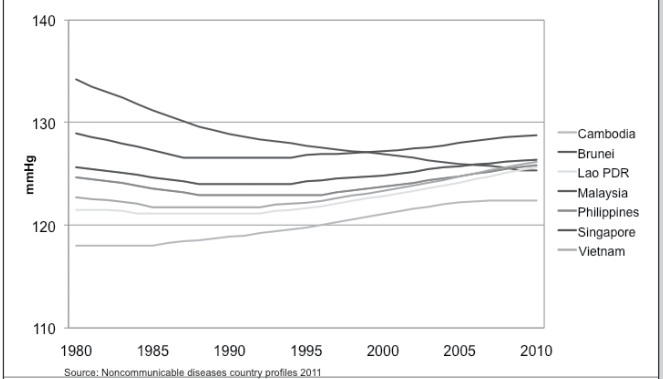
Age-standardized prevalence of raised fasting glucose (& mml/L) or on medication. Comparable country estimates, ASEAN, 2008

Age-standardized prevalence of raised blood pressure (SBP > 140 or DBP >90 or on medication). ASEAN, 2008



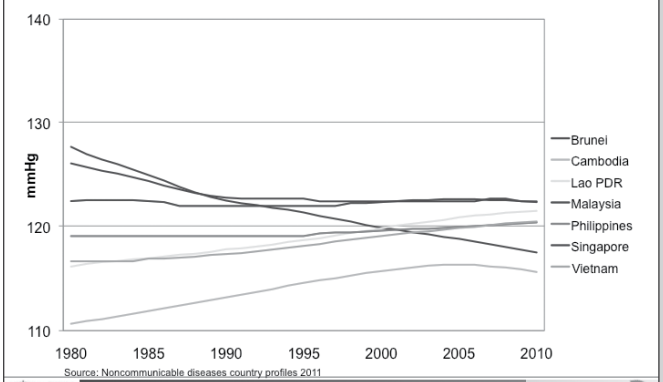
Source: WHO Global Status Report on Noncommunicable Diseases 2010

Mean Systolic Blood Pressure, Males 25+ years, ASEAN, 1980-2010



Source: Noncommunicable diseases country profiles 2011

Mean Systolic Blood Pressure, Females 25+ years, ASEAN, 1980-2010

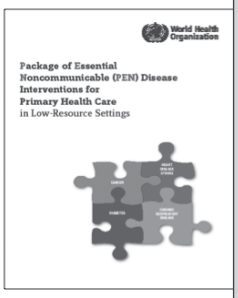


Source: Noncommunicable diseases country profiles 2011

Reduce salt (sodium) in food

WHO Package of Essential NCD Interventions (PEN)

- Cost effective interventions
- Adaptable to local settings
- Feasible at primary health care level
- Piloted in Vietnam, Philippines and Pacific Islands



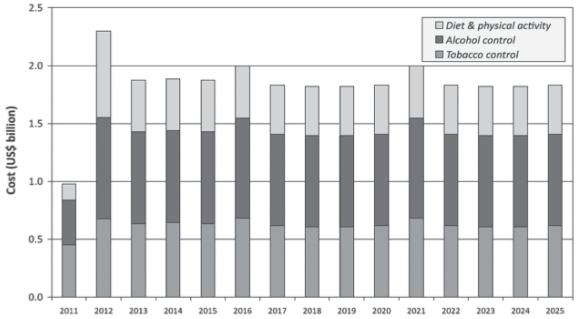
4. Surveillance and Monitoring for NCD

A set of best buys to prevent and control NCDs

Risk factor / disease	Interventions
Tobacco use	• Protect people from tobacco smoke • Warn about the dangers of tobacco • Enforce bans on tobacco advertising • Raise taxes on tobacco
Harmful use of alcohol	• Enforce bans on alcohol advertising • Restrict access to retailed alcohol • Raise taxes on alcohol
Unhealthy diet	• Reduce salt intake in food • Replace trans fat with polyunsaturated fat
Cardiovascular disease (CVD) and diabetes	• Provide counselling and multi-drug therapy (including glycaemic control for diabetes mellitus) for people with 10-year CVD risk > 30% • Treat acute myocardial infarction (with aspirin)
Cancer	• Hepatitis B vaccination to prevent liver cancer • Detection and treatment of precancerous lesions of the cervix and early-stage cervical cancer

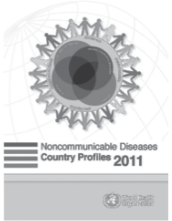
Estimated cost

Figure 6. Total estimated cost of scaling up best buy interventions for NCD risk factors in all low- and middle-income countries (US$ billion 2008)



NCD surveillance

- The ongoing, systematic collection and analysis of data on NCD burden, risk factors and determinants.
- Provides ability to track health outcomes and risk factor trends over time.
- Critical for informing policy and programme development and monitoring progress.



Accurate data from countries is vital to reverse the global rise in death and disability from NCDs

Monitoring NCDs - challenges

- Despite major improvement in recent years, reliable and comparable data on risk factors remain scarce in many countries
- Data not institutionalized with lack of integration into the national health information systems
- High quality mortality data requires long-term investment in civil registration systems and accurate cause of death certification is a challenge, even in high income countries.
- Strengthening vital registration systems, and cause-specific mortality statistics are a key priority.

Framework for NCD surveillance

1. **Exposures**
   - Behavioural risk factors: *tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet*
   - Metabolic risk factors: *raised blood pressure, overweight/obesity, raised blood glucose, and raised cholesterol.*
   - Social determinants: *education, material well being, access to health care*
2. **Outcomes**
   - Mortality: *NCD specific mortality*
   - Morbidity: *cancer incidence and type*
3. **Health System Response**
   - Interventions and health system capacity: *infrastructure, policies and plans, access to key health care interventions and treatments, partnerships.*

Surveillance systems are key

- **Invest and support development of accurate, timely, integrated and comprehensive systems**
- **Essential NCD surveillance includes**
  - **Vital statistics (with reliable cause of death)**
  - **Morbidity (e.g. National pop-based cancer registry)**
  - **Risk factors – behavioural and metabolic (e.g. STEPS)**
  - **Policy and implementation status**
- **Investment in capacity building for surveillance and public health institutions**

Developing Global NCD Targets and Indicators

- **UNHLM NCDs outcome document requests WHO to develop a comprehensive global monitoring framework for NCDs. This will include a set of indicators, capable of application across regional and country settings, to monitor trends and assess progress made in the implementation of national strategies and plans on NCDs.**
- **WHO is also requested to prepare recommendations for a set of voluntary global targets for the prevention and control on NCDs before end of 2012.**
- **The process for finalizing targets is being discussed with Member States.**

Process for Setting Global NCD Targets and Indicators

- **WHO established a technical Taskforce on NCD targets composed of international experts in NCD surveillance and WHO staff members.**
- **A draft set of Targets were shared with Member States in a web-based consultation. Extensive comments were received.**
- **The Taskforce will be expanded and a new proposal for voluntary global NCD targets will be presented to the WHO Governing Bodies for consideration.**
- **These global targets could be developed into national targets and indicators, for countries to assess their own progress in preventing and controlling NCDs and their risk factors and determinants.**

In selecting indicators and targets, the following criteria have been considered:

- **Coherence with the global framework for health systems priorities to monitor exposures, outcomes, and health systems response**
- **Specific to public health and epidemiological relevance**
- **Sensitivity to changes and comparisons across groups**
- **Existence of unambiguous data collection instruments**
- **Current availability of data or feasible for data future collection**
- **Potential to set a baseline, monitor changes over time, and set target**
- **Prior use of indicator internationally**

Targets (2025) currently under consideration by WHO (1)

Premature mortality from NCDs	25% relative reduction in mortality from cardiovascular disease, cancer, chronic respiratory disease, and diabetes
Diabetes	10% relative reduction in prevalence of diabetes
Tobacco smoking	40% relative reduction in prevalence of current daily tobacco smoking
Alcohol	10% relative reduction in per capita consumption of alcohol; 10% relative reduction in prevalence of heavy episodic drinking
Dietary salt intake	Reduction of mean population intake of salt to <5 grams/day
Obesity	Halt the rise in prevalence
Blood pressure	25% relative reduction in raised blood pressure

Targets (2025) currently under consideration by WHO (2)

Prevention of heart attack and stroke in primary care	80% coverage of multidrug therapy for people aged 30+ years with a 10-year risk of heart attack or stroke ≥ 30% or existing cardiovascular disease
Cancer prevention in primary care	▪ 70% of women age 30-49 screened for cervical cancer at least once ▪ 25% increase in proportion of breast cancer diagnosed early ▪ <1 % prevalence of HBsAg carriers among children aged ≤5 years
Policy approaches to dietary risk reduction	• Elimination of partially hydrogenated vegetable oil from the food supply • No marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt to children

Towards a target oriented NCD programme

- What gets measured, gets done!
- Who is responsible?
- What needs to be measured?
- How often?
- What are the resources?
- What are the gaps?
- What is needed in the next 12 months

Proposed actions

- Develop/strengthen a National mechanism for NCD surveillance and monitoring
- Core group with lead agency and responsible officer
  - NCD, Health information system, Tobacco, Nutrition, Vital statistics, Agencies responsible for national health surveys, National statistical office, public health, epidemiology and bio-statistics experts from academic institutions
- Take stock of the current surveys, data availability, data processing, reports, use of data etc
- What are indicators that can be measured?
- Can a STEPS/similar surveys be done once in 5 years covering the entire population?

Proposed actions (2)

- When was the last national health survey done
- What are the Strengths? What were the limitations?
- Where is the data? How was the data used?
- What are the specific requirements for doing a national health surveys (STEPS)

Proposed actions (3)

- What parameters are available from health information systems?
- What are the limitations?
- To identify some of the suggested indicators, what steps are needed?

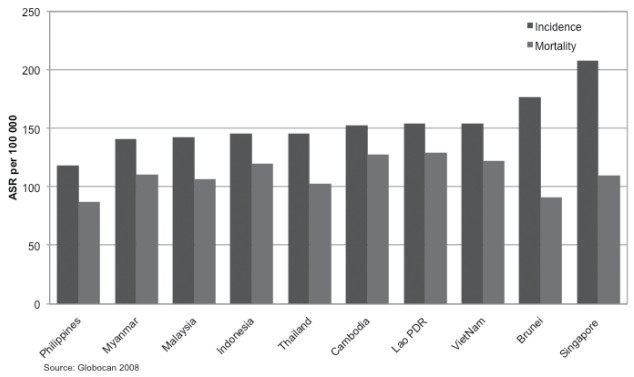
Setting targets

- What is the possibility of using the draft set of targets?
- Which is feasible without additional resources
- Which is not feasible and why?
- What are the steps needed?

Cancer can be prevented too

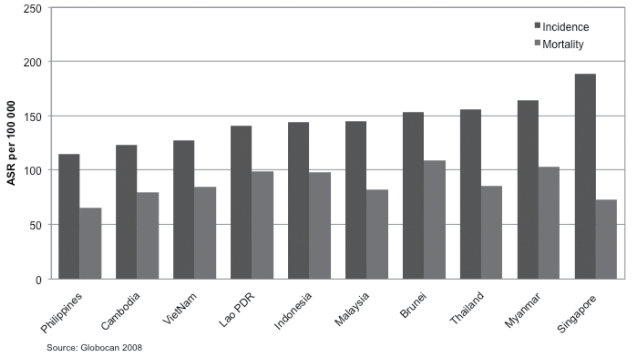
Cancer registry will help us to control cancer

Burden of Cancer, Male, ASEAN, 2008



Source: Globocan 2008

Burden of Cancer, Female, ASEAN, 2008

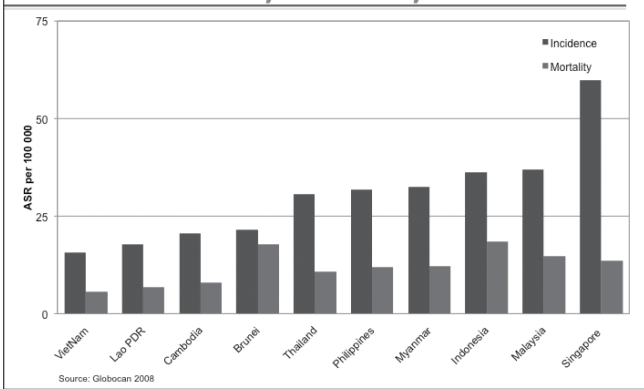


Source: Globocan 2008

Most Frequent Cancers in Men and Women, ASEAN countries, 2008

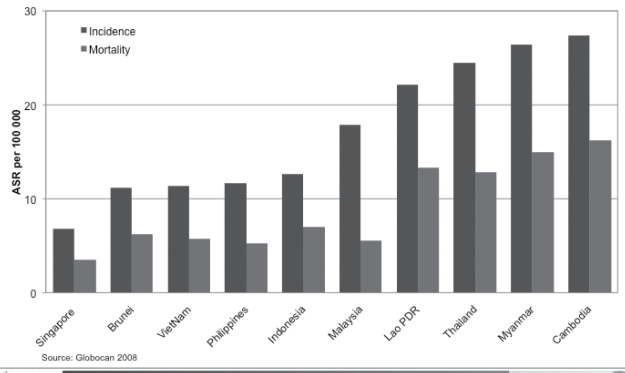
Country	Men	Women
Brunei	Colorectum, Prostate, Lung	Breast, Lung, Corpus uteri
Cambodia	Liver, Lung, Stomach	Cervix uteri, Breast, Lung
Indonesia	Lung, Colorectum, Nasopharynx	Breast, Colorectum, Cervix uteri
Lao PDR	Liver, Lung, Colorectum	Cervix uteri, Liver, Breast
Malaysia	Lung, Colorectum, Nasopharynx	Breast, Cervix uteri, Colorectum
Myanmar	Lung, Liver, Stomach	Breast, Cervix uteri, Lung
Philippines	Lung, Liver, Colorectum	Breast, Cervix uteri, Lung
Singapore	Colorectum, Lung, Prostate	Breast, Colorectum, Lung
Thailand	Liver, Lung, Colorectum	Breast, Cervix uteri, Liver
Viet Nam	Liver, Lung, Stomach	Liver, Lung, Breast

Burden of Breast Cancer, Female, ASEAN, 2008



Source: Globocan 2008

Cervix Uteri Cancer, ASR, ASEAN Countries, 2008



Source: Globocan 2008

Cancer Policy and Cancer Registry , Country Capacity Survey, ASEAN, 2010

Country	Operational policy/ strategy/action plan for cancer	Existence and scope of cancer registry
Brunei	No	Yes, National
Cambodia	Yes	Yes, National
Indonesia	Yes	Yes, Subnational
Lao PDR	DK	No
Malaysia	Yes	Yes, National
Myanmar	Yes	Yes, Subnational
Philippines	Yes	Yes, National
Singapore	Yes	Yes, National
Thailand	Yes	Yes, National
Viet Nam	Yes	Yes, National

Source: WHO Global Health Observatory http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=2396

Cancer registries in CI5 1966-2002) - ASEAN

Country	Vol. 1 1966	Vol. 2 1970	Vol. 3 1976	Vol. 4 1982	Vol. 5 1987	Vol. 6 1992	Vol. 7 1997	Vol. 8 2002	Vol. 9 2007
Malaysia									Penang, Sarawak
Philippines					Rizal	Manila, Rizal	Manila	Manila, Rizal	Manila
Singapore	S. Chinese		S. Chinese, S. Indian, S. Malay	S. Chinese, S. Indian, S. Malay	S. Chinese, S. Indian, S. Malay	S. Chinese, S. Indian, S. Malay	S. Chinese, S. Indian, S. Malay	S. Chinese, S. Indian, S. Malay	Singapore, S. Chinese, S. Indian, S. Malay
Thailand						Chiang Mai, Khon Kaen	Chiang Mai, Khon Kaen	Bangkok, Chiang Mai, Khon Kaen, Lampang, Songkhla	Chiang Mai, Lampang, Songkhla
Viet Nam							Hanoi	Hanoi, Ho Chi Minh	
Brunei, Cambodia, Indonesia, Lao PDR, and Myanmar	No population-based cancer registry reported in CI5 Vol. 1-9								

General availability of Services, Country Capacity Survey, ASEAN, 2010

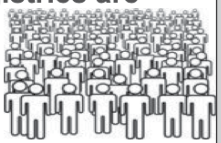
Country	General availability at the primary health care level				General availability in the public health system		
	Cervical cytology	Acetic acid visualization	Bowel cancer screening*	Breast cancer screening**	Oral morphine	Radiotherapy	Chemotherapy
Brunei	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cambodia	No	No	DK	Yes	Yes	No	No
Indonesia	No	No	No	No	No	No	No
Lao PDR	Yes	DK	Yes	Yes	DK	No	Yes
Malaysia	Yes	No	Yes	Yes	No	Yes	Yes
Myanmar	No	No	No	Yes	No	Yes	Yes
Philippines	No	No	No	Yes	Yes	Yes	Yes
Singapore	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thailand	Yes	No	Yes	Yes	No	Yes	Yes
Viet Nam	No	No	No	No	Yes	No	No

*By digital exam or colonoscopy; ** By palpation or mammogram

Source: WHO Global Health Observatory http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=2396

NCCP Challenges
Cancer Registration

- Population based cancer registries are very few
- Limitations in
  - Budget
  - Personnel –not enough, no dedicated staff
  - Software
  - Voluntary notification-poor coverage
  - Death registration weak and not linked
  - Irregular reports



How do we study cancer?

- Burden
  - Incidence
  - Prevalence
  - Mortality
- Survival rate
- Cancer registries can provide reliable information on cancer
- Prevalence of risk factors

History of cancer registration

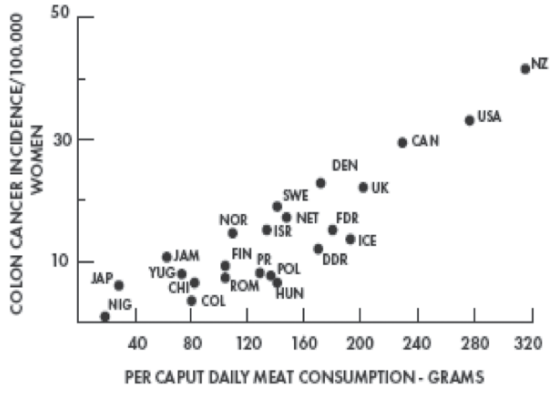
- 1728-First unsuccessful attempt in England
- 1899-Germany-Katz -general survey of cancer in Hamburg
- 1900- Cancer prevalence study in Germany
- 1902-1908-Netherlands, Spain, Portugal, Hungary etc…
  - In Germany "little more than half of the physicians addressed" had filled the questionnaires
- 1930-Wood -USA-suggested that cancer be made a notifiable disease
- 1941-Connecticut Registry
- 1942-Danish Cancer Registry

Use of cancer registry

- Epidemiological research
  - Distribution and determinants of disease
- Descriptive studies
  - Scale of the cancer problem
  - Number of cases, incidence rates
  - Prevalence of cancer
  - Comparison in different populations

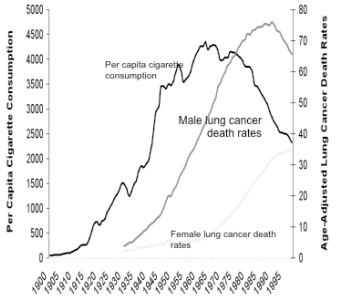
Use of cancer registry

- Analytical studies
  - Case-control studies
    - Completeness and representativeness
  - Cohort studies
    - End point ascertainment
    - Linkage with other registers, eg: Occupation



Tobacco Use and Lung cancer in the US, 1900-1998

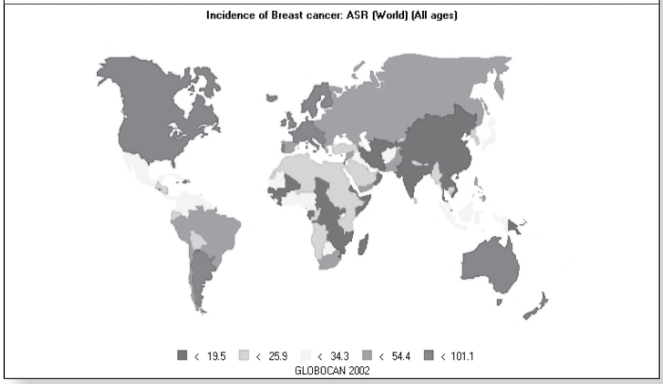
- ASK
  - ✓ About tobacco use
- ADVISE
  - ✓ In a strong and personalized manner
- ASSESS
  - ✓ Determine willingness to quit
- Assist
  - Provide counseling
- ARRANGE
  - ✓ Follow-up programme



*Age-adjusted to 1970 US standard population.
Source: Death rates: US Mortality Public Use Tapes, 1960-1998, US Mortality Volumes, 1930-959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2000; Cigarette consumption: Agriculture, 1930-1998

International and national comparison

Breast cancer



Use of cancer registry

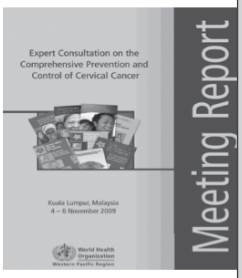
- Health Care Planning & monitoring
  - Planning & establishment of cancer treatment and care facilities
  - Projection of case loads, needs for treatment facilities
  - Specialized services-Paediatric Oncology

Use of cancer registry

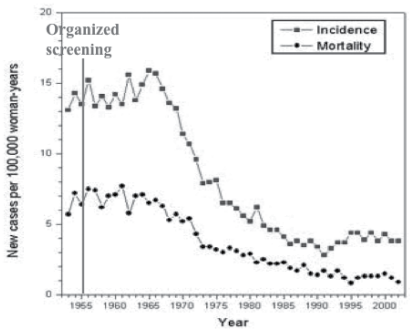
- Patient care
  - Pathways of referral
  - Treatment received by the patients
- Survival
  - Most important outcome of cancer care-population based survival rates
- Screening
  - Demonstrate the effect of mass screening programmes

Cervical cancer control

- Pap Smear
- VIA
- HPV vaccination
  - Needs to know the current incidence and mortality
  - Eligible population for each intervention
  - Annual incidence and mortality data to demonstrate the impact of screeing.



Incidence and mortality rates of cervical cancer in Finland in 1953-2002,
(Finnish Cancer Registry, 2004).



Source: http://www.cancer.fi/YN_Body_cid2_3g.asp?id=821&type_nr=0&cid=2

Cancer control-Outcome

- Change in Incidence
- Change in Survival
- Change in Mortality

Challenges

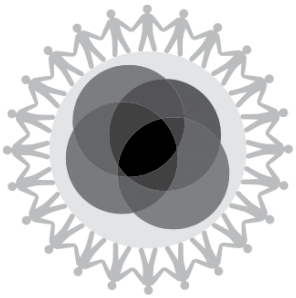
- Defined population
- Capture all new cancer cases
- Capture all deaths from cancer
- Microscopic verification (% path)
- Site and histological details
- ICD coding
- Stage of the disease (TNM, FIGO, etc)
- Collate all cases from the catchment population- avoid duplication
- Compute incidence and mortality data

Operational aspects

- Cancer Registry Committee
  - Director Pathology/Cancer Treating Physician-Chairperson
  - Cancer Registrar-Secretary
  - Statistical Assistant
  - Medical Superintendent
  - Representatives from
    - Clinical departments
    - Diagnostic facilities
    - Vital statistics offices
    - Health information systems

Improving cancer data

- What are the options for increasing the number of cancer registries (in countries which already have one population based cancer registry)?
- What are the gaps and needs?
- In countries with no population based cancer registries
  - Are hospital based registries feasible to start?
- What are the specific gaps and what is needed?
- Are cancer related indicators applicable/feasible?



Thank you

Appendix D

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

HealthPromotionBoard

Technical Consultation on NCD under ASEAN NCD Task Force

Country Update
Singapore Cancer Registry

Dr Chow Khuan Yew
Deputy Director
National Registry of Diseases Office

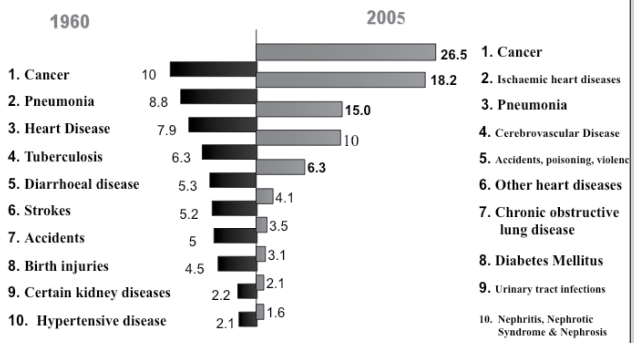
HealthPromotionBoard

Content

- Background of National Registries of Diseases (NRD)
- Work of Singapore Cancer Registry and its challenges
- Update on cancer trends
- Future strategic focus
- Learning points

HealthPromotionBoard

Leading Causes of Death in Singapore



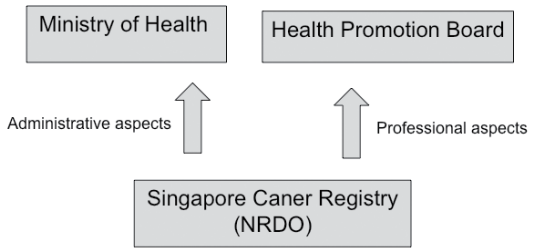
HealthPromotionBoard

Our journey began.....

- MOH set up National Registry of Diseases Office (NRDO) to manage national disease registries in 2001
- Mission
  - Provide data for national health policy and planning
  - Benchmark against international standards
  - Collaborate with stakeholders to drive public health research
- To leverage on research and data management expertise, NRDO is located in Health Promotion Board while taking charge of registries for MOH

HealthPromotionBoard

Reporting Structure



HealthPromotionBoard

Under one roof .....

- Altogether there are 6 registries
- Each registry has different historical background and operations

1968 : **Singapore Cancer Registry**

1987 : **Singapore Myocardial Infarction Registry**
(Acquired by NRDO in 2007)

1992 : **Singapore Renal Registry**

2001 : **Singapore Stroke Registry**

2009 : **Donor Care Registry**

2011 : **National Trauma Registry**

- The number of registries is growing

Our work

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DATA CAPTURE	DATABASE MANAGEMENT	DATA ANALYSIS & REPORTING
Forms	*Encryption*	*De-identified Data Files*
Files		*Results and Reports*

QUALITY CONTOL

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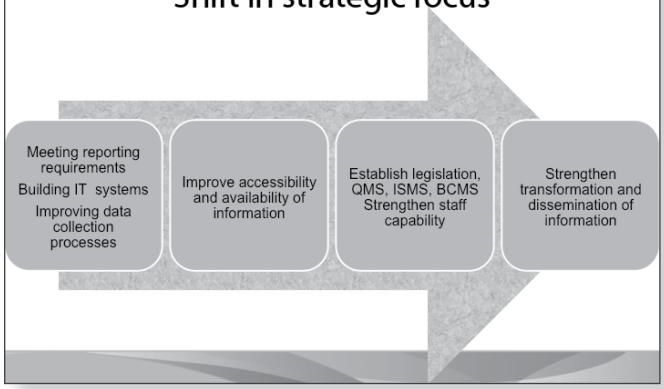
As we grow .....

Shift in strategic focus



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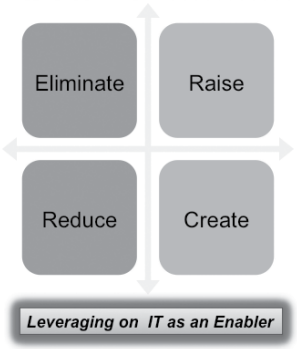
What did we do .....



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Eliminate unnecessary processes

Data collection -

- Electronic transmission of data instead of collection of notifications by staff
- Pathology listings reduce necessity for notifications by physicians

Data management –

- Central repository eliminates the need to manage multiple systems

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Reduce unnecessary efforts

Data collection -

- Verification of complex cases taken over by qualified Cancer Tumour Registrars instead of epidemiologists
- On line notifications replace hard copy notifications

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Raising standards

Quality assurance -

- Monitoring completeness and timeliness of information
- Improving data quality and standardisation of work processes
- Improving information security

Administration-

- Legislation
- Enhance capability of staff

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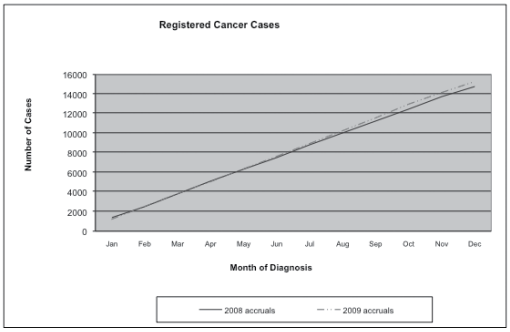
Timeliness



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Challenges in Quality Control "Going against the waves"

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Importance of Information Security

Preservation of :

- **Confidentiality** - Ensuring that only authorised persons have accessed to classified information
- **Integrity** - Ensuring information is correct and complete
- **Availability** - Ensuring that the information is made available when needed

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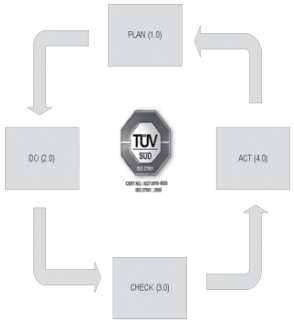
Information Security Management Framework – PDCA model

- **Plan :** activities required to establish the ISMS
- **Do :** activities required to implement and operate the ISMS
- **Check :**activities required to monitor and review the ISMS
- **Act :**activities required to improve the ISMS.



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Experience the tangible benefits

- Better understanding of information security risk posture
- Distinct improvement in security awareness
- Better and smoother operational processes
- Clear and strong management involvement in security activities
- Stronger staff confidence in information security management

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Challenges in maintaining information security

Organisational control of confidential information:

- Minimal necessary
- Control of access/use
- Disclosure accounting
- Policies and procedures
- Culture of confidentiality

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Challenges in maintaining information security

Promoting culture of information security:

- Gaining management support
- Increase awareness via training, communication session
- Making it a priority - KPI
- Continuous improvements versus failure

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Raising capability

Data management team:

Traditional roles

- System development, data editing , data conversion, record linkage, back up data

Expanded roles

- Data analysis
- Report generation
- Information security

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Raising Capability

•Each section trained to cover basic functions of another section

•Business continuity

•Career enrichment

Legislation

National Registry of Diseases Act Enacted in Dec 2007, key areas were:

- Facilitate comprehensive coverage
- Control the amount and type of information to be collected
- Ensure privacy protection and data security
- Provide clarity and transparency towards use of information

Diseases and conditions of high burden and high impact on public health are covered by the Act

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Milestones

ACHDR Consultation (to identify diseases under NRD Act)	June 2007
Public consultations on NRD Act	July 2007
Roadshow for NRD Act	Oct 2007
NRD Bill passed	Dec 2007
Roadshow for Cancer Regulations	Mar to May 2008
NRD Act operational	1 Aug 2009
Cancer Notifications Regulations 2009 promulgated	1 Aug 2009
Single Kidney – Post Nephrectomy (Donor) Regulations 2009 promulgated	1 Nov 2009
Liver – Post Hepatic Resection (Donor) Regulations 2009 promulgated	1 Nov 2009
Chronic Kidney Disease Stage 5	1 Mar 2011

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Notification of Reportable Disease

- Section 6: Duty to notify Registrar of reportable disease
  - Where a person is diagnosed with or undergoes treatment for a reportable disease at a healthcare institution
- Section 7: Collection of information
  - Upon a notification being made, the Registrar may require the manager of the healthcare institution who made the notification to provide additional information

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Section 8: Confidentiality

- Except as otherwise provided by the Act, the Registrar, Agents of Registry or any other person who acts under the direction of the Director or Registrar shall not disclose contents of any register or any individually identifiable information.
- Any person who fails to comply shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $10,000 or to imprisonment for a term not exceeding 12 months or to both

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Creating new ways of working

- Ease of information access via website reduce number of data requests
- Multiple roles in research collaborations e.g. driver, partner or supporter, widen the scopes of work
- Readily available web information improves public awareness on disease conditions

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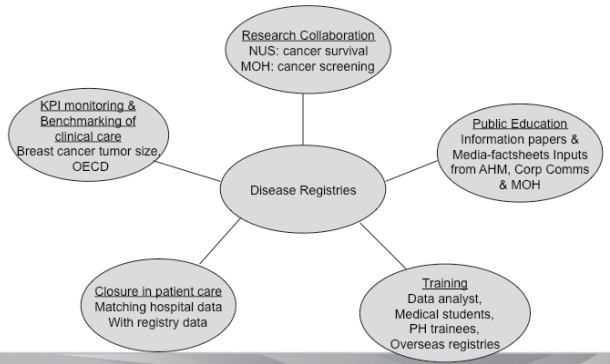
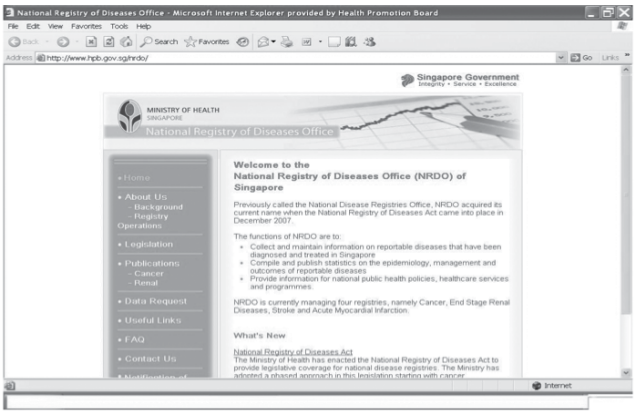
Use of Registry Data



HealthPromotionBoard



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THE STRAITS TIMES SATURDAY, MARCH 1 2008

More people here getting cancer — and dying of it

Colorectal cancer rates here among highest in the world

By Salma Khalik
Health Correspondent

CANCER is on the rise in Singapore, jumping by about 2 per cent annually over the last few years, according to figures released yesterday.

Now, about 9,000 people are told each year that they have the disease.

One of the biggest increases was in colon or colorectal cancer, the top cancer for which men die, with about 1,220 cases a year between 1998 and 2002 to 1,500 cases annually between 2003 and 2006.

The number of people who die of it has also gone up, from about 420 a year to some 600 a year over the same periods.

Professor Chia Kee Seng of the Centre for Molecular Epidemiology said colorectal cancer rates here are now "among the highest in the world".

The Health Promotion Board, which released the figures yesterday, blamed increasingly unhealthy diet and drinking habits, as well as lack of physical activity, for the rise.

Colorectal cancer is a slow-growing disease, and can often be detected with a simple stool test. Prof Chia said early detection results in more than four in five people living beyond five years, compared to just 15 per cent if it is diagnosed late.

Among women, the biggest threat came from breast cancer, which accounted for almost a third of their cancers. From 2001 to 2005, 6,405 women found they had this cancer – or more than 100 each month.

Ovarian cancer also went up from 211 cases a year between 1998 and 2002 to 236 cases from 2003 to 2005. Unlike breast cancer, which can be caught early with regular screening and treated successfully, ovarian cancer usually presents itself late and is often fatal.

Among men, prostate cancer has moved up from the fifth to the third most common type of the disease, with about 355 cases a year, up from 269 a year between 1998 and 2002.

While the higher number of cancer cases is fuelled in part by a larger population, the chances of people here getting the disease has also gone up.

About 249 per 100,000 women aged 30 and over had cancers from 2001 to 2005, compared with 240 from 1998 to 2002.

Among men, it went up from 231 per 100,000 to 236 over the same periods.

Lung cancer is the biggest killer for both men and women, followed by colorectal and liver cancers for men, and breast and colorectal cancers for women.

salma@sph.com.sg

» TOP 10 CANCERS (2001-2005)

In men	Number	In women	Number
Colo-rectum	3,685	Breast	6,405
Lung	3,657	Colo-rectum	3,142
Prostate	1,773	Lung	1,781
Liver	1,660	Ovary	1,251
Stomach	1,366	Corpus Uteri	1,176
Nasopharynx	1,163	Cervix Uteri	1,001
Skin (incl. melanoma)	908	Stomach	877
Lymphoma	859	Skin (incl. melanoma)	798
Bladder	647	Thyroid	647
Leukaemia	603	Lymphoma	619

SOURCE: SINGAPORE CANCER REGISTRY (interim report)

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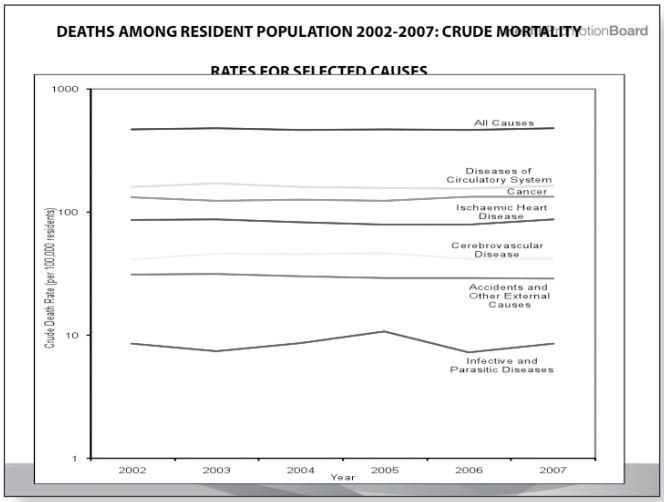
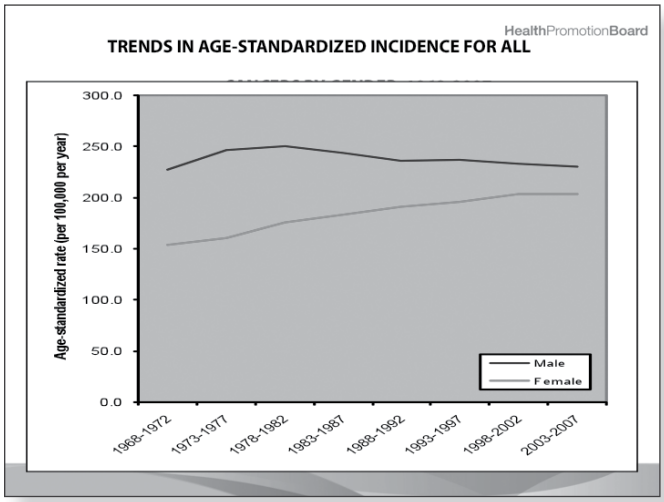
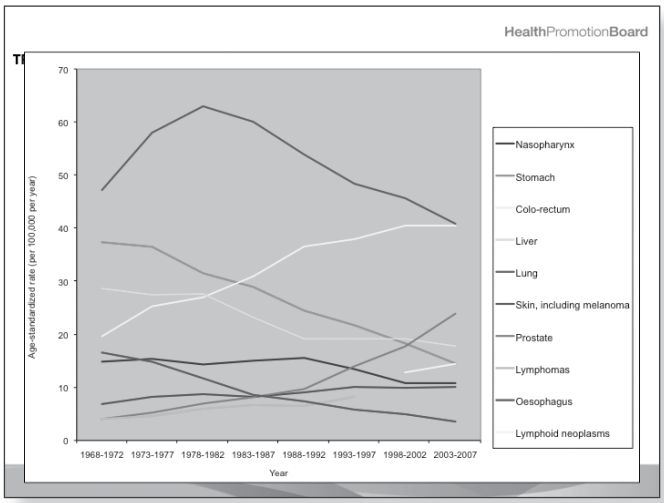
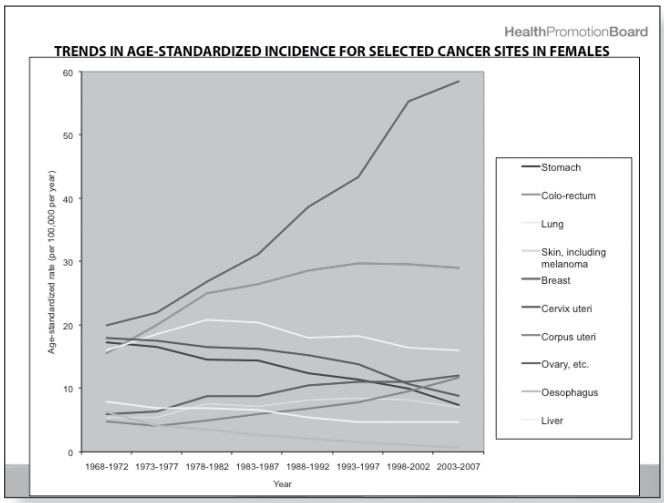
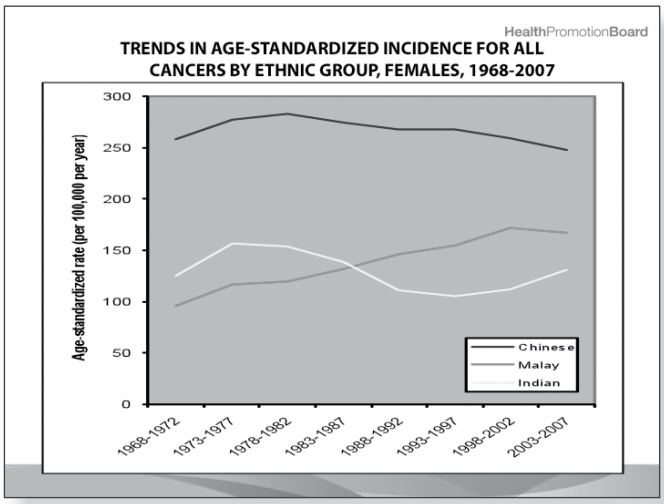
Update on Cancer Trends

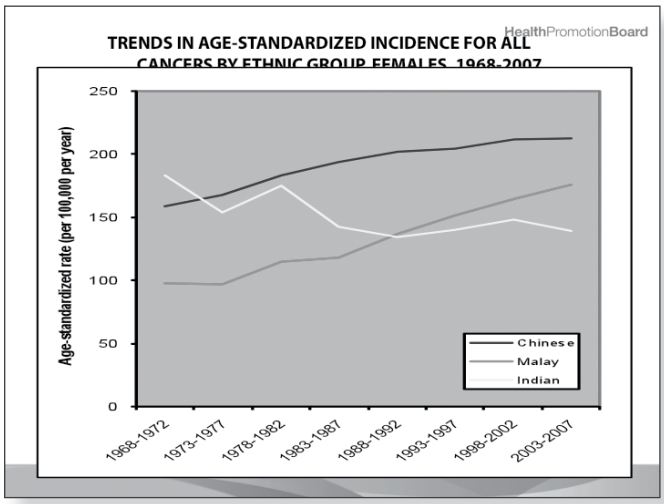

DEATHS AMONG RESIDENT POPULATION 2002-2007: CRUDE MORTALITY
RATES FOR SELECTED CAUSES
Crude Death Rate (per 100,000 residents)
1000
100
10
1
All Causes
Diseases of Circulatory System
Cancer
Ischaemic Heart Disease
Cerebrovascular Disease
Accidents and Other External Causes
Infective and Parasitic Diseases
2002
2003
2004
2005
2006
2007
Year


HealthPromotionBoard
TRENDS IN AGE-STANDARDIZED INCIDENCE FOR ALL
Age-standardized rate (per 100,000 per year)
300.0
250.0
200.0
150.0
100.0
50.0
0.0
Male
Female
1968-1972
1973-1977
1978-1982
1983-1987
1988-1992
1993-1997
1998-2002
2003-2007


HealthPromotionBoard
Age-standardized rate (per 100,000 per year)
70
60
50
40
30
20
10
0
Nasopharynx
Stomach
Colo-rectum
Liver
Lung
Skin, including melanoma
Prostate
Lymphomas
Oesophagus
Lymphoid neoplasms
1968-1972
1973-1977
1978-1982
1983-1987
1988-1992
1993-1997
1998-2002
2003-2007
Year


HealthPromotionBoard
TRENDS IN AGE-STANDARDIZED INCIDENCE FOR SELECTED CANCER SITES IN FEMALES
Age-standardized rate (per 100,000 per year)
60
50
40
30
20
10
0
Stomach
Colo-rectum
Lung
Skin, including melanoma
Breast
Cervix uteri
Corpus uteri
Ovary, etc.
Oesophagus
Liver
1968-1972
1973-1977
1978-1982
1983-1987
1988-1992
1993-1997
1998-2002
2003-2007
Year


HealthPromotionBoard
TRENDS IN AGE-STANDARDIZED INCIDENCE FOR ALL CANCERS BY ETHNIC GROUP, FEMALES, 1968-2007
Age-standardized rate (per 100,000 per year)
300
250
200
150
100
50
0
Chinese
Malay
Indian
1968-1972
1973-1977
1978-1982
1983-1987
1988-1992
1993-1997
1998-2002
2003-2007


HealthPromotionBoard
TRENDS IN AGE-STANDARDIZED INCIDENCE FOR ALL
Age-standardized rate (per 100,000 per year)
250
200
150
100
50
0
Chinese
Malay
Indian
1968-1972
1973-1977
1978-1982
1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

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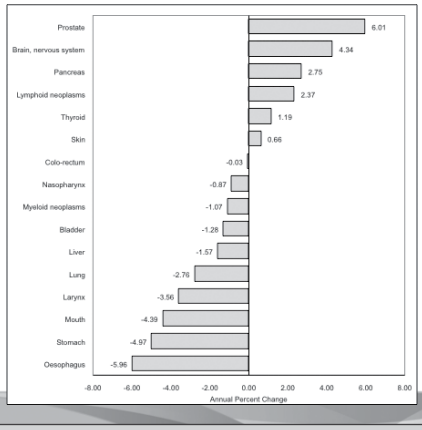
AVERAGE ANNUAL PERCENT CHANGE IN AGE-STANDARDIZED INCIDENCE RATE OF SELECTED



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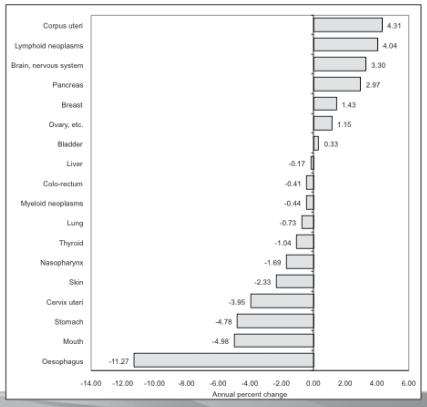
AVERAGE ANNUAL PERCENT CHANGE IN AGE-STANDARDIZED INCIDENCE RATE OF SELECTED CANCER SITES IN FEMALES, 1998-2007



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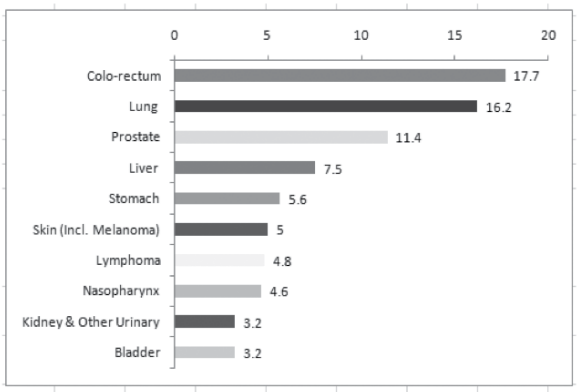
Ten Most Frequent Cancers (%) in Singapore Males, 2006 -2010



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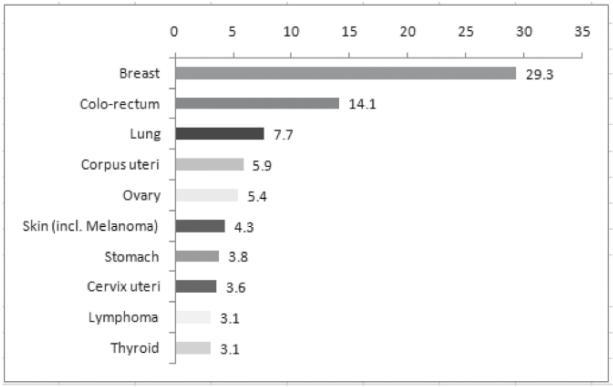
Ten Most Frequent Cancers in Singapore Females (%), 2006 – 2010



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Moving forward

Transformation and dissemination of information :

- Meeting needs of analysis – record linkages, geospatial analysis
- Enlarged scope of analysis – benchmarking of care

What we have learnt .....

- Build firm foundation on data collection, quality and security
- Strengthen capability to face changing needs
- Clarity and transparent towards use of data
- Build good relation with stakeholders
- Proactive in providing useful information

Appendix E

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

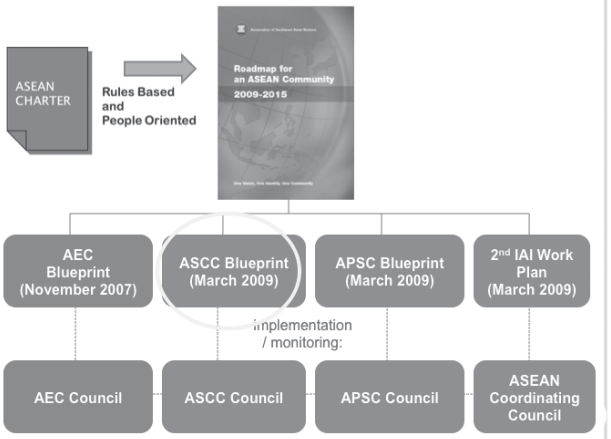
ASEAN Cooperation on Health: Non-Communicable Diseases (NCD)

Health and Communicable Diseases Division
ASEAN Secretariat

Presentation Content

- What is the basis of the regional cooperation on Non-Communicable Diseases?
- What are the updates on NCDs in ASEAN?
- What are the focus areas on NCDs in ASEAN?
- What are the implementation mechanisms and resource support?
- What needs to be done?

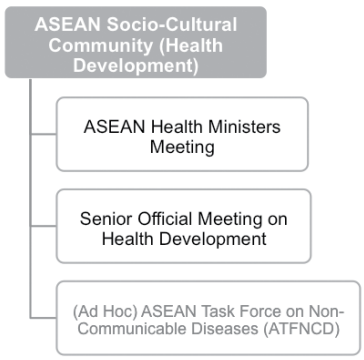
What is the Basis of the Regional Cooperation on NCDs?



ASCC: ASEAN Strategic Framework on Health Development

- Operationalizes the 55 health action lines of the ASCC Blueprint
- Regional activities in health involve:
  - B3. Enhancing Food Security and Safety
  - **B4. Access to healthcare and promotion of healthy lifestyle**
  - B5. Improving capability to control communicable diseases
  - B7. Building disaster-resilient nations and safer communities
    - Xii. Promote multi-sectoral coordination and planning on PPR at the regional level including development of a regional multi-sectoral PPR plan

ASEAN Bodies Related to Health and Non-Communicable Diseases



What are the Updates on NCDs in ASEAN?

- **Strategic Framework**
  - Strategic Framework on Health Development, 2010 - 2015
- **Planning Meeting**
  - Planning Meeting, February 2011, Tagaytay City, Philippines (lead country-Philippines)
  - TOR and Work Plan on NCDs (2011-2015)
- **SOMHD**
  - SOMHD, July 2011, Nay Pyi Taw, Mynamar
  - ASEAN Position on NCDs, Sept 2011 (Indonesia)

What are the Updates on NCDS in ASEAN?

- SOMHD:
  - Task Force is considered Ad Hoc (2011-2015)
  - AHMM endorsement of ad hoc task force
  - Endorsement of TOR and Work Plan by Official Focal Points
- ASEAN Blue Print on ASCC:
  - ASCC Scorecard indicators currently being consolidated
  - Implementation-Focused Monitoring System indicators currently being consolidated

ASEAN Health Ministerial Meeting (AHMM)

Senior Officials Meeting on Health Development (SOMHD)

ASEAN Expert Group on Communicable Diseases (AEGCD)	**ASEAN Task Force on AIDS (ATFOA)**	**ASEAN Expert Group on Food Safety (AEGFS)**

ASEAN Health Ministerial Meeting (AHMM)

Senior Officials Meeting on Health Development (SOMHD)

ASEAN Focal Point on Tobacco Control (AFPTC)	**ASEAN Technical Working Group on Pandemic Preparedness and Responses (ATWGPPR)**	**ASEAN Working Group on Pharmaceutical Development (AWGPD)**

ASEAN Health Ministerial Meeting (AHMM)

Senior Officials Meeting on Health Development (SOMHD)

Ad Hoc ASEAN Task Force on Mental Health	**Ad Hoc ASEAN Task Force on Maternal and Child Health**	**Ad Hoc ASEAN Task Force on Traditional Medicine**	**Ad Hoc ASEAN Task Force on Non-Communicable Diseases**

What are the Implementation Mechanisms and Resource Support?

Implementation Mechanisms

- Lead Countries
- Host Countries
- Support from Development Partners
- Funds from Dialogue Partners with MOU
- Support from SOMHD and other working groups
- Collaborative, Coordinative and Facilitative Role of ASEAN Secretariat

What are the Focus Areas on NCDs in ASEAN?

B4. Focus Area IV: Promotes ASEAN Healthy Lifestyle (NCDs)

- **Strategic Objective:** To ensure access to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN
- **Elements:**

  B4.x Promote collaboration in Research and Development on health promotion, healthy lifestyles and risk factors of NCDs in AMS

  B4.xi Promote the sharing of best practices in improved access to health products including medicines for people of ASEAN

  B4.xxi Strengthen existing health networking in AMS in order to push forward an active implementation on health services access and promotion of healthy lifestyles, as well as continually exchange of knowledge, technology and innovation for sustainable cooperation and development

ASEAN Work Plan on NCDs (2011-2015)

- Revitalization and implementation of "ASEAN Healthy Lifestyle, 2002"
  - Development of Advocacy Tool with WHO on Diabetes, Hypertension, Cancer, CVD, COPD (Philippines)
  - Advocacy on selected platforms (Philippines)
  - Policy advocacy (Philippines, Cambodia)

ASEAN Work Plan on NCDs (2011-2015)

- Facilitating enabling environment for ensuring promotion of healthy lifestyle for the people of ASEAN
  - Inventory of experts (Indonesia)
  - Networking on ASEAN Cancer Data & Registry Information Syustem (Malaysia)
  - Workshop (Key indicators on Healthy Lifestyle esp. on 5 NCDs) (Malaysia)
  - Best Practices (Philippines, Thailand)
  - Regional Forum on NCDs (Philippines)
  - Harmonization of Guidelines on Physical Activity (Singapore)
  - Integrated regional framework for NCD screening and management (Thailand, Singapore)

What needs to be done?

- Finalize list of official focal points on NCDs
- Finalized and endorse TOR
- Finalize and endorse Work Plan
- SOMHD endorsement

Appendix F

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Ncd Surveillance in Asean Countries: Risk Factor, Morbidity And Mortality

Country	NCD Risk Factors surveys	Morbidity	Mortality
Malaysia	Type: NHMS; 18 000; ≥ 18 years; standardized Coverage: Population-based; national Frequency: 10 years till 2006; every 4 years starting 2011 First year done: 1986 Last year done: 2011 Next round: 2015 Agency: MoH (Institute of Public Health; budgeted for) RF screened: • tobacco, alcohol (1996), unhealthy diet, physical inactivity (2006), mental health (2006) • Lab (blood) tests: FBS, TChol • Physiological: BMI, BP	Major NCD: CVD, Ca, COPD, DM: • Hospital admissions (COPD & CVD) • National Cancer Registry • DM Registry	• Hospital-based mortality data • National mortality data available
Myanmar	Type: STEPS (risk factors); 9000; ≥18 – 65 years Coverage: population-based; national Frequency: 5 years from now First year done: 2003; regional Last year done: 2009; national Next round: 2014 Agency: Dept of Health (Medical Div); budget: WHO/ MoH) RF screened: • tobacco, alcohol, unhealthy diet, physical inactivity • Lab (blood) tests: FBS, TChol • Physiological: BMI, BP, WC	Major NCD: CVD, Ca, COPD, DM: • Hospital based • No registry • HMIS – every 5 years	• National Death Registry
Brunei	Type: NHANSS (risk factors); 6000; Phase 1: < 5years; Phase II: 5-75 years; some STEPS questions includede.g. PA Coverage: population-based; national Frequency: Phase 1: 5 years; Phase II: 10 years First year done: 1997 Last year done: 2009; national Agency: Dept of Health; budget: National Development Plan) RF screened: • tobacco, alcohol (some questions only), unhealthy diet, physical inactivity • Lab (blood) tests: FBS, TChol, OGTT, HbAIC, FBC, Cr • Physiological: BMI, BP	Major NCD: CVD, Ca, DM: • Hospital inpatient & outpatient data • National Cancer Registry • DM Registry – hospital-based	• Hospital based mortality data • National mortality data available

Country	NCD Risk Factors surveys	Morbidity	Mortality
Indonesia	Type: National survey; ≥15 years; 17 000; standardized; STEPS questions included Coverage: population-based; national Frequency: 3 years First year done: 2007 Last year done: 2010 Next round: 2013 Agency: Dept of Health; budget: MoH/NIHRD RF screened: • tobacco, alcohol, unhealthy diet, physical inactivity • Lab (blood) tests: FBS, TChol • Physiological: BMI, BP, stress assessment	Major NCD: Ca, CVD, COPD, DM: • Provincial Cancer Registry • Hospital data – COPD, CVD, DM • DM – PHC	• Hospital-based
Philippines	Type: NNHS; ≥15 years; 17 000; standardized; STEPS questions included Coverage: population-based; national Frequency: 5 years First year done: 2003 Last year done: 2008 Next round: 2013 Agency: FNRI, DoH-NCDPC; budget: RF screened: • tobacco, alcohol, unhealthy diet, physical inactivity • Lab (blood) tests: FBS, TChol • Physiological: BMI, WC, BP	Major NCDs: Hospital data Registry: Cancer (1 province; 1 city)	• Hospital-based • National Death Registry
Singapore	Type: NHS (1992/2010); NHSS (2007); ≥18-74 years; 17 000; standardized; different from STEPS Coverage: population-based; national Frequency: 6 years First year done: NHS (1992/2010); Next round: 2016 Last year done: NHSS (2007); Next round: 2013 Agency: MOH – ENDC; budget RF screened: • tobacco, alcohol, unhealthy diet, physical inactivity • Lab (blood) tests: FBS, TChol • Physiological: BMI, BP	Major NCDs: COPD Hospital data Registry: National- Cancer, CVD, Hospital – DM	• Hospital-based • National Births & Deaths Register - MHA

Appendix G

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

TARGETS TO MONITOR PROGRESS IN REDUCING THE BURDEN OF NONCOMMUNICABLE DISEASES

Recommendations from a WHO Technical Working Group on Noncommunicable Disease Targets

(version dated 15 July 2011 for a web-based consultation with Member States)

Introduction

Noncommunicable diseases are the leading global cause of death, responsible for an estimated 36 million deaths, with 80% of these deaths occurring in low- and middle-income countries (LMICs). NCDs, mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases, are largely preventable. These NCDs share modifiable behavioural risk factors like tobacco use, unhealthy diet, lack of physical activity, and the harmful use of alcohol which in turn lead to overweight and obesity, raised blood pressure, and raised cholesterol. Feasible and cost-effective interventions exist to reduce the burden and impact of NCDs now and in the future. Sustained action to prevent risk factors and improve health care will avert millions of preventable premature deaths.

The Global Strategy for the Prevention and Control of NCDs has three key objectives which serve as basic components of any global or national programme to address NCDs: surveillance, prevention by reducing risk factors levels, and management by improved access to essential health care.

Surveillance and monitoring NCDs and their determinants provides the foundation for advocacy, policy development, as well as assessing national and global action. An effective surveillance system requires systematic collection, analysis, and presentation of data on NCD mortality, morbidity, risk factors, and interventions over time.

A comprehensive framework for NCD surveillance includes three major components at the global and national level: a) monitoring exposures (risk factors); b) monitoring outcomes (morbidity and disease-specific mortality; and c) health system response, which includes assessment of national capacity to prevent and control NCDs.

The *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases,* which was endorsed by the World Health Assembly in 2008, recommends critical actions for Member States to strengthen surveillance and standardize data collection on NCD risk factors, disease incidence and cause-specific mortality. The plan also calls on Member States to contribute, on a routine basis, data and information on trends related to NCDs and their risk factors stratified by age, sex and socioeconomic groups, and to provide information on progress made in implementation of national strategies and plans.

In the Moscow Declaration, endorsed during the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, held in Moscow, 28-29 April 2011, delegates committed to supporting WHO in developing a comprehensive global monitoring framework on NCDs. This call to develop the monitoring framework, along with the other recommendations included in the Moscow Declaration, was then endorsed by the World Health Assembly in May 2011.

A technical working group, composed of international experts in NCD surveillance and WHO staff members, recommended through several technical meetings the proposed targets and indicators presented in this document. The proposed targets and indicators are consistent with the recommendations of the WHO Reference Epidemiology Group established in 2009 on the framework and components of national NCD surveillance schemes and also the outcome of two WHO consultations on NCD surveillance conducted in 2009 and 2010.[1]

Proposed NCD Targets and Indicators

The targets have been set to achieve major reductions in NCDs and their risk factors by 2025. Table 1 summarizes each target, indicator, and main data source.

The "target" represents the specific goal to be achieved by 2025. The baseline for all targets is 2010. Interim targets for 2015 and 2020 will be set at a later date for all indicators. The "indicator" is used to assess progress and achievement towards the target. The "data source" describes the origins of information for the indicator.

Targets were established following scientific review of the current situation and trends, combined with a critical assessment of feasibility based upon demonstrated country achievement. Mortality and prevalence targets are age-standardized.

[1] WHO. Global Status Report on Noncommunicable Diseases 2010. See Chapter 3: Monitoring NCDs and their risk factors: A surveillance framework.

Table 1: Targets for achievements by 2025[2,3]

	Outcome targets	Indicator	Data Source(s)
1	**Premature mortality from NCDs** 25% relative reduction in overall mortality from cardiovascular disease[4], cancer, diabetes, and chronic respiratory disease	Probability of dying between ages 30-70 from, cardiovascular disease, cancer, diabetes, and chronic respiratory disease	Civil registration system, with medical certification of cause of death, or survey with verbal autopsy
2	**Diabetes** 10% relative reduction in prevalence of diabetes[5]	Prevalence of diabetes among persons aged 25+ years	Survey (with measurement)
	Exposure targets		
3	**Tobacco smoking** 40% relative reduction in prevalence of current daily tobacco smoking	Prevalence of current daily tobacco smoking among persons aged 15+ years[6]	Survey
4	**Alcohol** 10% relative reduction in per capita consumption of alcohol; and 10% relative reduction in prevalence of heavy episodic drinking	Per capita consumption of pure litres of alcohol among persons aged 15+ years; and prevalence of heavy episodic drinking among persons aged 15+ years	Official statistics and reporting systems for production, import, export, and sales or taxation data; and survey
5	**Dietary salt intake** Reduction of mean population intake of salt to < than 5 grams per day	Mean population intake of salt per day	Survey (with measurement)
6	**Obesity** Halt the rise in obesity[7] prevalence	Prevalence of obesity among persons aged 25+ years; and prevalence of physical inactivity among persons aged 25+ years[8]	Survey (with measurement)

[2] The baseline level for all targets is 2010. Interim targets will be set for 2015 and 2020
[3] Mortality and prevalence targets are age-standardized
[4] Cardiovascular disease includes coronary heart disease (heart attack), cerebrovascular disease (stroke), peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure
[5] Diabetes is defined as fasting plasma glucose ≥ 7.0 mmol/L (126, g/dl) or on treatment for diabetes
[6] Achieved through full implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), and in particular demand reduction measures
[7] Obesity is defined as Body Mass Index (BMI) equal or greater than 30kg/m^2
[8] Physical inactivity is defined as < 150 minutes of moderate physical activity or its equivalent per week

7	**Blood pressure/Hypertension** 25% relative reduction in prevalence of raised blood pressure[9]	Prevalence of raised blood pressure among persons aged 25+ years	Survey (with measurement)
	Health system targets		
8	**Prevention of heart attack and stroke in primary care** 80% coverage of multidrug therapy for people aged 30+ years with a 10 year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease	Multidrug therapy for people aged 30+ years with a 10 year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease	Survey; health facility data
9	**Cancer prevention in primary care** Cancer prevention and early detection scaled up to achieve: a) 70% of women between ages 30-49 screened for cervical cancer at least once; b) 25% increase in the proportion of breast cancers diagnosed in early stages; c) <1 % prevalence of HBsAg carriers among children aged ≤ 5 years (a risk factor for liver cancer)	a) Prevalence of women between ages 30-49 screened for cervical cancer at least once; b) Proportion of breast cancers diagnosed in early stages (I & II); c) Prevalence of HBsAg carriers among children aged ≤ 5 years	Survey (with measurement); health facility data; population based cancer registry
10	**Policy approaches to dietary risk reduction** Total elimination of partially hydrogenated vegetable oil (PHVO) from the food supply by 2020; and no marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt to children	Policies that eliminate PHVO in food; and policies with enforcement mechanisms that restrict marketing foods high in saturated fats, *trans*- fatty acids, free sugars, or salt to children	Policy review

Measurement needs

To monitor progress, a robust monitoring system is needed in all countries. Main components include:

- Death registration, with a reliable cause of death.

  High-quality mortality data can best be generated by long-term investment in civil registration. Recording all deaths and their cause on a country level is a critical

[9] Raised blood pressure is defined as systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90

requirement. Accurate reporting of the cause-of-death on the death certificate is a challenge, even in high-income countries. Only about two thirds of countries have vital registration systems that capture the total number of deaths reasonably well. Although total all-cause mortality may be reported reasonably well, accuracy problems exist for cause-specific certification and coding in a large number of countries. In these countries, national initiatives to strengthen vital registration systems and cause-specific mortality is a key priority. In settings where many deaths are not attended by a physician, alternate methods, such as verbal autopsy, may be used to complement data collected from death certificates until vital registration systems are adequately strengthened.

- Health surveys, with measurement

  All countries will need to collect data from the general population through representative household surveys conducted at least once every five years. Information is collected through interviews, physical measurement, and biological testing. A survey that includes an interview and measurement is called a health examination survey – the WHO STEPs survey is an example of this type of survey for NCD as are a number of nationally coordinated surveys.

- Policy reviews

  Assessment of policy indicators will require a regular, systematic, and independent review of national policies to determine if they are in place, implemented and enforced.

Reporting and review

Measurement of the indicators would be reported every five years, in 2015, 2020 and 2025. Reporting must balance country ownership and application, with comparability and transparency so that lessons can be shared and progress measured. This will require close coordination of country reporting with global analyses. The responsibility for compiling and interpreting the data and additional analyses lies with WHO, supported by an expert group of independent institutions. The reports will be presented and discussed at the World Health Assembly and the UN General Assembly.

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Appendix H

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Proposed NCD Targets for ASEAN countries

(Based on Draft WHO global targets)

Draft WHO Global Targets-2025	ASEAN Targets	Indicators
Outcome targets		
Premature mortality from NCDs 25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes and chronic respiratory disease **Diabetes** 10% relative reduction in prevalence of diabetes	• 10% relative reduction in premature mortality • 10% relative reduction in diabetes prevalence	• Probability of dying between 30-60 years from 4 major NCDs (CVD, Ca, COPD, DM) • Prevalence of diabetes among persons ≥25 years
Exposure		
Tobacco smoking 40% relative reduction in prevalence of current daily tobacco smoking **Alcohol** 10% relative reduction in per capita consumption of alcohol; and 10% relative reduction in prevalence of heavy episodic drinking **Dietary salt intake** Reduction of mean population intake of salt to < than 5 grams per day **Obesity** Halt the rise in obesity prevalence **Blood pressure/Hypertension** 25% relative reduction in prevalence of raised blood pressure	• 15% relative reduction in prevalence of current daily tobacco smoking • 10% relative reduction in per capita consumption of alcohol • Reduction of mean population intake of salt to < 5gm/day • Halt the rise in obesity prevalence • 25% relative reduction in prevalence of raised blood pressure	• Prevalence among persons ≥15 years • Per capita consumption of pure litres of alcohol among persons ≥15 years • Mean population intake of salt/day • Prevalence of obesity among persons ≥25 years & prevalence of physical inactivity among persons ≥25 years • Prevalence of raised blood pressure among persons ≥25 years
Health systems targets		
Prevention of heart attack and stroke in primary care 80% coverage of multidrug therapy for people aged 30+ years with a 10-year risk of heart attack or stroke ≥ 30% or existing cardiovascular disease **Cancer prevention in primary care** Cancer prevention and early detection scaled up to achieve: a) 70% of women between ages 30-49 screened for cervical cancer at least once; b) 25% increase in the proportion of breast cancers diagnosed in early stages; c) <1 % prevalence of HBsAg carriers among children aged ≤ 5 years (a risk factor for liver cancer)	• 50% coverage of multidrug therapy for people aged ≥30 years, with a 10-year risk of heart attack or stroke ≥30%, or existing cardiovascular disease • 50% of women between ages 30-49 screened for cervical cancer at least once • 25% increase in the proportion of breast cancers diagnosed in early stages • <1% prevalence of HBsAg carriers among children aged ≤ 5 years	• Multidrug therapy for people aged ≥30 years, with a 10-year risk of heart attack or stroke ≥30%, or existing cardiovascular disease • Prevalence (Proportion/ percentage) of women between ages 30-49 screened for cervical cancer at least once • Proportion of breast cancers diagnosed in early stages (I & II) • Prevalence of HBsAg carriers among children aged ≤ 5 years

Health systems targets		
Policy approaches to dietary risk reduction Total elimination of partially hydrogenated vegetable oil (PHVO) from the food supply by 2020; and no marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt to children	• Total elimination of partially hydrogenated vegetable oil (PHVO) from the food supply by 2020; & no marketing of foods high in saturated fats, trans-fatty acids, free sugars or salt to children	• Policies that eliminate (PHVO) in food & policies with enforcement mechanisms that restrict marketing of foods high in saturated fats, trans-fatty acids, free sugars or salt to children

Constraints:

- There is no baseline information to help set targets in some cases for some countries.
- More information is needed on definition of children, and also from EPI, for baseline information on Hep B vaccination.

Suggestions:

- 'prevalence' – proportion/percentage (cervical cancer)
- Childhood obesity indicators

Appendix I

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

FIRST GLOBAL MINISTERIAL CONFERENCE ON
HEALTHY LIFESTYLES AND
NONCOMMUNICABLE DISEASE CONTROL

ПЕРВАЯ ГЛОБАЛЬНАЯ МИНИСТЕРСКАЯ КОНФЕРЕНЦИЯ ПО
ЗДОРОВОМУ ОБРАЗУ ЖИЗНИ И
НЕИНФЕКЦИОННЫМ ЗАБОЛЕВАНИЯМ

First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control
(Moscow, 28-29 April 2011)

DISCUSSION PAPER
MONITORING NCDS AND THEIR RISK FACTORS: A FRAMEWORK FOR SURVEILLANCE

Summary

The current capacities for NCD surveillance are inadequate in many countries and urgently require strengthening. It is possible to have high quality risk factor surveillance even in low-resource countries and settings. A surveillance framework that monitors exposures (risk factors and determinants), outcomes (morbidity and mortality) and health-system responses (interventions and capacity) is essential. A common set of core indicators, is needed for each component of the framework. Sustainable NCD surveillance systems need to be integrated into national health information systems and supported with adequate resources. This paper reviews the framework for monitoring of NCD's as well as the providing recommendations on improving capacity of Countries to respond to them.

Noncommunicable disease surveillance

Noncommunicable disease surveillance is the ongoing systematic collection and analysis of data to provide appropriate information regarding a country's NCD disease burden, the population groups at risk, estimates of NCD mortality, morbidity, risk factors and determinants, coupled with the ability to track health outcomes and risk factor trends over time. Surveillance is critical to providing the information needed for policy and programme development and appropriate legislation for NCD prevention and control, and to support the monitoring and evaluation of the progress made in implementing policies and programmes.

Accurate data from countries is vital to reverse the global rise in death and disability from NCDs. Currently, many countries have little useable mortality data and weak NCD surveillance. (1) Data on NCDs are often not integrated into national health information systems. Improving country-level surveillance and monitoring must be a top priority in the fight against NCDs.

The *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases* (2) recommends critical actions for Member States to strengthen surveillance and standardize data collection on NCD risk factors, disease incidence and cause-specific mortality. The plan also calls on Member States to contribute, on a routine basis, data and information on trends related to NCDs and their risk factors stratified by age, sex and socioeconomic groups, and to provide information on progress made in implementation of national strategies and plans. NCD surveillance systems need to be integrated into existing national health information systems. This is all the more important where resources are limited. Table 1 provides a framework for a national NCD surveillance scheme. Three major components of NCD surveillance are: a) monitoring exposures (risk factors); b) monitoring outcomes (morbidity and disease-specific mortality; and c) health system responses, which also includes national capacity to

prevent NCDs (in terms of policies and plans, infrastructure, human resources and access to essential health care including medicines). A list of core and expanded indicators for consideration to be used with the framework above is provided in Annex 1.

Table 1: Framework for national NCD surveillance

Source: *Surveillance of Noncommunicable Diseases. Report of a WHO Meeting.* Geneva, World Health Organization, 2010

Exposures:

- Behavioural risk factors: *tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diet.*
- Physiological and metabolic risk factors: *raised blood pressure, overweight/obesity, raised blood glucose, and raised cholesterol.*
- Social determinants: *educational level, household income, access to health care.*

Outcomes:

- Mortality: *NCD-specific mortality.*
- Morbidity: *Cancer incidence and type.*

Health system response:

- Interventions and health system capacity: *infrastructure, policies and plans, access to key health-care interventions and treatments, partnerships.*

Monitoring exposures: risk factor surveillance

Monitoring of risk factors at the population level (or in a subset of the population) has been the mainstay of national NCD surveillance in most countries. Taking an incremental approach, the first phase of surveillance in many low- and middle-income countries should be based on their priority information needs for policy and programme development, implementation and evaluation. Surveillance activities in low-resource settings should place the highest priority on national needs and the Global Strategy Action Plan's emphasis on population exposures to risk factors.

Data on behavioural and metabolic risk factors is typically obtained from national health interview or health examination surveys, either addressing a specific topic (e.g. tobacco) or multi-risk factors. Data on social determinants, which can then be used to further understand risk factor patterns, is also typically obtained from these sources.

In this context, the WHO STEPS approach (3) to NCD risk factor surveillance is a good example of an integrated and phased approach that has been used and tested by many countries. It allows countries to develop a comprehensive risk profile of their national populations. Information on socio-demographic factors and behavioural risk factors is collected through self-reporting. Physical measurements of height and weight for body mass index (BMI), waist circumference and blood pressure are made, and biochemical measurements are obtained for fasting blood glucose and total cholesterol levels.

The principles of STEPS risk factor surveillance are repeated in cross-sectional, population-based household surveys. STEPS promotes the concept that surveillance systems require standardized data collection but with sufficient flexibility to be appropriate in a variety of country situations and settings.

A good example of a topic-specific risk factor survey is the Global Adult Tobacco Survey (GATS) (4), which captures additional information on knowledge, attitude and perceptions surrounding the health effects of tobacco use and exposure, advertising, promoting and economics of tobacco use, as well as information on cessation activities.

Monitoring outcomes: mortality and morbidity

An accurate measure of adult mortality is one of the most informative ways to measure the extent of the NCD epidemic and to plan and target effective programmes for NCD control. All-cause and cause-specific death rates, particularly premature deaths before age 60 or 70, are key NCD indicators. High-quality mortality data can only be generated by long-term investment in civil registration systems. (5)

Registering every death is a key first step. Accurate reporting of the cause of death on the death certificate is a challenge, even in high-income countries. Death registration by cause is neither accurate nor complete in a large proportion of countries. From a global perspective, there has been only limited improvement in the registration of births and deaths over the past 50 years. (6) Ascertaining all deaths and their cause on a country level is a critical requirement. Only about two thirds of countries have vital registration systems that capture the total number of deaths reasonably well. (7) Although total all-cause mortality may be reported, significant accuracy problems exist in many countries with cause-specific certification and coding. National initiatives to strengthen vital registration systems, and cause-specific mortality statistics, are a key priority.

In the meantime, where cause-specific mortality data is not available or inadequate from a coverage and/or quality perspective, countries should establish interim measures such as verbal autopsy for cause of death, pending improvements in their vital registration systems. (8)

Monitoring health system response and country capacity

Assessing individual country capacity and health-system responses to address NCD prevention and control in a comprehensive manner, and measuring their progress over time, is a major component of the reporting requirements stated in Objective 6 of the Global Strategy Action Plan. To monitor country capacity to respond to NCDs, WHO has conducted periodic assessments of the major components of national capacity in all Member States. This was carried out in 2000–2001, following the endorsement of the *Global Strategy for the Prevention and Control of Noncommunicable Diseases*, (9) and again in 2009–2010. A further assessment is planned for 2013.

The capacity assessments examine the public health infrastructure available to deal with NCDs; the status of NCD-relevant policies, strategies, action plans and programmes; the existence of health information systems, surveillance activities and surveys; access to essential health-care services including early detection, treatment and care for NCDs; and the existence of partnerships and collaborations related to NCD prevention and control.

Opportunities for enhancement

The dearth of reliable information and capacity, which includes important gaps in surveillance data, is a major challenge to NCD prevention and control in many countries. Tracking NCDs and their risk factors and determinants is one of the three key components of the *Global Strategy for the Prevention and Control of Noncommunicable Diseases*. Strengthening surveillance is a priority for every country. There is an urgent and pressing need for concerted efforts to improve the coverage and quality of mortality data, to conduct regular risk factors surveys at a national scale with standardized methods, and to regularly assess national capacity to prevent and control NCDs.

Numerous recommendations have been made to improve country capacity for the development and maintenance of health information systems, and many are clearly applicable to NCDs. A permanent infrastructure for surveillance activities is required. Data collection can be organized in several ways, but an institution or a network with the relevant expertise is needed to guarantee the sustainability and quality of surveillance over time. However, knowing what to do is not the primary obstacle; lack of experience in establishing health information systems, and obtaining the necessary resources, also remain key challenges.

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ANNEX I

Core indicators for consideration as part of the framework for NCD surveillance

Exposures

Behavioral risk factors

- Prevalence of current daily tobacco smoking among adults aged 15+ years.)
- Prevalence of insufficiently active adults (defined as % not meeting any of the following criteria: 30 minutes of moderate activity on at least five days per week *or* 20 minutes of vigorous activity on at least three days per week *or* an equivalent combination).
- Prevalence of adult population consuming more than 5 grams of dietary sodium chloride per day (%).
- Prevalence of population consuming less than five total servings (400 grams) of fruit and vegetables per day (%).
- Proportion of all energy derived from saturated and total fats (%).
- Adult per capita consumption of pure alcohol, in litres (recorded and unrecorded).

Physiological and metabolic risk factors

- Prevalence of raised blood glucose among adults (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126g/dl) or on medication for raised blood glucose) (%).
- Prevalence of raised blood pressure among adults (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥90 mmHg or on medication for raised blood pressure (%).
- Prevalence of overweight and obesity in adults, adolescents and children under 5 (defined as body mass index greater than 25 kg/m^2 for overweight or $30kg/m^2$ for obesity, for adolescents according to the WHO Growth Reference and for children according to the WHO Growth Standards) (%).
- Prevalence of low weight at birth (< 2.5 kg) (%).
- Prevalence of raised total cholesterol among adults (defined as total cholesterol ≥ 5.0 mmol/l or 190mg/dl) (%).

Outcomes

Mortality

- All-cause mortality by age, sex and region (urban and rural, or by other administrative areas, as available).
- Cause-specific mortality data (urban and rural, or other administrative areas, as available).
- Unconditional probability of death between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases.

Morbidity

- Cancer incidence data from cancer registries, by type of cancer.

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Unless specified otherwise, the data contained in this discussion paper is based on the 2004 update on the 'Global burden of disease'. Additional information is available at www.who.int/research.

Appendix J

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Developing/Strengthening National NCD Surveillance System in Asian Countries

Country	Institutional Mechanism	Responsible Officer	Working Groups	Budget
Malaysia	• Currently system under development (by 2016 according to Malaysia Development Plan 2010)	• Dep Dir NCD	• PH Institute • Nutrition Div • School Health, FH Div • HIS, Dev & Planning Div • Universities • HPB, Malaysia • HE Div, MoH • NGOs (Nat Ca Society, Diabetes Society etc)	• MOH (Dev & Planning Div)
Myanmar	• Under development	• University of Medicine II • Dept of Medical Care, MoH • Dept of Planning, MoH	• Dept of Health, MoH: CVD, Ca, DM) • University of PH • Dept of Medical Research	• MoH • WHO
Brunei	• Under development	• MoH - DGHS	• MoH – Dept Policy & Plng (R&D Div); Dept of Hlth Svc (Nutr Div, DCD); Dept of Med Svc; HPC;; UBD	• MoH (Nat Dev Plan budget from Dept of Economic Devt & Planning, PMO)
Indonesia	• NIHRD, MoH • Hospital Information System	• NIHRD (MoH) • MoH (NCD Div)	• MoH (NCD Div, Med Svc) • Hospitals • Universities • Statistics Bureau • Ministry of Internal Affairs	• MoH
Philippines	• Under development (NCD surveillance– National Epidemiology Centre, Information Management Service, NCD Service)	• NCD Office	• Internal: Epid Centre, IMS, NCD Office • External: Dept of Education, Food & Nutrition Research Institute (FNRI), academe	• NCD office • IMS
Singapore	• Existing; Nat Svc, administrative data, disease registries	• MoH (Epidemiology & Disease Control Div) • HPB (NRDO & Strat Plng Div)	• MoH • HPB	• MoH

Work Plan	Report	Dissemination	National Database	Challenges
• Every 5 years	• Annually (process indicators) & 5 years (outcome indicators)	• Health facts – annually • Website	NA	
• Every 5 years • Starting 2014	• Annually	• Publications • Website (MoH – Dept of Planning)	• Under construction (MoH)	• Focal person frequently changing • Sustainable budget • Integration of activity of relevant dept
• Every 5 years	• Annually • Every 5 years	• Publications • Website	NA	• Manpower
• Every 3 years	• 3 yearly reports	• Publications • Website	NA	• Integration • Manpower for registries
• IMS, DoH (annually) for registry • Hospital – standard form • 5 years (analysis)	• Annual reports	• Publication-Healthbeat • Website	• NNHS	• Manpower
• Every 3 years	• Annual reports • 6-yearly reports	• Publication • Website	• MoH • HPB	

Appendix K

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Cancer Registration in ASEAN: Current Status and Challenges

Countries without Cancer Registries:

Country	Options:	Obstacles
Malaysia	• Subnational → national	• Money • Manpower • Materials – need technical input Currently, the working paper is in process for submission to MoH
Brunei	• Hospital-based → national, population-based • Currently, registry with DCD, DoHS	• Manpower – expertise (tapping into WHO etc)

Countries without Cancer Registries:

Country	National coverage	Quality indicators	Intent
Malaysia	• National • Government & private • Plan to submit to CI5 (2008-2012)	• 94% microscopically verified • <5% reported by death certification	• Database being used for initial intent
Philippines	• 2 PBCR; incidence & mortality – expansion planned; survival -2 cohorts • Data only from government hospitals Run by NGO – Cancer Society – with funding from MoH		• Database being used for initial intent
Indonesia	• Subnational PBCR (Jakarta province) – public & private • Hospital & pathological cancer registries (major hospitals countrywide) for NGO & professional use • Plan to → national PBCR • Pan to submit to CI5; finalizing for 2012	• 70 - 80% microscopically verified • < 5% death certification	• To find out disease burden • To collect cancer screening processes
Singapore	• National coverage • PBCR • Data sent to CI5 every 5 years	• 100% coverage • 98% microscopically verified • 1% death certification	• For monitoring, programme planning, policy formulation, evaluation of cancer screening programmes

Moving forward	Issues
Specific issues: • Diagnosis • Regulation on data sources • Patients going abroad but they come back to see the same group of oncologists (advantage)	• Few Oncologists & pathologists • Missing data from private sector • Traditional healers
• Meetings, discussions with stakeholders & executive committee on way forward • Linkage with pap smear registry (& HPV)	• Identifying focal points or responsible office/unit

Improvement	Linkages	Challenges
• Data collection improved over the years, especially at hospital level	• Cancer control programme • Other registries: screening, pap smear, HPV registry	• Ownership & authority (Public Health vs Clinical Research Centre) • Same methods but different levels of progress in states • Voluntary notification • Manpower • Cooperation from data sources
• Completeness of reporting especially for cervical cancer (VIA)	• Death registry • Monitoring of cervical and breast cancer programmes	• Transfer of ownership from NGO to MoH • Linkage with private hospitals – currently no obligations to report to government
• Improvement in completeness; extension of data sources (public & private health centres, hospitals) • Web-based software	• Monitoring of cancer control programmes, especially screening	• Linkage • Cooperation between various hospitals & departments • Traditional healers
• Improvement in quality eg, heamopoetic malignancy (link with haematology dept)	• Death registry • Cancer screening programmes (breast, cervical, colorectal registries)	

Appendix L

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

Terms Of Reference Of The Ad Hoc Asean Task Force On Non-Communicable Diseases

Rationale

The Strategic Framework on Health Development (2010 – 2015) which was endorsed by the 5th Senior Officials Meeting on Health Development (SOMHD) and approved at the 10th ASEAN Health Ministers Meeting (AHMM) operationalizes the 55 health action lines of the ASEAN Socio-Cultural Community Blueprint (2009-2015). This Framework is the basis for the work plan activities of each of the subsidiary bodies involved in the regional cooperation on health.

Based on this document, one of two areas that have yet to be implemented and overseen by any existing ASEAN health subsidiary body are the activities under the Non-Communicable Diseases (NCDs) initiative. Activities under NCD are aimed for contributing to the attainment of the global target of NCD mortality reduction. As such, the 6th SOMHD last July 2011 agreed to have a temporary or ad hoc task force composed of focal points from each of the ASEAN Member States (AMS) that will focus on the implementation the NCD activities detailed in the Strategic Framework. This Terms of Reference (TOR) for the Ad Hoc ASEAN Task Force is needed to implement such activities.

Vision

Towards an ASEAN Community free from burden of preventable NCDs

Mission

To promote healthy lifestyle and adopt the integrated delivery of evidence-based quality interventions that will reduce the burden of Non-Communicable Diseases

Objectives

- To generate and share evidence-based strategies on the prevention and control of NCDs among ASEAN Member States
- To promote healthy lifestyle and delivery of quality NCD prevention and control services
- To strengthen capacity for the prevention and control of NCDs within ASEAN Member States
- To develop, implement, monitor, review progress and evaluate ASEAN regional cooperation, programmes/projects and action plans on the prevention and control of NCDs

Strategies

- To strengthen the ASEAN regional network, sharing of information, experience and best practices on NCD prevention and control
- To facilitate regional technical cooperation on NCD prevention and control in the ASEAN region, taking into consideration the strength and diversity of ASEAN Member States
- To strengthen multi-sectoral collaboration and partnerships in NCD prevention and control amongst ASEAN Member States, dialogue partners, international organisations, academia, civil society organizations, and private sector
- To develop and implement comprehensive work plans and cooperative mechanisms for regional collaboration on the prevention and control of NCDs specifically to focus on the risk factors
- To intensify capacity building in identified priority areas for the prevention and control of NCDs

Scope Of Work

In line with the above Vision, Mission, Objective, and Strategies, the work of the Ad Hoc ASEAN Task Force on NCDs (ATFNCD) will include the following:

1. To formulate and recommend to ASEAN Senior Officials Meeting on Health Development (SOMHD), ASEAN Health Ministers Meeting (AHMM) or ASEAN Summit, policies, strategies, and programmes for regional cooperation on NCD prevention and control;

2. To implement relevant directives emanating from the SOMHD;

3. To formulate, adopt and review strategies of work plans and programmes for regional cooperation to address ASEAN NCD-related concerns;

4. To explore, identify and specify priority areas of current interests for technical collaboration;

5. To evaluate and monitor outcome of the work programmes/plan of action to attain the objectives of the ATFNCD;

6. To serve as a forum for sharing lessons learned and best practices on NCD-related concerns and issues;

7. To promote active intra-sectoral links with related ASEAN bodies through the ASEAN Secretariat;

8. To strengthen and expand beneficial cooperation and collaboration with the World Health Organization and other international agencies, NGOs including mobilization of necessary resources;

9. To enhance the sharing of information and exchange technology and expertise on NCDs among ASEAN Member States

10. To convene ad-hoc meeting/working groups of experts as appropriate, to assist ATFNCD to carry out its functions;

11. To establish a network of professional bodies and research institutes on NCD within and outside the region; and

12. To promote and adopt cost-sharing arrangement in funding ATFNCD activities as strategy for enhancing self-reliance in the implementation of regional activities.

Mechanisms/Rules Of Procedures

1. The AMS shall nominate 2 to 3 focal points as members of the ATFNCD.

2. The ATFNCD will meet at least yearly and report to the SOMHD using the ASEAN standard procedures for reporting. The ATFNCD Meeting shall be attended by the representatives of all ASEAN Member States; representatives from the ASEAN Secretariat and relevant partners as agreed by the ATFNCD;

3. The ATFNCD Meeting will be held on rotation among ASEAN Member States or back-to-back with any identified meeting as stated in the work plan;

4. The Chair shall be from the host country and the Vice Chairperson shall be elected from the country hosting the next meeting; the tenures of both positions shall be held until next ATFNCD Meeting;

5. The Chair of ATFNCD shall be the ATFNCD coordinator and has the following duties and responsibilities:

   I. Attend SOMHD Meetings and present highlights of the ATFNCD Meeting;

   II. Be the focal point for any progress of ATFNCD activities;

   III. Work closely with the ASEAN Secretariat on matters pertaining to the ATFNCD particularly in the submission of proposals for funding;

   IV. Submit proposed provisional agenda of the next meeting to the next host country; and

   V. Represent the ATFNCD at relevant regional and international fora.

6. The provisional agenda for each meeting shall be drawn up by the host country of the Meeting of the ATFNCD in consultation with Member States and the ASEAN Secretariat;

7. The host country shall perform the functions stated in the TOR of the host country endorsed by the SOMHD.

8. The ATFNCD shall at each meeting recommend the date and venue of its next meeting;

9. The ATFNCD Meeting shall be convened on a cost-sharing basis whereby the hosting of the Meeting shall be borne by the Host Country whilst the participation of the delegations shall be born by the respective Member States.

Appendix M

MEETING REPORT

Kuala Lumpur, Malaysia
21-23 November 2011

(For SOMHD Endorsement) ASEAN Workplan on Non Communicable Diseases (2011-2015)

B.4: 2 FOCUS AREA IV: PROMOTES ASEAN HEALTHY LIFESTYLE (Non Communicable Diseases)

Note: Lead country for NCD according to Strategic

Strategic Objective

To ensure access to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN.

Relevant health elements under ASCC Blueprint

B.4.x Promote collaboration in Research and Development on health promotion, healthy lifestyles and risk factors of non-communicable diseases in ASEAN Member States;

B.4.xi Promote the sharing of best practices in improved access to health products including medicines for people in ASEAN

B.4.xxi Strengthen existing health networking in ASEAN Member States in order to push forward an active implementation on health services access and promotion of healthy lifestyles, as well as continually exchange of knowledge, technology and innovation for sustainable cooperation and development;

Expected Outcomes

Ensured accessibility to adequate and affordable health care, medical services and medicine and promote healthy lifestyle for the people of ASEAN

Proposed Projects/ Activities	Objectives	Expected Outputs	Lead Countries/ Partners	Timeframe
STRATEGY I. Revitalisation and implementation of ASEAN Health Life Style, 2002				
1.1 Collaborate with WHO for development of advocacy tool on selected NCDs that include: 1. Diabetes 2. Chronic Respiratory Disease 3. Cancer 4. CVD	To develop ASEAN advocacy tool for selected four NCDs	Advocacy package of four selected NCDs	Lead Country: Philippines (to explore possible co-leads)	By third quarter 2012

Proposed Projects/ Activities	Objectives	Expected Outputs	Lead Countries/ Partners	Timeframe
1.2 Promote healthy lifestyle and quality service delivery for NCD prevention and control services: a. Engage in advocacy opportunities at regional / international platforms b. Policy advocacy on NCD concerns that includes but not limited to: • Labeling and standards for healthy low salt food • Ethical advertising of food products for children • Alcohol consumption reduction	a. To gain commitment from government, development partners and other relevant stakeholders on NCD prevention and control b. To develop harmonized advocacy messages on selected NCD issues for policy makers	a. Selected NCD advocated at regional/ international platform such as: • the UN General Assembly on NCD, September 2011on NCD with the ASEAN Position Paper; • ASEAN Health Ministers Meeting (11th or 12th); • other events to be identified by the task force during its annual meetings b. Policy Notes/Briefs to be developed and shared to each AMS for reference in their national efforts c. Updated position paper/ declaration of ASEAN in implementing NCD commitments appropriate to the region following the output of the UN High Level Meeting on NCD, Sept 2011	Lead Country: a. Philippines (draft NCD position paper)/ Indonesia (as Chair of ASEAN to present position paper/ Malaysia (table agenda of NCD in the 7th SOMHD with host Philippines and in the 11th AHMM with host Thailand) b. Philippines/ Indonesia/ Cambodia c. Malaysia	UN General Assembly: April 2011 Draft ASEAN position May 2011, Circulating, June 2011, Finalisation July 2011, SOMHD approval First quarter 2012 First quarter 2012 to 2014 First quarter of 2012
Strategy II: Facilitating enabling environment for ensuring promotion of healthy lifestyle for the people of ASEAN				
Development an inventory of experts on four selected NCDs to be shared among AMS a. Develop the TOR of NCD experts definition (focus on 5 diseases) b. Develop the template, c. Compile data; d. Share inventory with AMS via appropriate means	To develop an inventory of ASEAN experts on NCD	Inventory of ASEAN Expert on Diabetes, CVD, Cancer, Chronic Respiratory Diseases Inventory utilised	Indonesia	Time Frame : Inventory completed by 2012 2012-2014 share inventory TOR to be developed by Indonesia and shared to AMS by 2012

Proposed Projects/ Activities	Objectives	Expected Outputs	Lead Countries/ Partners	Timeframe
Networking among ASEAN Cancer Data and Registry Information System a. Situation analysis on existing Cancer Data and Registry Information System among AMS; b. Identify areas for collaboration/ Networking	To promote networking on cancer references (research development, and, experts, sharing information system on cancer data and registry, etc.)	Situation analysis conducted Areas for collaboration identified Workshop Report	Malaysia/Singapore/ Brunei	2012
2.3 Workshop to identify key indicators on Healthy Lifestyle especially on 4 selected NCDs a. Develop the TOR of the workshop; b. Collaborate with WHO for technical assistances; c. Conduct a workshop; d. Implement monitoring and evaluation on selected NCDs	To develop and implement a systematically ASEAN monitoring system on five selected NCD	ASEAN Monitoring system on WorkshopReport	Malaysia/Brunei	2012
2.4 Sharing Best practices on 4 selected NCDs a. Develop a guideline on best practices b. Compile best practices c. Documentation or sharing best d. practices through identified platforms	To promote sharing of best practices on prevention and control of 4 selected NCDs	Best practices compiled and shared among AMS	Philippines	2013-2014

Proposed Projects/ Activities	Objectives	Expected Outputs	Lead Countries/ Partners	Timeframe
2.5 Conduct a Regional Forum on NCD in coordination with WHO based on the model of the Philippine NCD Coalition	To promote/exchange technical/ experiences/ knowledge/issues among AMS	Forum conducted	Philippines	2013
2.6 Regional Workshop to harmonize guidelines on physical activity in collaboration with WHO	To harmonize guidelines from each AMS on Physical Activity	ASEAN Harmonized Guideline on Physical Activity (NB. Back-to-back with 8th SOMHD activity in Singapore)	Singapore	2013
2.7 Integrated regional framework for NCD screening and management	To develop an integrated regional framework for NCD screening and management with minimum requirements common to AMS	Minimum requirements for an Integrated Regional Framework for Screening and Management of NCD	Singapore/Malaysia	2013- 2014 2012 – Preparatory Meeting of lead countries 2013 for implementation
2.8 Conduct of Annual Meeting of Task Force on NCD	To update work plan; develop implementation plans annually; monitor and evaluate programme progress; and, mobilize resources	Annual detailed work plan; identified sources of support for programme activities 1st Meeting of Ad Hoc ASEAN Task Force on NCDs conducted (back-to-back with SOMHD Meeting)	AMS Philippines as chair will host	A week before the 7th SOMHD Meeting in Philippines