

# Meeting Report

## Regional Meeting on National Multisectoral Plans for NCD Prevention and Control



Kuala Lumpur, Malaysia  
11–14 June 2012



 **World Health Organization**  
Western Pacific Region

  
Ministry of Health  
Malaysia

**Regional Meeting  
on National Multisectoral Plans  
for NCD Prevention and Control**  
Kuala Lumpur, Malaysia 11-14 June 2012

WPR/DHP/NHP (03)/2012

ENGLISH ONLY

REPORT SERIES NUMBER: RS/2012/GE/25 (MYS)

**REPORT**

**REGIONAL MEETING ON NATIONAL MULTISECTORAL PLANS  
FOR NCD PREVENTION AND CONTROL**

**CONVENED BY:**

**WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC AND  
MINISTRY OF HEALTH, MALAYSIA**

**KUALA LUMPUR, MALAYSIA  
11-14 JUNE 2012**

Not for sale  
Printed and distributed by:  
World Health Organization  
Regional Office for the Western Pacific  
Manila, Philippines

September 2012

## NOTE

The views expressed in this report are those of the participants at the Regional Meeting on National Multisectoral Action Plans for NCD Prevention and Control, and do not necessarily reflect the policies of WHO.

This report has been prepared for the Regional Office for the Western Pacific for the use of governments from Member States in the Region and for those who participated in the Regional Meeting on National Multisectoral Action Plans for NCD Prevention and Control, Kuala Lumpur, Malaysia, from 11 to 14 June 2012.

## SUMMARY

Noncommunicable diseases (NCDs) and their four main risk factors are responsible for an estimated 30 000 deaths every day in the Western Pacific Region and constitute one of the critical development challenges for the 21st century. NCDs are a serious threat to the economies of many Member States and are likely to increase inequalities. Preventing and controlling NCD is an urgent priority for all countries in the Region. Crucially, most of the drivers of NCDs and their risk factors lie outside the control of the health sector. The health sector alone cannot adequately prevent and control NCD. Multisectoral action (MSA) is required to create enabling environments in homes, villages and cities so that healthy choices are the easy choices. MSA is required to implement a number of the “Best Buys” identified by WHO for NCD prevention and control.

Through the Political Declaration on NCDs, heads of state and governments and their representatives committed to establish or strengthen by 2013 national multisectoral policies and plans for NCDs, taking into account the Global Strategy for the Prevention and Control of NCDs (endorsed by the World Health Assembly in 2000) and its Action Plan (2008).

To assist countries in formulating these national multisectoral policies and plans for NCDs, WHO and the Ministry of Health of Malaysia jointly hosted this Regional Meeting on National Multi-sectoral Action Plans for NCD Prevention and Control. The meeting was held in Kuala Lumpur, Malaysia, from 11 to 14 June 2012.

The objectives of the meeting were:

- (1) to review the progress of national policies and plans for NCD prevention and control in the Region and to identify gaps in the formulation of multisectoral national NCD plans;
- (2) operational aspects of the National Strategic Plan for Non-Communicable Disease in Malaysia; and
- (3) to identify the roles and responsibilities of multisectoral partners, explore feasible options for coordination in country-specific contexts and to work out concrete next steps.

Examples of MSA on NCD from around the Region were shared at the meeting. These included approaches at a national level and activities at a subnational or local level. Examples of MSA also were shared in relation to the four main NCD risk factors: unhealthy diet, physical inactivity, tobacco use and alcohol consumption. A number of entry points and opportunities were identified, along with key elements of successful approaches, despite the common challenges and gaps. In addition to plenary sessions, countries worked in small groups as country teams in outlining the next steps in working out MSA plans for NCD in their specific countries. WHO also used this meeting to inform countries of the process for reviewing the Global NCD Action Plan and for the further development of the global monitoring framework and voluntary global targets. Some preliminary feedback was received from participants at the meeting and Member States will have additional opportunities to contribute feedback over the coming months.

## CONTENTS

	<u>Page</u>
1. INTRODUCTION.....	1
1.1. Objectives .....	1
1.2. Participants .....	2
1.3. Organization .....	2
1.4. Opening ceremony.....	2
2. PROCEEDINGS .....	3
2.1 Session 1: Overview, current situation and approaches.....	3
2.2 Session 2: Country presentations.....	5
2.3 Session 3: Path forward for multisectoral action (MSA).....	7
2.4 Session 4: Group work 1: Gaps and barriers to MSA.....	10
2.5 Session 5: The who, why and how of MSA?.....	10
2.6 Session 6: Group work 2: Roles and responsibilities of sectors .....	12
2.7 Session 7: Group work 3: Next steps.....	12
2.8 Session 8: Draft a global NCD action plan and approach .....	12
2.9 Session 9: Draft set of voluntary global targets and indicators for NCD prevention and control .....	14
2.10 Closing ceremony .....	17
3. CONCLUSIONS AND RECOMMENDATIONS.....	18
3.1 Conclusions .....	18
3.2 Recommendations.....	18

## ANNEXES

1. List of participants, temporary advisers, resource persons, observers and secretariat
2. Programme of activities
3. Summary of country group work
4. Country next steps
5. Evaluation of the consultation
6. Background paper

## Keywords

Chronic disease – prevention and control/Regional Health Planning/Preventive Health Services/National Health Programmes/Health Promotion

## 1. INTRODUCTION

NCDs are a threat to the economies of many Member States and may lead to increasing inequalities between countries and populations. Governments have a primary role in responding to the challenge of NCDs through the engagement of all sectors of society to generate effective responses. Multisectoral actions through national multisectoral policies and/or plans are essential for NCD prevention and control as many of the risk factors are outside the health ministry. Multisectoral policies, plans and programmes are a reflection of the 'whole-of-government' approach for integrated NCD prevention and control.

The Regional Committee Resolution WPR/RC62.R2 on expanding and intensifying NCD prevention and control urged Member States to fulfill urgently the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases. Paragraph 45 of the political declaration commits to "promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases".

In the Western Pacific Region, nearly all Member States have an NCD plan or programme; however, only very few low- and middle-income countries have a truly multisectoral policy or programme with allocated resources and an operational mechanism. Responding to this need, the regional meeting on national multisectoral plans for NCD prevention and control in Kuala Lumpur, Malaysia was organized, co-hosted by the Ministry of Health, Malaysia. The meeting sought to assess the current national plans for NCD prevention and control and identify actions for advancing national multisectoral NCD policies and programmes.

The WHO action plan for the prevention and control of NCDs during the period 2013-2020 and the draft set of global voluntary targets and indicators for NCD prevention and control also were reviewed at this meeting.

### 1.1. Objectives

- (1) To review the progress of national policies and plans for NCD prevention and control in the Region and to identify gaps in the formulation of multisectoral national NCD plans.
- (2) To discuss the best practices in the Region, including the developmental and operational aspects of the National Strategic Plan for Non-Communicable Disease in Malaysia.
- (3) To identify the roles and responsibilities of multisectoral partners, explore feasible options for coordination in country-specific contexts and to work out concrete next steps.

## 1.2 Participants

The meeting was attended by 36 delegates from Member States, 17 observers and four temporary advisers and resource persons. The participating Member States were Australia, Brunei Darussalam, Cambodia, China, Hong Kong (China), Japan, the Republic of Korea, the Lao People's Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam. The meeting was hosted by the Ministry of Health, Malaysia. WHO staff from the Western Pacific Regional Office, WHO Country Offices, the Centre for Health Development in Kobe, Japan and from WHO Headquarters in Geneva, Switzerland, formed the Secretariat for the meeting. The list of participants, temporary advisers, resource persons and Secretariat members are in Annex 1.

## 1.3 Organization

The meeting comprised nine sessions and the opening and closing ceremonies. The sessions included presentations from temporary advisers, resource persons, WHO Secretariat and Country Representatives. Participants also were engaged in group discussions and presentations on current policy and programme arrangements in their countries and potential next steps for action in their countries. A full outline of the programme is presented in Annex 2. A background paper was developed with a brief review of the current situation and potential actions and was provided to the participants (Annex 6).

## 1.4 Opening ceremony

The meeting was opened by Dato' Sri Liow Tiong Lai, Minister of Health, Malaysia. He described how Malaysia had strengthened NCD prevention and control by formulating and implementing the National Strategic Plan for NCD 2010–2014. Malaysia has taken a 'whole-of-government' approach to this NCD strategic plan in recognition that most of the determinants of NCD fall outside the health sector and those policies in sectors other than health are important in preventing and controlling NCD.

Dr Shin Young-soo, Regional Director, Western Pacific Regional Office, thanked the Ministry of Health, Malaysia, for funding and hosting this meeting. He noted that years of advocacy have led to a truly global commitment to address NCDs and their risk factors. The Political Declaration of the High-level Meeting of the United Nations General Assembly was a milestone in the fight against NCDs, reinforced by the Western Pacific Regional Office Regional Committee resolution. He explained that with this global and regional mandate, WHO has been tasked with following up the commitments made in the Political Declaration of the High-level Meeting and that WHO does not take this task lightly. While many countries have made significant MSA progress, some countries have NCD plans that do not involve other sectors and some have no clear targets or objectives.

Dr Shin congratulated Malaysia on having already drawn up an MSA plan for NCD. Its effort has been exemplary in having a high-level multisectoral committee chaired by the Deputy Prime Minister. He noted that in relation to the four key NCD risk factors, there are a number of examples of cost-effective interventions from around the Region. Examples he highlighted included the president of Mongolia toasting the New Year with a glass of milk rather than alcohol and interventions in cities to promote physical activity and reduce exposure to tobacco.

Datuk Dr Lokman Hakim Bin Sulaiman of the Ministry of Health, Malaysia, was elected as Chairperson, Dr Hiu Yeung Jacqueline Choi of the Department of Health, Hong Kong (China), was elected as Vice-Chairperson and Maria Teresita Cucueco of the Philippines was elected as Rapporteur.



## 2. PROCEEDINGS

### 2.1 Session 1: Overview, current situation and approaches

Dr Hai-Rim Shin, Team Leader, Non-communicable Diseases and Health Promotion, Western Pacific Regional Office, provided an overview of NCD prevention and control and outlined the objectives of the meeting. She described the severity of the global threat that NCDs pose, both to the health of populations and the health of economies. She described the burden of disease for the major NCDs and their four common risk factors: tobacco, harmful use of alcohol, unhealthy diet and physical inactivity. She noted that the rising burden of NCDs is also because of underlying drivers: population ageing, urbanization and the social determinants of health (SDH).

Dr Han Tieru, Director, Division of Building Healthy Communities and Populations, Western Pacific Regional Office, gave an overview of the current status of national multisectoral plans for NCD in the Region and outlined some of the key challenges. He emphasized that MSA on NCD requires both:

- (1) 'Whole-of-government' approaches: Public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues.
- (2) 'Whole-of-society' approaches: Responsibility for health and SDH rests with the 'whole-of-society' and health is produced in new ways between society and the government.

Almost all countries in the Region have an NCD plan but many of the plans struggle with a number of weaknesses in terms of MSA:

- (1) low priority, no high-level political commitment;
- (2) not integrated into national health and development plan;
- (3) no budget or resource allocation or a limited one;
- (4) no monitoring and evaluation or inadequate; and
- (5) no feasible or measureable targets.

Dr Han noted that there are a number of exciting examples of successful MSA on NCD from around the Region. Having targets and indicators will provide a clear direction for MSA and facilitate identifying the roles and accountabilities of different sectors. A number of the WHO Best Buys involve MSA and provide an excellent starting framework to consider MSA in countries. Entry points exist at national, subnational and risk factor levels.

He outlined the following mechanisms, tools and instruments for MSA on NCD:

- (1) interministerial and interdepartmental committees;
- (2) community consultation and citizen's juries;
- (3) cross-sectoral action teams;
- (4) partnership platforms;
- (5) integrated budgeting and accounting;
- (6) cross-cutting information and evaluation; and
- (7) joined-up workforce development.

Dr Han explained that this meeting was a good starting point to assist countries to formulate national multisectoral plans by 2013. Countries may have to organize national consultations and build up the agenda for MSA. He said Day 3 of the meeting would be used to formulate country-specific action plans and he hoped these would produce a very practical set of actions. WHO will be working further with Member States guided by the outcome of this meeting.

Dr Zainal Ariffin Omar, Deputy Director, Disease Control Division, Ministry of Health, Malaysia, presented Malaysia's experience in formulating the National Strategic Plan for NCD Prevention and Control (NSP-NCD). Building upon an NCD programme of work started by the Ministry of Health in 1971, drawing up the NSP-NCD began in 2008 in response to a draft document distributed by the Western Pacific Regional Office in 2008.

Initially, Malaysia's efforts at NCD control focused on specific diseases and risk factors. Activities were disjointed, not well coordinated and not truly multisectoral. In contrast, the NSP-NCD targets the major common NCD risk factors in a comprehensive and integrated way. To help implement the strategy, the Cabinet Committee for a Health Promoting Environment was created. This committee is chaired by the deputy prime minister and includes 10 other ministers from various sectors. The plan outlines the key roles that various sectors have in addressing NCDs.

In Malaysia, the term "NCD" was not well understood by other sectors or the public. The Ministry of Health therefore decided to use diabetes and obesity as the entry points for NCD and NCD risk factors, respectively. These were well understood, made the NSP-NCD appear specific and were responsible for a large part of the disease burden. Input was sought from sectors other than health through an extensive consultation process.

Key lessons from the Malaysian experience:

- (1) start specific and simple;
- (2) the process took almost three years; consultation with all stakeholders and discussions with various committees within the Ministry of Health;
- (3) strong political will from the Ministry of Health and strong support from Director-General as the technical lead;
- (4) perseverance and compromise are important when working with other sectors;
- (5) existing relationships and a history of collaboration among ministries made the process easier (e.g. Ministry of Health and Ministry of Education had previously worked together on health in schools); and
- (6) the focus has to be healthy living and not disease in order to enable other ministries to take ownership as well.

## 2.2 Session 2: Country presentations

Each of the participating countries provided an overview of the situation in their country, with information regarding:

- (1) burden and trends in NCD;
- (2) current national plan, policy or programme for NCD prevention and control;
- (3) current intersectoral activities;
- (4) plans for formulating and strengthening the national multisectoral plan for NCD;
- (5) lessons learnt;
- (6) financing NCD prevention and control;
- (7) targets and indicators;
- (8) challenges; and
- (9) support needed for MSA.

In Cambodia, 42% of men smoke tobacco, but obesity and overweight are still low. A national NCD plan exists, but the role of non-health sectors is not defined in the strategy. Priorities include tobacco control, salt reduction and health-promoting schools. Interministerial committees already exist for tobacco control and for the environment and health. These could be used as a starting point for MSA on NCD. One of the lessons learnt is that MSA takes more time than expected and that limited resources and competing priorities in each ministry create a bottleneck.

In the Lao People's Democratic Republic, 48% of deaths are from NCDs, but no trend data is available. Risk factor trends show increasing blood pressure (BP) and body mass index (BMI). The budget for addressing NCD is very small. There is an opportunity to work through the Healthy Cities mechanism to progress with MSA on NCD. However, conflicts of interest between the Ministry of Health and other sectors and private companies (especially tobacco and alcohol) pose a significant challenge.

In Viet Nam in 2009, 63.3% of deaths were due to NCD, and this trend is rising. Fully 56.5% of men smoke, 30% of adults have high cholesterol, 80.4% have low fruit and vegetable consumption, 29% do not have sufficient physical activity but only 12% are overweight or obese. To support MSA on NCD, Viet Nam has found it helpful to assign specific tasks and funds for each sector. Viet Nam struggles with a lack of interest from other sectors, limited experience on MSA and overload on members of multisectoral committees.

Brunei Darussalam experiences a high and rising burden of NCDs. Lung cancer is the most common form of cancer death, 33% of adults are overweight and 27% are obese. Smoking rates are decreasing overall but are rising in men. Alcohol is not available. A number of factors have made MSA on NCD easier, including having a royal champion, cost-sharing with nongovernmental agencies (e.g. universities) and partnering with private entities (e.g. banks) as part of corporate social responsibility. Regular meetings are important to maintain momentum and relationships as well as clear terms of reference, objectives and roles. As one innovative example, the Department of Religious Affairs has issued a ban on smoking.

In China, NCDs currently cause 75% of deaths, mostly from cardiovascular disease, and this is increasing. The population's salt intake has been decreasing since 1992, although it is still high. China has implemented a number of health system reforms to strengthen the role of primary health care as a basis for NCD prevention and control. In addition, there are now 850 million electronic health records (a birth-to-death universal record) covering over 70% of the population.

In Mongolia, NCD deaths are high but stable. However, the prevalence of NCD risk factors is increasing. More than half of adults >45 years old have three or more risk factors. NCD prevention initiatives have been building since 2002. The revised Health Law 2011 (stating "every citizen is entitled to live free from health risks") is indicative of a very supportive policy environment in Mongolia. Challenges faced by Mongolia include increased alcohol and tobacco production and importation along with the increasing influence of alcohol and tobacco industries. Many NCD prevention initiatives have been funded through a Millennium Challenge project grant and there is concern about how to ensure sustainability of funding after this project ends.

The Philippines is also facing increasing NCD mortality, currently causing 80% of deaths. There is an increasing prevalence of risk factors. The rising female youth smoking rates are of particular concern. Health education alone will not lead to the required behaviour change in the population. MSA for NCD in the Philippines has centred on learning (public awareness), local government action and legislation. The Philippines is exploring the use of an excise tax on tobacco and alcohol as a mechanism for financing action on NCDs.

In Hong Kong (China) the prevalence of NCD risk factors are stable. The leading cause of death is cancer (lung first, but the incidence of colorectal cancer is rising). Intersectoral working

groups have been established to work on diet and physical activity (2008), alcohol and health (2009) and injuries (2012). In Hong Kong (China), MSA for NCD involves government, nongovernmental organizations (NGOs) and private stakeholders (not just government agencies). Greater use of charitable funds based in Hong Kong (China) is being explored as a financing option.

Japan's experience with MSA on NCD demonstrates that financial incentives work and that external pressure can be a driver of national action (e.g. the Framework Convention on Tobacco Control (FCTC)). Active local governments can be role models and a specific coordinating section is crucial for a successful MSA. Schools should be included as an important community partner (e.g. nutrition education, called "Shokuiku", and smoke-free schools). Japan noted the time gap between interventions and outcomes as a particular challenge when advocating for MSA for NCD.

The Republic of Korea emphasized the importance of credibility and trust between sectors and setting a common target to share. For financing, the Republic of Korea has introduced a surcharge on tobacco to be used only for disease prevention and control. Strong leadership has been important for success. Housewives were identified as an untapped group of partners in the fight against NCD.

In Singapore, premature deaths from NCDs are stable or decreasing slightly. Obesity, however, is increasing. Singapore emphasized that a top-down prescriptive approach to health education does not work. It emphasized the need to create a social movement, to apply bottom-up pressure to support advocacy for NCD. A continuing challenge Singapore faces is how to encourage active citizenry. Singapore is increasingly exploring cyberspace as a setting for health promotion. It is also critical to make a strong business case for MSA for NCD, especially when trying to engage with the private sector.

### 2.3 Session 3: Path forward for multisectoral action (MSA)

Building upon the country situation updates, Professor Don Matheson, of Massey University, New Zealand, provided an analysis of some of the complexities involved with MSA on NCD and suggested some ways forward. He noted that some of the key factors behind the success of the Malaysian efforts on MSA for NCD include: being early adopters of WHO-led reforms; a long history of action building over decades; and communication about obesity and diabetes, rather than the less well understood term "NCD". Action on NCDs in the Region has evolved from a communicable disease focus to an NCD clinical focus, to an NCD clinical and lifestyle focus, to seeking an NCD MSA approach. The next step in this process may be an MSA for health that more broadly addresses the social determinants of health.

Complex problems require complex solutions. The four NCD risk factors involve a spectrum of increasing complexity ranging from tobacco as the simplest issue to food with the most complex array of actors and drivers. Countries in the Region are at totally different starting points with different NCD risk factor epidemiology.

Bisectoral action may be more fruitful in some instances than MSA. Start with the simpler issues first and begin with existing relationships. Emphasis needs to be on integrating efforts to control and tackle NCDs with efforts to tackle infectious diseases, not setting up NCDs in competition with infectious disease or setting up entirely new structures. It is important to view MSA as a process of learning for the health and other sectors and partners.

Governments in the Region vary in their nature and composition and in their relationships with citizens, NGOs and the private sector. Actors differ. While formal 'whole-of-government' mechanisms are needed, it is important not to ignore the informal relationships with other departments. Other sectors are not focused on health. MSA on NCD needs to help other sectors meet their own agendas. A more helpful framing might be "intersectoral action for shared societal goals". For example, "equity" is being used as a unifying goal in the Philippines.

When we speak of a 'whole-of society' approach, we mean partnerships. In these situations, it is important to be clear about who are we dealing with and whether there actually is a common goal. Not all situations are win-wins. Clarity about partners' motivations is key. It is important to understand the motivations and drivers influencing the private sector.

With the private sector, "brand" is more important and valuable than the specific product, meaning that it can be negotiable when it comes to the composition of the product. Partners are often highly interconnected. These linkages are important to take into account (e.g. linkages between tobacco and alcohol companies). The reality is that any business is in business to make money and will usually only support MSA on NCD if it improves or protects profits.

### 2.3.1 Learning from the field

There are many good examples of multisectoral planning and actions on identified themes. This session illustrated some of these, using country experiences from around the Region. Australia, Japan and China shared their experiences with national-level planning. Mongolia and the Republic of Korea shared their experiences with "sin taxes" as a means of reducing unhealthy habits and raising resources for NCD prevention and control. Singapore presented its experiences in working with other sectors on the promotion of healthier dietary options and physical activity.

#### 2.3.1.1 National-level planning and action

Ms Sally Goodspeed, Assistant Secretary, Department of Health and Ageing in Australia, described the Partnership Agreement on Preventive Health as a key mechanism to promote MSA on NCD in Australia. This is a funding agreement between federal and state governments, not from health ministers but at the premier level. These agreements also include an accountability framework with a set of performance benchmarks relating to NCD risk factors. There are also a number of relevant initiatives led from outside the health sector, including the National Partnership on Closing the Gap in Indigenous Health Outcomes and the National Partnership Agreement on Indigenous Early Childhood Development.

The National Urban Planning policy, which aims to promote healthy lifestyles, demonstrates that the health sector does not necessarily need to take the lead. Australia has had strong support from the prime minister in its tobacco control measures, including plain packaging.

Professor Mike Daube, of Curtin University, Western Australia, described the process leading to the establishment of Australia's National Preventive Health Agency. The Government set up the National Preventative Health Taskforce with a focus on obesity, tobacco and alcohol, recognizing "preventative health care as a first order economic challenge". The agency was made up of government, NGO and private sector representatives, including the head of the Food and Grocery Council.

The consultation process was extensive and time-consuming. The task force's report clearly explained why the status quo was not an option and highlighted benefits of prevention in terms of broad national and societal goals (e.g. improved productivity). The comprehensive set of recommendations ranged from addressing environmental determinants to strengthening primary health care. A set of targets was proposed with financial penalties for jurisdictions if these are not met. The task force recommended the establishment of a continuing National Preventive Health Agency to oversee, coordinate and drive prevention efforts. High-level political leadership was present in the form of a strong, determined minister of health, who declared, "By not acting, we are killing people".

Dr Tomofumi Sone, of the National Institute of Public Health, Japan, described Japan's National Health Promotion and Disease Prevention Plan as "Health Japan 21". It prioritizes prevention and seeks an improvement of the social environment for staying healthy. It includes specific targets and monitoring and involves cooperation with various bodies, including NGOs and private companies. A key function of this plan is the coordination of national and local programmes, including health and nonhealth sectors. It was issued by the Ministry of Health Labour and Welfare, but only after other ministry involvement.

Dr Kong Lingzhi, of the Bureau of Disease Control, Ministry of Health, China, shared China's comprehensive new MSA plan for NCD prevention and control. It was released in May 2012, jointly issued by multiple ministries. Strong government leadership was a key factor in formulation of the plan, with the participation of multiple departments and the community. Building upon current intersectoral mechanisms, this plan includes a coordination committee, and establishes the platform for collaboration. The plan is accompanied by increased government investment in NCD prevention and control.

#### 2.3.1.2 Financing MSA

Dr Tumendemberel Namjil, State Secretary, of the Ministry of Health, Mongolia, described Mongolia's health promotion fund. It is made up of funds from the government budget, donor agencies a 2% excise tax on tobacco and a 1% excise on alcohol and imported drugs. Since its inception, this fund rapidly has increased in size, from US\$ 158 000 in 2009 to US\$ 1.6 million in 2012. Both financial and technical resources from WHO were important to this process. To fund further MSA on NCD, Mongolia is seeking to allocate resources from other budgets, e.g. the Ministry of Education and the mining sector along with further increases in tobacco and alcohol taxes. The Government also seeks to rebalance the allocation between communicable diseases and NCDs.

Dr Seo Soon Ryu, Korea Centers for Disease Control and Prevention, the Republic of Korea, explained how the establishment of the Korean Health Promotion Foundation in 2012 was associated with the doubling of the health promotion budget. This is in part due to a 2.5% surcharge on tobacco products, which only may be used for disease prevention and health promotion.

Discussion by participants emphasized that having the funds is only part of the issue and that whether and how the funds are used is also critical. A national plan needs to identify clearly the actions that funds will be spent on so that they are used well and within the required time. It also was noted that hypothecation is not always popular with ministries of finance, which do not like "handing over" pots of money for particular purposes.

### 2.3.1.3 Working with different sectors

Dr Noorul Fatha As'art, NCD Epidemiology and Disease Control Division of the Ministry of Health, Singapore, described Singapore's Healthier Hawker and Healthier Coffeeshop programmes. They not only worked with food retailers but also with the public in a demand for healthier food. Educating hawkers to produce healthier options was a key component (healthier oil, brown rice) and results show that 100% are now using healthier oil and 70% are using whole grains, leading to a 10% to 20% increase in sales of healthier ingredients.

Singapore's approach has included measures to address the entire food chain, from manufacturing to labelling to sales and to consumption. Important factors in success include the alignment of objectives and priorities among sectors and streamlining timelines (different sectors use different financial years, different deadlines, budgeting cycles, etc.).

Dr Truong Dinh Bac, of the General Department of Preventive Medicine, Ministry of Health, Viet Nam, shared Viet Nam's experience in working with the education sector to address NCD risk factors in schools. He noted the importance of the health sector being flexible and responding to priorities, e.g. 10% to 15% of rural and 30% to 35% of urban children in Viet Nam have refractive errors and 85% of children 6 years old to 8 years old have tooth decay. The ministries of health and education have a long history of collaboration, including the provision of health screening and first aid. Collaboration relating to NCD risk factors includes ensuring smoke-free schools and promoting physical activity. There is an opportunity to further build upon existing food safety initiatives to include more of a focus on nutritional quality.

## 2.4 Session 4: Group work 1: Gaps and barriers to MSA

Groups discussed the gaps in planning and implementation of MSA that exist in their countries. The results are summarized in Table 1 in Annex 3. Key common challenges and barriers included the lack of data or evidence in the format required to convince partners in other sectors, limited dedicated budgets, a lack of government commitment and disinterested non-health sectors. Competing government priorities, conflicts of interests among ministries (and between public and private interests) along with the need to make NCDs a health sector priority first were cited as common barriers to MSA for NCD.

## 2.5 Session 5: The who, why and how of MSA?

Dr Belinda Loring, a consulting public health physician from New Zealand, moved the discussion from barriers and challenges to describe some of the entry points and opportunities for MSA for NCD along with key elements for success. There are multiple examples of MSA for NCD already occurring around the Region, at national levels (e.g. Malaysia's national intersectoral committee), at local levels (e.g. Healthy Cities) and for each of the specific NCD risk factors. Countries do not need to start from a blank page but can build upon what they are already doing.

Opportunities countries may wish to explore include:

- (1) Building upon existing structures for intersectoral work (e.g. emergency response, food safety).
- (2) Working with the private sector to promote healthy environments (e.g. mining and manufacturing industries).



- (3) Making better use of civil society and NGOs.
- (4) Turning special events and disasters into opportunities to create a lasting legacy.
- (5) Using international alliances for leverage and support (e.g. United Nations High-level Declaration, Southeast Asia Tobacco Control Alliance (SEATCA), the Western Pacific Regional Office).
- (6) Identifying the cobenefits for other sectors (e.g. show how addressing NCD contributes to poverty reduction and economic growth or how promoting physical activity relieves traffic congestion).
- (7) Converting data into stories to tell a compelling case (data will not speak for itself; often a moving story of one person can be more powerful than millions in statistics).

Elements of successful approaches include:

- (1) a high-level commitment and champions (e.g. from mayors, royalty, health ministers, prime ministers);
- (2) having dedicated resources (the coordination function of MSA also needs resourcing);
- (3) institutional structures (can be at a range of levels, although structures alone are not sufficient and can add to overload);
- (4) joint planning (quality of the planning is as important as the plan; relationships can endure beyond the structures or particular issue);
- (5) legislative tools (either to reduce specific NCD risks or to set up structures for MSA);
- (6) accountability (does not matter who, but it needs to be clear. Can be shared or not, health sector or others); and
- (7) monitoring and reporting (targets focus action and results are important for advocacy).

There are many barriers to MSA for NCD, but there are also many opportunities in terms of the level of entry, the topic and the scope or the sectors involved. MSA for NCD is already happening to some extent in all countries in the Region. The challenge for countries is to build upon what they are already doing, using the leverage from international partners and agreements and the experiences shared by others. There is no one starting point or approach and it is important to build upon existing structures and relationships. Importantly, the health sector cannot expect other sectors to see the benefits of MSA for NCD. It is the job of the health sector to show other sectors how MSA on NCD will help other sectors meet their own goals.

## 2.6 Session 6: Group work 2: Roles and responsibilities of sectors

Groups discussed the roles and responsibilities for other sectors in relation to MSA for NCD. The results are summarized in Table 2 of Annex 3. The participants from other sectors generally reported positive experiences in working with the health sector. Bisectoral collaboration was the most common experience, especially between health and education and work on tobacco control. It was helpful for the health sector participants to hear about the priorities of other sectors. A common theme that emerged was that the health sector needed greater negotiation skills in working with other sectors.

## 2.7 Session 7: Group work 3: Next steps

Countries worked as teams to identify the next steps for formulating and strengthening national multisectoral plans for NCD prevention and control by 2013. The results for each country (of those who do not already have an MSA plan for NCD) are summarized in Annex 4. Countries were asked to consider the following questions in their work:

- (1) What is the overall goal?
- (2) What are the priorities?
- (3) What are the strengths, weaknesses, opportunities and threats?
- (4) Who can do what?
- (5) Technical and financial resources: What is needed and what are the sources?
- (6) Targets and indicators.
- (7) How to get an endorsement of an MSA plan for NCD.
- (8) What are the institutional mechanisms for coordination and implementation?

## 2.8 Session 8: Draft a global NCD action plan and approach

Dr Nicholas Banatvala, Senior Adviser, Noncommunicable Diseases and Mental Health, WHO Headquarters, discussed the approach to revising the Global NCD Action Plan. He began by reviewing the key objectives and content of the Global NCD Action Plan. He then discussed the changing political, technical and financial landscapes that have led to the need to revise the plan. He outlined the process for revising the plan:

- (1) A revised draft will be submitted for endorsement at the World Health Assembly in May 2013. The draft would need to go to the Executive Board in January 2013, meaning the draft would need to be completed by October 2012.
- (2) A mixture of technical and political processes and inputs.
- (3) Civil society and private sector engagement would proceed in parallel.

Dr Banatvala posed the following discussion questions to participants:

- (1) How can the plan best serve you?
- (2) What should be the objectives of the plan?
- (3) What key actions do you want to see in the plan?
- (4) How should health system strengthening and MSA be reflected in the plan?
- (5) What are your anxieties and concerns?

Feedback from participants:

- (1) About 50% of participants reported having seen the Global NCD Action Plan.
- (2) There was no interest for a further discussion paper before the production of a revised draft; countries expressed concern about limited time and capacity to comment on multiple drafts.
- (3) Can the associated mandates for MSA on SDH and health equity be reflected in the plan (to help build the case for MSA and to integrate and reinforce these related objectives?
- (4) Include access to medicines.
- (5) Include practical suggestions for countries facing the double burden of communicable diseases and NCDs.
- (6) How can we reflect the spirit of partnerships in the United Nations High-level Declaration and include other United Nations agencies in this plan?
  - (a) Could this be instead a United Nations action plan? WHO have been tasked with producing it but could it not be cobranded by other United Nations development agencies?
  - (b) We talk about MSA at a national level but Member States really need MSA at a global level. How can WHO work not just with other United Nations agencies but also signal a strong need to work on issues such as trade? If WHO says it is going to work on trade, that provides useful leverage to Member States to advocate for these with their leaders.
- (7) Can it be aligned to the targets and indicators?
- (8) NCD is too much for the health sector to cope with. Can the plan reposition NCDs so that they are not solely a health issue but a major economic and social challenge to development and well-being.
- (9) Providing input is a time-consuming matter for countries. It is important that the plan builds upon what we already have rather than starts fresh and that the plan is ambitious but realistic for countries to achieve.

## 2.9 Session 9: Draft set of voluntary global targets and indicators for NCD prevention and control

Development of a global monitoring framework, including indicators and a set of voluntary global targets for the prevention and control of NCD, is an important mandate for WHO and this session included a presentation on the global process followed by a discussion.

Dr Timothy Armstrong, Coordinator, Surveillance and Population-based Prevention Unit, WHO Headquarters, presented the process for development of a global monitoring framework, including indicators and a set of voluntary global targets for the prevention and control of NCD. The Political Declaration of the United Nations High-level Meeting on NCD requested that WHO, by the end of 2012, in full participation with Member States, put together a comprehensive monitoring framework, including indicators, and a set of voluntary global targets.

The World Health Assembly 2012 requested WHO to progress on the work of global targets and indicators and that Member States should be consulted on this work, including through Regional Committee meetings. The World Health Assembly 2012 also recommended adoption of a global target of a 25% reduction of premature NCD mortality by 2025.

Work on the draft set of voluntary global targets needs to be completed by end of October 2012 to meet timeframes for the next Executive Board and World Health Assembly meetings. Member States were to have the opportunity to comment through a third web-based consultation to be conducted from June to July 2012 (on a third WHO discussion paper). In addition, a formal Member States meeting will be held in October 2012. The intention is to specify a small number of “tracer” targets within a broader framework and set of indicators (targets set for 2025, with a baseline of 2010).

The following criteria have been recommended for selection of targets:

- (1) high epidemiological and public health relevance;
- (2) coherence with other global strategies (e.g. the Political Declaration of the United Nations High-level Meeting on NCD, Global NCD Action Plan, FCTC, Global Strategy of Diet and Physical Activity)
- (3) evidence-driven targets and indicators (must be evidence for effective and feasible public health interventions);
- (4) achievable at a country level (for high, middle and low income countries); and
- (5) unambiguous data collection instruments in existence, to set baseline data and monitor changes over time.

Feedback on the initial discussion paper highlighted gaps in indicators, including for physical inactivity and dietary risk factors, apart from salt and access to medicines and diagnostics. Feedback also was requested for indicators to monitor inequalities and ensure all indicators are stratified by major equity stratifiers (e.g. sex, urban/rural, ethnicity). The global

monitoring framework includes three thematic foci: outcomes, risk factors and health systems response, populated with 20 indicators. National targets should be consistent with global targets, but not necessarily the same. National targets need to reflect what is achievable for a specific country and may be more or less ambitious than the global target.

Dr Cherian Varghese, Noncommunicable Diseases and Health Promotion, Western Pacific Regional Office, followed this presentation of the global context by describing some of the issues relating to NCD surveillance and monitoring in the Region. Mortality is a powerful target and can reflect either both prevention efforts and improvements in access to management and treatment of NCD.

He said that the “25% by 2025” target refers to a 25% relative reduction in deaths from cardiovascular disease, cancer, diabetes and chronic respiratory disease in adults between 30 years old and 70 years old. For morbidity, the indicator proposed is cancer incidence. This only can be obtained through cancer registries; countries can begin with hospital registries but need to expand to population-based registries. This requires a unique identifier for each patient. Risk factor indicators proposed include reduction in BP, physical inactivity and salt intake. Standards for the measurement of these have been set, e.g. through the STEPS survey. Comparability of data over time is critical. Therefore, countries may use consistent measures and parameters. Monitoring of national policies is also important in terms of measuring health systems response.

Approach to strengthening surveillance:

- (1) develop and strengthen vital registration, cause of death certification, International Classification of Diseases (ICD) coding and computerization;
- (2) one national survey of NCD risk factors, e.g. STEPS every five years;
- (3) policy monitoring; and
- (4) disease registries, if feasible and sustainable.

Dr Oh Kyung-won from the Division of Health and Nutrition Survey, the Korea Centers for Disease Control and Prevention, the Republic of Korea, presented the experience of his country to illustrate the different components of NCD surveillance and monitoring. She described the Republic of Korea’s very comprehensive approach to NCD surveillance, consisting of the Korea National Health and Nutrition Examination Survey, the Korea Community Health Survey, the Korea Youth Risk Behaviour Web-based Survey and the Korea Central Cancer Registry.

An open discussion on the draft monitoring framework followed. The following comments and inputs from countries on the draft global set of indicators and country-specific support for strengthening NCD surveillance and monitoring were raised:

- (1) Human papillomavirus (HPV) vaccination is voluntary or not delivered in some countries, so they will not be able to track that indicator.
- (2) Definition of high intake differs among countries. Some countries do not agree with 5g as a target (e.g. use 6g instead).

- (3) Tobacco: Can we set a different target for low prevalence countries (e.g. for <10% prevalence)?
- (4) Medicines and diagnostics: Many countries do not track this. Also how does this sit with the Millenium Development Goal (MDG) target or any post-MDG target?
- (5) How do we measure MSA? [WHO: This has been considered in discussion on health systems response indicators, but there is difficulty in finding a meaningful indicator.]
- (6) Obesity: Is a relative reduction in obesity a feasible goal? [WHO: We do not have an example of a country that has managed to reduce the obesity prevalence, so a proposed global target is much less ambitious = “no rise in prevalence”.]
- (7) Lack of capacity is a problem (e.g. in the Lao People’s Democratic Republic) for data collection. A long process of capacity-building is required. Also, mortality data can be unreliable in cases in which most patients leave the hospital to die at home and no death certificate is issued (hospital data is not representative).
- (8) Salt intake is very important but is too difficult to measure in many countries. Is there a simpler method than a 24-hour urine test (e.g. spot urine?) [WHO: Salt intake is of such public health importance that we should not delay action because of a lack of data. Also, spot urine can be conducted for subsequent surveys after an initial 24-hour urine survey.]
- (9) NCD budgets: Is it useful to monitor the percent of the health budget that is earmarked for NCD and the overall health budget?
- (10) Ideally, national targets should be set first and used to determine the global target, although time does not permit this.
- (11) Hypertension: The more secondary prevention and early detection is scaled up on a population basis, the prevalence of “identified” hypertension will increase.
- (12) As a population ages, some NCD is inevitable. The goal in aged societies is not to completely eliminate NCD and precursors but to ensure a healthy old age. Quality of life measures are important.
- (13) The age marker of 70 years old is too high for “premature” mortality for some countries. What about 60 years?
- (14) More transparency is required for the process of finalizing voluntary global targets. Currently, it is not clear how inputs from Member States are reflected in revised drafts.
- (15) Exposure indicators: Age groups vary for these. Is there any flexibility on this? [WHO: WHO has taken into account the availability of data in global surveys, and surveys are often restricted to adults because of consent issues. Does not preclude countries including younger age groups to meet their circumstances.]

- (16) Has any modelling been done to connect exposure indicators to outcomes, e.g. to help us demonstrate “how much of the burden of disease would be reduced by x amount of progress on this indicator”? [WHO: No, this modelling is complex and has not been done at a global level. This type of analysis is more likely to be meaningful at a country level.]

#### Finalization of country inputs

- (1) Country input required by end of July to feed into paper for the Regional Committee Meeting (RCM) 2012.
- (2) However, the process for input will not be closed. It will be continuing, including through web-based global consultation.

#### 2.10 Closing ceremony

Dr Han Tieru, Director, Division of Building Healthy Communities and Populations, Western Pacific Regional Office, thanked the Ministry of Health, Malaysia, for hosting the meeting, and for its leadership and technical support. He thanked the chairs, rapporteurs, temporary advisers and resource persons for their assistance during the meeting and thanked the participants for their enthusiastic and dedicated contributions. The Chair, Datuk Dr Lokman Hakim Bin Sulaiman, thanked WHO and all participants and support people for a productive and successful meeting.

### 3. CONCLUSIONS AND RECOMMENDATIONS

#### 3.1 Conclusions

From the proceedings of the meeting and the group work, it was clear that MSA is not a new concept to countries in the Region; all are already doing it in some capacity. The difficulty is not in the understanding, it is in the implementation. The challenge for meeting participants is to take home what they learnt from the meeting and work to expand MSA on NCD in their countries, building upon the structures, relationships and priorities that exist in their contexts.

There is no one-fits-all approach or step-by-step instruction manual for MSA; learning needs to occur through doing. It is important to create “learning systems” so that the lessons from attempts at MSA are remembered and incorporated into improving future approaches. The country representatives demonstrated this at the meeting by the enthusiastic manner with which they approached their work as country teams in outlining the next steps in formulating MSA plans for NCD in their specific countries.

Countries are aware of the process for reviewing the Global NCD Action Plan and for the further development of the global monitoring framework and voluntary global targets. Some preliminary feedback was received from participants at the meeting and Member States have additional opportunities to contribute feedback over the next few months.

.../

#### 3.2 Recommendations

##### 3.2.1 Countries have the option to do the following:

- (1) To formulate a national MSA plan for NCD prevention and control, building on the draft plans worked out during this meeting.
- (2) To use the Best Buys as the starting point for multisectoral activities.
- (3) To base multisectoral activity on an understanding of the shared goal among sectors. Multisectoral activity is more likely to succeed if it has resonance with a higher societal goal than a sole focus on NCD prevention and control.
- (4) To identify the entry points for MSA most suitable for a specific country. These may be built on existing activities (such as multisectoral mechanisms already established for tobacco or the environment), strategic positioning of the NCD prevention and control agenda at the national level (as in the example of Malaysia) through action on a specific risk factor or through subnational action at the provincial or urban authority level.
- (5) To carefully consider which sector or sectors need to be involved in the development of multisectoral activities based on the likelihood of positive NCD prevention and control outcomes.
- (6) To prioritize MSA such that engagement is with those sectors that can assist in making the greatest gains for NCD prevention and control.



- (7) To consider the Global NCD Action Plan from a specific country's perspective and to provide formal feedback on the revised draft through the country's diplomatic channels.
- (8) To consider the global targets and indicators from a country's perspective and to provide formal feedback on them through the country's diplomatic channels.

3.2.1 WHO can do the following:

- (1) To offer tailored support to individual countries in the Region that still need to formulate an MSA plan for NCD.
- (2) To facilitate the sharing of experiences and what was learnt on MSA for NCD among countries of the Region and share key information from elsewhere in the world.
- (3) To facilitate further opportunities for countries in the Region to provide feedback to the revision of the Global NCD Action Plan, the proposed global monitoring framework and voluntary global targets.
- (4) To continue to support countries in the Region to improve surveillance and monitoring systems for NCD.

**LIST OF PARTICIPANTS, TEMPORARY ADVISERS  
RESOURCE PERSONS, REPRESENTATIVES/OBSERVERS, AND SECRETARIAT**

**1. PARTICIPANTS**

**AUSTRALIA**

Ms Sally Goodspeed, Assistant Secretary, Health in Social Policy Branch Department of Health and Ageing, GPO Box , 9848, Canberra ACT 2601, Australia, Switchboard: 02 6289 1555, Tel. No.: 1800 020 103

**BRUNEI DARUSSALAM**

Dr Hajah Norlila Dato Paduka Haji Abdul Jalil, Deputy Permanent Secretary (Professional and Technical), Ministry of Health, Jalan Menteri Besar Brunei Darussalam BB 3910, Bandar Seri Begawan, Tel No.: (238) 1142, Fax No.: (238) 0948, E-mail: [norlila\\_abduljalil@yahoo.com](mailto:norlila_abduljalil@yahoo.com)

Mr Hj Zakaria Hj Ahmad, Senior Administrative Officer, Prime Minister's Officer, Bandar Seri Bagawan, Tel. No.: (673) 8813029, Fax No.: (673) 2222687

Dr Hajah Roseyatei Dato Paduka Haji Yaakub  
Senior Dietitian, Community Nutrition Division Block 30, Simpang 32-37, Department of Health Services, Ministry of Health, Anggerek Desa Flats, Bandar Seri Begawan BB3713, Tel. No.: 6738890750, Fax No.: 6732334897  
E-mail: [rbhn123@brunet.bn](mailto:rbhn123@brunet.bn)

**CAMBODIA**

Dr Chi Mean Hea, Deputy Director General for Health  
Ministry of Health, Directorate General for Health  
No. 151-153 Street Kampuchea Krom, Phnom Penh  
Tel. : (855) 12757900, E-mail: [chimeanhea@gmail.com](mailto:chimeanhea@gmail.com)

Ms Pen Sopakphea  
Deputy Director General  
General Department of Taxation  
Ministry of Economy and Finance  
Tax Building, Boulevard Mao Stetong, Toul Kok Phnom Penh  
Tel. No.: (855) 12535443  
Fax No.: (855) 23886702  
E-mail: [psopakphea@gmail.com](mailto:psopakphea@gmail.com)

Mr By Pitou, Director, Industrial Techniques, Ministry of Industry Mines and Energy, 345 Norodom Boulevard, Khan Daun, Phnom Penh, Tel. No.: (855) 12478998,  
E-mail: [bypitou@yahoo.com](mailto:bypitou@yahoo.com)

**CHINA, PEOPLE'S  
REPUBLIC OF**

Ms Kong Lingzhi, Deputy Director General  
Bureau of Disease Control, Ministry of Health, China,  
No. 1, Xi Zhi Men Wai Nan Lu, Beijing, 1000044  
Tel. No.: (8610) 68792368  
Fax No.: (8610) 68792514  
E-mail: [klz1953@yahoo.com](mailto:klz1953@yahoo.com)

## Annex 1

Mr Wu Liangyou, Director, Division of NCD and Nutrition Management, Bureau of Disease Prevention and Control Ministry of Health, No. 1 Nanlu, Xizhimenwai, Beijing, 100044  
Tel. No.: (8610) 68792348, Fax No.: (8610) 68792370  
E-mail: [wuly@moh.gov.cn](mailto:wuly@moh.gov.cn)

Ms Wu Jing, Deputy Division Director, Division of NCD Control and Community Health, CDC, P.R. China, 155 Changbai Road, Changping District Beijing, Tel. No.: (8610) 58900078, Fax No.: (8610) 58900247, E-mail: [wujing@moh.gov.cn](mailto:wujing@moh.gov.cn)

Mr Pan Yangbin, Section Chief, Development and Planning Department, Ministry of Agriculture, 11# NongzhanNanli, Chaoyang District Beijing, Tel. No.: (8010) 59193285, E-mail: [pyb\\_001@163.com](mailto:pyb_001@163.com)

### **HONG KONG (China)**

Dr Hiu Yeung Jacqueline Choi, Principal Medical Officer (Noncommunicable Disease), Surveillance and Epidemiology Branch, Centre for Health Protection, Department of Health, Hong Kong SAR Government, 17-21/F, Wu Chung House, 213 Queen's Road East, Wanchai, Hong Kong, Tel. No.: (852) 29618960, Fax No.: (852) 25744263,  
E-mail: [jacquelinechoi@dh.gov.hk](mailto:jacquelinechoi@dh.gov.hk)

### **JAPAN**

Dr Tomofumi Sone, Director, Department of International Health and Collaboration, National Institute of Public Health, Japan, 2-3-6 Minami, Wako City, Saitama, 351-0197  
Tel. No.: (8148) 4586159, Fax No.: (8148) 4692768, E-mail: [sonetom@niph.go.jp](mailto:sonetom@niph.go.jp)

### **LAO, PEOPLE'S DEMOCRATIC REPUBLIC**

Dr Phisith Phoutsavath, Deputy Director General Health Care Department, Department of Health Care, Ministry of Health Vientiane Capital, , Dondeng Village, Chanthabouly District, Vientiane, Tel. No.: (856) 2055527721, Fax No.: (856) 21217848, E-mail: [Psavath@gmail.com](mailto:Psavath@gmail.com)

Associate Professor Chu Vang, Head of Cardiology Department, Cardiology Department, Mahosot Hospital Vientiane Capital City, Lao PDR, Tel. No.: (856) 205430399  
E-mail: [wachuvang@yahoo.com](mailto:wachuvang@yahoo.com)

Mrs Wassarinh Choulamany, Technical Staff, Ministry of Education, Dongdok Village, Xaythany District, Vientiane  
Tel. No.: (856) 2022206258, Fax No.: (856) 2028977065  
E-mail: [vachulamany@yahoo.com](mailto:vachulamany@yahoo.com)

Mr Vilakone Soudachanh, Technical Staff, UN System Division, Department of International, and Cooperation, Ministry of Planning and Investment, Kua Luang Village, Chanthabouly District, Vientiane, Tel. No.: (856) 2099979222  
Fax No.: (856) 21222214,  
E-mail: [un.system.division@gmail.com](mailto:un.system.division@gmail.com)

**MALAYSIA**

Datuk Dr Lokman Hakim Bin Sulaiman, Deputy Director General of Health (Public Health) Ministry of Health Malaysia  
Level 12, Block E7, Complex E Federal Government Administrative Centre, 62590 Putrajaya, Tel. No.: (603) 88922544, Fax No.: (603) 88895601  
E-mail: [lokman.hakim@moh.gov.my](mailto:lokman.hakim@moh.gov.my)

Dr Zainal Ariffin Omar, Deputy Director, Disease Control Division, Ministry of Health Malaysia, Level 2, Block E3, Complex E, Federal Government Administrative Centre 62590 Putrajaya, Tel. No.: (603) 88924409, Fax No.: (603) 88924526, E-mail: [dr.zainal@moh.gov.my](mailto:dr.zainal@moh.gov.my)

Mr Cyril Christopher Singham, Principal Assistant Director School Management Division, Ministry of Education Malaysia  
Level 4, Block E2, Complex E, Federal Government Administrative Centre, 62590 Putrajaya, Tel. No.: (603) 88849322, Fax No.: (603) 88849342, E-mail: [cyril@moe.gov.my](mailto:cyril@moe.gov.my)

Mr Syed Zahiruddin Syed Zainulabidin, Principal Assistant Director, Social Services Section, Economic Planning Unit Prime Minister's Department, Level 3, Block B6, Complex B Federal Government Administrative Centre, 62590 Putrajaya  
Tel. No.: (603) 88725583, Fax No.: (603) 88883689  
E-mail: [zahiruddin@epu.gov.my](mailto:zahiruddin@epu.gov.my)

**MONGOLIA**

Mr Tumendemberel Namjil, State Secretary, Ministry of Health, Mongolia, Government Building VIII, Olympic Street 2 Sukhbaatar District, Ulaanbaatar 14210, Tel. No.: (976) 99112334, Fax No.: (976) 11320916, E-mail: [tumendemberel@moh.mn](mailto:tumendemberel@moh.mn)

Mr. Munkhbileg Gendenjamts, Director-General, Finance and Investment Department, Ministry of Road, Transportation, Construction and Urban, Development of Mongolia, Government Building 12, Builders' Square 3, Ulaanbaatar 15170  
Tel. No.: (976) 5126388, Fax No.: (976) 323627  
E-mail: [munkhbileg@moh.mn](mailto:munkhbileg@moh.mn)

Ms Yanjmaa Bineriya, Director, Division of International Cooperation, Ministry of Health, Mongolia, Government Building VIII, Olympic Street 2, Sukhbaatar District, Ulaanbaatar 14210, Tel. No.: (976) 99994560, Fax No.: (976) 11320916, E-mail: [yanjmaab@moh.mn](mailto:yanjmaab@moh.mn)

Dr Baigalmaa Dangaa, Deputy Director, Department of Public Health, Policy Implementation and Coordination, Ministry of Health, Mongolia, Government Building VIII, Olympic Street 2 Sukhbaatar District, Ulaanbaatar 14210, Tel. No.: (976) 88084452, Fax No.: (976) 11320916  
E-mail: [baigalmaa12@yahoo.com](mailto:baigalmaa12@yahoo.com)

## Annex 1

### **PHILIPPINES**

Ms Maria Teresita Cucueco, Executive Director, Department of Labor and Employment, Occupational Safety and Health Center, North Avenue corner Agham Road, Diliman, Quezon City 1104, Tel. No.: (632) 9286690, Fax No.: (632) 9296030  
E-mail: [oshc\\_dole@yahoo.com](mailto:oshc_dole@yahoo.com)

Dr Ernie V. Vera, Medical Officer VII, National Center for Disease Prevention and Control, Department of Health, Sta. Cruz, Manila, Tel. No.: (632) 7322493, E-mail: [ervavemd@gmail.com](mailto:ervavemd@gmail.com)

Dr Maria Loida L. Alzona, Chief, Plans, Program Development and Monitoring Division, Health, Public Safety and Environmental Protection Office, Metro Manila Development Authority, MMDA Building Orense Street corner EDSA Guadalupe, Makati City, Tel. No.: (632) 8820870; 639229688363, Fax No.: (632) 8820870  
E-mail: [drlalzono@yahoo.com.ph](mailto:drlalzono@yahoo.com.ph)

Ms Luz B. Tagunicar, Supervising Health Program Officer National Center for Health Promotion, Department of Health Bldg 18, San Lazaro Compound, Sta. Cruz, Manila Tel. No.: (632) 9487655, E-mail: [luztagunicar@yahoo.com](mailto:luztagunicar@yahoo.com)

### **KOREA, REPUBLIC OF**

Dr Seo Soon Ryu, Research Officer, Division of Chronic Disease Control, Korea Centers for Disease Control and Prevention, Osong Health Technology Administration Complex 187 Osongsaengmyeong2(i)-ro, Gangoe-myeon, Cheongwon-gun, Chungcheongbuk-do, Tel. No.: (8243) 7197384 Fax No.: (8243) 7197458, E-mail: [seos@korea.kr](mailto:seos@korea.kr)

### **SINGAPORE**

Dr Noorul Fatha As'art, Assistant Director, Noncommunicable Diseases, Epidemiology and Disease Control Division Ministry of Health, Singapore, College of Medicine, Building 16 College Road, 169854 Singapore, Tel. No.: (65) 63253425 Fax No.: (65) 63259072  
E-mail: [Noorul\\_FATHA@moh.gov.sg](mailto:Noorul_FATHA@moh.gov.sg)

### **VIET NAM**

Mr Nguyen Tuong Son, Deputy Director, Department of Labor, Culture and Social Affairs, Ministry of Planning and Investment, Viet Nam, No. 6 Asley 28/29 Ongiekhkiem Street Badinh District, Hanoi, Tel. No.: (84) 438435531; mobile: (84) 913596898, Fax No.: (84) 08043986  
E-mail: [sonnt@mpi.gov.vn](mailto:sonnt@mpi.gov.vn)

Mr Nguyen Anh Son, Officer, Department of Pupil and Student Affairs, Ministry of Education and Training, 49 Dai Co Viet, Hanoi, Tel. No.: (84) 912218578; (84) 38694029 Fax No.: (84) 38694029  
E-mail: [nason@moet.edu.vn](mailto:nason@moet.edu.vn); [nason@moet.gov.vn](mailto:nason@moet.gov.vn)

Dr Truong Dinh Bac, Head, NCD Control and School Health  
General Department of Preventive Medicine, Ministry of Health,  
Viet Nam, 138-A-Giang Vo-Ba Dinh, Hanoi, Tel. No.: (844)  
37368378, Fax No.: (844) 37367379  
E-mail: [truongdinhbac@gmail.com](mailto:truongdinhbac@gmail.com)

Dr Truong Le Van Ngoc, Medical Expert on Noncommunicable  
Disease, Department of the Medical Service Administration,  
Ministry of Health, Viet Nam, No. 40 Autrieu Street, Hoankiem  
District, Hanoi, Tel. No.: (844) 62732445  
Fax No.: (844) 62732094, E-mail: [ngoctruongmoh@gmail.com](mailto:ngoctruongmoh@gmail.com)

## **2. TEMPORARY ADVISERS**

Professor Mike Daube, Professor of Health Policy, Director, Public Health Advocacy Institute, Director,  
McCusker Centre for Action on Alcohol and Youth, Curtin University, P.O. Box 1987, Perth 6845, Tel.  
No.: (0409) 933933, Fax No.: 9266 9244, E-mail: [M.daube@curtin@curtin.edu.au](mailto:M.daube@curtin@curtin.edu.au)

Dr Oh Kyungwon, Division of Health and Nutrition Survey, Korea Centres for Disease Control  
and Prevention, 194 Tongilo, Nokbeon-dong, Eunpyung-gu, Seoul, Republic of Korea,  
E-mail: [kwoh27@korea.kr](mailto:kwoh27@korea.kr)

## **3. RESOURCE PERSONS**

Dr Belinda Loring, Consultant Public Health Physician, Senior Policy Officer, Global Action for Health  
Equity Network, The National Centre for Epidemiology, and Population Health Mills Road  
The Australian National University, Canberra, ACT 0200 Australia, Tel. No.: (612) 61250721; Mobile:  
(64) 212941620, Skype: belindaloring, E-mail: [bjloring@yahoo.com](mailto:bjloring@yahoo.com)

Professor Donald P. Matheson, Massey University - Wellington Campus, Centre for Public Health  
Research, Private Box 756, 1st Floor, 102 Adelaide Road, Newton, 6140 Wellington, New Zealand  
Tel. No.: (644) 8015799, Fax No.: (644) 3800600, E-mail: [D.P.Matheson@massey.ac.nz](mailto:D.P.Matheson@massey.ac.nz)

## **4. REPRESENTATIVES/OBSERVERS**

### **CENTER FOR DISEASE CONTROL AND PREVENTION MACAO, CHINA**

Ms Lou Ou Lei, Senior Technician  
Unit for NCD Prevention and Health Promotion  
Health Bureau, Macao SAR/Secretary-General  
Committee on NCD Prevention and Control  
Alameda Dr Carlos d'Assumpcao no 335 341, Macao SAR, Tel.  
No.: (853) 28533525, Fax No.: (853) 28533524, E-mail:  
[lououlei@ssm.gov.mo](mailto:lououlei@ssm.gov.mo)

## Annex 1

**INTERNATIONAL FEDERATION  
OF RED CROSS AND RED  
CRESCENT SOCIETIES  
INTERNATIONAL FEDERATION  
ASIA PACIFIC ZONE**

Mr Jim Catampongan, Emergency Health Coordinator  
The Head of Zone, International Federation of Red Cross  
and Red Crescent Societies, International Federation Asia  
Pacific Zone Office, 50450 Kuala Lumpur, Malaysia  
Tel. No.:(03) 92075779, E-mail: [jim.catampongan@ifrc.org](mailto:jim.catampongan@ifrc.org)

**KOREA CENTERS FOR  
DISEASE CONTROL AND  
PREVENTION**

Ms Yang Miae, Director, Division of Chronic Disease Control  
Korea Centers for Disease Control and Prevention  
Saedlomeo@106-1001, Dae-dong, Dong-gun, Daejeon  
Republic of Korea 363-951, Tel. No.: (8243) 7197411  
Fax No.: (8243) 7197458, E-mail: [godvma@nate.com](mailto:godvma@nate.com)

**MALAYSIAN HEALTH  
PROMOTION BOARD**

Dr Yahya Baba. Chief Executive Officer  
Malaysian Health Promotion Board, Level 9,11 & 12, Menara,  
Prisma, 26. Boulevard, Pesiaran Perdana, Precint 3, 62675  
Putrajaya, Malaysia, Tel: (038888) 7700, Fax: (038888) 7400  
Email: [yahya.baba@mysihat.moh.gov.my](mailto:yahya.baba@mysihat.moh.gov.my)

**MINISTRY OF HEALTH  
MALAYSIA**

Dr Hj Lailanor bin Haji Ibrahim, State Health Director  
Pulau Pinang, Ministry of Health Malaysia, Level 12, Block E7,  
Parcel E, Federal Government, Administrative Centre  
62590 Putrajaya, Malaysia, Tel. No.: (603) 88832545  
Fax No.: (603) 88888692

Dr Ismail bin Abu Taat, State Health Director, Kedah, Ministry of  
Health Malaysia, Level 12, Block E7, Parcel E  
Federal Government, Administrative Centre, 62590 Putrajaya,  
Malaysia, Tel. No.: (603) 88832545 Fax No.: (603) 88888692

Dr Ismail bin Ali, Deputy State Health Director (Public Health)  
Melaka, Ministry of Health Malaysia. Level 12, Block E7, Parcel  
E. Federal Government, Administrative Centre  
62590 Putrajaya, Malaysia, Tel. No.: (603) 88832545  
Fax No.: (603) 88888692

Dr Fatimah Othman, Deputy State Health Director (Public Health),  
Johor, Ministry of Health Malaysia, Level 12, Block E7, Parcel E,  
Federal Government, Administrative Centre  
62590 Putrajaya, Malaysia, Tel. No.: (603) 88832545  
Fax No.: (603) 88888692

Dr Ummi Kalthom binti Shamsuddin, Deputy State Health  
Director (Public Health), Wilayah Persekutuan Kuala Lumpur and  
Putrajaya, Ministry of Health Malaysia, Level 12, Block E7,  
Parcel E, Federal Government, Administrative Centre  
62590 Putrajaya, Malaysia, Tel. No.: (603) 88832545  
Fax No.: (603) 88888692

Dr Zainudin Abdul Wahab, Deputy State Health Director (Public  
Health), Selangor, Ministry of Health Malaysia  
Level 12, Block E7, Parcel E, Federal Government, Administrative  
Centre, 62590 Putrajaya, Malaysia  
Tel. No.: (603) 88832545, Fax No.: (603) 88888692

Dr Madihah Mustafa, Senior Principal Assistant Director  
Disease Control Division, Ministry of Health Malaysia  
Level 12, Block E7, Parcel E, Federal Government,  
Administrative Centre, 62590 Putrajaya, Malaysia  
Tel. No.: (603) 88832545, Fax No.: (603) 88888692  
E-mail: madihah\_m@moh.gov.my

Ms Viola Michaels , Dietitian Disease Control Division Ministry  
of Health Malaysia Level 12, Block E7, Parcel E Federal  
Government, Administrative Centre 62590 Putrajaya, Malaysia  
Tel. No.: (603) 88832545 Fax No.: (603) 88888692 E-mail:  
[violamichael@moh.gov.my](mailto:violamichael@moh.gov.my)

Ms Ruhaya Salleh, Nutritionist, Disease Control Division  
Ministry of Health Malaysia, Level 12, Block E7, Parcel E  
Federal Government, Administrative Centre, 62590 Putrajaya,  
Malaysia, Tel. No.: (603) 88832545, Fax No.: (603) 88888692  
E-mail: ruhaya\_rs@moh.gov.my

**SOUTHEAST ASIA TOBACCO  
CONTROL ALLIANCE**

Dr Mary Assunta, Senior Policy Advisor, Southeast Asia  
Tobacco Control Alliance, P.O. Box 4708, Sydney,  
NSW 2001 Australia; Tel. No.: (61) 0280634115mobile: (61)  
0400119985Fax No.: (61) 0280634101  
E-mail: [mary.assunta@cancer.org.au](mailto:mary.assunta@cancer.org.au)

**UNION FOR INTERNATIONAL  
CANCER CONTROL**

Ms Ranjit Kaur, Representative, Union for International  
Cancer Control,Chief Executive Officer  
Breast Cancer Welfare Association Malaysia  
5<sup>th</sup> Floor Bangunan Sultan Salahuddin Abdul Aziz Shah  
16 Jalan Utara, 46200 Petaling Jaya, Selangor, Malaysia  
Tel. No.: (603) 79540133; (603) 79549039  
mobile: 6012 2771998. Fax No.: (603) 79540122  
E-mail: [ranjit@breastcancer.org.my](mailto:ranjit@breastcancer.org.my)

**THE UNITED NATIONS  
CHILDREN'S FUND EAST ASIA  
PACIFIC REGIONAL OFFICE**

Dr Nabila Zaka, Maternal and Child Health Specialist  
Young Survival and Development Section  
UNICEF East Asia Pacific Regional Office  
Tel. No.: (6602) 3569420  
E-mail: [nzaka@unicef.org](mailto:nzaka@unicef.org)

**THE WORLD BANK**

Mr Toomas Palu, Sector Manager, Health Nutrition and  
Population, The World Bank, Bangkok Office  
30th Floor, Siam Tower, 989 Rama 1 Road, Pathumwan  
Bangkok 10330 Thailand, Tel. No.: 66 (02) 6868300  
Fax No.: (202) 4776391, E-mail: [tpalu@worldbank.org](mailto:tpalu@worldbank.org)



## Annex 1

### **4. SECRETARIAT**

Dr Han Tieru, Director, Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, P.O. Box 2932 1000 Manila Philippines, Tel. No.: (632) 5289980, Fax No: (632) 5260279, E-mail: [hant@wpro.who.int](mailto:hant@wpro.who.int)

Dr Hai-Rim Shin, Team Leader, Noncommunicable Diseases and Health Promotion, WHO Regional Office for the Western Pacific, P.O. Box 2932 1000 Manila Philippines, Tel. No.: (632) 5289860 Fax No: (632) 5260279, E-mail: [shinh@wpro.who.int](mailto:shinh@wpro.who.int)

Dr Cherian Varghese (Responsible Officer), Senior Medical Officer, Noncommunicable Diseases and Health Promotion, WHO Regional Office for the Western Pacific, P.O. Box 2932 1000 Manila Philippines, Tel. No.: (632) 5289866, Fax No: (632) 5211036, E-mail: [varghesec@wpro.who.int](mailto:varghesec@wpro.who.int)

Dr Khim Sam Ath, National Programme Officer, WHO Representative Cambodia, No. 177-179 corner Pasteur (51) and 254, Phnom Penh, Cambodia, Tel. No.: (855) 23-216610, Fax No: (855) 232166211 E-mail: [aths@who.int](mailto:aths@who.int)

Dr Mukundan Sugunan Pillay, Technical Officer (Environmental Health), WHO Representative People's Republic of China, 401 Dongwai Diplomatic Office Building, 23 Dongzhimenwai Dajie. Chaoyang District, Beijing 1000600, China, Tel. No.: (8610) 65327189, Fax No: (8610) 65322359 E-mail: [pillaym@wpro.who.int](mailto:pillaym@wpro.who.int)

Dr Yunguo Liu, WHO Representative Lao PDR, 125 Saphanthong Road, Unit 5, Ban Saphangthongtai, Sisattanak District, Vietiane Capital, Lao PDR, Tel. No.: (856) 21353902, Fax No: (856) 21353905 E-mail: [liuy@wpro.who.int](mailto:liuy@wpro.who.int)

Dr Chun Paul Soo, National Programme Officer, WHO Representative Malaysia, 1st Floor, Wisma UN, Block C, Komplek Pejabat, Damansara, Jalan Dungun, Damansara Heights, 50490 Kuala Lumpur, Malaysia, Tel. No.: (603) 20921184, Fax No: (603)20937446, E-mail: [sooc@wpro.who.int](mailto:sooc@wpro.who.int)

Dr Bayandorj Tsogzolmaa, National Programme Officer (Noncommunicable Diseases), WHO Representative Mongolia, Ministry of Health, Government Building-8, Ulaanbaatar, Mongolia Tel. No.: (976) 11327870, Fax No: (976) 11324683, E-mail: [bayandorjt@wpro.who.int](mailto:bayandorjt@wpro.who.int)

Dr John Juliard Go, National Programme Officer (Noncommunicable Diseases), WHO Representative Philippines, National Tuberculosis Centre Building, Second Floor, Building 9, Department of Health San Lazaro Hospital Compound, Sta Cruz, Manila, Philippines, Tel. No.: (632) 5289063 Fax No: (632) 7313914, E-mail: [goj@wpro.who.int](mailto:goj@wpro.who.int)

Dr Lai Duc Trung, Technical Officer (Noncommunicable Diseases), National Programme Officer WHO Representative Viet Nam, 63 Tran Hung Dao Street, Hoan Kiem District, Hanoi, Socialist Republic of Viet Nam, Tel. No.: (844) 39433734, Fax No: (844) 39433740 E-mail: [laid@wpro.who.int](mailto:laid@wpro.who.int)

Dr Francisco A. Armada Perez, Technical Officer, Health Governance Research, Urbanization and Health Equity, World Health Organization Centre for Health Development (WHO Kobe Centre) 1-5-1 Wakino-hama-Kaigandori, Chuo-ku, Kobe 651-0073 Japan, Tel. No.: (81) 782303100 E-mail: [armadaf@wkc.who.int](mailto:armadaf@wkc.who.int)

Dr Nicholas Banatvala, Senior Adviser, WHO/HQ/NMH/NMA, Avenue Appia 20  
1211 Geneva 27, Switzerland, Tel. No.: (4122) 7911882, Fax No: (4122),  
E-mail: [banatvalan@who.int](mailto:banatvalan@who.int)

Dr Timothy Armstrong, Coordinator, Surveillance and Population-based Prevention Unit  
Department of Chronic Diseases and Health Promotion, Noncommunicable Diseases and Mental Health  
World Health Organization, CH-1211 Geneva 27, Switzerland, Tel. No.: (4122) 7911274; mobile: (41)  
794452026, Fax No.: (4122) 7911581, E-mail: [armstrongt@who.int](mailto:armstrongt@who.int)

Dr Kwok-cho Tang, Coordinator, Health Promotion, World Health Organization, CH-1211 Geneva 27,  
Switzerland , Tel. No.: (4122) 7913299, E-mail: [tangkc@who.int](mailto:tangkc@who.int)

Dr Feisul Idzwan Mustapha, Public Health Specialist, Disease Control Division, Ministry of Health  
Malaysia, Level 12, Block E7, Parcel E, Federal Government, Administrative Centre, 62590 Putrajaya,  
Malaysia, Tel. No.: (603) 88832545, Fax No.: (603) 88888692, E-mail: [dr.feisul@moh.gov.my](mailto:dr.feisul@moh.gov.my)

Ms Normah Md Rais, Diabetes Educator, Disease Control Division, Ministry of Health Malaysia  
Level 12, Block E7, Parcel E, Federal Government, Administrative Centre, 62590 Putrajaya, Malaysia  
Tel. No.: (603) 88832545, Fax No.: (603) 88888692, E-mail: [norish@moh.gov.my](mailto:norish@moh.gov.my)

DETAILED PROGRAMME OF ACTIVITIES

WORLD HEALTH  
ORGANIZATION



ORGANISATION MONDIALE  
DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC  
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL MEETING  
ON NATIONAL MULTISECTORAL PLANS FOR NCD PREVENTION AND CONTROL  
Kuala Lumpur, Malaysia, 11 to 14 June 2012

PROGRAMME OF ACTIVITIES

Monday, 11 June 2012

08:00-09:00	Registration	
09:00-09:10	Security briefing	<b>Mr Devendra Patel</b> Security Advisor United Nations Department of Security and Safety Malaysia, Singapore and Brunei Darussalam
09:10-09:30	Self-introduction of participants	
09:30-10:15	<b>Opening ceremony</b>	
	Opening remarks	<b>Dato' Sri Liow Tiong Lai</b> Minister of Health Malaysia
	Opening address	<b>Dr Shin Young-soo</b> Regional Director WHO WPRO
	(Election of Chair and Co-Chair)	
10:15-10:45	<b><i>Group photo and coffee break</i></b>	
	<b>Overview, current situation and approaches</b>	
10:45-11:05	Overview of NCD prevention and control and objectives of the meeting	<b>Dr Hai-Rim Shin</b> Team Leader, NHP WHO WPRO

## Annex 2

<b>11:05-11:25</b>	National multisectoral plans for NCD: Current status and challenges	<b>Dr Han Tieru</b> Director, Division of Building Healthy Communities and Populations WHO WPRO
<b>11:25-11:45</b>	National strategic plan for NCD prevention and control in Malaysia	<b>Dr Zainal Ariffin Omar</b> Deputy Director Disease Control Division MOH Malaysia
<b>11:45-12:00</b>	Discussion	
<b>12:00-13:00</b>	<b><i>Lunch</i></b>	
<b>13:00-13:45</b>	<b>Country presentations</b> <i>Group 1:</i> Cambodia, Lao PDR, Viet Nam	
<b>13:45-14:00</b>	Discussion	
<b>14:00-15:15</b>	<i>Group 2:</i> Brunei Darussalam, China, Macao (China), Mongolia, Philippines	
<b>15:15-15:30</b>	Discussion	
<b>15:30-16:00</b>	<b><i>Coffee break</i></b>	
<b>16:00-16:45</b>	<i>Group 3:</i> Hong Kong (China), Japan Republic of Korea, Singapore	
<b>16:45-17:00</b>	Discussion	
<b>19:30-21:00</b>	<b><i>Welcome dinner hosted by MOH Malaysia</i></b>	

## Tuesday, 12 June 2012

<b>08:30-08:45</b>	Recap of Day 1	
<b>08:45-09:10</b>	<b>Path forward for multisectoral action (MSA)</b>	<b>Professor Don Matheson</b> Massey University, New Zealand
<b>09:10-09:30</b>	Discussion	
<b>09:30-10:00</b>	<b><i>Coffee break</i></b>	
	<b>Learning from the field</b>	
<b>10:00-11:15</b>	<i>(1) National level planning and action</i>	

Annex 2

10:00-10:15	Australia	<b>Ms Sally Goodspeed</b> Health in Social Policy Branch, Department of Health and Ageing Canberra, Australia
10:15-10:30		<b>Professor Mike Daube</b> Curtin University Perth, Western Australia
10:30-10:45	Japan	<b>Dr Tomofumi Sone</b> National Institute of Public Health, Saitama, Japan
10:45-11:00	China	<b>Ms Kong Lingzhi</b> Bureau of Disease Control Ministry of Health, China
11:00-11:15	Discussion	
<b>11:15-12:00</b>	<i>(2) Financing MSA</i>	
11:15-11:25	Mongolia	<b>Mr Tumendemberel Namjil</b> State Secretary Ministry of Health, Mongolia
11:25-11:35	Republic of Korea	<b>Dr Seo Soon Ryu</b> Korea Centers for Disease Control and Prevention Republic of Korea
11:35-12:00	Discussion	
<b>12:00-13:00</b>	<b><i>Lunch break</i></b>	
<b>13:00-13:45</b>	<i>(4) Working with different sectors</i>	
13:00-13:15	Singapore	<b>Dr Noorul Fatha As'art</b> NCD Epidemiology and Disease Control Division Ministry of Health, Singapore
13:15-13:30	Viet Nam	<b>Dr Truong Dinh Bac</b> NCD Control and School Health, General Department of Preventive Medicine, Ministry of Health, Viet Nam
13:30-13:45	Discussion	
<b>13:45-15:30</b>	<b>Group work 1: Gaps and barriers to MSA</b>	
	<i>Group 1:</i> Cambodia, Lao PDR, Viet Nam	
	<i>Group 2:</i> Brunei Darussalam, China Macao (China), Mongolia, Philippines	
	<i>Group 3:</i> Australia, Hong Kong (China), Japan Republic of Korea, Malaysia, Singapore	

## Annex 2

**15:30-16:00**                      *Coffee break*

**16:00-17:00**                      Group presentations and discussion

### Wednesday, 13 June 2012

**08:30-08:45**                      Recap of Day 2

**08:45-09:10**                      **Who, why and how of MSA?**

**Dr Belinda Loring**  
Global Action for Health  
Equity Network,  
New Zealand

**09:10-09:30**                      Discussion

**09:30-10:00**                      *Coffee break*

**10:00-11:15**                      **Group work 2: Roles and responsibilities  
of sectors**

*Group 1: NCD focal points*

*Group 2: Social sector focal points*

*Group 3: Finance/Planning focal points*

**11:15-12:00**                      Group presentations and discussion

**12:00-13:00**                      *Lunch break*

**13:00-14:00**                      **Group work 3: Next steps**

*(Country groups to identify next steps  
for developing/strengthening national multisectoral  
plans for NCD prevention and control by 2013)*

**14:00-14:30**                      **Coffee break**

**Presentation by countries and discussion**

**14:30-15:00**                      Cambodia, Lao PDR, Viet Nam

**15:00-16:00**                      Brunei Darussalam, China, Macao (China)

Malaysia, Mongolia, Philippines

### Thursday, 14 June 2012

**08:30-08:45**                      Recap of Day 3

**08:45-09:15**                      Draft global NCD action plan and approach

**Dr Nicholas Banatvala**  
WHO Geneva

**09:15-10:00**                      Discussion

**10:00-10:30**                      *Coffee break*

**Draft set of voluntary global targets and  
indicators for NCD prevention and control**

Annex 2

<b>10:30-10:50</b>	Process of development of a global monitoring framework including indicators and a set of voluntary global targets for the prevention and control of NCD	<b>Dr Timothy Armstrong</b> WHO Geneva
<b>10:50-11:05</b>	NCD surveillance and monitoring in the Region	<b>Dr Cherian Varghese</b> WHO WPRO
<b>11:05-11:20</b>	Discussion	
<b>11:20-11:40</b>	NCD surveillance and monitoring	<b>Dr Oh Kyungwon</b> Division of Health and Nutrition Survey, Korea Centers for Disease Control and Prevention Republic of Korea
<b>11:40-12:00</b>	Discussion	
<b>12:00-13:00</b>	<b><i>Lunch break</i></b>	
<b>13:00-14:00</b>	Country inputs into the set of voluntary global targets and indicators and review of the draft regional document	
<b>14:00-14:30</b>	Finalization of country inputs	
<b>14:30-15:00</b>	<b><i>Coffee break</i></b>	
<b>15:00-15:30</b>	<b>Closing ceremony</b>	<b>Dr Han Tieru, DHP</b> <b>Ministry of Health, Malaysia</b>

## SUMMARY OF COUNTRY GROUP WORK

Table 1 - Group work session 1: Gaps &amp; Barriers to MSA

	Group 1: Cambodia, Lao PDR, Viet Nam	Group 2: Brunei Darussalam, China, Mongolia, Philippines	Group 3: Hong Kong (China), Japan, Republic of Korea, Malaysia, Singapore
<b>Gaps</b>	<ul style="list-style-type: none"> <li>➤ Limited budget</li> <li>➤ Lack of commitment of non-health sectors</li> <li>➤ Lack of NCD data</li> <li>➤ No governance structure for MSA</li> <li>➤ No specific MOH unit for NCD</li> <li>➤ No national MSA committee – only ad hoc meeting</li> <li>➤ Lack of budget/capacity for public information, communication and education about NCDs</li> <li>➤ No policy or strategy for NCD prevention</li> <li>➤ Big gap between policy and implementation</li> <li>➤ No experience with community-based prevention for NCD</li> <li>➤ Low commitment from government</li> </ul>	<ul style="list-style-type: none"> <li>➤ Lack of data or evidence to convince partners of address problem</li> <li>➤ Absence of dedicated budget</li> <li>➤ Lack of commitment and understanding of NCDs in other sectors</li> <li>➤ Lack of capacity to do advocacy campaigns</li> <li>➤ Lack of coherence in mandates of various sectors (eg ministry of industry vs health on tobacco)</li> <li>➤ Lack of a mechanism to encourage, motivate other sectors to work with other sectors</li> <li>➤ Poor co-ordination</li> </ul>	<ul style="list-style-type: none"> <li>➤ Different sectors have different goals and priorities</li> <li>➤ Different mind-set</li> <li>➤ Need to have shared goals</li> <li>➤ MOH &amp; environment have shared goals – but other sectors eg customs and industry are more dissimilar</li> <li>➤ Privacy protection is strong</li> <li>➤ Gap in implementation</li> <li>➤ Gap in knowledge of what is effective between sectors</li> <li>➤ Ministries used to working in silos</li> <li>➤ Lack of leadership</li> <li>➤ Have multiple forums for discussion, but implementation is a problem</li> <li>➤ Good planners but not good implementers</li> <li>➤ Medical mindset – cure/health care focused rather prevention</li> </ul>
<b>Barriers</b>	<ul style="list-style-type: none"> <li>➤ Conflict of interest: <ul style="list-style-type: none"> <li>○ Between public health and private sector, and</li> <li>○ Between ministries</li> </ul> </li> <li>➤ Non-health sectors do not understand NCD</li> <li>➤ Difficulty finding win-wins</li> <li>➤ Lack of human resources/capacity to address NCD</li> <li>➤ Government has other priority – poverty reduction, and other priorities within MOH</li> <li>➤ Health sector does not have same targets as other sectors</li> <li>➤ Lack of evidence for best-buys and effectiveness of</li> </ul>	<ul style="list-style-type: none"> <li>➤ Lack of capacity in MSA – human resources and expertise</li> <li>➤ Lack of leaders/champions in other sectors</li> <li>➤ Industry interference (Philippines)</li> <li>➤ Poor implementation and monitoring and evaluation of policies</li> <li>➤ Geographic and cultural peculiarities</li> <li>➤ Mostly internal barriers, although industry barriers both internal and</li> </ul>	<ul style="list-style-type: none"> <li>➤ Competing priorities not shared between sectors</li> <li>➤ No MSA coordination at top level</li> <li>➤ Priorities focused on KPI</li> <li>➤ All sectors have “politics” driven agenda</li> <li>➤ Civil society support needs to be stronger</li> <li>➤ Need to address cultural barriers</li> <li>➤ No clarity on who is host and who is implementing – everyone wants to</li> </ul>



	<p>actions (in terms of the strength of the science, and how this information is presented for advocacy purposes) – need local data/evidence. Global data lacks power.</p> <ul style="list-style-type: none"> <li>➤ Focus of health sector – is on treatment not prevention, hospital-focus consumes health budget.</li> <li>➤ Ministry of health does not have any power</li> <li>➤ Tobacco and alcohol tax – Ministry of Finance support raising revenue, but not hypothecation – additional revenue should be allocated to priorities. Health sector needs to make strong business case.</li> <li>➤ Perceptions of NCDs – slow, not urgent, also self-induced through individual behaviour</li> <li>➤ Donor requirements – rigid – prevent flexible use of existing structures, eg for infectious disease</li> </ul>	external	<p>minimise their task</p> <ul style="list-style-type: none"> <li>➤ Busy schedules</li> <li>➤ Need leadership at top and community levels</li> <li>➤ Implementation, resources, human capacity, monitoring and targets</li> <li>➤ Trade issues – health sector not involved in trade agreement negotiations</li> <li>➤ Long economic recession</li> <li>➤ Political sensitivities between countries</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>➤ Need to make NCD a priority within health sector first</li> <li>➤ Need to establish a co-ordination mechanism</li> <li>➤ Need to build alliances with other ministries (esp finance) to advocate with Prime Minister)</li> <li>➤ Need to align NCD with poverty reduction goals</li> <li>➤ Make links between NCD and GDP</li> <li>➤ Set up high-level NCD committee</li> <li>➤ Healthy Cities (eg Vientiane)</li> <li>➤ Expand smoke-free environments, schools workplaces</li> <li>➤ Expand scope of existing multi-sectoral committees (eg for tobacco or environmental health)</li> <li>➤ Lobby donors for investment in NCD</li> <li>➤ Scale up data collection for NCD – better utilise STEPS data. Better utilise WHO's "Best-Buys" data</li> <li>➤ Build upon existing relationships eg between Ministries of health and education</li> <li>➤ Expand food safety measures to include nutritional quality (eg salt).</li> </ul>	<ul style="list-style-type: none"> <li>➤ Even in countries with “adequate data” other sectors still need to be convinced - turning evidence into compelling story. Risk communication is critical issue – information alone is not sufficient</li> <li>➤ All sectors believe they are working to promote good human development, but the consequences reveal unintended effects (eg obesity, food poisoning from contaminants) – health can work with other sectors to influence policy decisions to avoid these unintended consequences (eg through HIA)</li> </ul>	

**Table 2 - Group work 2: Roles & responsibilities of non-health sectors**

Sector	Interests	How NCD relevant	Experience with health
<b>Office of the Prime Minister (Brunei)</b>	<ul style="list-style-type: none"> <li>➤ Security</li> <li>➤ Economic Development</li> <li>➤ Welfare</li> </ul>	<ul style="list-style-type: none"> <li>➤ Health of the Military</li> <li>➤ General Welfare of the Population</li> <li>➤ Healthy Workforce contributes to development and economy</li> <li>➤ Socio-economic impact of NCDs</li> </ul>	<ul style="list-style-type: none"> <li>➤ NCD taken up on a national scale</li> <li>➤ NCD should be discussed in Cabinet Meetings</li> </ul>
<b>Ministry of Labor, Occupational Health &amp; Safety (Philippines)</b>	<ul style="list-style-type: none"> <li>➤ Safety and health in highly hazardous</li> <li>➤ Capacity Building</li> <li>➤ Green Workplaces – using green technologies (environmental concerns)</li> <li>➤ Big Issues like employment, wages and migrant workers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Capacity Building to as entry point for NCDs</li> <li>➤ Civil Service Commission – taking care of Government Offices</li> </ul>	<ul style="list-style-type: none"> <li>➤ Member various Technical Working Groups</li> <li>➤ Working with MOH to push NCD goals</li> <li>➤ Quite familiar with the NCD goals of MOH</li> </ul>
<b>Metro Manila Development Authority (Philippines)</b>	<ul style="list-style-type: none"> <li>➤ Traffic – to reduce traffic and improve physical activity</li> <li>➤ Urban Planning</li> <li>➤ Health – to bring down the air pollution level of Metro Manila</li> </ul>	<ul style="list-style-type: none"> <li>➤ Traffic Management</li> <li>➤ Urban Planning to consider more parks, walkable streets</li> <li>➤ Smokefree transport terminals</li> </ul>	<ul style="list-style-type: none"> <li>➤ Mandate of MMDA has health impacts</li> <li>➤ No difficulty working with MOH</li> <li>➤ With established working relationship with MOH</li> </ul>
<b>Ministry of Agriculture (China)</b>	<ul style="list-style-type: none"> <li>➤ Food Security – sufficient food</li> <li>➤ Food Quality- nutrition, variety of food and safety</li> <li>➤ Increased Income for Farmers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Food Security – sufficient food which available and affordable -especially fruits and vegetables</li> <li>➤ Food Quality- nutrition, variety of food and safety; food fortification program, pesticide quality control</li> <li>➤ Increased Income for Farmers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Long term relationship with MOH</li> <li>➤ Production of food has shifted from quantity to quality to address health goals</li> <li>➤ MOH should speak to Agriculture using their language</li> <li>➤ MOH should find the shared interest between Agriculture and Health</li> </ul>
<b>Ministry of Education (Malaysia)</b>	<ul style="list-style-type: none"> <li>➤ Our focus is education but not health per se we know what the children want to eat, but not what is good for them;</li> </ul>	<ul style="list-style-type: none"> <li>➤ Nutritionist Skills needed in MOE - staff are teachers, not health experts</li> <li>➤ Need a main committee at national level – little control over hawkers outside the school – local council's jurisdiction</li> </ul>	<ul style="list-style-type: none"> <li>➤ MOE: Good working relationship with MOH, budget restrains with the MOE –</li> </ul>
<b>Prime Minister's Department (Malaysia)</b>	<ul style="list-style-type: none"> <li>➤ PM's Department – Economic Planning Unit – looking at developmental issues and budget (developmental budget)</li> </ul>	<ul style="list-style-type: none"> <li>➤ Economic impact of NCD on population is huge – need more collaboration, dedicated forum where related agencies come together</li> </ul>	<ul style="list-style-type: none"> <li>➤ Health is a federal matter – not very engaged with the NCD unit – need more engagement especially with central agencies – our plans are general, enhance</li> </ul>

		social and economic status of population and improve quality of life
<b>Ministry of Finance (Cambodia)</b>	<ul style="list-style-type: none"> <li>➤ Targets for tax collection</li> <li>➤ Increase tax base</li> <li>➤ Increase excise tax on tobacco (from 10 to 20%)</li> <li>➤ Licensing alcohol retailers</li> <li>➤ Agricultural subsidies</li> <li>➤ No food taxes (burden on poor)</li> <li>➤ 5 key ministries: health, education, rural development, agriculture</li> </ul>	<ul style="list-style-type: none"> <li>➤ Collaborate on IMC on tobacco</li> </ul>
<b>Ministry of Industry, Investment &amp; Mining (Cambodia)</b>	<ul style="list-style-type: none"> <li>➤ Government sector</li> <li>➤ Private sector production (including traditional alcohol)</li> <li>➤ Consumers</li> <li>➤ Marketing of alcohol</li> <li>➤ Salt reduction &amp; trans-fat</li> </ul>	<ul style="list-style-type: none"> <li>➤ Collaborates more commonly on non NCD issues (eg food safety)</li> </ul>
<b>Ministry of Planning (Viet Nam)</b>	<ul style="list-style-type: none"> <li>➤ Plans budgets for government expenditure each year</li> <li>➤ Activities and budgets – approves annual work plans of every Ministry and Province</li> </ul>	<ul style="list-style-type: none"> <li>➤ Has to cooperate with MOH and Education on NCD</li> <li>➤ Contributes to National NCD policy</li> <li>➤ Also works with Local authorities</li> </ul>
<b>Ministry of Education (Viet Nam &amp; Lao PDR)</b>	<ul style="list-style-type: none"> <li>➤ Good learning</li> <li>➤ Good teaching</li> <li>➤ Good health</li> </ul>	<ul style="list-style-type: none"> <li>➤ Collaborate with MOH on school health: <ul style="list-style-type: none"> <li>○ No smoking</li> <li>○ De-worming</li> <li>○ Safe foods</li> <li>○ Physical activity</li> <li>○ Sanitation &amp; water</li> </ul> </li> <li>➤ Annual report back to MOH</li> <li>➤ Health, education &amp; agriculture collaborate on “planting day”</li> <li>➤ MOH staff assigned to support schools</li> </ul>

## COUNTRY SPECIFIC NEXT STEPS IN DEVELOPING NATIONAL MULTISECTORAL ACTION PLANS FOR NCD

	Cambodia	Brunei Darussalam	Lao PDR
<b>What is the overall goal?</b>	To prevent and control of noncommunicable diseases in Cambodia and address the effect it has on individuals, families and societies (2013-2020)	A Nation That Embraces and Practices A Healthy Lifestyle	<ol style="list-style-type: none"> <li>1. To prevent and control NCD in Lao PDR</li> <li>2. To improve the health status in Lao PDR</li> <li>3. To reduce the mortality rate due to NCD</li> </ol>
<b>What are the priorities?</b>	<p><b>Best buys:</b></p> <ul style="list-style-type: none"> <li>➤ Unhealthy diet and physical inactivity</li> </ul> <p><b>Feasibility:</b></p> <ul style="list-style-type: none"> <li>➤ Public awareness programme about diet and physical activity</li> <li>➤ Salt reduction through mass media campaigns and reduced salt content in processed foods</li> <li>➤ Replacement of trans-fats with polyunsaturated fats</li> </ul> <p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>➤ Human and financial resources</li> </ul>	Obesity – 60% of population obese + overweight (2 <sup>nd</sup> . NHANSS, 2010-2011)	<ul style="list-style-type: none"> <li>➤ Consider national context</li> <li>➤ NCDs major public health and socioeconomic issue</li> <li>➤ An opportunity to reduce modifiable risk factors</li> <li>➤ A whole of government and society response is needed and is possible</li> <li>➤ Best buys</li> <li>➤ Best buys for all major modifiable NCD risk factors</li> <li>➤ This plan focuses on tobacco use, the harmful use of alcohol and unhealthy diet</li> <li>➤ There are a set of cost effective and evidence-based approaches for tackling these risk factors</li> </ul>
<b>Strengths</b>	<ul style="list-style-type: none"> <li>➤ Pooled fund (Health Sector Support Programme)</li> <li>➤ Commitment from Minister of Health</li> </ul>	<ul style="list-style-type: none"> <li>➤ Leadership commitment and champion</li> <li>➤ National Health Promotion Committee</li> <li>➤ Health Promotion Centre as focal point</li> <li>➤ Health Promotion Blueprint (2011-2015)</li> <li>➤ National Physical Activity Guidelines</li> <li>➤ Community-based wt management program</li> <li>➤ Hospital-based obesity control program</li> </ul>	<ul style="list-style-type: none"> <li>➤ FCTC ratified</li> <li>➤ National legal framework in place</li> <li>➤ National Committee in place</li> </ul>

<b>Weaknesses</b>	<ul style="list-style-type: none"> <li>➤ Lack of technical capacities in implementation of existing NSP on NCD</li> <li>➤ Coordination mechanism with other non-health sectors</li> <li>➤ Limited budget</li> </ul>	<ul style="list-style-type: none"> <li>➤ Human resource constraint –limited technical capacity and numbers</li> <li>➤ No specified allocated funding for NCD/obesity</li> <li>➤ Food Culture,</li> <li>➤ Body image &amp; perception</li> </ul>	<ul style="list-style-type: none"> <li>➤ Agreement in place between tobacco industry and government that is in conflict with the national legal framework</li> <li>➤ limited NGO/agencies engaged on tobacco control</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>➤ NCD Task Force</li> <li>➤ Provincial NCD Focal Points</li> <li>➤ IMC on Tobacco Control</li> <li>➤ IMC for Environment and Health</li> </ul>	<ul style="list-style-type: none"> <li>➤ Royal Patronage for Health Promotion</li> <li>➤ National Health Promotion Committee as platform for MSA</li> <li>➤ Partnership with media</li> <li>➤ Existing partnership PMO, MoE, MORA, Mukim Consultative Councils</li> </ul>	<ul style="list-style-type: none"> <li>➤ Draft decree for tobacco taxation being debated</li> <li>➤ TFI being implemented in one province – i.e. experience to build on</li> </ul>
<b>Threats</b>	<ul style="list-style-type: none"> <li>➤ Low community participation (around 30% of the people under poverty line and BCC)</li> <li>➤ Conflict of interest from food industries</li> <li>➤ Conflict of interest from different ministries</li> </ul>	<ul style="list-style-type: none"> <li>➤ Food imports energy-dense, nutrient-poor food (EDNP)&amp; beverages</li> <li>➤ Marketing of EDNP food &amp; beverages- esp. cross-boarder</li> <li>➤ Affordability of EDNP food &amp; beverages</li> <li>➤ Relatively expensive healthier options</li> <li>➤ Changing food habits</li> <li>➤ Sedentary lifestyles</li> </ul>	<ul style="list-style-type: none"> <li>➤ Challenge of turning legal framework into action</li> <li>➤ Foreign investors encourage growing of tobacco</li> </ul>
<b>Priority selected for remainder of questions</b>	Diet & physical activity	Obesity	Tobacco
<b>Who can do what?</b>	<p><b>All:</b></p> <ul style="list-style-type: none"> <li>➤ Develop Muntisectoral Plans for NCD</li> <li>➤ MoH:</li> <li>➤ Coordination</li> <li>➤ Advocacy for government and development partners to support NCD prevention and control</li> </ul> <p><b>Ministry of Industry Mine and Energy (MIME):</b></p> <ul style="list-style-type: none"> <li>➤ Advocacy for political support from the MIME</li> <li>➤ Raise awareness among food producers</li> <li>➤ Develop guidelines on reducing salt, sugar, trans-fat in processed foods</li> </ul>	<p><b>Prime Minister Office</b></p> <ul style="list-style-type: none"> <li>➤ Policy directions on anti-obesity through joint-committee HiAP, championing healthy workplace</li> <li>➤ Price control of foods – making healthier choice cheaper</li> </ul> <p><b>Ministry of Development</b></p> <ul style="list-style-type: none"> <li>➤ Parks and recreations, pedestrian walkways, bicycle walkways</li> </ul> <p><b>Ministry of Finance</b></p> <ul style="list-style-type: none"> <li>➤ Dedicated budget allocation for obesity-controlled programs at national level</li> </ul> <p><b>Ministry of Industry &amp; Primary Resources</b></p> <ul style="list-style-type: none"> <li>➤ Control importation fresh foods</li> </ul>	<p><b>Excise tax increase</b></p> <ul style="list-style-type: none"> <li>➤ Government and PM office to agree the decree and MoJ to enforce</li> </ul> <p><b>Smoke free indoor workplaces and public places</b></p> <ul style="list-style-type: none"> <li>➤ Ministry of Health</li> <li>➤ Local authority</li> </ul> <p><b>Health information and warnings about tobacco</b></p> <ul style="list-style-type: none"> <li>➤ Ministry of Culture and Information ,</li> <li>➤ Ministry of education and sport,</li> <li>➤ Ministry of industrial and trade</li> </ul>

	<p><b>MoEYS:</b></p> <ul style="list-style-type: none"> <li>➤ Health Promoting School</li> <li>➤ Ministry of Information:</li> <li>➤ Ban advertisement on unhealthy foods including non-alcohol beverages targeting to children</li> <li>➤ Promote healthy lifestyles through mass media</li> </ul> <p><b>Ministry of Transport:</b></p> <ul style="list-style-type: none"> <li>➤ Walking and cycling lanes</li> </ul> <p><b>Ministry of Urban and Land Management:</b></p> <ul style="list-style-type: none"> <li>➤ Place for doing physical exercise</li> </ul> <p><b>Local authority:</b></p> <ul style="list-style-type: none"> <li>➤ Healthy cities</li> </ul>	<ul style="list-style-type: none"> <li>➤ Development &amp; Promotion of healthier variety of rice e.g. high-fibre</li> </ul> <p><b>Media partners</b></p> <ul style="list-style-type: none"> <li>➤ Marketing health promotion messages</li> </ul> <p><b>Ministry of Home Affairs</b></p> <ul style="list-style-type: none"> <li>➤ Healthy Town</li> <li>➤ Healthy hawker stalls</li> </ul> <p><b>Health sector</b></p> <ul style="list-style-type: none"> <li>➤ Engaging non-health sector and the public on importance of healthy lifestyles, healthy diets etc.</li> <li>➤ Provides technical expertise and advice to non-health sectors through PA Guidelines, National Dietary Guidelines</li> <li>➤ Strengthen our own Programs on NCD Control &amp; Prevention</li> <li>➤ Ensure integration of all NCD Programs</li> <li>➤ Ensure implementation</li> <li>➤ Monitor progress</li> </ul>	<p><b>Bans on advertising and promotion</b></p> <ul style="list-style-type: none"> <li>➤ Ministry of industrial and trade</li> </ul>
<b>Technical and financial resources</b>	<p><b>What is needed?</b></p> <ul style="list-style-type: none"> <li>➤ Development of healthy food standard</li> <li>➤ Capacity building</li> <li>➤ IEC materials</li> <li>➤ Local authority participation</li> <li>➤ WHO</li> </ul> <p><b>What are the sources?</b></p> <ul style="list-style-type: none"> <li>➤ Government budget</li> <li>➤ Bilateral donor</li> <li>➤ WHO</li> </ul>	<p><b>Technical</b></p> <ul style="list-style-type: none"> <li>➤ Dedicated NCD (Obesity) under the Health Promotion Centre with adequate staffs and skills</li> <li>➤ Exploring Possibility of HPC becoming an independent board (statutory body)</li> <li>➤ Capacity building</li> <li>➤ Fact-finding mission</li> </ul> <p><b>Financial</b></p> <ul style="list-style-type: none"> <li>➤ Dedicated budget allocation for obesity-controlled programs at national level</li> </ul>	<p><b>What is needed?</b></p> <ul style="list-style-type: none"> <li>➤ Task force available</li> <li>➤ Tobacco control committee/unit available</li> <li>➤ Funds for health promotion</li> <li>➤ New agreement between Lao government and tobacco companies</li> </ul> <p><b>What are the sources?</b></p> <ul style="list-style-type: none"> <li>➤ Technical assistance</li> <li>➤ Capacity building for tobacco control</li> <li>➤ Legal advice for deal with agreement</li> <li>➤ Financial resources (for research, advocacy, etc...)</li> </ul>
<b>Target and indicators</b>	<ol style="list-style-type: none"> <li>1. Age-standardized mean population intake of salt per day in grams in adults aged 18+ years = 10g in 2020 (2010 Baseline =17g)</li> <li>2. Age-standardized prevalence of insufficient physical activity in adults aged</li> </ol>	<p><b>Short term (2013-2015)</b></p> <ul style="list-style-type: none"> <li>➤ Halting the increase in prevalence of overweight and obesity</li> </ul> <p><b>Medium Term (2013-2018)</b></p> <ul style="list-style-type: none"> <li>➤ 5% relative reduction</li> </ul>	<p>% of daily current smokers = 15% in 2020, and 17% in 2015 (baseline = 19% in 2010)</p>

	18+ years = 5% in 2020 (2010 Baseline =10.6%)	<b>Long term (2013-2023)</b> <ul style="list-style-type: none"> <li>➤ 20% relative reduction in overweight and obesity prevalence</li> </ul>	
<b>How to get endorsement of MSA plan for NCD</b>	<ul style="list-style-type: none"> <li>➤ National advocacy forum</li> <li>➤ NCD agenda will be discussed in the IMC for Environment and Health</li> <li>➤ Submit Multisectoral Plans on NCD to Council Minister for approval</li> </ul>	<ul style="list-style-type: none"> <li>➤ Stakeholder consultation-socializing the proposal and getting feedback from non-health sectors</li> <li>➤ Getting buy-in at Permanent secretary forum</li> <li>➤ Approval from National Health Promotion Committee</li> <li>➤ Chair of National HP Committee will submit for Royal consent</li> </ul>	<ul style="list-style-type: none"> <li>➤ Report to MOH minister</li> <li>➤ NCD Unit set up in MoH</li> <li>➤ MSA meeting</li> <li>➤ National MSA committee</li> <li>➤ Draft of National MSA plans to submitted to PM to consider and get it signed</li> </ul>
<b>What are the institutional mechanisms for coordination and implementation?</b>	<ul style="list-style-type: none"> <li>➤ IMC for Environment and Health</li> <li>➤ Secretariat of Multisectoral Action</li> <li>➤ Preventive Medicine Department, MoH</li> <li>➤ Council of Agriculture and Rural Development (CARD)</li> </ul>	<ul style="list-style-type: none"> <li>➤ National Health Promotion Committee</li> <li>➤ National Committee on NCD Prevention &amp; Control with 5 technical sub-committees – reporting to NHPC</li> <li>➤ Health Promotion Centre as one of secretariat</li> </ul>	<ul style="list-style-type: none"> <li>➤ Healthy city approach</li> <li>➤ Healthy village</li> </ul>

## COUNTRY SPECIFIC NEXT STEPS IN DEVELOPING NATIONAL MULTISECTORAL ACTION PLANS FOR NCD (Continued)

	Mongolia	Philippines	Viet Nam
<b>What is the overall goal?</b>	Reduce NCD mortality by 15%	Reduce NCD mortality and risk factors	To reduce mortality and disabilities caused by major non- communicable diseases to contribute to improve health of population.
<b>What are the priorities?</b>	<ol style="list-style-type: none"> <li>1. Health impacts assessment of other sectors' policies</li> <li>2. Best buys: prevention, early detection and management of NCD risk factors <ol style="list-style-type: none"> <li>a) Harmful use of alcohol</li> <li>b) Unhealthy diet (salt intake, fast food and soft drinks marketing)</li> <li>c) Tobacco use</li> <li>d) Physical activity</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Overweight and Obesity</li> </ol>	<ol style="list-style-type: none"> <li>1. Reduce population based salt consumption.</li> <li>2. Reduce smoke prevalence.</li> <li>3. Raise awareness of population on NCDs prevention and control.</li> <li>4. Strengthen primary health care system to respond NCDs prevention and control.</li> <li>5. Improve preventive medicine system for prevent NCDs risk factors.</li> <li>6. Strengthen NCDs surveillance system.</li> </ol>
<b>Strengths</b>	<ol style="list-style-type: none"> <li>1. FCTC based law (2005)</li> <li>2. Standards on tobacco control endorsed and implemented</li> <li>3. Data available (WHO STEPS, GYTS, GSHS)</li> <li>4. NRT is included in the essential drug and medicine list</li> <li>5. First integrated NCD prevention and control national programme has been implemented successfully. Funds were raised to implement this programme .</li> </ol>	<ol style="list-style-type: none"> <li>1. DOH has an existing program with budget</li> <li>2. Trained Health Workers on NCD</li> <li>3. Has established networks and alliances</li> <li>4. Technical Expertise</li> <li>5. Public trust in DOH</li> <li>6. Experience in multi-sectoral engagement in Tobacco and TB</li> <li>7. Available Data</li> <li>8. Physical Activity Guidelines</li> </ol>	<ol style="list-style-type: none"> <li>1. "Best buy"</li> <li>2. Experience in disseminating iodization salt for population.</li> <li>3. Impact come soon (hypertension).</li> <li>4. Integration with national school health program.</li> </ol>
<b>Weaknesses</b>	<ol style="list-style-type: none"> <li>1. Low tax and price on tobacco products</li> <li>2. Increasing import and local production of tobacco</li> <li>3. No institutionalization of tobacco prevention and control</li> <li>4. Lack of regulation on tobacco control</li> <li>5. Lack of strong commitment from NGOs</li> </ol>	<ol style="list-style-type: none"> <li>1. DOH has not adequately engaged the sectors outside of Health</li> <li>2. Poor coordinating mechanism for multisectoral work</li> <li>3. Lack of leadership in other sectors</li> <li>4. No shared goals</li> <li>5. No sustained health promotion campaigns</li> <li>6. Lack of budget</li> </ol>	<ol style="list-style-type: none"> <li>1. Low public awareness including health professionals.</li> <li>2. Traditional eating habits (pickle, bacon, use fish sauce every meal)</li> <li>3. National data unavailable</li> </ol>



<b>Opportunities</b>	<ol style="list-style-type: none"> <li>1. Ratified FCTC</li> <li>2. HPF is functional and dedicate 2% of excise tax</li> <li>3. Health warnings on cigarette packs</li> <li>4. Health sector leadership at local and national levels</li> <li>5. NCD and tobacco control technical committees in place</li> <li>6. MSA Coordinator at local level</li> <li>7. Healthy city and healthy settings initiatives</li> </ol>	<ol style="list-style-type: none"> <li>1. International donors and partners</li> <li>2. Strong NGO and LGU support</li> <li>3. Presence of the Philippine Coalition for the Prevention and Control of NCD</li> <li>4. Media Support</li> </ol>	<ol style="list-style-type: none"> <li>1. Multisectoral committee are established.</li> <li>2. Authorities from national government.</li> <li>3. Potential capacity of National Nutrition Institute and preventive medicine system.</li> <li>4. Support of WHO</li> </ol>
<b>Threats</b>	<ol style="list-style-type: none"> <li>1. Lack of interest from other sectors</li> <li>2. High level lobbying from tobacco industry</li> <li>3. Lack of commitment from the Government</li> <li>4. Lack of understanding from public</li> <li>5. Lack of understanding of agriculture sector and other sectors on tobacco as it is considered as an ordinary commodity</li> <li>6. Turnover of high-level senior officials (health and other sectors)</li> </ol>	<ol style="list-style-type: none"> <li>1. Industry Interference</li> </ol>	<ol style="list-style-type: none"> <li>1. Food industry and restaurants, providers</li> <li>2. More occasion in eating outside, free fish sauce in restaurants.</li> <li>3. Low salt price and available.</li> </ol>
<b>Priority selected for remainder of questions</b>	Tobacco	Obesity	Salt intake
<b>Who can do what?</b>	<u><b>Health sector</b></u> <ul style="list-style-type: none"> <li>➤ Play a leading role for MSA</li> <li>➤ Provide technical guide to other sectors (specific to each sector in line with health in all policies)</li> <li>➤ Invite all sectors to reflect health aspects from each sector</li> <li>➤ MOU for 4 years with each sector (Cabinet term)</li> <li>➤ Leadership on the healthy settings</li> </ul>	<u><b>Health sector (will provide leadership)</b></u> <ul style="list-style-type: none"> <li>➤ Directions, policies and guidelines</li> <li>➤ Provide Data and Information for Advocacy</li> <li>➤ Provide the coordinating mechanism</li> <li>➤ Provide preventive/ management services</li> <li>➤ Resource mobilization within government and other sources</li> <li>➤ Regulation or Guidelines for <ul style="list-style-type: none"> <li>○ Mandatory Labelling/ Health</li> </ul> </li> </ul>	<u><b>Health:</b></u> <ul style="list-style-type: none"> <li>➤ Develop national multisectoral action plan on how to reduce salt intake.</li> <li>➤ Raise awareness by conducting communications campaign and advocacy workshops (with Ministry of Culture-Information and Communication, MOET, Woman Union)</li> <li>➤ Develop technical guidelines on implementation of reduce salt intake for</li> </ul>

development

**Other sectors**

1. Food, Agriculture and Light Industry (special permit)
2. Finance (tax and funds allocation)
3. Education (school curriculum, prohibition of tobacco retail around school)
4. Foreign Affairs and Trade (special permit for tobacco import and export )
5. State Inspectorate Control (smoke-free regulation)

Claims

- Marketing of Food and Non-alcoholic Beverages to Children

**Education**

- Values Formation
- Availability of Healthy Foods in the Canteen
- Increase Hours for Physical Activity
- Integration of Good Nutrition and Physical Activity

**Workplace/Labour/Civil Service:**

- Awareness Raising
- Risk Assessment as part of pre-employment and annual Physical Examination
- Healthy Canteen
- Fitness facilities in the Workplace
- Signage and IECs
- Incentives and Awards

**Agriculture:**

- Production of More Fruits and Vegetables
- Establishment of Trading Centers especially in urban areas
- Promotion of Backyard Gardening through provision of seeds and seedlings

**Metro Manila Development Authority:**

- Engage 17 local government units (LGUs) of Metro Manila
- Signage in Major thoroughfares and in public places
- Promote use of pedestrian lanes and overpasses
- Clearing of sidewalks

**National Parks Development Committee**

- Development of safe parks
- Provision of Healthy foods in the park

prevent NCDs (with National Nutrition Institute)

- Conduct national survey on salt intake to get first baseline information (with National Nutrition Institute)
- Improve capacity for primary health care worker to provide counseling on salt intake reduction for patients.
- Pilot model on reduction salt intake in schools and communities (with MOET)
- Ministry of Trade and Industry.
- Reduce salt in industry food (with MOH)
- Food labeling(with MOH)

<p><b><u>Media and Ad Board</u></b></p> <ul style="list-style-type: none"> <li>➤ Educate the public on the importance of healthy eating and physical activity</li> <li>➤ Self-regulation of ads on food and beverages</li> </ul> <p><b><u>Department of Trade &amp; Industry</u></b></p> <ul style="list-style-type: none"> <li>➤ Awareness Raising</li> <li>➤ Teach consumers how to read the label</li> <li>➤ Ensure food and nutrition labels for food and beverages</li> </ul>			
<b>Technical and financial resources</b>	<p><b>Needs:</b></p> <ul style="list-style-type: none"> <li>➤ Develop and endorse MSA on NCD</li> <li>➤ High level multisectoral committee comprised of vice ministers from different ministries</li> <li>➤ Conduct health impact assessment (provision of tool, capacity building)</li> <li>➤ Capacity building of health sector to implement MSA</li> <li>➤ Establish a mechanism for mobilization, motivation and accountability of each sector on MSA</li> </ul> <p><b>Sources:</b></p> <ul style="list-style-type: none"> <li>➤ Government of Mongolia</li> <li>➤ WHO</li> <li>➤ HPF funds (increase sin tax on tobacco)</li> <li>➤ Other sources (INGOs including faith based NGOs, , Bloomberg Initiatives)</li> </ul>	<p><b>Needs:</b></p> <ul style="list-style-type: none"> <li>➤ Clinical skills, e.g Health and nutrition counselling</li> <li>➤ More tools on physical activity/ exercise e.g video</li> <li>➤ Technical collaboration on development of national preventative strategy</li> <li>➤ Technical collaboration on implementation of healthy food in the park</li> <li>➤ Financial Resources</li> </ul> <p><b>Sources:</b></p> <ul style="list-style-type: none"> <li>➤ Special societies / professional group</li> <li>➤ DOH</li> <li>➤ Singapore experience</li> <li>➤ Australia experience</li> <li>➤ Government</li> <li>➤ Private Sector (CSR, Foundation, PPP)</li> <li>➤ International Donors' Support</li> </ul>	<p><b>Technical support needed:</b></p> <ul style="list-style-type: none"> <li>➤ Documentations, guidelines of WHO, other countries</li> <li>➤ Best practice on salt intake of other countries</li> <li>➤ Study tour in abroad on successful model on reduction salt intake</li> <li>➤ National survey for measurement of salt intake by urine.</li> <li>➤ Experience on develop and monitor food labelling, food with low salt.</li> <li>➤ Multisectoral collaboration</li> </ul> <p><b>Sources:</b></p> <ul style="list-style-type: none"> <li>➤ National target program on school health, NCDs.</li> <li>➤ WHO, NGO</li> <li>➤ Others?</li> </ul>
<b>Target and indicators</b>	<ul style="list-style-type: none"> <li>➤ Tobacco prevalence – 10% reduction</li> <li>➤ Tobacco prevalence in men – 20% reduction</li> <li>➤ Tobacco prevalence in women – to be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>➤ Maintain current level of overweight and obesity (27%)</li> <li>➤ Increase in per capita vegetable consumption from 111.0 g/day to 133.0 g per day</li> </ul>	<ul style="list-style-type: none"> <li>➤ An approved national multisectoral action plan by 2012</li> <li>➤ Raised awareness of the population (60% by 2015, 80% by 2020)</li> <li>➤ Reduced salt in industry food (10% by 2015,</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Tobacco prevalence in young people - to be confirmed</li> <li>➤ Exposure to second-hand smoking - to be confirmed</li> <li>➤ Import level of tobacco products - to be confirmed</li> <li>➤ Export level of tobacco products - to be confirmed</li> <li>➤ Number of retails points around schools - to be confirmed</li> <li>➤ Number of smoke free cities and provinces - to be confirmed</li> </ul>	<ul style="list-style-type: none"> <li>➤ Decrease prevalence of adults with physical inactivity by 10% from 60.5% to 50.8 by 2016</li> </ul>	<ul style="list-style-type: none"> <li>➤ 20% by 2020)</li> <li>➤ Average salt consumption = 10g/day in 2015, 9g/day in 2020 (baseline = 10.8g/day in 2012)</li> </ul>
<b>How to get endorsement of MSA plan for NCD</b>	<ul style="list-style-type: none"> <li>➤ To be endorsed by the Cabinet</li> <li>➤ MOU for 4 years with each sector (Cabinet term)</li> </ul>	<b>DOH-NCDPC</b> <ul style="list-style-type: none"> <li>➤ Organize TWG</li> <li>➤ Prepare Concept Paper</li> <li>➤ Multisectoral Consultations</li> <li>➤ Endorse to DOH Secretary</li> <li>➤ DOH Sec. to present to social development cluster of Cabinet</li> <li>➤ President issues EO</li> </ul>	<ul style="list-style-type: none"> <li>➤ Multisectoral committee have meeting to discuss on NMP.</li> <li>➤ Consultation with relevant sectors from beginning of developing NMP.</li> <li>➤ Advocacy</li> <li>➤ Approval from the highest office /Cabinet/Prime Minister</li> </ul>
<b>What are the institutional mechanisms for coordination and implementation?</b>	<p><b><u>Coordinating Body</u></b></p> <ul style="list-style-type: none"> <li>➤ Chair -Deputy Prime Minister</li> <li>➤ Members – Vice ministers of participating ministries</li> </ul> <p><b><u>Technical Committee</u></b></p> <ul style="list-style-type: none"> <li>➤ Chair- Vice Minister for Health</li> <li>➤ Members -Technical officers from participating ministries and agencies</li> </ul>	<p><b>Permanent NCD Multisectoral Taskforce</b></p> <ul style="list-style-type: none"> <li>➤ To provide policy directions, oversee implementation and M &amp; E</li> </ul> <p><b>Committees, Thematic (Healthy Workplace, Health Promoting School, Healthy Park, Healthy Cities)</b></p> <ul style="list-style-type: none"> <li>➤ Advocacy</li> <li>➤ Plan and Program Development</li> <li>➤ Research and Surveillance</li> <li>➤ Monitoring and Surveillance</li> </ul>	<ul style="list-style-type: none"> <li>➤ Multisectoral Steering Committee, Working group established.</li> <li>➤ Leader: MoH</li> <li>➤ National Multisectoral Steering Committee have annual meeting. Group working monthly.</li> <li>➤ Budget mechanism:</li> <li>➤ + All sectors have to allocate budget for their activities,.</li> <li>➤ + National school health program, NCDs program, WHO, NGOs etc.</li> </ul>

## EVALUATION OF THE CONSULTATION

### A. Questionnaire

# Evaluation of the Regional Meeting on National Multisectoral Plans for NCD Prevention and Control

11-14 June 2012

This questionnaire aims to know your impressions and learnings in the Regional Meeting on *National Multisectoral Plans for NCD Prevention and Control*.

This evaluation takes about 10 minutes to complete and this outcome will be used to identify the achievements by the participant and to help us improve joint meeting designs and content.

We sincerely appreciate your very kind assistance.

(Please check)

I was

☐ a participant

☐ a facilitator/a resource person

☐ an observer

☐ secretariat

# Questionnaire 1

What was your overall impression of this meeting?

Please rate your impression of this meeting by filling the applicable number.

1: Excellent 2: Good 4: Not very good 5: Not good

5~1

## **A. The participation in this meeting was**

Comments, if any,

## **B. The facilitation in this meeting was**

Comments, if any,

## **C. The leadership in this meeting was**

Comments, if any.

## **D. Transport for the meeting was**

Comments, if any,

## **E. Facilities of this meeting was**

Comments, if any,

## **F. Accommodation of this meeting was**

Comments, if any,

## **G. Meals of this meeting were**

Comments, if any:

## **H. The overall impression of this meeting was**

Comments, if any:

## Questionnaire 2

Please rate your achievement by filling the applicable number.

1: Excellent 2: Good 4: Not very good 5: Not good

### **Day 1“Overview and situational analysis”**

5~1

- a. to understand the objectives
- b. to participate in discussion (i.e., questions, analyses, or remarks)
- c. to collect information
- d. to exchange views and information in group discussion
- e. to learn from the experience of other countries
- f. Please add any specific experience/learning you achieved.


### **Day 2 “Path forward for MSA and learning from the field”**

5~1

- a. to understand the objectives
- b. to participate in discussion (i.e., questions, analyses, or remarks)
- c. to collect information
- d. to exchange views and information in group discussion
- e. to learn from the experience of other countries
- f. Please add any experience/learning you achieved.


### **Day3“Roles and responsibilities of sectors and next steps”**

5~1

- a. to understand the objectives
- b. to participate in discussion (i.e., questions, analyses, or remarks)
- c. to collect information
- d. to exchange views and information in group discussion
- e. to learn from the experience of other countries
- f. Please add any experience/learning you actually achieved.


### **Day4“Draft global NCD action plan and set of NCD voluntary global targets”**

5~1

- a. to understand the objectives
- b. to participate in discussion (i.e., questions, analyses, or remarks)
- c. to collect information
- d. to exchange views and information in group discussion
- e. to learn from the experience of other countries
- f. Please add any experience/learning you achieved.


## Questionnaire 3

Please let us know your comments and suggestions. Please provide a maximum of 5 comments per question.

1. How can your sector/department/agency contribute in the national multisectoral plans for NCD prevention and control?
2. What are the additional support/information that will help you to do this work?

## B. Results

### QUESTIONNAIRE 1

	Excellent	Good	Not very good	Not good
The participation in this meeting was	47%	53%	0%	0%
The facilitation in this meeting was	58%	39%	3%	0%
The leadership in this meeting was	65%	35%	0%	0%
Transport for the meeting was	33%	63%	7%	0%
Facilities of this meeting was	50%	50%	0%	0%
Accommodation for this meeting was	70%	30%	0%	0%
Meals of this meeting were	56%	44%	0%	0%
The overall impression of this meeting was	53%	47%	0%	0%

### QUESTIONNAIRE 2

	Excellent	Good	Not very good	Not good
<b><i>Day 1 "Overview and situational analysis"</i></b>				
to understand the objectives	61%	39%	0%	0%
to participate in discussion (i.e., questions, analyses, or remarks)	30%	70%	0%	0%
to collect information	27%	73%	0%	0%
to exchange views and information in group discussion	35%	65%	0%	0%
to learn from the experience of other countries	45%	55%	0%	0%
<b><i>Day 2 "Path forward for MSA and learning from the field"</i></b>				
to understand the objectives	47%	53%	0%	0%
to participate in discussion (i.e., questions, analyses, or remarks)	39%	61%	0%	0%
to collect information	30%	70%	0%	0%
to exchange views and information in group discussion	32%	68%	0%	0%
to learn from the experience of other countries	40%	60%	0%	0%
<b><i>Day3 "Roles and responsibilities of sectors and next steps"</i></b>				
to understand the objectives	42%	58%	0%	0%
to participate in discussion (i.e., questions, analyses, or remarks)	31%	69%	0%	0%
to collect information	29%	71%	0%	0%
to exchange views and information in group discussion	28%	72%	0%	0%
to learn from the experience of other countries	30%	70%	0%	0%



***Day4 "Draft global NCD action plan and set of NCD voluntary global targets"***

to understand the objectives	44%	56%	0%	0%
to participate in discussion (i.e., questions, analyses, or remarks)	22%	78%	0%	0%
to collect information	25%	75%	0%	0%
to exchange views and information in group discussion	25%	75%	0%	0%
to learn from the experience of other countries	17%	80%	3%	0%

**Feedback on Questionnaire 3**

**1. How can your sector/department/agency contribute in the national multisectoral plans for NCD prevention and control?**

Participants

- Coordinate with MOH to initiate MSA on NCD
- Increase the quality of food, make sure it is healthy
- Optimise the structure of food, make sure some people have enough nutrition
- Increase the income of people, make sure people can buy high quality food
- Guide the tobacco farmer to plant other food – grants if they give up tobacco production
- Commitment in terms of:
  - Provide dedicated staff to ensure implementation of the NHP
  - Provide budget support to activities under the NHP
  - Institutionalise the NHP as a policy initiative
  - Sustained leadership
- Engage the local chief executives eg Metropolitan Manila: the 17 mayors are the policy makers of the Metro Manila Development Authority (MMDA)
- Solicit support of the local chief executives through approval of a resolution in support of the national multisectoral plan on NCD
- MMDA as an active partner of the department of Health on advancement of NCD prevention and control
- Assist in the advocacy campaign by providing existing MMDA structures for the display of IEC materials on NCD prevention and control
- Utilising the existing partnerships of MMDA in the enforcement of smoke-free policy towards advancement of NCD prevention and control

- By advocacy and using win-win approaches and shared goals in order to persuade non-health sectors to take up NCD prevention and control in their programmes and initiatives
- MOH
  - Head agency
  - Provide guidance and expertise to other non-health sectors
  - Health sector must know negotiation and social marketing skills in order for other non-health agencies to “buy-in”
  - Socialise the issue first to the public as well as other non-health agencies
  - Draft the national NCD action plan
- NCDs and their risk factors – advocacy to non-health sectors
- Leadership in NCD multisectoral action plans
- The health sector will definitely lead and initiate the multi-sectoral planning and implementation to prevent and control NCD. The health sector has the responsibility to engage other sectors to address the determinants of NCD.
- As part of a non-health sector:
  - We will include NCDs as targets for our sector
  - We will always mobilise our own stakeholders to advocate for the prevention of NCDs
- Happy to share experiences through learnings
- Coordination with other sectors about NCD prevention and control plan in our country
- Involve all of NCD preventions and control contents into subject of the main curriculum of education system
- Continue to implement all of the ways to prevent NCD and risk factors: safe food and good nutrition; no smoking in schools and more physical activity in schools.
- Establish multisectoral steering committee for NCD
- Stronger coordination of MOH
- Roles/responsibilities are very specific
- Budget to implement MSA
- The role of multisectoral mechanisms in preventing NCD
- To socialise the plan with non-health sectors

- To assist them in gathering the non-health sectors to meet
- To discuss the plan at the senior government level
- Through:
  - Council of Ministers
  - MOH
  - Education
  - Sport
  - Local government
- Report to the Minister on the NMP-NCD for supporting
- Set up the working group and role relevant NMP-NCD
- Prepare guideline
- Give awareness to private sector and SHEs association.
- Provide more evidence for policy-makers process
- Technical support
- Strengthening surveillance and information systems
- Contribute by participation to develop inter-ministerial framework
- Increase awareness of people
- Convince civil society or other ministries to support
- Mass media campaign
- Develop regulation for manufacturing products
- By:
  - Expand members of technical working group on NCD with relevant minister's concerned.
  - Identify role of each ministry in responding to NCD risk factor prevention
  - Develop action plan of each ministry related to the reduction of NCD risk factors (tobacco, alcohol, unhealthy food and physical inactivity)
  - Combine action plan into national NCD action plan and advocacy for political commitment on NCD prevention and control
  - Submit to Prime Minister's Cabinet for approval
- Consolidating the steering committee of NCDs prevention program to promote ISA

- Promoting and coordinating with relevant ministries and sectors to develop, improve and promulgate the policies, strategies and plans in order to address economic and social causes of NCDs. (Develop NCD prevention strategies under the preventive health system for the period 2012-2020, making NCD prevention policy in schools, policies relating to reducing consumption of salt and salt in food)
- Developing and implementing programmes of the health sector on prevention of NCD risk factors (Developing HP models)
- Raising awareness and promoting risk behavioural change through health communication and education

#### Secretariat/observers

- Excellent coordination and convening role
- Building partnerships
- Sharing info and knowledge
- Help build capacity
- By bringing together formal, informal, grassroots and formal sectors into this mission is what we strive to do
- By advocating and voicing out for transparent collaboration and involvement of industrial and trade sectors, especially private sector
- We are willing to work with the government and NGOs for NCD action on prevention and control
- Support government to develop MSA plans for NCD prevention and control
- Be proactive to engage other sectors
- Raise importance at higher level in sense of national context
- Advocacy to raise funds
- Resource mobilisation
- Strong commitment
- We can contribute in the following ways:
  - Development of plans, by bringing in the perspectives of civil society and those outside of government structures, as well as the perspectives of communities
  - Implementation of plans by mobilising our networks as well as ongoing/future programs to address NCD issues
  - Advocacy and M&E of plans if engaged

## **2. What are the additional support/information that will help you to do this work?**

### Participants

- MSA on NCD plan from high level such as Minister of MOH of each country
- Health department must find the common interests with other sectors
- Have a larger view for this work – improve other departments to do the work in relation with the NCD
- Political declarations from WHO, eg WHA reports, etc
- Provision of IEC materials for distribution to local government units, and display along major thoroughfares
- Technical expertise in presentation of the NCD program/plan to officials of the local governments
- Capacity building by the team engaged in tobacco control
- Open communication lines to orient us on the updates and happenings about NCD around the Western Pacific Region and the world
- Access to information on research and surveillance
- Computerise data on NCDs (DALYs, mortality, financial burden, economic considerations)
- Clear cut framework on the prevention and control of NCDs (policy guidance at global, regional and country level)
- Basic marketing concepts and strategies (as experienced by other countries)
- Capacity building, and bilateral arrangements with some of the countries who have developed “successful” programmes eg Singapore, Australia etc
- More staffs who are competent, skilled, hard-working and committed in carrying out this job
- Each country has their own situation - appropriate MSA approach should be chosen according to the situation in their respective country
- We can learn from each other, and help others in this field.
- We need to experience and technical expertise of the global community in terms of MSA
- Technical expertise
- Capacity building
- Facilitate experience sharing among member states

- Stronger commitment of members of government on NCDs prevention and control
- More budget from government and more funds from WHO, NGOs etc.
- Technical support from WHO on NCD prevention and control
- Global Strategy for NCD
- Action plan for NCD of WHO
- “Best buy” on NCD by multisectoral mechanism
- Political commitment
- Statistical evidence on NCD
- The need for concrete proposals or plans
- Share more experiences of health surveillance and information systems in other countries
- Best-buys of other countries
- Experience sharing based on website?
- Need WHO to engage Minister of Health to agree the objective of WPRO
- Need model strategy of development country
- Need all health partner support
- Need multi-sectoral support, and monitoring the result
- Health impact assessment on urbanization effect on NCDs risk factors (related to transport, infrastructure, food processing & beverages)
- Financial support to implement the action plan
- Regulation to scale up NCDs action
- Develop national NCD norms in order to evaluate the progress of MSA
- Negotiate with UN organisations and others partnerships (eg Bloomberg, Gates) to support NCD programmes.
- Guidance document on risk factor prevention, techniques and processes to implement early detection, prevention management, counselling in the community.
- Training to improve capacity of preventative medicine network in prevention of NCDs, such as officials to study and exchange experiences.
- Establishing a surveillance network for NCDs and risk factors in the community, which bases on integrating into available surveillance systems
- Funding

#### Secretariat/observers

- Compilation of all papers and presentations
- Cooperation, collaboration and inclusion of NGOs into government planning and action
- Indicate more detailed steps/roadmap to establish comprehensive MSA plans for NCD prevention and control
- In the future, continued inter-country exchange will be very helpful
- Involvement and engagement in various relevant for a for us to better understand the issues, needs and gaps, and how/where we can fit in/contribute.
- Global action (2013-2020)
- Technical support from WHO
- Raise awareness of UN agencies at country level
- Information sharing among countries
- Tools for engagement of other sectors (negotiating & communication skills)

---

# MULTI-SECTORAL ACTION TO ADDRESS NONCOMMUNICABLE DISEASE IN THE WESTERN PACIFIC REGION:

## LEARNINGS AND OPPORTUNITIES

---

WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC

REGIONAL MEETING ON NATIONAL MULTISECTORAL PLANS FOR NCD  
PREVENTION AND CONTROL

---

KUALA LUMPUR, MALAYSIA

10-14<sup>TH</sup> JUNE 2012

---

BACKGROUND PAPER

---



---

## TABLE OF CONTENTS

---

List of Acronyms.....	3
1. Introduction .....	4
2. Why do we need MSA for NCD prevention and control? .....	4
3. What is MSA? .....	5
4. MSA in the Western Pacific Region.....	6
4.1 National level approaches in the Region .....	6
4.2 Sub-National & Local approaches .....	10
4.3 MSA for specific NCD risk factors.....	12
5. What are the barriers and challenges for MSA? .....	17
6. Approach to MSA .....	19
6.1 Steps for MSA.....	19
6.2 Elements for success .....	21
7. Entry points and opportunities .....	23
7.1 Building upon existing structures .....	24
7.2 Working with the Private Sector .....	24
7.3 Civil society/NGOs.....	24
7.4 Disasters & special events.....	25
7.5 International partnerships .....	25
7.6 Identifying common interests & co-benefits .....	26
7.7 Making the case for MSA – the power of stories.....	26
7.8 Role of the health sector: Initiating vs enabling? .....	27
Annex 1 Resources .....	28
Annex 2 References .....	31

## LIST OF ACRONYMS

ALAC	Alcohol Advisory Council
DHB	District Health Board
FCTC	Framework Convention on Tobacco Control
HIA	Health Impact Assessment
HIA	Health Impact Assessment
HiAP	Health in All Policies
HPB	Health Promotion Board
HPC	Health Promotion Centre
ICAP	International Center for Alcohol Policies
Lao PDR	People's Democratic Republic of Lao
LBD	Let's Beat Diabetes
MHLW	Ministry of Health, Labour and Welfare
MSA	Multi-sectoral action
NCD	Noncommunicable Disease
NEHAP	National Environmental Health Action Plan for Cambodia
NGO	Non-government organisation
NSAP-TC	Cambodia National Strategic Action Plan for Tobacco Control
SEATCA	Southeast Asia Tobacco Control Alliance
SMHPC	Shanghai Municipal Health Promotion Committee
UN	United Nations
VAT	Value Added Tax
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

---

## 1. INTRODUCTION

---

Noncommunicable diseases (NCDs) and their four main risk factors are responsible for an estimated 30,000 deaths every day in the Western Pacific Region and constitute one of the critical development challenges for the 21st century. NCDs are a serious threat to the economies of many Member States and are likely to increase inequalities. Through the Political Declaration on NCDs (1), Heads of State and Government and their representatives committed to: establish or strengthen, by 2013, national multisectoral policies and plans for NCDs, taking into account the Global Strategy for the Prevention and Control of NCDs (endorsed by the World Health Assembly in 2000) and its Action Plan (2008).

To assist countries in developing these national multisectoral policies and plans for NCDs, this paper describes examples of multi-sectoral action (MSA) on NCD from around the Western Pacific Region. It considers approaches at a national level, as well as activities at a sub-national or local level. It also describes MSA in relation to the four main NCD risk factors: unhealthy diet, physical inactivity, tobacco use and alcohol consumption. The paper synthesises some of the common themes, methods, challenges and opportunities that emerge from these experiences, and highlights key elements of successful approaches.

---

## 2. WHY DO WE NEED MSA FOR NCD PREVENTION AND CONTROL?

---

Preventing and controlling NCD is an urgent priority for all countries in the Region. Crucially, most of the drivers of NCDs and their risk factors lie outside the control of the health sector. The health sector alone cannot adequately prevent and control NCD. Multi-sectoral action is required to create enabling environments, in homes, villages and cities, so that healthy choices are the easy choices. To achieve this, action is required in domains such as trade, food and pharmaceutical production, agriculture, urban development, pricing, advertising, information and communication technology and taxation policies (2). Multi-sectoral action is required to break the cycle of poverty and NCDs. The prevention and control of NCDs and their risk factors have a positive impact not only on health, but also on productivity and economic and social development.

Multi-sectoral action is required to implement a number of the “best buys” identified by WHO for NCD prevention and control (Table 1). These best buys are interventions with compelling evidence for cost-effectiveness that are also feasible, low-cost and appropriate to implement within the constraints of the local health system (3). Policy-makers can consider best buys as a core set of multisectoral interventions that are a priority to bring to scale.

**Table 1 - "Best Buys" for NCD Prevention and Control**

NCD core intervention set (best buys)		
Population-based interventions addressing NCD risk factors	Tobacco use	<ul style="list-style-type: none"> <li>- Excise tax increases</li> <li>- Smoke-free indoor workplaces and public places</li> <li>- Health information and warnings about tobacco</li> <li>- Bans on advertising and promotion</li> </ul>
	Harmful use of alcohol	<ul style="list-style-type: none"> <li>- Excise tax increases on alcoholic beverages</li> <li>- Comprehensive restrictions and bans on alcohol marketing</li> <li>- Restrictions on the availability of retailed alcohol</li> </ul>
	Unhealthy diet and physical inactivity	<ul style="list-style-type: none"> <li>- Salt reduction through mass media campaigns and reduced salt content in processed foods</li> <li>- Replacement of trans-fats with polyunsaturated fats</li> <li>- Public awareness programme about diet and physical activity</li> </ul>

Source: (3)

Governments have a key responsibility to coordinate action across sectors, if the NCD crisis is to be averted. The recognition of whole-of-government responses by the Political Declaration on NCDs highlights the responsibilities and opportunities of government to lead and facilitate actions of many sectors (3). However, governments cannot do this alone – action also needs to come from the private sector, community organisations and international organisations, and effective partnerships are required to ensure that co-benefits are maximised.

### 3. WHAT IS MSA?

Working together across sectors to improve health and influence its determinants is often referred to as *multi-sectoral action on health*. A number of terms are used, often interchangeably, for engaging sectors outside of health. These include: intersectoral action for health, multi-sectoral action, whole-of-government, health-in-all-policies, and healthy public policies (3). This paper uses the term “multi-sectoral action” in line with its use in the Political Declaration on NCDs.

International experience indicates that governments can make substantial achievements in reducing the disease burden, disabilities, and premature mortality caused by NCDs through multisectoral approaches (4). While experience is still emerging, preliminary evidence shows that strengthening commitment to address NCDs and forging new collaborations and partnerships to do so are critical to making progress. Partnering can occur among and through different stakeholders (4):

- Individuals, families, and communities
- Government, communities and NGOs (including religious institutions, civil society, academia, media, voluntary associations)
- Governments, the development partner community (within countries), as well as with civil society and, as appropriate, the private sector

Countries in the Western Pacific Region are approaching the NCD challenge from very different starting points. The priority issues and opportunities/entry points to initiate MSA vary. MSA on NCDs is highly influenced by context. There is no “one-size-fits-all” approach, and the types of effective approaches and processes vary between different socio-political contexts. An approach that works

well in one country or with one issue, may not work in another. It is therefore of limited use to offer countries prescriptive step-by-step instructions on how to implement MSA on NCDs. There are however multiple examples of countries around the Region who have successfully undertaken MSA for NCDs.

## 4. MSA IN THE WESTERN PACIFIC REGION

### 4.1 NATIONAL LEVEL APPROACHES IN THE REGION

#### Key messages:

- A high-level national government plan or vision can be a useful foundation for developing national MSA for NCD.
- Many countries have existing multi-sectoral mechanisms for health that could be used.
- Existing HiAP or Healthy Islands approaches are well suited to be applied to the prevention and control of NCD.
- Having a national multi-sectoral mechanism for identifying priorities and actions is helpful for multiple “complex” problems beyond NCDs.
- Some countries have developed a national multi-sectoral strategy for NCD overall, others have started with particular NCD priorities such as tobacco or nutrition.
- Some countries have used a very centrally led approach, where others devolve more responsibility for integrated planning and implementation to local bodies.
- Countries in the Region have developed multiple approaches for sharing accountability across sectors.

Multi-sectoral partnerships can take many forms, and can include partnering with communities, NGOs, local governments, and the private sector. Not all MSA on NCD occurs at the national level, however national level collaborations and partnerships are vital, because priority setting and resource allocation occurs at this level (4).

National strategies for MSA on NCD across the Region broadly fall into two categories:

- A whole-of government or “*Health in all policies*” approach, which integrates a systematic consideration of health concerns into all other sectors’ routine policy processes.
- More issue-centred approaches, aiming to integrate specific health concerns into relevant sectors’ policies, programmes and activities.

#### WHOLE OF GOVERNMENT OR “HEALTH IN ALL POLICIES” APPROACHES

A whole-of-government or “health-in-all-policies” strategy aims to integrate a systematic consideration of health concerns into all other sectors’ routine policy processes, and identify approaches and opportunities to promote better quality of life (5). It is important to note that terms such as “Health in All Policies” (HiAP) can work well in some settings, but can be problematic in others. HiAP can be seen as health-centric, with the health sector imposing their objectives on other sectors. MSA for NCD needs to seek out opportunities for enabling other sectors to achieve their objectives in a way that supports better health outcomes.

Brunei Darussalam’s **Health Promotion Blueprint 2011-2015** (6) has been developed to fulfil one of the three aims outlined in the National Vision for 2035: for the country to be recognised for its

quality of life. The Blueprint sets out a number of strategic objectives for the prevention and control of NCDs and the promotion of healthy lifestyles:

1. Establishing and strengthening health in all policies across Government, where relevant public policies will need to be strategically aligned and more inclusive of health and well-being outcomes;
2. Developing effective, quality and innovative health promotion programmes, particularly to address risk factors for NCDs;
3. Enhancing inter-sectoral collaboration and partnership between Government agencies, NGOs, private sector, civil societies and communities in the implementation of specific initiatives; and
4. Developing and enhancing skills and competencies in health promotion.

At the national level, an inter-sectoral mechanism on health promotion already exists: the National Committee on Health Promotion. This multi-sectoral committee is currently chaired by the Minister of Health and its members include representatives from several government agencies, non-government agencies and the private sector.

#### **Health in All Policies - South Australia**

Acknowledging that the best opportunities to influence health lie outside the direct control of the health sector, the Government of South Australia adopted Health in All Policies (HiAP) as part of its Strategic Plan - the Government's overarching vision to which all government agencies were accountable. Oversight for HiAP was placed with a supra-ministerial committee (the Executive Committee of Cabinet) reflecting the importance of the work. The HiAP health lens analysis process builds on traditional health impact assessment methodology and provides a mechanism for collaborative work to achieve goals of different sectors in a way that is also good for health. Key to this approach is the understanding that Health in All Policies works on the issues of other sectors, not just health issues in these sectors. Investing in building strong inter-sectoral relationships provides an opportunity to explore some of the interconnections between strategic targets, and to identify joint areas of work to achieve a win-win solution (7).

In the Pacific, a vision of "Healthy Islands" has proven to be a powerful unifying driver for taking a more holistic approach to health and environmental wellbeing (8). This could equally be applied to take a HiAP approach to the prevention and control of NCD.

Having a national multisectoral mechanism for identifying priorities, and determining a coherent plan of action, can be useful for many issues (beyond NCD). Many of the major development challenges facing low and high income countries alike (eg climate change, economic crises, urbanisation) do not fit neatly in the realm of a single sector. These complex or 'wicked' problems require a multi-sectoral assessment and response, and a single national co-ordination mechanism could be set-up to address many of these problems as an ongoing governance structure.

#### **OTHER NATIONAL LEVEL APPROACHES**

Alternatively, a narrower, more issue-centred strategy can be used where the goal is to integrate a specific health concern into other relevant sectors' policies, programmes and activities (5). There are a number of examples from around the Region, where countries have developed a national multi-sectoral strategy either for NCD overall, or for particular NCD priorities such as tobacco or nutrition. These examples emphasise the need for the policy response to be built out of the local context - for instance the strong family structure in Philippine society is used as a core element of the response in the country. Other examples reflect the degree of comfort in the society with

centrally planned interventions. Understanding a society's political economy is a crucial step in designing what sort of approach would be most successful.

As an example of a centrally-led approach, Malaysia's **National Strategic Plan for Non-Communicable Disease 2010-2014** (9) targets the major common NCD risk factors in a comprehensive and integrated way:

"Prevention, control and management of Cardiovascular Disease and Diabetes will be made accessible for all population with participation in partnership with various stakeholders and integrated into the social, economic and environmental systems to establish a robust platform for effective reduction of these diseases."

Many activities in the national strategic plan fall outside the mandate of Ministry of Health. Therefore, to help implement the strategy, the "Cabinet Committee for A Health Promoting Environment" was created. This committee is chaired by Deputy Prime Minister, and includes 10 other Ministers from various sectors. The plan outlines the key roles that various sectors have in addressing NCDs. For example, the Ministry of Agriculture is requested to promote the availability of fresh local fruits and vegetables, via subsidies for farmers and to hold more regular agricultural fairs. The Ministry of Information, Communication, Arts and Culture is tasked with regulating the advertising of unhealthy food/drinks to children, and the Ministry of Domestic Trade, Co-operation and Consumerism is responsible for using regulations and fiscal measures as a barrier to consuming unhealthy food and drinks.

In other countries, the approach to MSA for NCD is centrally co-ordinated but more locally implemented. The Philippines' **National Policy on strengthening prevention and control of lifestyle related NCD** (10) is centred around promoting an integrated approach to NCD prevention at the family and community level. Responsibility for personal health services has been devolved to local government units, and this strategy argues that the same should apply to NCD prevention. The Department of Health takes lead, to develop a national program and plan of action for prevention and control of lifestyle-related NCDs, and then advocates/provides template for this program to be integrated into the annual health action plans of local government units and other partners. The Department of Health will also focus on developing grassroots community partnership and participation, to "establish broad base of support" for planned interventions.

Some countries have used specific NCD issues as the focus for multi-sectoral planning. Cambodia's **Health Strategic Plan 2008-2015** (11) notes that NCDs are expected to increase, and "the Ministry of Health needs to become a focus for inter-ministerial coordination to bring disease prevention aspects into policy formulation work in all ministries." In Cambodia, NCD related strategic plans currently being developed include: the National Strategic Plan for Non-Communicable Diseases 2007-2010, National Environmental Health Action Plan for Cambodia 2007-2010 (NEHAP), Mental Health Strategic Plan 2008-2012, and the Cambodia National Strategic Action Plan for Tobacco Control 2006- 2010 (NSAP-TC). The draft National Strategic Plan for Non-Communicable Disease provides the overarching framework for all NCD planning. The NSAP-TC and NEHAP are multi-sectoral plans, engaging not only the Ministry of Health but also other Ministries and National Authorities, including Environment, Education, Labour, Commerce, Justice, Water Resources, National Assembly, and the National Disaster Management Committee.

Other countries demonstrate the opportunity for growing the NCD agenda as an extension of an existing health agenda. Whilst the focus of the People's Democratic Republic of Lao's **National Nutrition Policy 2008** (12) is currently on under-nutrition, the approach outlined in the policy

provides an equally applicable framework to address emerging NCDs. Key principles of the policy include:

- Decentralization: bottom-up planning supported by increased implementation at provincial and district level;
- Integration and effective cooperation: integrating nutrition interventions into all relevant sectors;
- Institutionalizing nutrition within government: establishing coordination mechanisms for planning, implementation, management and monitoring of the nutrition program;

By Prime Ministerial decree, the Lao Ministry of Health is responsible for coordinating with other Ministries, concerned organizations, and local authorities at all levels on nutrition, in order to implement effectively the National Nutrition Policy.

Mongolia has consolidated several diffuse national strategies into an overarching national response to NCD. Mongolia's **National Programme on Integrated Prevention and Control of Noncommunicable Diseases 2007** (13) directs the Minister of Health, Minister of Finance, Minister of Food and Agriculture and the Governors of Capital City and provinces to contribute funds towards implementing the programme. Several separate national programs had previously been implemented in Mongolia to combat with the increasing number of NCDs. Mongolia found that this approach, based on multiple strategies for separate NCD risks/conditions, was a poor use of a limited budget and capacity, and was exacerbated by a lack of cooperation between agencies. Therefore, in line with WHO recommendations, this new strategy represents a move from old risk/disease specific approaches towards integrated NCD risk factors prevention and control addressing several risk factors. In order to create sustainable mechanism for coordination and to improve participation of other sectors, the National Council of Public Health will be responsible for overall coordination with other stakeholders in implementing the programme. Local Sub-councils of Public Health headed by the local Governors will be responsible for management, coordination and monitoring of the programme at the local level.

Mongolia's plan outlines extensive specific responsibilities for other sectors – eg the Foreign Affairs Ministry is to reflect national NCD policy in contracts with foreign donors, the Ministry of Justice is to intensify implementation of alcohol control objectives, and Ministry of Finance is to implement tax/pricing incentives to reduce consumption of tobacco, alcohol and unhealthy foods. This list includes the military, private sector (eg food industry) and mass media. It is unclear how these requirements will be enforced or enacted for those partners who are not government agencies.

In developing Hong Kong's **Strategic Framework for Prevention and Control of Non-communicable Diseases** (14), an important initial task was to set a clear vision, to provide focus and remind people of the long-term purposes of their work. The following vision was developed:

"Hong Kong will have a **well-informed population** that is able to take responsibility for their own health, **a caring community** that integrates public and private sectors to ensure healthy choices for the public, **a competent healthcare profession** that views health promotion and preventive medicine as priorities, and a **sustainable healthcare system** that incorporates strong elements of health promotion, disease prevention and curative care for our people, thereby **significantly reducing the toll of disease burden including disability and premature death related to NCD.**"



## 4.2 SUB-NATIONAL & LOCAL APPROACHES

### Key messages:

- MSA for NCD has also been successfully used at a sub-national level in the Region, either as an adjunct to or in the absence of national action.
- Successful local approaches commonly have a high-level local political leader (eg mayor) to champion the cause.
- Existing Healthy Cities networks and Healthy Villages models provide a strong starting point to enhance local MSA on NCD.
- Local approaches are often led by municipal authorities, rather than the health sector.

Intersectoral approaches have also been successful at a local level. Sub-national leadership can be particularly important in a diverse and decentralized country. For example, a number of cities in the Region have demonstrated the important role that local governments can play in promoting smoke-free environments, especially if there is weak national tobacco control.

In Japan, Kanagawa became the first prefectural government to pass a local ordinance to restrict smoking in indoor public places in March 2009 (15). It acted in the absence of effective national tobacco control measures to protect people from exposure to second-hand tobacco smoke. The ordinance aims to protect people from the negative health impacts of second-hand smoke. Its rapid enactment benefited from the political leadership of the governor as well as intensive communication between the government and a wide range of stakeholders in Kanagawa and beyond. The smoke-free efforts of Kanagawa could facilitate smoke-free action by other subnational and national governments for healthier environments.

### HEALTHY CITIES/VILLAGES

The WHO Healthy Cities Program has encouraged MSA on NCD risk factors in many cities across the Asia Pacific region. There is an active Alliance of Healthy Cities in the region, with members from Australia, Cambodia, China, Japan, Republic of Korea, Malaysia, Mongolia, Philippines and Viet Nam. Members of the Alliance are municipal governments, national governments, NGOs, private sectors, academic institutions, and international agencies. The Alliance promotes the interaction of people and information exchange, research development, and capacity building programs. It also issues Partnership Development awards to acknowledge cities which demonstrate outstanding MSA. Recent awardees include the Health Promotion Board, Singapore, for its successes with partnerships; Sai Kung District, Hong Kong SAR, for extending the breadth and depth of intersectoral partnership through a district-wide holistic health promotion campaign; and Gangnam-gu, Seoul, for developing a partnerships to create a walking-friendly Eounju Street (16).

A “healthy villages” model, such as that being implemented in Lao PDR could be a useful entry-point for building in MSA on NCD. At present, the Lao model focuses on primary health care, sanitation and safe water supply, but this could easily be expanded to incorporate other priority NCD issues. To qualify for a model healthy village, a village should maintain a clean environment and practice basic hygiene principles: having safe water, eating well cooked food and maintaining clean housing. In addition, primary health care, immunization, safe motherhood practices, medicines, etc, should be available for the village.

## OTHER LOCAL EXAMPLES

Songjiang District in Shanghai established a working mechanism for comprehensive prevention and control of chronic diseases called "government-led, multi-sectoral cooperation and professional support, and social participation"(17). District government formulated a series of supportive policy documents. Measures implemented included health education through media, schools, workplaces and community markets, smoke-free hospitals and schools, In addition, tape measures and measuring spoons to control salt and oil were distributed to homes, and 35km of walking paths were constructed.

### **Let's Beat Diabetes - Auckland, New Zealand**

Let's Beat Diabetes (LBD) is an example of a local level-community partnership multi-sectoral approach, led by the health sector. A wide group of community partners, led by the Counties Manukau District Health Board (DHB) developed a five year district-wide multi-sectoral strategy aimed at long-term, sustainable change to prevent and slow diabetes. It was guided by the basic concept that a '*whole society, whole life course and whole whanau/family*' approach was needed including action on social determinants (18). LBD has been successful in facilitating and supporting a considerable range of collective action and broadened relationships from over 500 partners. These partners range from 'grassroots' community groups, NGOs, and churches, to government agencies, large employers and multinational food companies.

LBD demonstrates the potential for health led MSA action to leverage funding from other sources. A small focus of LBD activity was to encourage the number of community vegetable gardens – this activity drew attention and co-funding from the Ministry of Health, the Ministry of Māori Development and charitable trusts; the local Manukau Institute of Technology developed an accredited horticulture course, the local councils have supported the activity on council controlled land, and neighbouring district health boards are introducing similar projects (18).

LBD also demonstrated some exciting partnerships with the private sector to address the environmental determinants of diabetes. The DHB and food industry representatives collaborated to undertake a range of practical activities, including making sugar-free drink the default option across 21 McDonald's restaurants, which saw a 17% reduction in sugar consumption across the drinks range in 6 months, around 10 tonnes less sugar consumed (18). Other initiatives included fruit and vegetable promotion through a low cost supermarket chain, with pricing discounts, promotional activity and meal preparation demonstrations, as well as agreement by four large dairy providers to work together on increasing milk consumption – but with a greater proportion being low fat milk (18).

### 4.3 MSA FOR SPECIFIC NCD RISK FACTORS

#### Key messages:

- Starting with one NCD risk factor or issue can be an entry point to initiate MSA for NCD.
- Bi-sectoral approaches (eg between health and education) can also be used as a starting point if more comprehensive MSA is difficult.
- A number of countries have worked with the food industry and retailers to make progress with salt and trans-fat reduction – usually led by the health sector.
- For NCD risk factors, MSA addressing both the demand and supply side is important.
- Trade interests can serve as a barrier to implementing MSA on unhealthy food, tobacco and alcohol. Other governments, private corporations and international organisations can be powerful sources of resistance.
- Most MSA for physical activity focuses on promoting physical activity in schools and workplaces. Partnerships for physical activity could be strengthened, especially between ministries of transport, education and public works/infrastructure, to modify built environments.
- Multi-sectoral collaboration has seen smoke-free legislation successfully introduced in a number of countries in the Region.
- There are strong financial arguments for increasing taxation on tobacco and alcohol, making it an easier “win-win” for health and finance sectors.
- The WHO FCTC and existing national MSA structures for tobacco controls, make tobacco control a strong starting point from which to expand MSA for NCD.
- Ministries of Justice and the police are important allies in MSA on alcohol.

### PROMOTING A HEALTHY DIET & SALT REDUCTION

Countries in the region have implemented a range of multi-sectoral strategies to promote a healthier diet, including working with the food industry to reformulate foods, raising consumer awareness/demand for healthy products, labelling and price mechanisms. In terms of improving the nutritional quality of food, a number of sectors could take the lead, including the Ministry of Health, Ministry of Agriculture or Ministry of Trade. The Ministry of Health may have the least power to act, on issues of food standards and taxation. One strategy to take a whole-of-government approach would be to set up a national agency to look not only at biological and chemical contaminants of food (“food safety”), but also at nutritional quality (high level of trans-fat, salt etc) of the food (19).

Some countries in the region have been able to regulate the food industry, such as Singapore’s legislation restricting trans-fat to no more than 2g per 100g product for fats and oils and requiring mandatory labelling trans-fat levels (20). Other countries have been able to work with the food industry (eg Malaysia, China) to implement voluntary labelling and guidelines to reduce the amount of salt, sugar and trans-fat in food. The Malaysian Health Ministry has succeeded in getting major food and drink manufacturers to commit to reducing the salt, sugar and trans-fat content in their products, as well as provide nutritional content labels on the food and drink packaging (21). In 2011 manufacturers agreed to reduce the salt content in 11 food products; and in 2012 will expand this to another five products (ketchup, sauces, biscuits, instant soup and instant noodles). Voluntary codes of practice can be effective, but require monitoring and the threat of legislation. Voluntary systems

are quicker and easier to implement and more flexible. They form part of a cascade of tools ranging from guidelines, codes of practice, self-regulatory measures, to government regulation and enforcement.

However in other countries in the region it can be more difficult to engage with the food industry (eg Viet Nam) (19). This is especially true in countries highly dependent on imported food products from neighbouring countries (eg Brunei Darussalam, Pacific Island Countries). Other governments have bypassed the industry by banning the importation of certain unhealthy food items (eg Samoa banning turkey tail imports). Countries that embark on these strategies must prepare themselves for strong resistance from more powerful exporting nations and industry groups. For example, in response to pressure from the WTO, Samoa has agreed to reverse its ban on turkey tail imports (22). International co-operation across the region is desirable, for example to create multi-national agreements for certain products. In countries such as Lao PDR the context for action on salt is complex – domestic salt producers are lobbying for government help to enhance production (23), salt is given away free to families in health and poverty alleviation programmes, and salt fortification with fluoride and iodine is instrumental to other health and dental programmes (24).

Engaging directly with food retailers has proved successful in a number of countries (eg Singapore, Hong Kong, the Philippines). Singapore has worked to stimulate public demand for healthier food options, to apply bottom-up pressure on the food industry to produce healthier options. In Japan, the Ministry of Health, Labour and Welfare, and the Ministry of Agriculture, Forestry and Fisheries jointly compiled a “Dietary Guidelines for Japanese”, and “Japanese Food Guide Spinning Top” to provide easy-to-understand information on what and how much to eat and thus encourage individuals to follow an appropriate lifestyle.

#### **Promoting demand & supply for healthy food - Singapore**

The Singapore Health Promotion Board (HPB) has worked with independent and chain restaurants to provide healthier dishes (25). The HPB also works with the Ministry of Education to help schools conduct culinary training for tuck-shop vendors and assess food and drinks sold in the tuck-shops. Hawkers are encouraged to use healthier ingredients (e.g. brown rice, whole-grain noodles) and sell those meals at a lower price. In addition the HPB has been gaining the support of local politicians and working with community leaders to generate demand for healthier products (eg educating the public to “ask for less oil” or “ask for the skin to be removed”).

The Healthier Coffeeshop initiative (26), a partnership between the HPB and Bukit Batok East Constituency, has produced Singapore’s first healthy coffeeshop, aiming to make healthy lifestyle choices accessible and affordable for residents. All eight food and beverage stalls are committed to serving healthier choices using more wholesome ingredients such as brown rice, wholegrain noodles and healthier oil, which is lower in saturated fat. The calorie count of these dishes is also displayed at the stalls’ menu boards. For example, the chicken rice is served with brown rice and skinless chicken, and the Muslim dishes are cooked using healthier oil and less salt. The coffeeshop owner is so convinced of the viability of this business model that he is currently working with HPB to convert all nine of his coffeeshops into Healthier Coffeeshops.

Fiji, Samoa, Nauru and French Polynesia have all taken a MSA approach to implementing taxes on sugary drinks (27). Samoa also introduced its 2011 Healthy Food Bill to control imports of unhealthy food (28). Interaction between the Ministries of Health, Finance and Revenue occurred at almost every stage of the policy making process in these countries. In regard to agenda-setting, relevance to government fiscal priorities was important in gaining support for soft drink taxes. However, the active involvement of health policy makers was also important in initiating the policies, particularly

in Nauru and French Polynesia. The use of existing taxation mechanisms also appeared critical for success.

#### **Multi-sectoral action on salt: Shanghai, China**

In 2008, multi-sectoral salt control action was launched by the Shanghai Municipal Health Promotion Committee (SMHPC) (29). The project involved a range of government departments, organizations and citizens in the city. In early 2008, the multi-sectoral cooperation mechanism was established leading by SMHPC, including Shanghai Municipal Health Bureau, Shanghai Municipal Medical Insurance Bureau, Shanghai Municipal Education Committee, Publicity Department of the CPC Shanghai Municipal Committee and Shanghai Municipal Administration of culture, radio, film and TV. Shanghai Municipal Transportation Bureau ran non-profit advertising for salt control on television screens in the subway in rush hour. Major cinema chains played non-profit advertising for salt control in conjunction with movie trailers. Control spoons which can contain two grams of salt were delivered to 6 million families by Shanghai Post Company in one month. Shanghai Municipal Education Committee distributed control salt spoons in all primary schools in Shanghai. Workplaces and restaurants also received spoons and participated in education activities.

#### **PHYSICAL ACTIVITY**

Effective multi-sectoral interventions to promote physical activity include physical education in schools; incentives for work-site healthy-lifestyle programmes; and increasing the availability of safe environments in public parks and recreational spaces to encourage physical activity (3). A number of countries have made progress with implementing these measures and others.

MSA to promote physical activity in the Region has largely occurred at a local government level. For example, Shanghai's "four controls, one move" initiative in 2007 focused on dietary salt control, dietary oil control, weight control, smoking control and supporting citizens to take 10 000 steps per day (30). The approach was to move the NCD control strategy "upstream" from a purely medical model of treating disease. The key elements for success of this strategy were the high-level political support and advocacy (from the Vice Mayor) as well as the engagement of individuals, families, restaurants and the food industry.

Other key partnerships at a national level have involved ministries of transport, education and public works/infrastructure. For example Malaysia's **National Strategic Plan for Non-Communicable Disease** (9) includes the expansion of an efficient public transport system throughout Malaysia, and policies to limit the use of private transportation in the city centres to promote the use of active public transport. It also plans to increase the availability of facilities in the community to promote physical activity and exercise in a safe environment, e.g. public parks, public sports complexes, jogging and cycling paths, and public gymnasiums.

Cambodia intends to work with municipalities, governors, the Ministry of Public Works and Transportation, and schools to advocate for and develop a draft policy which may include:

- Provision of adequate footpaths, cycle ways and open spaces in new areas or development sites including new slum areas
- Promote use of existing facilities and beautify/maintain existing green areas and walkways
- Urban planning policies that encourage walking or cycling rather than motorized vehicles eg cycle ways
- Motor free zones

Mongolia's **National Strategy on Healthy Diet and Physical Activity** (31) is jointly the responsibility of the Minister of Health and the Minister of Food, Agriculture and Light Industry. The action plan to implement this strategy outlines an ambitious number of actions to promote physical activity, and specifies which sectors/agencies are responsible for delivering these. Specific activities include:

- Create safe environments for commuting on bicycles and wheelchairs on grounds belonging to state institutions and business entities.
- Include construction of sport grounds in city planning design, and improve quality of these.
- Increase number of parks and gardens for public physical activities and sports in aimags, capital city, soums and districts.
- Provide state support through tax benefits and loans to organizations renovating or creating new buildings to provide public sport services.
- Support domestic production of sport equipment and goods.
- Include in the physical education curricula in all educational institutions a test on physical development of students, and make it one of the indicators to evaluate work of the gym teachers.
- Establish indoor and outdoor sport facilities in dormitories of all schools and create conditions for continuous operation thereof.
- Organize physical activity groups and training rooms within business entities and organizations.
- Increase ratio of information on nutrition and physical exercise in mass media, radio and TV programs, and enrich types and forms of information broadcasted.

## TOBACCO CONTROL

Multi-sectoral collaboration has seen smoke-free legislation successfully introduced in a number of countries in the Region, at both national and sub-national levels. For example, Hong Kong has smoke-free legislation for all indoor public places, restaurants, workplaces, public transport and some outdoor public spaces (32).

In other countries in the Region, tobacco control remains an area of enormous untapped potential for action. The fact that all WPRO countries have signed the WHO FCTC means this may be an "easier" place to begin MSA for NCD. Tobacco control in New Zealand has been boosted by the announcement of a whole of government goal to be smoke-free by 2025 (28). This occurred as a result of a Maori Affairs Select Committee inquiry into the tobacco industry and Maori smoking rates, which received over 260 submissions from the public and from NGOs, health organisations, universities, Maori tribal groups, and industry groups. A key strategic feature of this inquiry was that the behaviour of the tobacco industry was being called to account, rather than smokers or the health impact of smoking. In response, the Government agreed to develop targets for reducing smoking rates with the goal of becoming a smoke-free nation. It will also consider law changes around the promotion, packaging and display of tobacco products as part of the Smoke-free Environments (Controls and Enforcement) Bill currently before Parliament. The Government agreed to set specific mid-term targets as a means to ensure meaningful progress towards the longer term goal of making New Zealand essentially a smoke-free nation by 2025 (33).

### **Smoke-free public spaces – Davao, Philippines**

Davao implemented a city ordinance prohibiting smoking in indoor and some outdoor public places before a national tobacco control law was adopted. Its legislation process greatly benefited from support of a local political leader, participation of wide range of local stakeholders, and long-term awareness campaigns. Initiated by the Mayor, with support of the Council, in consultation with the Davao City Chamber of Commerce, Davao Association of Tourist Attraction, City Health Office, City Legal Office, the Davao City Police Office, owners and managers of various hotels, malls, department stores, restaurants, bars, drivers association, and other establishments in Davao City (34). Community leaders also participated. A “Smoke-free Prison” campaign for Davao City Jail inmates was also launched. It led to the prison warden discouraging the selling of cigarettes inside the jail and to implement a “no smoking policy” within the prison cells. Moreover, law enforcers were not exempted from the orientation and training. Police were ordered not to smoke while on duty or wearing uniforms.

A key lesson from Davao’s experience is to build a wide partnership. Initially, the Davao Anti-Smoking Task Force consisted only of representatives from local government offices. In time, it came to include a wider partnership of health professionals, religious leaders and other advocates tasked to conduct awareness programmes and lectures in schools, workplaces and communities. This valuable resource, formalised by the creation of the Association of Smoke-Free Davao Advocates, enabled the reach and effectiveness of awareness raising and inspection to be enhanced significantly.

### **ALCOHOL**

The Korean National Alcohol Policy (Blue Bird Plan 2010) involves a wide range of multi-sectoral activities to reduce the harm from alcohol use. It places restrictions on advertisement and sponsorship of liquor companies and on liquor sales, drinking areas, age and hours (35). It includes a number of activities to create alcohol-harm free environments, including alcohol-free zones in public parks and compulsory treatment/education for drinking drivers and violators of other alcohol regulations. NGOs and the community are key partners in the Korean strategy. Stores selling alcoholic beverages are designated as “clean stores” if they refuse to sell alcohol to underage people three times. Testing is carried out by an NGO, supported financially by the Ministry of Health, Social Welfare and Family Affairs. The Blue Bird Plan also includes the establishment of the “Blue Bird Forum” – a regular meeting with related organisations and civil groups to: promote a campaign to advertise the seriousness of alcohol harm, create alcohol control friendly atmosphere (restrictions on liquor drinking areas and hours) (35).

Cambodia, Lao PDR and Vietnam have yet to adopt alcohol policy, but a Parliamentary Seminar on Alcohol Policy in Indo-China was held in September 2011, with high-level representation from health and social government agencies from all three countries (36). High level champions can be extremely useful. In 2008, the Cambodian Prime Minister issued a directive about not using and selling alcohol before and after the election. Since then, at least 10 communes and sangkats have issued orders banning alcohol consumption (36). In Viet Nam, the Ministry of Health’s 2007 draft National Alcohol Policy proposes banning ads for all imported or local alcohol products with over 4.5% alcohol. It also proposes banning marketing that is targeted children and adolescents under 18 years of age, alcohol sponsorship for cultural, artistic or sporting activities, alcohol prizes in promotions and competitions, alcohol brand names or icons on vehicles, and advertising alcohol-based tonics. Alcohol advertisements inside alcohol outlets should not be visible from outside (37).



### *Who should lead?*

In Japan, the Ministry of Health, Labour and Welfare (MHLW) takes a major role in alcohol policy. However, there is a higher level of coordination by the Cabinet Office, which ensures collaboration between MHLW, National Tax Agency, National Police Agency and the Ministry of Education, Culture, Sports, Science and Technology (37). The involvement of the Tax Agency in this coordination is useful, given the importance of taxation policy for alcohol control policy. In New Zealand, a separate government agency, the Alcohol Advisory Council (ALAC), funded from a levy on alcohol sales, complements the work of the Ministry of Health on alcohol policy (37). One aspect of ALAC's work is running regular conferences attended by people from many sectors involved in implementing alcohol policy. These cover issues such as: monitoring and enforcement; initiatives to reduce intoxication; policy, planning and evaluation; and evaluation of community projects. A number of provinces in Papua New Guinea have introduced alcohol bans, led by the police. Mongolia's National Programme on Prevention and Control of Alcoholism 2003 was led by the National Council on Prevention of Crime, in conjunction with the Ministry of Justice and Internal Affairs and the Ministry of Health.

## 5. WHAT ARE THE BARRIERS AND CHALLENGES FOR MSA?

MSA is not easy. Barriers and challenges can include structural/organisational barriers, culture/language barriers, challenges regarding the process itself, and capacity/technical barriers. Countries will also be able to identify other challenges that they encounter in their specific context. Table 2 summarises some of the common barriers and challenges encountered when undertaking MSA.

**Table 2 - Barriers and challenges to multi-sectoral action**

<b>Structural barriers</b>
Different sectors work within very different organisational contexts
Collaboration between unequal partners – when sectors have different levels of resources and hence power
If donors and International organisations do not work collaboratively, it is very difficult to institute this way of working further down the chain
Who has the overall responsibility for MSA?
Who is accountable for achieving objectives in joint working arrangements?
<b>Cultural and language barriers</b>
Health is seen as a dominating sector, with an attitude of superiority. (Public health is also “dominated” by the curative health care sector)
Health is already seen as consuming more than its fair share of funding. Bulk of this expenditure is on downstream health care services – it is difficult for policy makers to refuse additional funding for these services.
Mismatch between values of recipients and donors
Corruption
Different sectors have different understandings of the world and ways of describing it.
Different sectors use different forms of evidence
<b>Process challenges</b>
How to manage conflicting interests, especially in situations where there is no clear win-win and trade-offs have to be made
Trying to deal with long-term problems and solutions in short-term political cycles
Mismatch between donor project timeframes and long-term action on NCD prevention



Who should be initiator/driver? Pros and cons of having central agency, health or non-health sectors lead. Also pros and cons of existing system change versus setting up new agencies.

#### Capacity/technical challenges

Lack of data

Data is not in a format that is comparable

Poor mechanisms for sharing data between sectors

Data produced but not turned into usable information

Insufficient institutional capacity to meet demands for more data collection

Source: Adapted from World Health Organization (38)

Many positive aspects are emerging from the MSA plans for NCD in the Western Pacific Region. However these plans also highlight a number of the common challenges involved in MSA:

- **Implementation** – many plans are clear on the high-level outcomes and objectives they wish to achieve through MSA on NCD, but there is a lack of specificity about how these objectives are going to be achieved, and how the MSA is to be implemented.
- **Dedicated resources** – MSA is all too often included as an “extra” requirement for participating sectors, without any additional or dedicated resource. This serves as a barrier to MSA, as sectors prioritise the activities that they are funded to deliver, and MSA is seen as an additional imposition, rather than core-business.
- **Human capacity** – MSA requires people with the capacity, willingness and skills to make it work. Very few MSA plans for NCD make mention of the human resource required to implement it successfully. There is a lack of recognition that the “co-ordination” aspect of MSA often requires dedicated personnel in itself, and that those involved may need additional training to be able to understand and work with other sectors.
- **Monitoring and targets** – having clear targets for MSA on NCD is important to focus multiple sectors on common goals. This challenge is reflected in the plans of a number of countries in the Region. There is either a lack of targets altogether, high-level process targets only (eg “the number of partnerships”) or so many pages of targets that there are no unified goals between sectors.
- **Accountability** – accountability for MSA is a challenge. Ensuring all sectors are held accountable for working with others is a key strategy to incentivise MSA. However working out how to share accountability for joint outcomes is more complex. This becomes even more complicated when working with stakeholders who are not directly controlled by the government. A number of the MSA plans specify actions for the private sector and NGOs, and it is not clear how these can be enforced.

Multi-sectoral co-operation is easiest when there is a clear win-win situation for all involved. However situations where everybody wins are not the norm. How to manage situations that involve costs or trade-offs for another sector, whilst preserving an effective collaborative working relationship, is one of the biggest challenges for MSA (38). Trade-offs are often between long term and short term options, and there will always be a tendency to favour the option that offers short-term benefits. Those stakeholders who need to bear short term losses often do not benefit from potential long term gains which are beyond both political and budgetary cycles.

### Challenges of “industry-led” MSA

The International Center for Alcohol Policies (ICAP), an organization supported by major producers of beverage alcohol, has been attempting to pre-empt countries’ work on developing MSA plans to reduce alcohol consumption, by organizing a series of multi-sectoral policy conferences that issue industry-favourable policy recommendations (39). At these industry-sponsored conferences, government officials, academics, and NGO representatives are asked to endorse the implementation of national alcohol policies that differed markedly from those proposed by WHO. For example, the policies proposed by ICAP discourage the use of taxation and controls on alcohol marketing (39). In WPRO, ICAP have organised such conferences in Viet Nam, Singapore, China, and Korea.

For example, ICAP launched a training workshop for policymakers in July 2011 in Xi’an as part of the Global Actions Drink Driving Initiative (40). The workshop was attended by a wide range of sectors, including the Chinese Center for Health Education, Municipal Government, Bureau of Public Security, Bureau of Transportation, Bureau of Education, Bureau of Cultural, Broadcasting & News, Xi’an Institute for Health Education, China Alcoholic Drinks Industry Association, and members of the law enforcement, transportation, and public health communities.

---

## 6. APPROACH TO MSA

---

### 6.1 STEPS FOR MSA

There are a series of steps that can be taken to initiate and accomplish multi-sectoral action on health. The steps described below are relevant to both issue-centred approaches and to the general *Health in All Policies* strategy (3):

#### 1) Self-assessment

- a) Assess the health sector’s capabilities, readiness, existing relationships with relevant sectors and participation in relevant intergovernmental bodies.
- b) Strengthen institutional capacity by improving staff abilities to interact with other sectors (e.g. public health expertise, overall understanding of public policies, politics, economics, human rights expertise etc.), in order to identify intersectoral opportunities and communicate potential co-benefits.

#### 2) Assessment of other sectors

- a) Achieve a better understanding of other sectors, their policies and priorities, and establish links and means of communication to assess their relevance to the established health priorities.
- b) Use health impact assessment as a tool to identify potential (positive and negative) health impacts of other sectors’ policies, actions that can enhance positive impacts and reduce risks; and the roles and responsibilities of other sectors in achieving healthy policies.
- c) Conduct a stakeholder and sector analysis. Identify relevant intersectoral processes, bodies, laws, mandates for intersectoral action.
- d) Improve interaction and strengthen mutual, intersectoral engagement, including through participation in activities led by other sectors.

#### 3) Analyse the area of concern

- a) Define the specific area of concern and potential interventions.

- b) Present sector-specific, disaggregated data focusing on the impact on other sectors and analyse the feasibility of the intervention.
  - c) Build your case using convincing data to describe how policies in the sector of interest affect health, and propose ways these can be changed to promote health-related co-benefits. Use evidence to highlight potential co-benefits.
- 4) Develop engagement plans**
- a) Develop a strategy to involve relevant sectors. The emphasis is on win-win and the creation of a climate of trust. Salient features of the plan include shared goals and targets; pooled resources; defined tasks, roles and responsibilities. Selection of an engagement approach is a key component in the plan and the approach can be on sector, issue or even “opportunistic” basis.
- 5) Use a framework to foster common understanding between sectors**
- a) A key factor for successful intersectoral action is the ability to identify a common understanding of the key issues and required actions to address them. This can be aided through the use of the same framework to facilitate a common understanding of the causal pathways and key intervention points.
- 6) Strengthen governance structures, political will and accountability mechanisms**
- a) Establish/strengthen governance structures to ensure successful intersectoral action. Examples include national constitutions, presidential mandates, adoption of new laws, compulsory reporting, human rights accountability, shared budgets, and implementation of international agreements such as the FCTC.
  - b) Develop accountability mechanisms by means such as promoting open access to information, meaningful public/ civil society participation at all levels, disclosure, grievance and ombudsperson functions.
  - c) Utilize relevant sections of human rights treaties, and reporting mechanisms mandated by international agreements, to support integration of health determinants across sectors.
- 7) Enhance community participation**
- a) Enhance community participation throughout the policy development, implementation and evaluation processes through public consultation/hearings, disseminating information using mass media, web-based tools and facilitating the equal and meaningful involvement of constituency/NGO representatives at all levels.
- 8) Choose other good practices to foster intersectoral action**
- a) Join other sectors in establishing common policies/programmes/initiatives with joint reporting on implementation with common targets.
  - b) Be an agent in other sectors’ policies/programmes/initiatives, and invite other sectors to be an agent in yours.
  - c) Provide tools and techniques to include health in the policies of other sectors and to address health inequalities/inequities (eg health impact assessment, economic analysis, data disaggregated by gender, class, ethnicity, participatory research, and qualitative analysis etc).
- 9) Monitor and evaluate**
- a) Follow closely the implementation of intersectoral action through monitoring and evaluation processes in order to determine the progress in achieving planned outcomes, and identify opportunities for productive changes in approach.

## 6.2 ELEMENTS FOR SUCCESS

Experience from the Region and around the world points to a number of elements for successful MSA. A range of tools/instruments exist, although we still have insufficient information on “when” to use a particular type of tool and “how” to use it most successfully. Given that there is no “one-size-fits-all” approach to MSA, it is helpful to be fluent with a number of different methods.

### HIGH LEVEL COMMITMENT

High-level commitment is critical – whether from the Prime Minister in progressing alcohol controls in Cambodia, or from the Mayor in championing smoke-free legislation in a city such as Davao. Give high-profile leaders a central role in driving initiatives. Strong personalities with influence on policy makers and the general public are well placed for bringing different actors together to collaborate towards a well-defined NCD prevention goal. Mayors, Presidents, Prime Ministers, and First Ladies have frequently been at the forefront of national and other efforts (41).

### DEDICATED RESOURCES

Options for financing MSA on NCDs include taxation for products such as tobacco and alcohol, and potentially for foods that are unhealthy, as well as consideration of subsidies and incentives (3). Other options include expanding universal access schemes to include NCDs, and incentivizing private sector support through workplaces, insurance and other financial services (3).

A number of countries across the Region have dedicated taxation from tobacco and alcohol products to health promotion activities, including the Republic of Korea, Tonga, Australia, and Mongolia. Mongolia’s Health Promotion agency is funded from a 2% tobacco tax, a 1% tax on alcohol and a 2% VAT on imported drugs (42). Progress is hampered by the influence of the alcohol and tobacco industries. Brunei’s Health Promotion Centre (HPC) established in 2008 was funded by Royal Dutch Shell. The HPC provides the secretariat for the national inter-sectoral mechanism on health promotion, the National Committee on Health Promotion. The HPC is responsible for advocating and influencing policy changes to integrate the promotion of healthy lifestyle into policies across government ministries and departments, and other agencies.

### INSTITUTIONAL STRUCTURES

A variety of institutional structures are being used to facilitate MSA on NCD in the Region, ranging from existing committees within the health sector, to brand new multi-sectoral task forces. These structural arrangements are also at different levels – including supra-Cabinet, Cabinet, Minister, Ministerial advisory level, within departments of health or within local government structures. Singapore has a number of multi-sectoral committees on NCD, including the National Smoking Control Programme, Senior Physical Activity Committee, National Tripartite Committee on Workplace Health, National Advisory Committees for Diabetes, Stroke and CHD. Viet Nam has a national steering committee on NCD. Cambodia is advocating, both within the Ministry of Health and with other ministries/sectors, for an inter-ministerial working group, to address issues and policies that lie outside the Ministry of Health. These include urban policy, transport and school health policies. Other countries such as Lao PDR do not currently have an inter-ministerial/departmental mechanism or structure for addressing NCDs, except for tobacco control.

Conducive structures are necessary but not sufficient to achieve MSA on NCD. In 2002 Mongolia established a National Public Health Council, headed by the Prime Minister and represented by all line ministries. This exciting mechanism for nurturing and initiating intersectoral collaboration for

public health, sadly remained almost inactive for a number of years, despite public health being a major part of the Ministry's and the Government's remit (43).

## JOINT PLANNING AND BUDGETING

Creating MSA plans for NCD has been easier in some countries in the Region because of a planning process that establishes a long term vision for the country, combined with a government that has sufficient capacity and will. It is critical to have an agreed instrument that sets out national goals that all sectors can work towards.

When it comes to encouraging collaborative working, the quality of the planning is often more important than the plan (38). Fundamental principles include ensuring that stakeholders are engaged at the beginning of the planning process, at the problem definition stage rather than once the policy solution has been formulated, taking the time to build relationships, and having the right people at the table.

### *Incentivising joint planning at local level*

Incentives for local authorities can be linked to their performance against a measure of joint working, such as the Index of Decentralised Management in the Bolsa Familia programme in Brazil (38). In this example, each municipality receives budget transfers that will increase or decrease based on the achievement of specific process and outcome indicators selected to reflect MSA. The peer pressure arising from comparison to the performance of other municipalities against the same joint working indicators, acts as an additional incentive for MSA.

### *Budgetary tools*

There are a number of specific budgeting mechanisms to encourage MSA. In participatory budgeting an elected (often local) authority leads a discussion on priorities with all sectors, and there can also be broader community involvement. Outcome oriented budgeting is a top down mechanism, where central government sets national strategic goals many of which are multi-sectoral in nature (38). Linking funding to these goals encourages several sectors to work together to achieve the goals.

## LEGISLATION

A number of countries in the Region have used legislation to assist in setting up the institutional structures for undertaking MSA on NCD. In Japan, the Health Promotion Law was enforced in May 2003 to establish legal foundations for facilitating greater health promotion efforts. The Basic Law on Shokuiku (Food and Nutrition education), was enforced in July 2005 to assist in the dissemination of basic food education principles, and to clarify the responsibilities of both national and local governments. In 2000, Singapore passed legislation to establish the Health Promotion Board (HPB) as a statutory body. The HPB acts as the main driver for national health promotion and disease prevention programmes, "with a vision to build a nation of healthy people". Multiple countries in the region have used legislative tools to address specific NCD risk factor areas such as tobacco control and food labelling.

Whilst laws and regulations are valuable tools, it is important to recognise that laws by themselves do not create a culture change. National constitutions can be instrumental in setting the basis for multi-sectoral working and common social goals. Regulation can be used to align the budgets of different sectors, or to require cross-sectoral consultation (38).

## ACCOUNTABILITY

Accountability for MSA needs to be clearly defined. There are a number of approaches for this. In some countries in the Region, multi-sectoral plans allocate particular responsibilities and actions to

each sector or partner involved (eg Mongolia). In other countries, the responsibility for aspects of the work is shared to a greater degree. For example, delivery may be jointly the responsibility of two Ministers.

Hong Kong takes an even more inclusive multi-sectoral approach to implementing and overseeing MSA for NCD. Rather than dividing up responsibilities to particular sectors, multi-sectoral working groups are tasked with overseeing work on particular topics (eg healthy eating, physical activity). To develop Hong Kong's **Strategic Framework for Prevention and Control of Non-communicable Diseases** (14), the Department of Health held an Expert Group Meeting with over 40 participants from academic, business, education, healthcare and social sectors, other government departments and NGOs to map out a strategic framework on prevention and control of NCD. To oversee the development and implementation, a high-level steering committee which comprises representatives of the Government, public and private sectors, academia, professional bodies, industry and other local key partners will be set up. Under this, respective working groups will be formed to advise on priority actions, draw up targets and action plans, including practical guides, tools and specifications of how the various sectors of the society can participate as partners. While the Government will have a leading role in taking the agenda forward and mobilise intersectoral collaboration, the working groups are expected to develop the action plans.

## MONITORING & REPORTING

Assessment, monitoring, evaluation, and reporting are required throughout the whole process. Proper assessment of the problem, its determinants and social, political and cultural context are crucial to frame the issue and benefits to various sectors. Regular monitoring and evaluation of health impacts is required to maintain focus on outcomes and identify the strengths and weaknesses of interventions.

In some areas, new data collection is required to assist multi-sectoral work on NCDs. It is also important that adequate data is collected to be able to demonstrate outcomes of MSA. Often data collection is of variable quality between sectors, and the capacity to collect and use data also varies between sectors. We need to be careful that calls for more data collection do not paralyse rather than accelerate the process, by consuming already scarce human, technical and financial resources. Duplication in data collection and analysis weakens institutional capacity.

Often data is already being collected, but it exists in sectoral silos and there is poor sharing of data between sectors. As well as being shared, data needs to be in a form that can be compared between sectors. In order to ensure that data is comparable between sectors, this needs to be resolved at the stage of data collection. It is important to acknowledge that different sectors understand “evidence” differently – and place a different balance of importance on quantitative versus qualitative sources of evidence. Data needs to be turned information – there cannot be information without data, but data cannot be used without information. There is also a need to translate data into stories for policymakers.

---

## 7. ENTRY POINTS AND OPPORTUNITIES

---

The core responsibility for MSA rests with government. However, governments cannot do it alone. A number of other entry points exist, that can be acted upon by a range of actors including NGOs and municipalities.

## 7.1 BUILDING UPON EXISTING STRUCTURES

In countries where no multi-sectoral mechanism or structure exists for NCD, it may be possible to utilise existing structures that have been established for other purposes, such as cross-agency pandemic/emergency planning mechanisms, or bodies convened to respond to tobacco. That approach was being used in Palau, which declared a state of emergency with regard to noncommunicable diseases. Moving implementation of strategies for the prevention and control of noncommunicable diseases from the health sector to a multi-sectoral entity with an emergency orientation was good model for mobilizing communities (30). Another area worth exploring relates to HIV/AIDS. The intersectoral response has been very strong in most countries with national and provincial AIDS councils, business engagement etc. With a move now to “mainstream HIV”, it is an opportunity to learn from the intersectoral experience and see if some of these structures can take on additional mandate of NCDs.

## 7.2 WORKING WITH THE PRIVATE SECTOR

The private sector plays an important role in improving or undermining NCD prevention efforts. Government agencies share an overall similar aim in pursuing a public interest. In the case of the private sector, its main purpose is the maximisation of profits. Some industry profits support NCD prevention (such as increased trade in fresh fruit and vegetables) and others are a threat to NCDs, such as sale of tobacco, fatty and salty food. It is important to consider to what extent the private sector should be engaged, and what their motivation might be. Advocates need to be able to describe to the business sector the benefits that helping to prevent NCD will offer in achieving their goals. Identifying and show-casing examples of good practice also provide good publicity for the businesses involved. Governments need be made aware of the full spectrum of instruments that they have to influence private sector activity on NCDs (eg regulation, taxations, incentives, public-private partnerships, subsidies). Poorer countries could do with support from neighbours and other partners in negotiating with more powerful industry stakeholders. MSA on NCD will most commonly involve the tobacco, alcohol food and beverage industries. It is important that governments are alert to the possible tactics of these industries (42).

Beyond the tobacco, alcohol, food and beverage industries, private sector partnerships can be a powerful entry-point for MSA on NCD. Many countries in the region are currently experiencing major growth in extractive industries. These industries usually operate mining or drilling activities for defined periods, preceded by negotiations with governments on their social and environmental impact. This negotiation phase is an opportunity to work with the company to address the NCD implications of the industry's activities, as well as garner support from the company for addressing the NCD issues in the wider community where the mine is operating. Explicitly highlighting trade-offs can be useful. For example, in Lao PDR, investments in agro-based industries, hydropower, and mining sectors present economic development potential. However, uncontrolled development in these sectors presents an increasing risk to food security and NCD, as people's access to natural food resources and environmental sustainability in general is compromised.

## 7.3 CIVIL SOCIETY/NGOS

Multi-sectoral alliances can also be initiated and led from outside government. The China Salt Reduction Institute, co-hosted by The George Institute in China, and the Peking University Health Science Center, launched a national salt reduction campaign in late 2010. The campaign brings together professionals from medicine, science, the food industry, media, consumer associations,



government and non-governmental organisations in China (44). NGO and community groups can be powerful allies in applying bottom-up pressure for MSA on NCD. Including communities as partners in the planning process to develop multi-sectoral solutions, creates policies that are more likely to be relevant, appropriate, effective and supported by the public.

## 7.4 DISASTERS & SPECIAL EVENTS

A number of countries, including the Republic of Korea and China, have used **major events as an opportunity** to undertake MSA for NCD. For example, Shanghai's hosting of the 2010 World Expo served as a stimulus for MSA on tobacco control (45). Shanghai People's Congress passed the "Smoking Control Regulation in Public Places" - the first provincial legislation on tobacco control in the country. At the same time, the health related departments engaged in warning about the hazards of smoking and building smoke-free social norms through establishing health communication network. Shanghai hosted the first smoke-free World Expo in the history. The progress Beijing made with tobacco control as a result of the Beijing Olympics is another example (46).

**Disasters** can also be an opportunity to mobilise new resources or work in a different way. The 2009 tsunami in Samoa was associated with an injection of funds which helped in the short term to resuscitate the economy (47). Village sustainable development plans are now being used in all 366 villages in Samoa as the basis for delivering services. The methodology for these plans was adopted and scaled up from similar planning processes used in the 22 communities that had been affected by the 2004 tsunami, emphasizing data collection and the prioritization of village goals through an inclusive process involving traditionally marginalized groups (48).

## 7.5 INTERNATIONAL PARTNERSHIPS

The Southeast Asia Tobacco Control Alliance (SEATCA) is a multi-sectoral alliance established to support ASEAN countries in developing and putting in place effective tobacco control policies, in response to a grave need to fast track tobacco control policies in Southeast Asia (333). SEATCA is a unique network that combines representation from various Governments, Non-Governmental Organizations (NGOs), research institutions and WHO at national and regional levels. The alliance works to identify tobacco control priorities in the region and to coordinate efforts on these priorities, and promotes knowledge-sharing among countries for effective, evidence-based tobacco control measures and regional cooperation among its advocacy partners.

### *Working with donors*

A number of characteristics of donor agencies make MSA on NCD difficult. Donors often have sector-specific focused interests. The current multilateral lending environment is not conducive to MSA. Cambodia's **Health Strategic Plan 2008-2015** (11) identifies that the "fragmented aid architecture prevents a broader systemic approach to health sector management and drives health service delivery towards more non-integrated vertical approaches and project approaches". The Accra Agenda for Action, and Busan Partnership for Effective Development Cooperation (49) provide a good framework to encourage more collaborative ways of working (between donors, between donors and governments and between multiple sectors within governments), and a greater use of aid to fund more long term activities on NCD prevention and addressing "the causes of the causes". South-South cooperation can play a role to show donor countries that integrated and broader development goals are possible.



### *Other governments can help as well as hinder*

MSA on NCD not only requires a negotiation between sectors (eg health and trade) at a national level, but can also run into opposition from other countries. For example, the Philippines' proposed law HB 5727, dubbed the sin tax bill, aims to replace the current multi-tiered tax system for alcohol and tobacco products with a unitary tax rate that would impose a 1,000 percent excise tax increase on low-priced cigarettes and a 1,500 percent increase on low-priced alcohol products (50). This has drawn wide-spread national support from health and economic agencies (and was actually a Department of Finance proposal, rather than a health one). The World Bank has agreed that the Philippines "needs to introduce tobacco and alcohol tax to meet economic growth targets". The Philippines has some of the cheapest cigarettes and alcohol in Asia owing to low taxes imposed on these products - increasing taxes on cigarettes and alcohol will give an additional 0.6 to 0.9 % of GDP to economic growth. However the U.S. Chamber of Commerce and US ASEAN Business Council have raised their concerns before the House of Representatives over the impact of a pending tax bill that seeks to impose high tax increases on alcohol and tobacco products on investors and the domestic economy.

International pressures and interests can also result in undoing of previous national efforts to prevent NCD. The removal of tariffs on imported spirits and wine when China joined the World Trade Organization (WTO) led to increased availability of imported spirits in city supermarkets and hypermarkets (39). This undermined Chinese policy to reduce the total alcohol consumed. In Taiwan, China, alcohol advertising was severely restricted, but this was eased as part of Taiwan's bid to join the WTO and in response to pressure from its trading partners (39).

## **7.6 IDENTIFYING COMMON INTERESTS & CO-BENEFITS**

MSA for NCD can gain support because it aligns with broader government priority. For example, the Government of Lao PDR's 'National Growth and Poverty Eradication Strategy' has the ultimate goal of shedding its Least Developed Country Status by 2020. This strategy recognises that MSA is required to achieve the MDGs to reduce human poverty and hunger globally by 2015. This requires effective cooperation between concerned development sectors in particular health, education, agriculture, environment, industry/trade, social development sectors, and others in order to achieve not only food security at household as well as at national level, but also nutritional well-being.

It is important to align NCD prevention with the objectives of other sectors. Identifying the sectors that share vested interests in activities on a particular issue, and highlighting to them how joint action on addressing NCD can help them achieve their objectives is important. A good understanding of the imperatives and objectives of other sectors is a key prerequisite for this. For example, promoting active transport will also mean reduced traffic congestion, and tobacco control is also a means to poverty alleviation. The argument for NCD prevention and control can be strengthened by presenting the consequences of not taking action, as well as being able to demonstrate the cost benefits of acting versus the status quo.

## **7.7 MAKING THE CASE FOR MSA – THE POWER OF STORIES**

Policy is made irrationally, not based on statistics. Ultimately for policy-makers, it often comes down to a story with a human face. Therefore, there is a need to use data sensitively to translate it into a story that touches on emotions, and use these stories as a window to a broader issue (38). Stories can also be used to shame policy makers, especially when the information is described according to

the level of responsibilities (eg obesity or tobacco use by municipality, to identify poorly performing mayors). At the same time, it is important to offer solutions when highlighting problems.

To be effective, people need to see themselves in issues/stories. Stories work best when they are interesting, evoke emotion, have some tension, are a little surprising, and involve some element that the audience can relate to. Sometimes a counter-intuitive messenger can be powerful. The health sector often produces a continuous stream of bad news and there can be a degree of immunity to bad news about health (38). Good news stories about health may be more unexpected, and could come from other sectors.

### *The media*

The media is a powerful ally in making the case for MSA on NCD. However it is important to remember that a story has to meet a journalist's agenda as well (eg to create tension and be interesting). Success with the media is not a one day event – it has to be an ongoing strategy, to get multiple hits in the media in a number of ways over a long time (38). It is helpful to make use of the full repertoire of new social media, to harness the power of the “non-media media” (civil society, NGOs, advocates) and actively integrate them into the conversation. These new technologies are a means to an end, not a paradigm in themselves – an uninteresting message will still be uninteresting in these media.

### *Advocacy*

Organisational partnerships start with individual connections, and leaders need to do consciously build in advocacy into their daily lives, to establish connections and ensure they are not alone on issues (38). There is a need to be strategic about both the issue selected and the people involved. Encouraging senior bureaucrats to champion the cause can be especially useful, as bureaucratic willingness can be more enduring than political willingness. In any advocacy campaigns about NCD issues, it is also important to include vulnerable groups who have the greatest potential to benefit – both as audiences and as messengers.

## **7.8 ROLE OF THE HEALTH SECTOR: INITIATING VS ENABLING?**

As the only sector with a mandate to approach health issues from a holistic point of view, the health sector must play a central role in NCD prevention and mitigation efforts. This role includes: assessing the size of the NCD problem and the nature of its drivers; initiating dialogue with relevant actors and helping them develop priority interventions; and monitoring and evaluating outcomes.

The health sector also has a key role in influencing whether health issues, and NCD in particular, gain traction as a national political priority. A number of criteria inform these decisions, including the current and projected burden of diseases (or their underlying risk factors, such as tobacco use), the cost-effectiveness, fairness and feasibility of implementing interventions, and political considerations. The health sector is uniquely positioned to collect and provide the information that is needed to stimulate the development and support the implementation of all kinds of initiative. It can identify NCD risk factors and the immediate drivers of the epidemic. In this way, it can initiate dialogue with relevant actors and help them identify priority interventions.

Finally, the health sector has the fundamental role of monitoring and evaluating the outcomes and results of interventions, prompting any shifts that may be necessary to correct a course of action. The health sector can act as a catalyst through identifying policy windows across various sectors including international trade, climate change, education, and many others. Health Impact Assessment (HIA) provides a systematic approach to determine the health effects of implementing policies external to the health sector (3).

---

## ANNEX 1 RESOURCES

---

### MULTI-SECTORAL ACTION FOR NCD

World Health Organization (2012) Effective approaches for strengthening multisectoral action for NCDs. WHO Discussion Paper 1 (Version dated 19 March 2012) Available from:

[http://www.searo.who.int/LinkFiles/mhnd\\_SMA.pdf](http://www.searo.who.int/LinkFiles/mhnd_SMA.pdf)

World Health Organization (2012) Lessons learned from existing multisectoral partnerships that may inform the global response to NCDs. WHO Discussion Paper 2 (Version dated 19 March 2012)

Available from: [http://www.searo.who.int/LinkFiles/mhnd\\_limp.pdf](http://www.searo.who.int/LinkFiles/mhnd_limp.pdf)

World Health Organization (2012) Annex to WHO Discussion Paper 1: Effective approaches for strengthening multisectoral action for NCDs (Version dated 19 March 2012) Available from:

[http://www.who.int/entity/nmh/events/2012/annex\\_discussion\\_paper1.pdf](http://www.who.int/entity/nmh/events/2012/annex_discussion_paper1.pdf)

Meiro-Lorenzo M, Villafana T, Harrit M (2011) Effective responses to non-communicable disease: Embracing action beyond the health sector. Health, Nutrition and Population (HNP) Discussion Paper. The World Bank. Available from:

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/EffectiveResponsestoNCDs.pdf>

World Health Organization Regional Office for the Western Pacific (2011) Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Disease Prevention and Control. Seoul, the Republic of Korea, 17-18 March 2011. Available from:

[http://www.wpro.who.int/entity/noncommunicable\\_diseases/regional\\_hlm\\_on\\_scaling\\_up\\_multisectoral\\_actions.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/regional_hlm_on_scaling_up_multisectoral_actions.pdf)

World Health Organization (2010) Intersectoral Action on Health: Impact on noncommunicable diseases through diet and physical activity. Report of an Expert Consultation 6–7 September 2010 Helsinki, Finland. WHO Centre for Health Development (Kobe)

[http://www.who.int/entity/kobe\\_centre/publications/isa\\_report\\_helsinki\\_2010.pdf](http://www.who.int/entity/kobe_centre/publications/isa_report_helsinki_2010.pdf)

### MULTI-SECTORAL ACTION FOR HEALTH

World Health Organization (2011) Consultation on implementing action on social determinants of health to reduce health inequities: the contribution of collaborative work between sectors. Meeting Report. Wasan Island, Ontario, Canada, 20-24 September 2010

[http://www.who.int/sdhconference/resources/eng\\_Wasan\\_Meeting\\_Report.pdf](http://www.who.int/sdhconference/resources/eng_Wasan_Meeting_Report.pdf)

World Health Organization (2011) Intersectoral action on health: A path for policy makers to implement effective and sustainable action on health. WHO Centre for Health Development (Kobe),

[http://www.who.int/kobe\\_centre/publications/intersectorial\\_action\\_health2011/en/index.html](http://www.who.int/kobe_centre/publications/intersectorial_action_health2011/en/index.html)

Adelaide Statement for Health in All Policies (2010), World Health Organization

[http://www.who.int/social\\_determinants/hiap\\_statement\\_who\\_sa\\_final.pdf](http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf)

Kickbusch I & Buckett K (Eds) (2010) Implementing Health in All Policies - Adelaide 2010. Government of South Australia.

<http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf>

World Health Organization (2010) Working across sectors for health. Special consultation with mayors, governors and ministers on Intersectoral Action on Health, 15 November 2010, Kobe, Japan  
[http://www.who.int/entity/kobe\\_centre/publications/isa\\_report\\_2009.pdf](http://www.who.int/entity/kobe_centre/publications/isa_report_2009.pdf)

World Health Organization (2009) Health Equity in All Urban Policies. A report on the Expert Consultation on Intersectoral Action (ISA) in the Prevention of Noncommunicable Conditions 22–24 June 2009, Kobe, Japan  
[http://www.who.int/entity/kobe\\_centre/publications/report\\_isa\\_session\\_global-forum.pdf](http://www.who.int/entity/kobe_centre/publications/report_isa_session_global-forum.pdf)

Public Health Agency of Canada (2007) Crossing Sectors - Experiences in Intersectoral Action, Public Policy and Health [http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/pdf/cro-sec\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/pdf/cro-sec_e.pdf)

## MULTI-SECTORAL ACTION FOR KEY NCD RISK-FACTORS

World Health Organization Regional Office for the Western Pacific (2011) Technical Consultation on Identifying Approaches to Control Obesity. Melbourne, Australia 11-13 April 2011.  
[http://www.wpro.who.int/entity/noncommunicable\\_diseases/documents/docs/IdentifyingApproachesToControlObesity.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/documents/docs/IdentifyingApproachesToControlObesity.pdf)

World Health Organization (2011) Making cities smoke-free. Geneva: World Health Organization; Available from: [http://whqlibdoc.who.int/publications/2011/9789241502832\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502832_eng.pdf)

World Health Organization Regional Office for the Western Pacific (2010) Regional Consultation on Strategies to Reduce Salt Intake. Singapore, 2-3 June 2010.  
[http://www.wpro.who.int/entity/noncommunicable\\_diseases/documents/docs/RCStratReduce\\_Salt\\_Intake.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/documents/docs/RCStratReduce_Salt_Intake.pdf)

World Health Organization Regional Office for the Western Pacific (2009) WHO Western Pacific Regional Strategy to Reduce Alcohol-Related Harm: How to develop an action plan to implement the strategy.  
<http://www.wpro.who.int/publications/docs/HowToDevelopActionPlanToImplementStrategy.pdf>

## GLOBAL NCD REPORTS AND STRATEGIES

The Global Status Report on Non-communicable Diseases 2010 (2011). World Health Organization  
[http://www.who.int/nmh/publications/ncd\\_report\\_full\\_en.pdf](http://www.who.int/nmh/publications/ncd_report_full_en.pdf)

Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011)  
[http://www.un.org/ga/search/view\\_doc.asp?symbol=A/66/L.1](http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1)

The WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010)  
[http://www.who.int/substance\\_abuse/alcstratenglishfinal.pdf](http://www.who.int/substance_abuse/alcstratenglishfinal.pdf)

2008-2013 WHO Action Plan for the Global Strategy for the Prevention and Control of NCDs (2008)  
[http://whqlibdoc.who.int/publications/2009/9789241597418\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf)

The WHO Global Strategy on Diet Physical Activity and Health (2004)  
[http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy\\_english\\_web.pdf](http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf)

The WHO Framework Convention on Tobacco Control (2003)  
[http://www.who.int/fctc/text\\_download/en/index.html](http://www.who.int/fctc/text_download/en/index.html)

---

## ANNEX 2 REFERENCES

---

1. United Nations General Assembly. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Sixty Sixth Session. New York: United Nations; 2011.
2. World Health Organization. Global Status Report on Non-communicable Diseases [Internet]. World Health Organization; 2011. Available from: [http://www.who.int/nmh/publications/ncd\\_report\\_full\\_en.pdf](http://www.who.int/nmh/publications/ncd_report_full_en.pdf)
3. World Health Organization. Effective approaches for strengthening multisectoral action for NCDs. WHO Discussion Paper 1 (Version dated 19 March 2012) [Internet]. Geneva: World Health Organization; 2012. Available from: [http://www.searo.who.int/LinkFiles/mhnd\\_SMA.pdf](http://www.searo.who.int/LinkFiles/mhnd_SMA.pdf)
4. World Health Organization. Lessons learned from existing multisectoral partnerships that may inform the global response to NCDs. WHO Discussion Paper 2 (Version dated 19 March 2012) [Internet]. Geneva: World Health Organization; 2012. Available from: [http://www.searo.who.int/LinkFiles/mhnd\\_llmp.pdf](http://www.searo.who.int/LinkFiles/mhnd_llmp.pdf)
5. World Health Organization. Annex to WHO Discussion Paper 1: Effective approaches for strengthening multisectoral action for NCDs (Version dated 19 March 2012) [Internet]. Geneva: World Health Organization; 2012. Available from: [http://www.who.int/entity/nmh/events/2012/annex\\_discussion\\_paper1.pdf](http://www.who.int/entity/nmh/events/2012/annex_discussion_paper1.pdf)
6. Ministry of Health, Brunei Darussalam. Health Promotion Blueprint 2011-2015. Brunei Darussalam; 2011.
7. AP-HealthGAEN. An Asia Pacific spotlight on health inequity: Taking Action to Address the Social and Environmental Determinants of Health Inequity in Asia Pacific, 2011 [Internet]. Canberra: Global Action for Health Equity Network (HealthGAEN); 2011. Available from: <http://healthgaen.org/wp-content/uploads/2011/10/Full-Report.-An-Asia-Pacific-spotlight-on-health-inequity-Taking-Action-to-Address-the-Social-and-Environmental-Determinants-of-Health-Inequity-in-Asia-Pacific-2011.pdf>
8. Galea G, Powis B, Tamplin SA. Healthy Islands in the Western Pacific—international settings development. Health Promotion International. 2000 Jun 1;15(2):169–178.
9. Ministry of Health, Malaysia. National Strategic Plan for Non-Communicable Disease (2010-2014) [Internet]. Putrajaya; 2010. Available from: <http://www.moh.gov.my/images/gallery/nspncd/NSPNCD.pdf>
10. Department of Health, Republic of The Philippines. National Policy on strengthening prevention and control of lifestyle related NCD. Manila; 2011.
11. Ministry of Health, Kingdom of Cambodia. Health Strategic Plan 2008-2015. 2008.
12. Ministry of Health, Lao People's Democratic Republic. National Nutrition Policy. Vientiane; 2008.
13. Ministry of Health, Mongolia. National Programme on Integrated Prevention and Control of Noncommunicable Diseases. Ulan Baatar; 2007.

14. Department of Health, Hong Kong SAR of China. Strategic Framework for Prevention and Control of Non-communicable Diseases [Internet]. Hong Kong, SAR of China; 2008. Available from: [http://www.dh.gov.hk/english/pub\\_rec/pub\\_rec\\_ar/pdf/ncd/ENG%20whole%20DOC%2016-10-08.pdf](http://www.dh.gov.hk/english/pub_rec/pub_rec_ar/pdf/ncd/ENG%20whole%20DOC%2016-10-08.pdf)
15. Kashiwabara M, Armada F, Yoshimi I. Kanagawa, Japan's tobacco control legislation: a breakthrough? *Asian Pac. J. Cancer Prev.* 2011;12(8):1909–16.
16. The Alliance for Healthy Cities. Alliance for Healthy Cities awarded 16 cities, four organizations and 1 expert for their efforts in healthy cities movement [Internet]. Tokyo: Alliance for Healthy Cities; 2010. Available from: [http://www.alliance-healthycities.com/PDF/AFHCAward2009\\_10/AFHCpress\\_release\\_28Oct10.pdf](http://www.alliance-healthycities.com/PDF/AFHCAward2009_10/AFHCpress_release_28Oct10.pdf)
17. Shanghai Municipal Health Promotion Committee Office. The comprehensive prevention and control of chronic diseases and the effect evaluation in Songjiang District of Shanghai [Internet]. Shanghai: Shanghai Municipal Health Promotion Committee Office; 2010. Available from: <http://www.shawh.gov.cn/common/images/skins/shawh/ptf/A5.pdf>
18. Paraone C, Barron T, Orr-Walker B, Sinclair S. Let's Beat Diabetes. Looking Back - Moving Forward. A Review of Progress since 2005 and Recommendations for the Future [Internet]. Auckland: Counties Manukau District Health Board; 2009. Available from: [http://www.betterfuture.co.nz/file/cphac-report-on-lbd\\_final\\_-17nov09.pdf](http://www.betterfuture.co.nz/file/cphac-report-on-lbd_final_-17nov09.pdf)
19. World Health Organization Regional Office for the Western Pacific. Regional Consultation on Strategies to Reduce Salt Intake. Singapore, 2-3 June 2010 [Internet]. Manila: World Health Organization Regional Office for the Western Pacific; 2010. Available from: [http://www.wpro.who.int/entity/noncommunicable\\_diseases/documents/docs/RCStratReduce\\_Salt\\_Intake.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/documents/docs/RCStratReduce_Salt_Intake.pdf)
20. Asian Food Regulation Information Service. Sale of Food Act - Food (Amendment) Regulations (Draft) - 02/05/2012. Singapore [Internet]. Asian Food Regulation Information Service; 2012. Available from: <http://www.asianfoodreg.com/asia.php?id=19>
21. Mandating a healthy diet (Editorial). *New Straits Times* [Internet]. Malaysia; 2012 Apr 17; Available from: <http://www.nst.com.my/opinion/editorial/mandating-a-healthy-diet-1.74670#ixzz1u9A1GFRQ>
22. World Trade Organization. Working Party adopts Samoa's membership package [Internet]. 2011 [cited 2012 May 18]. Available from: [http://www.wto.org/english/news\\_e/news11\\_e/acc\\_wsm\\_28oct11\\_e.htm](http://www.wto.org/english/news_e/news11_e/acc_wsm_28oct11_e.htm)
23. KPL Lao News Agency. Salt producers need government help [Internet]. *Lao Voices*. 2011. Available from: <http://laovoices.com/salt-producers-need-government-help/>
24. UNICEF. Iodized salt means a brighter future for Laos and its children [Internet]. 2004 [cited 2012 May 4]. Available from: [http://www.unicef.org/spanish/nutrition/index\\_22839.html](http://www.unicef.org/spanish/nutrition/index_22839.html)
25. Webster J. Salt reduction in the Western Pacific Region: strategies for action [Internet]. Sydney, Australia: The George Institute for International Health; 2009. Available from: <http://www.georgeinstitute.org.cn/sites/default/files/pdfs/Salt%20reduction%20in%20the%20Western%20Pacific%20Region-%20strategies%20for%20action.pdf>

26. Health Promotion Board. Health Promotion Board rolls out Singapore's first Healthier Coffeeshop in partnership with Bukit Batok East constituency [Internet]. Singapore: Health Promotion Board; 2012 Feb. Available from: [http://www.hpb.gov.sg/uploadedFiles/HPB\\_Online/News\\_and\\_Events/News/2012/Media%20Release%20-%20Healthier%20Coffeeshop%20Initiative%20Final.pdf](http://www.hpb.gov.sg/uploadedFiles/HPB_Online/News_and_Events/News/2012/Media%20Release%20-%20Healthier%20Coffeeshop%20Initiative%20Final.pdf)
27. Thow AM, Quested C, Juventin L, Kun R, Khan AN, Swinburn B. Taxing Soft Drinks in the Pacific: Implementation Lessons for Improving Health. *Health Promot. Int.* [Internet]. 2010 Aug 25 [cited 2012 May 3]; Available from: <http://heapro.oxfordjournals.org/content/early/2010/08/24/heapro.daq057>
28. International Diabetes Federation. Government Statements at the UN High-Level Summit on NCDs, 19-20 September 2011 [Internet]. International Diabetes Federation; 2011. Available from: <http://www.idf.org/sites/default/files/attachments/Summary-Table-of-Government-Statements-at-the-UN-Summit.pdf>
29. Jiang Zongmin Dai Junming. An Action on Salt Control among Residents in Shanghai [Internet]. Shanghai: Shanghai Municipal Health Promotion Committee Office; 2010. Available from: <http://www.shawh.gov.cn/common/images/skins/shawh/ptf/B3.pdf>
30. Regional Committee for the Western Pacific. Regional Committee for the Western Pacific Sixty-Second Session. Manila, Philippines 10-13 October 2011. Final Report of the Regional Committee. [Internet]. Manila: World Health Organization Regional Office for the Western Pacific; 2011. Available from: [http://www.wpro.who.int/NR/rdonlyres/DD2D452A-2D26-4088-8142-8087792A6B38/0/RC62\\_final\\_report\\_21Dec2011.pdf](http://www.wpro.who.int/NR/rdonlyres/DD2D452A-2D26-4088-8142-8087792A6B38/0/RC62_final_report_21Dec2011.pdf)
31. Government of Mongolia. National Strategy on Healthy Diet and Physical Activity. Ulan Baatar; 2009.
32. World Health Organization. Making cities smoke-free [Internet]. Geneva: World Health Organization; 2011. Available from: [http://whqlibdoc.who.int/publications/2011/9789241502832\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502832_eng.pdf)
33. Government of New Zealand. Government Response to the Report of the Māori Affairs Committee on its Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori (Final Response). Presented to the House of Representatives in accordance with Standing Order 248 [Internet]. Wellington: New Zealand Parliament; 2011. Available from: [http://www.parliament.nz/NR/rdonlyres/3AAA09C2-AD68-4253-85AE-BCE90128C1A0/188520/DBHOH\\_PAP\\_21175\\_GovernmentFinalResponsetoReportoft.pdf](http://www.parliament.nz/NR/rdonlyres/3AAA09C2-AD68-4253-85AE-BCE90128C1A0/188520/DBHOH_PAP_21175_GovernmentFinalResponsetoReportoft.pdf)
34. World Health Organization Centre for Health Development. Advancing the enforcement of the smoking ban in public places – Davao City, Philippines [Internet]. Kobe, Japan: World Health Organization; 2011. Available from: [http://www.who.int/kobe\\_centre/interventions/smoke\\_free/davao\\_city\\_web\\_final.pdf](http://www.who.int/kobe_centre/interventions/smoke_free/davao_city_web_final.pdf)
35. Korea Ministry of Health & Welfare. National Alcohol Policy: Blue Bird Plan 2010. Korea: Korea Ministry of Health & Welfare; 2006.
36. The National Assembly of the Kingdom of Cambodia. Parliamentary Seminar on Alcohol Policy in Indo-China [Internet]. [cited 2012 May 9]. Available from: [http://www.national-assembly.org.kh/eng/index.php?option=com\\_content&view=article&id=189%3Aparliamentary-seminar-on-alcohol-policy-in-indo-china&catid=1%3Ampactivities&Itemid=1&lang=en](http://www.national-assembly.org.kh/eng/index.php?option=com_content&view=article&id=189%3Aparliamentary-seminar-on-alcohol-policy-in-indo-china&catid=1%3Ampactivities&Itemid=1&lang=en)



37. World Health Organization Regional Office for the Western Pacific. WHO Western Pacific Regional Strategy to Reduce Alcohol-Related Harm: How to develop an action plan to implement the strategy. Geneva: World Health Organization; 2009.
38. World Health Organization. Consultation on implementing action on social determinants of health to reduce health inequities: the contribution of collaborative work between sectors. Meeting Report. Wasan Island, Ontario, Canada, 20-24 September 2010 [Internet]. Geneva: World Health Organization; 2011. Available from: [http://www.who.int/sdhconference/resources/eng\\_Wasan\\_Meeting\\_Report.pdf](http://www.who.int/sdhconference/resources/eng_Wasan_Meeting_Report.pdf)
39. Zeigler D, Babor T. Challenges and Opportunities Implementing the WHO Global Strategy on Alcohol. World Medical & Health Policy [Internet]. 2011 Dec 7;3(4). Available from: <http://www.psocommons.org/wmhp/vol3/iss4/art6>
40. International Center for Alcohol Policies (ICAP). Global Actions China Launches Drink Driving Initiative in Xi'an [Internet]. 2011 [cited 2012 May 1]. Available from: <http://www.icap.org/LinkClick.aspx?fileticket=tRahLdADM7I%3D&tabid=71>
41. Meiro-Lorenzo M, Villafana T, Harrit M. Effective responses to non-communicable disease: Embracing action beyond the health sector. Health, Nutrition and Population (HNP) Discussion Paper. [Internet]. Washington DC: The International Bank for Reconstruction and Development/The World Bank; 2011. Available from: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/EffectiveResponsestoNCDs.pdf>
42. World Health Organization Regional Office for the Western Pacific. Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Disease Prevention and Control. Seoul, the Republic of Korea, 17-18 March 2011 [Internet]. Manila: World Health Organization; 2011. Available from: [http://www.wpro.who.int/entity/noncommunicable\\_diseases/regional\\_hlm\\_on\\_scaling\\_up\\_multisectoral\\_actions.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/regional_hlm_on_scaling_up_multisectoral_actions.pdf)
43. Bolormaa T et al. Mongolia: health system review. Health Systems in Transition 9(4): 1–151. Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems and Policies; 2007.
44. The George Institute for International Health. China's costly love affair with salt [Internet]. 2010 [cited 2012 May 4]. Available from: <http://www.georgeinstitute.org.cn/news-and-events-china/news/china-s-costly-love-affair-salt>
45. Shanghai Municipal Health Promotion Committee Office. Tobacco control strategy and action in Shanghai [Internet]. Shanghai; 2010. Available from: <http://www.shawh.gov.cn/common/images/skins/shawh/ptf/B5.pdf>
46. Yan L. Olympic Games in China—a Catalyst for Smoke-Free Environments. Tob Control. 2008 Jan 8;17(4):217–217.
47. World Health Organization Regional Office for the Western Pacific. Technical Consultation on Identifying Approaches to Control Obesity. Melbourne, Australia 11-13 April 2011 [Internet]. Manila: World Health Organization Regional Office for the Western Pacific; 2011. Available from: [http://www.wpro.who.int/entity/noncommunicable\\_diseases/documents/docs/IdentifyingApproachesToControlObesity.pdf](http://www.wpro.who.int/entity/noncommunicable_diseases/documents/docs/IdentifyingApproachesToControlObesity.pdf)

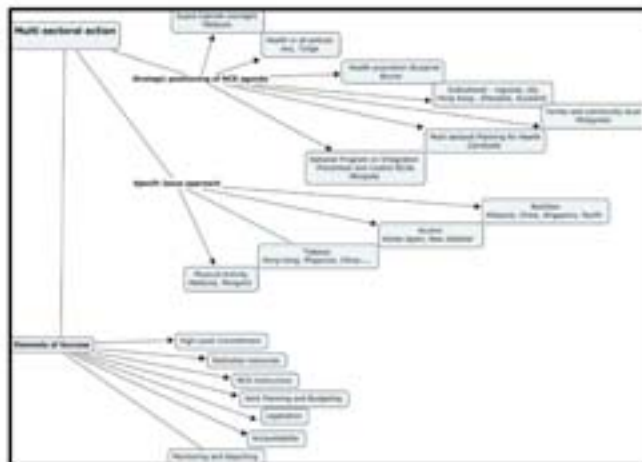
48. Regional Bureau for Asia and the Pacific United Nations Development Programme. Helping empower lives and build resilience in Asia-Pacific. UNDP Regional Bureau for Asia and the Pacific 2010 results report. [Internet]. New York: UNDP; 2011. Available from: <http://www.undp.org/asia/pdf/DevResults2010.pdf>
49. Busan Partnership for Effective Development. Fourth High Level Forum on Aid Effectiveness, Busan, Republic of Korea. 29 Nov- 1 Dec 2011 [Internet]. 2011. Available from: <http://www.aideffectiveness.org/busanhlf4/en/component/content/article/698.html>
50. Manila Bulletin Publishing Corporation. Business Groups Nix Tax Increases. Manila Bulletin [Internet]. 2012 4May; Available from: <http://www.mb.com.ph/articles/358814/business-groups-nix-tax-increases>

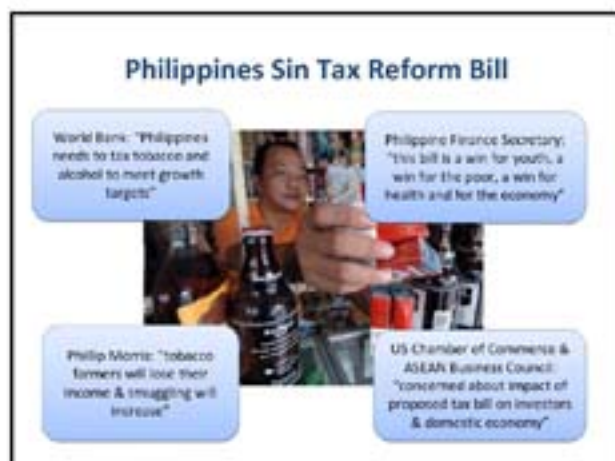
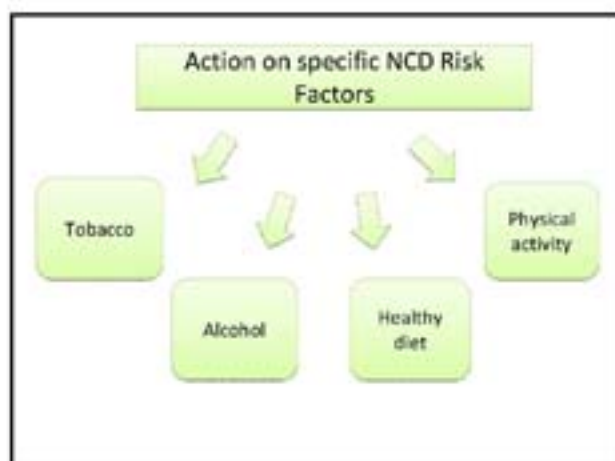
## Multisectoral Action for NCD Who, why and how?

Dr Belinda Loring  
13<sup>th</sup> June 2012

## Overview

- MSA in the Western Pacific Region
  - National level
  - Sub-national & local approaches
  - Specific NCD risk factors
- Elements for success
- Entry points & opportunities





## Elements for success

High-level commitment & champions	<ul style="list-style-type: none"> <li>Mayors, Royalty, Prime Ministers, Health ministers, First Ladies</li> </ul>
Dedicated resources	<ul style="list-style-type: none"> <li>Taxation, private sector (CSR, PPPs)</li> <li>Co-ordination function needs resourcing</li> </ul>
Institutional structures	<ul style="list-style-type: none"> <li>Cabinet, whole health, advisory task forces, local government</li> <li>Structures are not sufficient - you still need buy-in &amp; resolve. Do not discount informal relationships</li> </ul>
Good planning	<ul style="list-style-type: none"> <li>Quality of the "planning" can be more important than the "plan"</li> </ul>
Legislative tools	<ul style="list-style-type: none"> <li>Japan (Basic Law on "Shokukoku"), Smokefree, setting up structures (Singapore's HPA)</li> </ul>
Accountability	<ul style="list-style-type: none"> <li>Doesn't matter who, but needs to be clear (shared or not, health or non-health)</li> </ul>
Monitoring & reporting	<ul style="list-style-type: none"> <li>Targets focus action</li> <li>Results are important for advocacy</li> </ul>

## Entry points & opportunities (1)

Building upon existing structures	<ul style="list-style-type: none"> <li>Polio "state of emergency" for NCD</li> </ul>
Working with the private sector	<ul style="list-style-type: none"> <li>Eg mining &amp; manufacturing industries</li> </ul>
Civil society/NGOs	<ul style="list-style-type: none"> <li>Eg China Salt Production Institute (academic-led, health professionals, food industry, media, consumers, government / NGO)</li> </ul>
Disasters/special events	<ul style="list-style-type: none"> <li>Shanghai World Expo 2010 &amp; Beijing Olympics for tobacco control</li> <li>Samoa tsunami - inspection of new lands, village development plans</li> </ul>

## Entry points & opportunities (2)

International alliances	<ul style="list-style-type: none"> <li>WUATCA - multi-sectoral alliance to support ASEAN countries control tobacco</li> <li>Process - Action Agenda &amp; Asian Partnership Frameworks to take integrated approach to acc, and address "Savies of the cause"</li> <li>High level dedication, WHO/UNESCO as leverage &amp; support</li> </ul>
Identifying co-benefits	<ul style="list-style-type: none"> <li>Show how addressing NCD contributes to poverty reduction &amp; economic growth</li> <li>Show how promoting physical activity reduces traffic congestion</li> <li>Show &amp; quality of air promotes educational outcomes, how footballer versus promote sales</li> </ul>
Making the case	<ul style="list-style-type: none"> <li>Turn data into stories - the story of one person can be more compelling than national statistics</li> <li>Story needs to meet journalist's agenda as well</li> <li>Enhance the power of the "non-media media"</li> <li>Organisational partnership can add individual connections</li> </ul>

## Key messages

Many barriers but also many opportunities	<ul style="list-style-type: none"> <li>And it's happening now: level of entry, time, scope, sectors</li> </ul>
"MSA" describes a process not a thing	<ul style="list-style-type: none"> <li>Learning to do, and learn from each other</li> </ul>
No one starting point or approach	<ul style="list-style-type: none"> <li>Build upon what you already have (structures &amp; relationships)</li> <li>Be opportunistic, events, and non-NCD events</li> </ul>
Data will not speak for itself	<ul style="list-style-type: none"> <li>Do not expect other sectors to make the connection between NCD and their goals</li> </ul>





## National Multisectoral Plans for NCDs:

### Current Status and Challenges in Developing Multi-Sectoral Approach (MSA)

Dr Han Tienr  
Director, Building Healthy Communities and Populations  
WHO, WPRO

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
10-14 June 2013, Kuala Lumpur, Malaysia



## Structure of the Presentation

1. Global and regional mandates of MSA
2. 'Whole-of-Government' and 'Whole-of-society' approaches
3. Assessment of gaps in national plan of action and multisectoral approach
4. Targets, indicators, 'Best buys' and MSA
5. Examples of best practices and effective approaches for MSA
6. Mechanisms, tools and instruments
7. Next steps

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
10-14 June 2013, Kuala Lumpur, Malaysia



## 1. Global and Regional Mandates

Heads of State and Government and representatives committed to:

- Establish/strengthen, **by 2013**, national multisectoral policies and plans for NCDs
- Integrate NCDs policies and programmes into **health-planning processes** and the **national development agenda** of each Member State
- Develop **national targets and indicators** based on guidance provided by WHO and give greater priority to **surveillance**

Mandate for WHO:

- UN HLM Political declaration mandated **WHO to lead and coordinate** the global response to NCDs.
- RCM resolution in 2011 called for **development of national multisectoral plans**



## 2. 'Whole-of-Government' and 'Whole-of-Society' approach

- *'Whole-of-Government' denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues*
- Responsibility for health and its social determinants rests with the whole society, and health is produced in new ways between society and government.



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
10-14 June 2013, Kuala Lumpur, Malaysia



## Helping to improve health

Fig. 2. The health gradient



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
10-14 June 2013, Kuala Lumpur, Malaysia



## 3. Assessment of Gaps in National Plan of Action (NPA)

1. Low priority, no highest political commitment
2. No integrated into national health and development plan
3. No or limited budget allocation and human resources
4. No or inadequate monitoring and evaluation
5. No feasible and measurable targets to measure outcome



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
10-14 June 2013, Kuala Lumpur, Malaysia



## Assessment of Gaps in MSA

- No or ineffective multisectoral mechanism at national level
- No high-level commitment and support for coordinated operation
- No or low level representation from different sectors in MSA mechanisms
- No mandate, agreed roles and responsibility of sectors
- No joint plan with agreed target, indicator approach, and inputs
- No auditing and valid reporting mechanism



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-13 June 2012, Kuala Lumpur, Malaysia



## 4. NCD Targets and MSA

- 25% relative reduction in NCD mortality (between 30-70 years) has been adopted as a global target
- A set of global targets and indicators will be finally decided in Oct 2012
- No well defined and shared targets and indicators, no effective multisectoral actions
- Having targets and indicators will provide clear direction for MSA and facilitate identifying the role and responsibility and accountability for the different sectors

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-13 June 2012, Kuala Lumpur, Malaysia



## "Best Buy" and MSA

"Best buys" interventions to address NCDs

Population-based interventions addressing NCD risk factors	Tobacco use	<ul style="list-style-type: none"> <li>Excise tax increases</li> <li>Smoke-free indoor workplaces and public places</li> <li>Health information and warnings about tobacco</li> <li>Bans on advertising and promotion</li> </ul>
	Harmful use of alcohol	<ul style="list-style-type: none"> <li>Excise tax increases on alcoholic beverages</li> <li>Comprehensive restrictions and bans on alcohol marketing</li> <li>Restrictions on the availability of retail alcohol</li> </ul>
	Unhealthy diet and physical inactivity	<ul style="list-style-type: none"> <li>Salt reduction through mass media campaigns and reduced salt content in processed foods</li> <li>Replacement of trans-fats with polyunsaturated fats</li> <li>Public awareness programme about diet and physical activity</li> </ul>

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control, 11-13 June 2012, Kuala Lumpur, Malaysia



## MSA, 'Best Buys' and Sectors

ADVOCACY, HEALTH IMPACT ASSESSMENT → HEALTHY IN ALL POLICIES



HEALTHY CITIES AND ISLANDS SETTINGS SUCH AS SCHOOLS, WORKPLACES

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-13 June 2012, Kuala Lumpur, Malaysia



## 5. Examples of best practices and effective approaches for MSA - Tobacco Control

- Tobacco taxation and Health Promotion Foundations in Australia, Lao PDR, Korea, Malaysia, Mongolia, Tonga, Viet Nam
- Plain packaging- a path breaking approach in Australia



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-13 June 2012, Kuala Lumpur, Malaysia



## Examples of best practices and effective approaches for MSA - Promoting Healthy Diet

- Healthier foods in Singapore-Hawker Fare
- Salt reduction in China and Mongolia
- Eat smart restaurants (700+), Hong Kong (China)
- Eat smart @ school (400), Hong Kong (China)



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-13 June 2012, Kuala Lumpur, Malaysia





### Examples of best practices and effective approaches for MSA

#### — Promoting Physical Activity

- Exercise equipment in public parks in Lao PDR, China, Korea
- Walk paths, and cycling tracks in Cambodia, Korea, China, Malaysia
- Community physical exercise groups clubs in Seongbuk, Korea and Shanghai, China
- Walking days in Dalin, Seongbuk, Xiamen



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia



### Examples of best practices and effective approaches for MSA - Tobacco Control

#### — Reducing Harm from Alcohol

- The Mongolia's President initiative in alcohol control, non-alcohol in government's function and new alcohol legislation
- Development of legislation: drinking and driving, use of helmet, blood testing: China, Cambodia, Philippines, Vietnam
- Regulating informal alcohol control in Vietnam



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia



### Examples of best practices and effective approaches for MSA

#### - Healthy Cities

- Smoke Free Cities  
Harbin, Qingdao, China  
Makati and Marikina, Philippines  
Luang Prabang, in Lao PDR,  
Siem Reap, Cambodia
- Environmentally sustainable healthy urban transport (ESHUT) in 5 Asian cities  
Promote walking, cycling  
public transport system  
Reduce use of private vehicles  
Smoking ban  
Promoting health and hygiene  
Barrier-free transport environments



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia



### Examples of best practices and effective approaches for MSA—Healthy Settings: Health Promoting Schools and Work Places

- Health Promoting schools for multiple health interventions- Singapore, Hong Kong, Macao (China)
- Healthy workplaces - Shanghai, Hong Kong, China



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia



### 6. Mechanisms, Tools and Instruments for MSA

- Inter-ministerial and inter-departmental committees
- Community consultations and Citizens' Juries
- Cross-sector action teams
- Partnership platforms
- Integrated budgets and accounting
- Cross-cutting information and evaluation systems
- Impact assessments
- Joined-up workforce development
- Legislative frameworks

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia



### Adelaide Statement *Health in All Policies works best when:*

- a clear mandate makes joined-up government an imperative;
- systematic processes take account of interactions across sectors
- mediation occurs across interests;
- accountability, transparency and participatory processes are present;
- engagement occurs with stakeholders outside of government;
- practical cross-sector initiatives build partnerships and trust.

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2010, Kuala Lumpur, Malaysia





## MSA-Entry Points

<p><b>National</b> National multi-ministerial forum</p> <ul style="list-style-type: none"> <li>Effective only with commitment at the highest level, need a good driver, Health in All Policies</li> </ul>	<p>Inter ministerial</p>	
<p><b>Subnational</b> City/District/Village level</p> <ul style="list-style-type: none"> <li>More feasible, leverage local government, collective voice of community, government closer to the community, local ordinances</li> </ul>	<p>Local Government</p>	
<p><b>Risk factor</b> Tobacco/Alcohol/Physical Activity</p> <ul style="list-style-type: none"> <li>Facilitators-activism, pressure groups, champions, international agreements (FCTC), global reporting, more palpable interventions, common good /common enemy</li> </ul>	<p>Cross sector working groups</p>	

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2013, Kuala Lumpur, Malaysia

## MSA-Accountability and Reporting

- Experiences from MDG 4 and 5 in accountability framework
- Agreed national targets and indicators
- Sector-specific roles, responsibility, target, inputs and outputs
- Joint statement and joint plan
- Across sectors audit, evaluation
- Public reporting



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2013, Kuala Lumpur, Malaysia

## 7. Next steps

- National multisectoral plans by 2013
- National multi-sectoral mechanisms
- The most feasible interventions
- National targets and indicators
- WHO country specific support

WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2013, Kuala Lumpur, Malaysia

## Let us Work Together for a Region Free of Avoidable NCD Deaths



WHO Regional Meeting on National Multi-Sectoral Action Plans for NCD Prevention and Control  
11-14 June 2013, Kuala Lumpur, Malaysia