



THE REPORT OF THE III GLOBAL FORUM ON NCD PREVENTION AND CONTROL

CONVENED IN RIO DE JANEIRO, BRAZIL

9 – 12 November 2003

Department of Noncommunicable Disease Prevention and Health Promotion

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Abbreviations

AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas (see PAHO)
CARMELA	Cardiovascular Risk Factors Multiple Evaluation in Latin America
CARMEN	Conjunto de Acciones para Reduccion Multifactorial de Enfermedades No transmisibles (Set of actions for the multifactorial reduction of NCDs)
CCDPC	Centre for Chronic Disease Prevention and Control (Canada)
CDC	Centers for Disease Control and Prevention (Atlanta, USA)
CINDI	Countrywide Integrated Noncommunicable Diseases Intervention Programme
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DALY	Disability Adjusted Life Years
EC	European Community
EMAN	Eastern Mediterranean Approach to Noncommunicable Disease
EMRO	WHO Regional Office for the Eastern Mediterranean
EURO	WHO Regional Office for Europe
FCTC	Framework Convention on Tobacco Control
IDF	International Diabetes Federation
INCA	National Cancer Institute
ICN	International Council of Nurses
IUATLD	International Union Against Tuberculosis and Lung Diseases
IUHPE	International Union for Health Promotion and Education
KTL	National Public Health Institute of Finland
LMI	Low- and middle-income (countries)
MNC	Department of Management of Noncommunicable Diseases
MAOANA	Mobilization of Allies in Noncommunicable Disease Action
MOH(s)	Ministry(ies) of Health
NANDI	Network of African Noncommunicable Diseases Interventions NCD(s) Noncommunicable disease(s)
NGO(s)	Nongovernmental organization(s)
NMH	Noncommunicable Disease and Mental Health Cluster
NPH	Department of Noncommunicable Disease Prevention and Health Promotion
PAHO	Pan American Health Organization (see AMRO)
PHC	Primary Health Care
QALE	Quality-Adjusted Life Expectancy
SEARO	WHO Regional Office for South-East Asia
STEPS	WHO STEPwise approach to surveillance
UICC	International Union Against Cancer
VHL	Virtual Health Library
WHA	World Health Assembly
WHF	World Heart Federation
WHO	World Health Organization
WMA	World Medical Association
WPRO	WHO Regional Office for the Western Pacific
YLD	Years Lived with Disability
YLL	Years of Life Lost

III GLOBAL FORUM ON NCD PREVENTION AND CONTROL

RIO DE JANEIRO, BRAZIL
9 – 12 NOVEMBER 2003

INTRODUCTION

The Global Burden

The Third Global Forum on Noncommunicable Disease Prevention and Control took place in Rio de Janeiro, Brazil, from 9 to 12 November 2003. This third annual meeting offered an important international platform for a worldwide overview of the progress being made in developing an integrated response to the growing worldwide toll of death and disability from the noncommunicable diseases (NCDs), which today account for approximately 59% of the 56.5 million total deaths and 46% of the global burden of disease.

They include cardiovascular diseases, which are the largest cause of death worldwide and account for almost 17 million fatalities annually, as well as cancers, diabetes, respiratory diseases and obesity-related conditions. Three common risk factors are responsible for a majority of these diseases, namely **tobacco use, unhealthy diets and physical inactivity**.

Globally, the burden of NCD has rapidly increased. Today, the majority of the toll of morbidity, disability and mortality falls not, as one might expect, upon the wealthier parts of the world but upon populations in developing countries.

Integrated NCD Prevention

The World Health Organization (WHO) is seeking to develop an integrated response to these insidious diseases through a combined effort of all its regional networks, WHO headquarters and its many global partners. The representatives of these groups came to Rio to share experiences and decide on common future actions.

The *World Health Report 2002*, with its subtitle *Reducing risks, promoting healthy life*, indicated that the mortality, morbidity and disability attributed to the major noncommunicable diseases (NCD) currently account for almost 60% of all deaths and 43% of the global burden of disease. By 2020 their contribution is expected to rise to 73% of all deaths and 60% of the global burden of disease. Moreover, 79% of the deaths attributed to these diseases occur in the developing countries.

Four of the most prominent NCD – cardiovascular disease (CVD), cancer, chronic obstructive pulmonary disease and type 2 diabetes – are linked by **common and preventable biological risk factors**, notably high blood pressure, high blood cholesterol and overweight, and by **three related major behavioural risk factors**, namely unhealthy diet, physical inactivity and tobacco use. It is very clear that actions to prevent these major NCD should focus on controlling these and other key risk factors in a systematic and well-integrated manner.

The global threat to health posed by the growing burden of NCDs and the need to provide an urgent and effective public health response had earlier been recognized by the 51st World Health Assembly in 1998, when it requested the Director-General to prepare a global strategy for NCD prevention and control (Resolution WHA 51.18). This strategy was subsequently developed and endorsed by the WHO Executive Board (EB 105/42) and formally adopted by the 53rd Assembly in 2000 (Resolution WHA 53.17). This requested the Director-General to continue giving priority to the prevention and control of NCDs. The Resolution placed special emphasis on developing countries, on the need for leadership to be provided by WHO in combating NCDs and their risk factors, and on giving technical support and guidance to Member States.

The Global Strategy for NCD Prevention and Control promotes global partnership and global networking, and provides technical support and strategic support for research and development. There was a clear need for a regular meeting-place where experiences in this field could be shared, initiatives could be described, and progress in all countries and regions could be measured. Since practices in the developed and the developing world may differ, it was judged important that the strategy should be applicable in all circumstances.

Development of an integrated approach that will target all major common risk factors of Cardiovascular disease (CVD), Diabetes Mellitus (DM), Cancer and Chronic respiratory disease is the most cost-effective way to prevent and control them. An integrated approach responds not only to the need for intervention on major common risk factors with the aim of reducing premature mortality and morbidity of NCD, but also to the need to integrate primary prevention, secondary and tertiary prevention, health promotion and diseases prevention, and related programmes across sectors and disciplines.

Notable progress has been made in upgrading NCD prevention within WHO's agenda and in providing support to countries for NCD prevention. This has included addressing the common risk factors of unhealthy diet, physical inactivity and especially tobacco use, for example through the Framework Convention on Tobacco Control passed by WHA 56 in 2003. These activities, together with multi-stakeholder consultations, resulted in the formulation of a Global Strategy for diet, physical activity and health to counter those risk factors.

Regional Networks

Since WHO began placing increasing emphasis on this work in 2000, many countries in different WHO regions have sharply upgraded their work in NCD prevention and control and have joined the respective regional networks.

The networks of national or demonstration programmes for NCD prevention and control are currently at different stages of development. Two well-established ones, *CINDI* and *CARMEN*, are active in European and American countries. *EMAN* for the Eastern Mediterranean Region of WHO and *NANDI* for the Africa Region were launched in 2001. The Western Pacific Region and the South-East Asia Region are preparing to establish the equivalent regional networks for integrated NCD prevention and control.

The Global Forum

The year 2000 saw the creation of *the Global Forum on NCD Prevention and Control* – a vehicle for close collaboration between WHO, its regional networks, international nongovernmental organizations, WHO collaborating centres and concerned UN agencies. The overall goal of the Global Forum is to contribute to Global NCD prevention by promoting integrated NCD prevention and control, particularly in low and middle income countries, working through regional networks and always in line with the Global Strategy. The Forum facilitates frank exchanges of experiences and the formulation of common actions for national and global NCD prevention. It has already increased the global visibility of NCD prevention, which has become a major priority and challenge for global public health. The three annual meetings held so far have been: Global Forum I at Geneva in 2001, Global Forum II at Shanghai in 2002, and Global Forum III at Rio de Janeiro in 2003. Canada will be the host country for the IV Global Forum, scheduled for 4-6 November 2004, in Ottawa, with a programme developed jointly by WHO, PAHO and Health Canada.

One of the key approaches of the Global Forum has been to generate regional networks for NCD integrated prevention and control. Developed as tools for collaboration between countries active in this field, these networks disseminate information, exchange experiences, support regional and national initiatives and help to implement evidence-based preventive measures.

In a nutshell, the Forum seeks to promote intensive networking and to strengthen inter-country and inter-regional collaboration in developing, implementing and evaluating integrated NCD prevention programmes. It will do this through policy and strategy development, aimed specifically at advocacy, surveillance research, capacity building and training. The accent is heavily on partnership and resource mobilization.

Raising awareness about NCDs at the regional and global levels is seen as a key mechanism for disseminating information, advocating best practices, and providing support to national integrated prevention and control programmes.

Addressing Common Risk Factors

Under WHO's mandate to give much greater emphasis to the prevention and control of NCDs, the Global Strategy for NCD Prevention and Control seeks to address three major behavioural risk factors:

- tobacco use
- unhealthy diet
- physical inactivity.

The *Framework Convention on Tobacco Control* (FCTC), unanimously adopted by WHA56 in 2003, has been a major development in tobacco control. The FCTC, the first ever treaty negotiated under the auspices of WHO, represents a new era in global and national tobacco control activities. Since its adoption, new evidence has revealed that, in the single year 2002, 4.83 million people died from tobacco-related causes, just 50% of them in the developing world. Without further intervention, it is estimated that the death toll will reach 10 million in the next two decades. The FCTC provides a powerful tool with which to effectively reduce this rate.

WHO's Global Strategy on Diet, Physical Activity and Health is an initiative that was mandated by successive WHA resolutions, and a first report from WHO and FAO was published as the evidence on which the initiative is supported. A series of consultations were held with more than 80 Member States and leading UN agencies, NGOs and civil society. The initiative is now in draft form and will be submitted to the WHA in 2004.

WHO was charged with developing the Strategy after consulting with Member States, UN agencies, civil society, NGOs and the private sector. This strategy has involved a complex interaction with multiple stakeholders, and has brought together leading experts in the fields of physical activity, diet and nutrition, and NCD prevention. The Strategy should provide a firm basis for WHO and its Member States to work with other stakeholders in promoting global changes towards healthier diets and increased physical activity. The end product should be to prevent NCDs and improve population health in general.

Once the Global Strategy has been approved, it will give much-needed visibility to the question in point, but does not necessarily change the problem to be faced. Specific strategies to prevent NCDs that address the main risk factors of incorrect diet, inadequate physical activity and tobacco use all need to be integrated into existing national programmes. The participation of NGOs in developing and implementation national strategies is essential in this respect. The strategy will build on the experience of member countries as well as that of other stakeholders.

WHO hopes to draw up a preliminary implementation plan in consultation with the NCD Networks and WHO regions. The strategy itself focuses on the key role that must be played by Ministries of Health in drafting national guidelines for physical activity and diet; in establishing communication policies and, for example, defining the necessary information that should be written on food labels; in laying down a pricing policy; and in expanding the epidemiological surveillance system.

In the coming months, it is hoped that a workshop on the strategy will be arranged, when it will be important to hear the varied experiences of those NCD Networks that have already been implemented. The progress achieved in different areas will need to be emphasized, such as risk factor prevention, capacity building, research, the impact of health programmes in schools, and so forth.

Move for Health Initiative. WHA55/23 recommended that Member States should celebrate an “Annual Move for Health Day”, following the successful World Health Day 2002 which had this as its theme. The initial event was celebrated in Sao Paulo, Brazil, with the participation of the Director-General of WHO, in recognition of the outstanding “Agita Brazil” Campaign to promote physical activity and healthy behaviours. The concept of an annual *Move for Health* event was developed in consultation with Member States. The initiative triggered considerable interest and won the commitment of political leaders and decision-makers in many Member States. A Steering Committee met in Geneva in September 2003 to advise on the planning of *Move for Health* events in 2004 and 2005.

Capacity Building

Capacity-building is essential to ensure effectiveness. Special attention is being paid to strengthening the competence of personnel and institutions involved in reducing risk factors, drafting policies and strategies, establishing national or demonstration programmes, and monitoring and evaluation. Regional offices, working with WHO collaborating centres, have started training programmes for integrated prevention. The Rotating International Visitors Programme was launched in Isfahan, Iran, in 2003 by WHO in collaboration with the Isfahan Heart Health Project. Two five-day training seminars on “Evidence-Based Public Health: A CINDI Training Course in Chronic Disease Prevention” took place in Schruns, Austria, in 2002 and 2003. The 5th and 6th CINDI Winter School – training seminars for public health professionals on community-based health promotion and chronic diseases prevention – were organized in 2002 - 3 and were hosted by the National Public Health Institute, Finland.

A WHO research study was initiated in 2002 to determine the effectiveness of community-based prevention and control programmes.

THE THIRD GLOBAL FORUM

Global Forum III brought together in Rio de Janeiro representatives from the regional networks and national programmes, as well as participants from WHO, all the principal nongovernmental organizations and partners, and relevant WHO collaborating centres.

Its objectives included an intensive review of the progress made by the networks since the previous meeting of the Forum, held in Shanghai in November 2002, in increasing public awareness about NCD prevention and control initiatives. It also examined the progress being made in the field of NCD prevention and control, in particular by the rapidly growing regional networks. Besides exchanges of experiences with existing integrated NCD prevention programmes, the Forum discussed innovative ways of implementing the Global Strategy, notably through advocacy, greater inter-regional collaboration and international partnerships, and collaborative research and capacity building, especially in relation to primary and secondary prevention.

The Forum called for much wider dissemination of scientific evidence and experience in all relevant fields, including making full use of state-of-the-art information technology, not least in order to provide updated guidance on primary and secondary prevention of NCDs.

Global Forum III also saw the launch of a new WHO initiative, the Global Fruit and Vegetable Programme, as well as the announcement of PAHO's Virtual Health Library on NCDs.

Opening of the Third NCD Global Forum

At the opening session of the Third Global Forum on 9 November, senior officials of the Brazilian Government and of Rio de Janeiro welcomed the delegates to the city.

Dr Jarbas Barbosa da Silva Jr., State Secretary of Health Surveillance with the Brazilian Ministry of Health, pointed out that Brazil was one of the first countries to sign the Framework Convention on Tobacco Control. Welcoming the Fruit and Vegetables Initiative, he commented: "Due to the lack of information and difficulty in making choices, the poor have less than healthy eating habits. There is evidence that both higher levels of cholesterol and obesity are more often found in poorer populations than in those with better access to knowledge, culture and goods."

In a keynote address, **Dr Sylvie Stachenko**, Director-General of the Centre for Chronic Disease Prevention and Control, Population and Public Health Branch, Health Canada, said: "We want to raise the awareness of the public at large, of policy-makers and of potential donors about the urgent need and opportunity to prevent NCDs. In this regard, we could make better use of success stories and case studies internationally, and we need to effectively communicate three basic messages: that NCDs

threaten the health and well-being of all people; that prevention *is* effective; and that failure to intensify preventive efforts now will entail heavy costs with health care in the future.”

Dr Carissa Etienne, PAHO’s Assistant Director-General, pointed out that this meeting was taking place at a time when developing and developed countries alike were battling the scourge of an ever-widening HIV epidemic, and facing a great challenge with the resurgence of uncontrolled infectious diseases as well as the ever-increasing burden of non-communicable diseases. In this Millennium, she said, we were once again summoned to extend the global agenda and to call for a collective response to noncommunicable disease prevention and control.

This is a major problem worldwide, and in the Americas is expanding across all regions and social classes. In Latin America, NCDs are the main cause of premature death. The 2002 World Report indicates that all major factors – hypertension, tobacco use, alcohol consumption, high cholesterol, obesity and the diseases associated with them – are becoming more prevalent in the developing nations. Significantly, in Latin America and the Caribbean the magnitude of NCDs associated with these factors is higher among the poor. Indeed it is as high in the poorer countries of the region as it is among middle- and high-income countries. “Malnutrition and obesity coexist among the poor in our countries,” she said.

To be effective, she said, we must provide actions within programmes aimed at making continuous progress in prevention and rehabilitation. The urgent need for health care, made worse by the lack of health centres for the population that suffers most from these diseases, cannot be ignored and must be effectively addressed through cost-effective means. This will require continuous public health interventions, such as surveillance and technical capacity, and the work should include civil society much more widely. No one division, no one unit or sector can respond adequately to this challenge.

Dr Etienne put emphasis on the countries’ expectations regarding technical cooperation, with integrated action in every area aimed at the development and maintenance of partnerships, the identification of priority groups and the reduction of inequalities as key operational principles guiding the work of the organization. CARMEN is one initiative which is working to transform country demands into action and technical support.

She concluded: “We should always be alert, following global thinking, and at the same time should be committed to acting locally, within countries, communities and families so that the battle can be won.”

Dr Pekka Puska, the Director of WHO’s Department of Noncommunicable Disease Prevention and Health Promotion, presented an overview of the present epidemiological transition in world health. He pointed out that **five out of all the six health regions** of WHO showed a similar profile, with deaths from cardiovascular diseases representing one-third of worldwide mortality. The NCDs in general could all be attributed to certain leading risk factors, and seven out of ten of these related to physical inactivity, unhealthy diet and tobacco use. Lifestyle transitions must be added to other shifting patterns that are characterized by community dynamics which affect both adults and children.

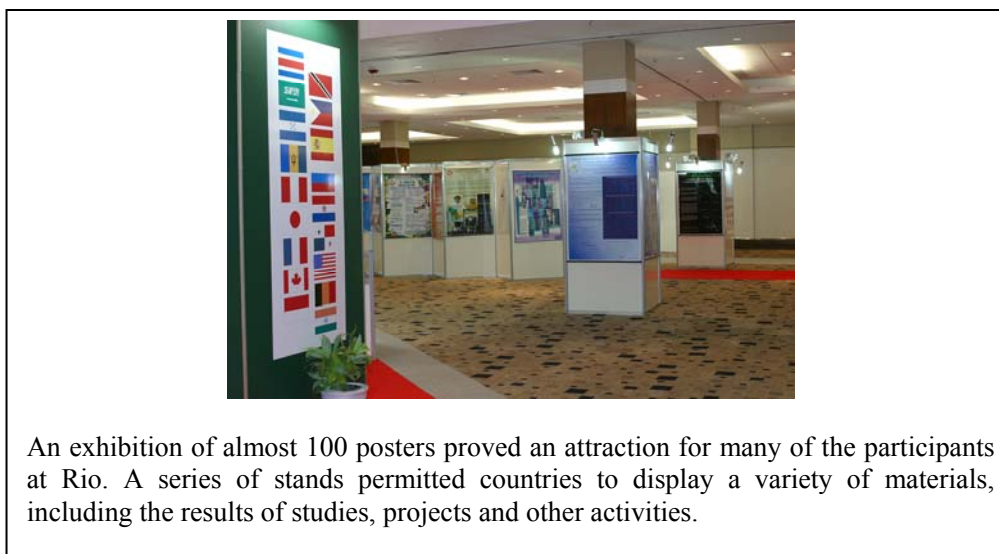
He said that the WHO Global Strategy on NCD Prevention and Control was based on a comprehensive approach determined by prevention from an integrated perspective. It is intended to target common risk factors with gains that can be made with quite modest expenditures. It is flexible, permitting a mix of different intervention strategies so as to arrive at a cost-effective balance.

Part of this strategy is to encourage countries to work together. This perspective of prevention and integrated work was endorsed by WHO's last official report. Since the actions are relatively simple, several gains for the health of the collectivity can be obtained, for example, with adequate eating habits, or even a simple reduction in the use of salt, in the case of hypertension.

NCD prevention and control should involve an effective mix of strategies with governmental support to finance the activities, comprehensive advertising and work undertaken within the concept of networks of national programmes for NCD prevention and control, as is the case with CINDI in Europe and CARMEN in the Americas.

The tone of the three-day meeting was set by **Dr Catherine Le Galès-Camus**, WHO Assistant Director-General, Noncommunicable Diseases and Mental Health, She was unable to attend the meeting, but in a video-recorded message she told the participants: "Clearly, unhealthy diet, smoking, physical inactivity, excessive use of alcohol and psychosocial stress are among the major lifestyle issues globally. This adds up to a huge challenge for all countries, and in particular for those in the developing world. First of all, we need to focus on the principal common risk factors: tobacco use, unhealthy diet and physical inactivity."

She stressed that the Framework Convention on Tobacco Control, unanimously adopted by the World Health Assembly in 2003, represented a new era in tobacco control and provided a roadmap to help reduce the appalling toll of death and disability caused by smoking. A Global Strategy on Diet, Physical Activity and Health has been finalized, and is being put before WHO's governing bodies for approval.



An exhibition of almost 100 posters proved an attraction for many of the participants at Rio. A series of stands permitted countries to display a variety of materials, including the results of studies, projects and other activities.

Launching the Global Fruit and Vegetable Programme

Dr Pekka Puska and Dr José Carlos Tubino, Representative of the Food and Agriculture Organization of the United Nations (FAO) in Brazil, formally launched the Global Fruit & Vegetable Programme, an initiative developed jointly by WHO and FAO. The purpose is to promote much greater consumption, worldwide, of fruit and vegetables in view of the growing body of evidence that these help to prevent such major NCDs as cardiovascular diseases, type 2 diabetes, obesity and certain cancers. Low intake of these foods is estimated to cause some 2.7 million deaths each year. Specifically, low intake accounts for about 31 percent of ischaemic heart disease and 11 percent of stroke, between five and 12 percent of all cancers, and up to 20 or 30 percent of cancers of the upper gastrointestinal tract.

Il faut manger pour vivre et non pas vivre pour manger.

One should eat to live, and not live to eat

Molière, 1622-1673, in *L'Avare* (The Miser)

Increased fruit and vegetable consumption can also help to displace excessive consumption of foods high in fats, sugars or salt. The WHO/FAO Joint Report on Diet, Nutrition and the Prevention of Chronic Diseases recommends the intake of a minimum of 400 grams of fruit and vegetables per day (excluding starchy tubers such as potatoes). Dr Puska added that eating a wide variety of these foods will ensure an adequate intake of most micronutrients, dietary fibres and a host of beneficial non-nutrient substances.

Launching The Virtual Health Library on NCDs

Dr Sylvia Robles of PAHO announced the launch of the Virtual Health Library on Noncommunicable Diseases, in recognition of the need for timely information to reach policy-makers, ministries of health and health service managers. This Library will provide scientific and technological information in three languages, and is envisaged as “a users’ library in a virtual community.” Users are expected to contribute and to share their experiences so that a true community, both virtual and practical, can emerge from this initiative.

She said it can serve as a vehicle to increase communication among member countries, and as a forum to discuss policy issues which need multiple-country collaboration.

Dr Elizabete Duarte, from the Ministry of Health in the Brazilian Ministry of Health, was elected Chairman of the meeting and **Dr Viliami Tau Tangi**, Health Minister of Tonga, as vice-chairman. Appointed as the meeting’s official rapporteurs were the representative of WHO’s Secretariat, **Dr Darling Castañeda**, from Costa Rica, and **Dr Gina Watson**, from Trinidad and Tobago.

Achievements and progress

Progress Reports from the Networks

AMR/CARMEN Network:

In the Region of the Americas, CARMEN is the Spanish acronym for the integrated non-communicable disease prevention network created in 1996 by WHO to help to prevent NCDs. Benefiting from the prior experience of the CINDI programme in Europe, CARMEN required a flexible model that could be adjusted to the wide variety of situations and conditions existing in the countries of the Americas.

There is now a framework document for CARMEN, and a model has been approved at PAHO that recognizes the need for a systemic response to NCDs. Policy definitions must be capable of responding to changes in the profiles of the countries concerned, and it is clear that the needs and expectations of the community must be addressed with and through their effective participation.

CARMEN's objective is to support and promote the reduction of NCDs in the Americas. There are three lines of action and levels: policy development, community-based action, and responsive health service strategies. Interventions must be integrated, with demonstrable effect, and always with a view to promoting health equity. Each Member State must have a national plan.

CARMEN has already contributed to opening up the health services to the community and bringing together other partners to respond to problems that may be beyond the scope of the health sector. The demonstrable effect means identifying the successful interventions based on demonstration areas as the first introductory approach, so as to be assured of the effectiveness and impact of the intervention on mortality and morbidity factors. The risk reduction component relates to the promotion of health equity with a view to reducing the gaps between different population groups. An example of this is the nutrition policy in Brazil.

Further network development will depend on developing cost-effective interventions, obtaining political support, and promoting a regional agenda to prevent and control NCDs.

EUR/CINDI Network (Programme):

CINDI, the Countrywide Integrated Non-communicable Disease Intervention Programme aims to assist Member States to control and prevent NCD epidemics. Its purpose is to implement an integrated approach towards NCD prevention and control through effective networking and the use of health promotion and disease prevention measures implemented at national, regional and demonstration area levels. Several examples of such interventions were presented. Examples of intervention projects included a CINDI-Portugal project on hypertension prevention and control "Measure blood pressure and walk", the international smoking cessation campaign "Quit and Win," a joint CINDI/EuroPharm Forum project on pharmacy-based hypertension management, international and national training

seminars on NCD prevention and control at community level (e.g. the CINDI Winter School), and a number of publications and training initiatives in member countries.

The CINDI network has more than 30 participating countries with 28 Member States as full members of the network, and globally CINDI also coordinates with other countries, networks and organizations. It is developing programmes at country level that address risk factors according to each given situation. Other intervention strategies include capacity building (training and development of training materials) in health promotion and disease prevention, NCD policy development, research into NCD preventive measures, and dissemination of the knowledge gained.

A network paper from EURO noted that a regional proposal for NCD prevention and control has been prepared and was submitted to the Regional Director in 2003. Last but not least, CINDI is developing a database to serve as an important partnership platform.

EMR/EMAN Network:

The Eastern Mediterranean Region has a profile of “epidemiological transition,” in that it recognizes that, while the burden of disease has shifted, the services haven’t. Thus a better coordinated, comprehensive healthcare system is required alongside the standard acute approach. Diabetes emerges as one of the major issues along with associated health risk factors such as smoking, obesity and lack of physical activity. The EMAN network recognizes that NCDs cannot be neglected since the cost of doing so simply becomes unaffordable, in view of their burden of morbidity and mortality. It is proving essential to train many more personnel in NCD prevention and control, to improve the collection of mortality and other relevant data, and to monitor more closely the cost-effectiveness of interventions.

There are nine countries in the network with different levels and complexities of services. While some material is being published in this field, the limitations include weak policies and strategies, meagre resources and fragmentation of response. The collaborating centres have great potential for strengthening training, arranging visiting programmes and improving care facilities in general.

AFR/NANDI Network:

Five major programmes are in action in the African Region. The Network was established in 2001, and in keeping with global and national strategies for addressing the NCDs, it builds on other experiences, principally those of CARMEN. It seeks to emphasize that the control of NCDs is of top priority, and calls for full commitment of governments to the prevention and control of these diseases.

NANDI recognizes that it is to some degree in competition with efforts to contain the communicable diseases (CD), whose prevalence and incidence are very much of political concern. Consequently, the network has started with a surveillance approach that is integrated with CD surveillance, and involves training to develop the necessary skills to deal with both these scourges.

Three training, management and research centres have been established for cervical cancer, and other similar ones are being started. A programme to foster rheumatic fever/rheumatic heart disease control

has been launched, together with initiatives for tobacco control, better school health, promotion of the WHO global diet recommendations, physical activity, and action against hypertension in pregnancy.

WHO/SEAR Network:

The process of initiating the regional network for NCD prevention and control in SEAR is progressing, and four countries are being supported in setting up national networks. A regional meeting to initiate the network in SEAR is planned in 2004. The instrumental role played by the Global Forum in stimulating and facilitating this process is much appreciated. At the 2003 Global Forum meeting in Shanghai, the Region was represented by Sri Lanka and Thailand, two SEAR countries where NCD surveillance and prevention activities are rapidly advancing. At the Rio de Janeiro Forum there were representatives from Indonesia, a SEAR mega country which has successfully established a national NCD surveillance network and has demonstrated a strong commitment to developing a national NCD policy and strategy.

There are 11 countries in SEAR. Even though all of them are categorized as developing countries, the epidemiological transition is in an advanced stage. According to WHO estimates for 2002, 50 per cent of all deaths and 42 per cent of the disease burden measured in disability-adjusted life years (DALY) lost are already attributed to NCD. Most prominent among the important risk factors for NCD in SEAR are high arterial blood pressure and tobacco use. They contribute respectively to an estimated 8 per cent and 10 per cent of all deaths occurring in the region. Another important risk factor for NCD that has not attracted adequate attention is indoor air pollution caused by extensive use of biofuel for cooking and heating purposes.

Although NCDs are clearly assuming increasingly high proportions and are becoming the leading causes of mortality, morbidity and disability in SEAR, the situation has not yet evoked an appropriate public health response in the region. This is reflected in the limited resource allocation and inadequate commitment of the governments to identifying and addressing priorities related to the prevention and control of major NCDs.

The important regional NCD initiatives of recent years include the launch of the regional NCD surveillance network and adoption of a regional strategy for NCD surveillance. Eight SEAR countries are being supported in conducting standardized NCD risk factor surveys and Global Youth Tobacco Surveys. Facilitating mechanisms such as intercountry training, a statistical support group and a regional equipment pool have been instituted to support NCD risk factor surveillance activities in SEAR. Another recent development in the area of surveillance is the initiation of a chronic diseases' risk factor infobase.

SEARO coordinates the activities of the regional NCD surveillance network, established in 2002. It focuses on facilitating cooperation among countries, capacity building and promotion of appropriate use of available information. The Regional Strategy for NCD Surveillance, adopted in SEAR in 2003, aims at supporting member countries in developing national strategic plans of action for the sustainable collection of core information for advocacy and for NCD programme development and evaluation.

Three pilot projects on integrated community-based prevention of NCD were initiated in Bangladesh, India and Indonesia in 2000; these have currently entered their demonstration phases. New interventions are being planned in Maldives and Sri Lanka. Long-term sustainability of community-based intervention projects and appropriate monitoring and evaluation are matters of serious concern.

WPR/MAOANA:

The Western Pacific Region's network - Mobilization of Allies in Noncommunicable Disease Action (MAOANA) is still being built up. Nevertheless the indications are that risk factors and NCDs are increasing along with changes in traditional practices, some of which are less desirable. An example is the commonly held view that child obesity is an indicator of healthy development. The available information shows that traditional food has changed in energy density and portion size.

Components of the NCD programme are related to changing environments, changing lifestyles and reorienting health services. In 2003 the Tonga Declaration to promote a healthy lifestyle and supportive environments was endorsed and is supported by all countries. Ten countries in particular have adopted its STEP intervention framework, and the results will be assessed in 2005.

National initiatives include developing training manuals and setting standards for skills development. Emphasis on reducing tobacco use has already had measurable positive results, and projects aimed at curbing obesity are under way. Clinical management guidelines have been developed for NCDs, with emphasis on diabetes mellitus and hypertension. All these initiatives are linked within the framework of the global strategy.

NCD prevention

Dr Pekka Puska told the participants that global campaigns and activities can be extremely practical interventions and provide proven tools to target the three risk factors of physical inactivity, unhealthy diet and tobacco use. Under a WHA Resolution, the observance on 10 May each year of "Move for Health" with its accent on regular physical activity provides an opportunity to advocate healthier lifestyles and strengthen partnership with different sectors. The theme 2004 theme will be focused on children, and in 2005 on a supportive environment.

The Fruit and Vegetables initiative is addressed from the perspective that if consumption of these items is increased, millions of lives can be saved. They replace high energy items and provide good sources of vitamins and mineral. Their production is simple, with high productivity potential, and they can contribute to alleviating hunger and malnutrition, while offering advantages to global marketing. The recommended intake goal is of more than 400 grams per day, with an average of five portions per day.

The joint proposal from WHO/FAO is aimed at stimulating change from unhealthy to healthy diets through a positive message. Agricultural and marketing policies and issues of quality need to be addressed and supported, including production, consumption and distribution at country level. The

scientific base for the initiative is being strengthened and appropriate kits are being prepared for country.

Ms. Amalia Waxman, WHO, Geneva told participants that WHO Member States requested the secretariat in May 2002 to develop a Global Strategy on Diet, Physical Activity and Health within the framework of NCD prevention. This Strategy, to be approved at the World Health Assembly in May 2004 was developed through a wide range of consultations with all stakeholders.

The Strategy has four main aims:

1. to reduce risk factors for NCDs that stem from unhealthy diets and physical inactivity through public health action
2. to increase awareness and understanding about the influences of diet and physical activity on health
3. to encourage the development, strengthening and implementation of policies to improve diets and increase physical activity
4. to monitor scientific data and key influences on diet and physical activity.

Among the key policy recommendations the strategy addresses the importance of the Ministry of Health's leading role, the need for national guidelines for physical activity and diet; the establishment of communication policies and improving the information environment as regards issues such as marketing of food and food labeling, the importance of fiscal policies in making healthy foods available to the poor and the critical role of strengthening national surveillance system.

WHO intends to develop an implementation plan in consultation with countries, the NCD Networks and WHO regions.

FCTC and Smoking Cessation

[Smoking is] a custome lothsome to the eye, hateful to nose, harmefull to the brain, dangerous to the lungs, and the blacke stinking fume thereof nearest resembling the horrible Stigian smoke of the pit that is bottomless.

King James I of England 1566-1625

The Framework Convention on Tobacco Control (FCTC), adopted in 2003, was recognized by the Forum participants as a major breakthrough in efforts to curb smoking in all countries. The Forum was told that, at the level of the individual, smoking prematurely kills every second smoker, unless he or she stops in time.

Among the key areas covered by the Convention are price control through taxation, advertising and marketing, smokefree zones, tobacco control messages, preventing children from starting to smoke, and the monitoring of trends and determinants within the industry.

Unlike the Fruit and Vegetables Initiative, first announced at the Third Global Forum in Rio in 2003, the **Tobacco Framework Convention** is a positive promotion-driven initiative and requires each country to examine its legal framework after ratifying the convention. So far, just three countries have done this – Fiji, Malta and Norway. The convention becomes effective after a majority of member countries have done so, and in the meantime it remains a binding commitment to those already ratifying the framework.

The FCTC has also provided a unique opportunity for WHO to forge global partnerships at all levels, firstly with Member States but also with most of the other major UN agencies through the work of the UN Ad Hoc Interagency Task Force on Tobacco Control. National and international NGOs also played a crucial role in the negotiations leading to adoption of the Convention. Regional economic integration bodies are playing their part, including the European Union, which advocates having tobacco control recognized as an integral part of the development agenda.

Because the FCTC calls for governments to take wide-ranging action to curb tobacco use, many government ministries (health, finance, taxation, labour, agriculture and others) are working closely together for the first time on these complex issues. The powerful momentum of the FCTC process and of the partnerships forged as a result are providing an excellent foundation on which to build in the next phase. WHO will now focus on making the FCTC a reality on the ground and at country level.

A campaign to encourage cessation of smoking, called “**Quit and Win**,” has been running since 1994, when 13 CINDI countries and 60,000 individuals participated in the event. By 2002, this had swollen to 700,000 individuals from 77 countries, competing for very substantial prizes.

The competition is an international smoking cessation contest for adults. Smokers from all over the world try to abstain from smoking for a four-week period. Follow-up studies have shown that after one year, some 20 per cent of the participants have remained tobacco-free. The contest is supported by WHO and has several international partners. There are optional contests for non-smokers as supporters of the event, and other sub-contests for health professionals, worksite colleagues and so forth. Lottery draws are arranged in each country, followed later in the year by a draw for international Super Prizes.

Seen as a simple, practical and cost-effective tool, Quit and Win gets ample coverage in the media and each year brings home to millions of people the advantages of giving up smoking. It also helps to create partnerships and encourage international and interregional networking. One popular related slogan has been: *Smoking is a mass problem that calls for mass action also in cessation.*

Referring to the “**Quit and Win**” tobacco campaign, Dr Puska said this decade-long initiative has a common protocol and timetable in which all countries are invited to participate. The campaign is

simple and cost-effective. It provides an opportunity to collaborate with the health services in advocating beneficial change, and having a real impact on tobacco cessation. Additional environmental factors such as stress also need to be considered in the context of the initiative.

Move for health

Health is not to be purchased by idleness and inactivity, which are the greatest evils attendant on sickness, and the man who thinks to conserve his health by indolence and ease does not differ from him who guards his eyes by not seeing, and his voice by not speaking. For a man in good health could not devote himself to any better object than to numerous humane activities.

Plutarch 46 – 120 A.D.

Besides the Global Fruit and Vegetables Programme described above, the Forum reported on the success of the Move for Health Day which many countries now sponsor in order to promote physical activity as essential for health and well-being. Each year on 10 May (or the closest day feasible) events are sponsored according to locally chosen themes, with messages disseminated through the media and backed by senior officials and “role-models” from the sporting or entertainment sectors.

Move for Health is intended to be an occasion for individuals to increase their physical activity practices, and for governments to scale up effective policies and programmes aimed at increasing physical activity among the population.

The WHO Global-Regional InfoBase

Dr Kathleen Strong of WHO/HQ and **Dr Jerzy Leowski** of WHO/SEARO presented jointly their experience in establishing WHO’s Global-Regional NCD InfoBase. The InfoBase focuses on the eight risk factors that determine the majority of avoidable chronic disease deaths and the disease burden globally. All the data are available online to member countries and enable them to construct tailor-made country profiles. The InfoBase relies on a multiplicity of information sources, with some texts in local languages, to create a useful and sustainable tool. The next steps are to build in country data on the prevalence, incidence and mortality of principal chronic conditions, and to harmonize all data.

A regional NCD InfoBase is being established at SEAR in order to facilitate deployment of the tool to member countries in the Region. This will further contribute to capacity building for collection, management and utilization of information at national level. By 2005, at least nine countries will have set up national NCD databases.

The NCD InfoBase is intended to function as a single source for surveillance data that will be transparent and accessible. It assembles all recent and most representative information necessary to make data usable. It provides national and regional statistics on prevalence and mean values of major chronic disease risk factors by age-group(s) and sex. As the data collection expands, it is expected that data quality will steadily improve.

Implementing the Global Strategy

Global, regional and national strategies for tackling the main risk factors for NCD include implementation of the Framework Convention on Tobacco Control, initiatives to promote greater physical activity, and measures to encourage healthier diets. Participants also examined the role of the health services in these activities, the surveillance and evaluation of the information base, and the value of community-based programmes. Much emphasis was placed on an evidence-based approach, using sound medical research as well as effective community-based demonstration programmes and large-scale prevention measures. Participants agreed that partnerships with all interested parties will be of vital importance to NCD prevention.

Speakers emphasized the role of the media, whose support should be sought at the three levels of policy, the community and the health services. Policy issues must be related to marketing all topics relating to risk factors. It was felt that revisiting the primary health care approach would also provide opportunities to reach out to the public. Because awareness of the complexity of the problem is lacking, epidemiological transition is occurring at a faster rate than the institutional changes that the situation calls for.

Analysis of cost-effectiveness is urgently required to relate the cost of policy implementation to the individual risk and the cost of treating NCDs. While models are useful in providing rapid information for decision-making based on current knowledge, they are often subject to gaps in the database. As a result, models were being constructed on the often erroneous assumption that implementation would affect all groups equally.

Translating Science into Action and Policy

Dr Ruitai Shao, from WHO/HQ, underlined the need for ongoing research to develop the tools needed to make integrated NCD prevention a reality. Over the past 50 years, many major epidemiological studies, clinical trials and community-based programmes had accumulated vast scientific knowledge and experience in NCD prevention and control that could provide evidence of practical, measurable results. He presented examples of studies already under way and of intervention tools already being used, including those targeting risk factors related to CVD.

Awareness of the threat that NCDs pose to health is critical to NCD prevention. DALYs and QALEs offer measurable indicators to show how disease patterns change within a population. Outlining some of the many well-known studies that have been made into heart disease and into chronic conditions resulting from tobacco use, unhealthy diets and stress, he highlighted the Framingham and seven countries studies which provided clues linking such behavioural risk factors with chronic diseases, particular cardiovascular disease. Many projects focused on high-risk populations. He cited the North Karelia, Stanford and Minnesota projects as successful approaches for bringing about positive lifestyle change, and presented a diagram portraying the commonality of related risk factors.

Dr Shao identified the priority areas for action as: awareness raising; the marketing of NCDs and their prevention to the general public; the establishment and development of national strategies, policies, initiatives and programmes; skills training; and networking. Among the constraints to progress in this field, he listed competition with the communicable diseases in countries where there is a double burden from those and the NCDs, confusion in the public mind about how personal behaviours impact on public health in general, and myths about the true impact of unwise lifestyles on health.

Dr Sylvia Robles, from PAHO, said that the policy issues that have to be faced in translating evidence into practice include:

- the difficulty of marketing, at the global level, such health risks as tobacco use and unhealthy diet;
- the fact that health systems are designed to provide episodic, acute health care, rather than sustained advocacy campaigns of the type needed for NCD prevention;
- the slow pace of institutional transition cannot match the pace of epidemiological transition;
- a general lack of awareness of the complexity and gravity of the problem.

Speaking on the method of modeling risks for decision-making, she said the main advantage was that this provides rapid information on complex processes based on what is currently known. The disadvantage is that several assumptions need to be made in order to construct the model.

As an example of national action, **Dr Satoshi Sasaki**, of the National Institute of Health and Nutrition, Tokyo, described the “Health Japan 21” initiative, with data on the epidemiological profile showing how NCDs have become a serious problem for that country. He felt that they should be considered as lifestyle-related diseases in order to raise greater awareness about lifestyle improvement. Strategies being implemented under this programme include advocacy about improving lifestyles by various measures, establishing systems for health promotion with supporting regional plans, and promoting sensible health care activities. The central government is supportive of these efforts, aware that local governments often do not have the resources to undertake their own surveys and research, or to collect evidence on which to base policies.

Implementing NCD Prevention within the Health Services

"No longer can each chronic illness be considered in isolation. Awareness is increasing that they share common, usually related risk factors, and that integrated strategies can be effective for many different conditions."

Health care organization entails programme continuity and coordination, encouraging quality through leadership and intensive courses, organizing and equipping teams for health care, the use of information systems, self-management and prevention.

All the actions mentioned above are considered extremely important because they view lifestyles as part of health care, and positive changes can reduce health systems costs. Health care offers a vast array of services, from maternity care to chronic disease treatment. People have their very first contact with primary health care even before they are born. Families look for health care when they have a problem, and for that very reason they are more motivated to change their behaviour. This statement may not always apply, but it is important nonetheless to bear it in mind.

Health workers' participation in NCD prevention and control is fundamental, especially in view of the respect and credibility they inspire in the population. Their directions are not only influential, but have direct repercussions. This aspect should be reinforced in health centres that serve high-risk populations.

Creating a positive political environment to implement the prevention of chronic conditions in the health services entails: strengthening partnerships; supporting the legislative structure; policy integration; promotion of consistent financing; development of human resources; leadership; and advocacy. A coordinated strategic approach to the prevention of chronic diseases will support and strengthen all complex and long-term care initiatives.

Participants underlined the need for healthier lifestyles to be recognized as being part of care, and stressed that lifestyle changes can actually reduce service costs. It is self-evident that sick persons are motivated to change and, furthermore, that health staff are respected by the population and can influence changes, for instance by ensuring a smoke-free environment in their workplace.

The Global Strategy for Diet, Physical Activity and Health

WHO's Fruit and Vegetables Campaign

Besides the "Quit and Win" movement and "Health Japan 21" described above, further details on WHO's Fruit and Vegetables Campaign were presented by the Project Manager, **Ms Amalia Waxman**. She said that the evidence for health benefits of a high consumption of fruit and vegetables are very strong. According to the WHO World Health Report 2002, up to 2.7 million lives could be saved every year if the consumption of fruits and vegetables was higher. In addition to that, up to 30% of gastrointestinal cancers could be prevented, as well as cardiovascular diseases (CVD) and obesity.

Moreover, fruit and vegetables are low in energy, but high in nutrients, specifically vitamins and minerals.

The WHO/FAO expert report on Diet, Nutrition and the Prevention of Chronic Disease Prevention (2003) recommends the intake of at least 400 grams of fruit and vegetables per day.

There are many programmes around the world promoting the increased consumption of fruit and vegetables. These programs, mainly in developed countries, often involve the public and the private sector and focus on specific target groups e.g. children in school. However, the messages given, such as eat "5 A Day" or "5 to 9 A Day" are not unified and the definitions of what fruit and vegetables are, vary.

WHO and FAO have joint forces to promote fruit and vegetables. These activities are, from WHO's side, carried out within the framework of the Global Strategy for Diet, Physical Activity and Health. Emphasis is being made on a positive approach - eat more fruit and vegetables and move from an unhealthy diet to a healthier dietary pattern.

The challenges of enhanced fruit and vegetable promotion include availability and distribution, hence any promotion programme should be adjusted to accommodate different cultures and realities. Also national food and agricultural policy can support fruit and vegetable production and marketing. Further, by improving international standards, the access to fruit and vegetables can also be increased.

The WHO/FAO initiative for fruit and vegetable promotion has two pillars:

- to promote production and consumption of fruit and vegetables so as to promote and improve health and to help prevent noncommunicable diseases;
- to advance science in the areas of fruit and vegetable production, distribution, increased consumption, and benefits for health.

Activities planned, include the preparation of a practical tool kit for countries interested in beginning a fruit and vegetable promotion program, the support to in-country pilot projects, the strengthening of the scientific base, and support to and collaboration with the international "5 A Day" community. The initiative also advocates adequate production, distribution and consumption policies to increase the access to fruits and vegetables. With regard to research, there are still many gaps, and quite a board research agenda to be fulfilled.

Towards Healthy Ageing

"The developed world became rich before they became old; the developing world became old before they became rich. A culture of ageing is a culture of solidarity."

Dr Alex Kalache, Coordinator of WHO’s Ageing and Life Course Programme, emphasized that prevention of NCDs must be valid across the entire life course. The ideal paradigm for preventive actions from primary health care upwards involves an extensive range of biological, psychosocial and behavioural factors, and the life course perspective presupposes an interdisciplinary framework for guiding research into human development and ageing.

This approach in fact sheds greater light on the relation between “socio-economic position” – or specifically, poverty – and NCD incidence, rather than on the age factor. Nevertheless, ageing needs to be addressed as the world population continues increasingly to grow old in all parts of the world. This means that the quality of life and healthy ageing are fundamental aspects to be addressed at the individual and collective levels. Global fertility rates in many countries are now below replacement levels and this threatens to compromise future investment in human and social development, and to critically challenge the prospects for healthy ageing.

The Global Strategy recognizes the challenges posed by ageing, and appreciates that the life course is different and declines very rapidly for underprivileged groups by comparison to that of similar groups living in more favoured conditions. Dr Kalache recalled the WHO Brasilia Declaration on Ageing in 1996, which stated: “Ageing is a development issue. Healthy older persons are a resource for their families, their communities and the economy.” And he added: “In all countries, and in developing countries in particular, measures to help older people remain healthy and active are a necessity, not a luxury.”

Developing Community-based Programmes and Strengthening Monitoring and Evaluation

Building Healthy Communities

Dr Gauden Galea, Regional Adviser on NCD in WHO’s Western Pacific Regional Office, emphasized that the community approach must be interactive. For example, in the Fiji Islands each community currently has its own plan with its own objectives. Thus it is necessary for the population of each community to have power to make their own decisions. Building the capacity of a community means that they will elaborate their own plan; they cannot be told to use this or that protocol.

He noted that small environmental changes, such as reducing the levels of fat in everyday foods or reducing the size of potato chip bags are potentially interesting examples of actions that can be implemented.

Dr Viliami Tau Tangi, Health Minister of Tonga, described his country’s approach to NCD prevention through population-based risk-factor interventions which fully involve the health services in promoting effective policies, creating enabling environments, engaging in partnerships with stakeholders and intersectoral work, and undertaking surveillance and monitoring. The overall strategy

is based on the STEPwise framework developed at the Meeting of Pacific Ministers of Health in March 2003.

Establishing the Community-Based Programmes

Dr R. Shao suggested that the ultimate goal of community-based demonstration projects is to develop public policies aimed at bringing about lifestyle changes. So far the results of such programmes have been disappointing due to time constraints, a lack of focus, poor documentation and a lack of careful monitoring and evaluation. In addition there has been a tendency to focus on individual changes rather than on societal change. Demonstration projects are therefore required that can test different methods of disease prevention, evaluate their feasibility, validate their effects and be a source of public and professional inspiration.

The focus has to be on tackling the common risk factors and combining population and high-risk population approaches, together with comprehensive integrated NCD prevention. But developing demonstration programmes at grassroots level calls for a very practical approach, using simple methods and indicators, and selecting those interventions that are most likely to result in measurable changes.

Evaluation of NCD Prevention and Control Programmes

Dr Kathy Douglas, from WHO's Department of Noncommunicable Disease Prevention and Health Promotion, told the Forum that evaluation of NCD prevention and control initiatives for informed decision-making must examine a range of methods and models, keeping an eye open for potential pitfalls and systematically assessing the relevance, effectiveness and impact of activities in the light of their objectives.

Public health has to be accountable, since resources are limited, and it is no simple matter to evaluate the changes brought about by a programme within a complex environment like the community. Evaluation has to move from process evaluation to effect evaluation, and must consider both pre- and post-data.

The aim should be to learn from experience and to make programme improvements and adjustments accordingly. Particular challenges identified during the evaluation of community-based programmes related to the varying degrees of exposure to the interventions, and the difficulty in controlling that exposure. In addition, programmes often had to be run in multiple locations, and this made it hard to account for community-level variance in the evaluations.

Partnership, Capacity Building and Training

The Forum acknowledged that Partnership means working together to reach common objectives, by building alliances and by pooling resources among common NGOs with shared interest. The elements to be considered in this process are the rapidly changing environments and lifestyles, and the reorientation of health services in the direction of lobbying, advocacy and community-based care. The way forward is clearly to continue with the integrated approach, to further develop the concept of the NGO forum and multi-stakeholder forums, and to highlight the need for the kind of teamwork that will encourage partnership involvement in the process.

Key partners identified were the health professional organizations, physicians and hospitals. The point was made that individual doctors tended to be generally excluded, and some would certainly require retraining if they were to respond positively to the situation.

Other valuable partners were identified as:

- Trade unions, which have the potential to bring about changes, particularly with relation to smoking;
- The pharmaceutical and food industries have clearly much to contribute;
- So too have the insurance companies, which are also a good source of data due to their experience in risk management and incentive schemes;
- The mass media as a potential partner can be considered as “uncontrollable,” therefore more effort needs to be invested in providing them with good stories that will appeal to the general public;
- Municipalities and local government are important, since it is at their level that the demonstration projects occur;
- Role models such as artists, sportsmen, spiritual leaders and elders can be effective partners in getting the message across.

Resource mobilization does not relate only to raising money for programmes. In this context, partnership also means promoting and advocating NCD prevention so as to keep it “on the front burner” alongside other national priorities that sometimes obscure the menace of NCDs, such as HIV/AIDS or malaria in Africa.

There is a need for more open debate with partners, with greater visibility for the global strategy and a more systematic planning process, perhaps even a more business-oriented methodology.

The value of international visitors’ programmes was underlined during discussions on capacity building and training, on the lines of such ongoing successful projects as the North Karelia Project, the CINDI School, and the Rotating International Visitors’ programme, initiated by WHO, as applied in Iran, which aimed at improving the capacity of participants who are key persons in developing national programmes through learning theory, and visiting the fields of the on-going NCD prevention projects. Country-level skill building should include the training of trainers.

Capacity building and training represented one of the weakest areas of the networks at all levels. The process is recognized as a long-term one that needs to be closely linked to the political agenda. Team building and capacity development is required within the network, and training should be inclusive for all stakeholders, particularly women's groups, public health schools and NGOs.

Development of a work plan

A proposal was put forward to establish a steering committee integrated by WHO at all levels, with representatives from key agencies and NGOs. WHO would form the Secretariat but coordination would be established via electronic means. This could be started early in 2004, and the format would include the participation of a worldwide role model that would attract the media and mobilize resources. An open public forum via satellite conferencing would increase visibility and would comprise a frank discussion with partners as to the best way forward and the action plans to be considered.

Working Groups

The organization of the Third Global Forum included three working groups, which were required to report on: an overall review of progress with pertinent comments; implementing the global strategy; and partnership plus capacity building and ongoing work.

GROUP 1: An Overall Review of Progress

Group 1 proposed that a good basis for viable prevention and control programmes was “to think globally and work locally.” Global strategies should deploy concrete evidence-based messages that are adaptable to all levels of the population, and can also be viewed as a marketing tool to strengthen regional interventions. Global initiatives in turn can act as a stimulator and provide a “menu” of useful activities for country implementation.

Discussion on methodology revolved around implementation and the role of the ministry of health. There was recognition and approval of CARMEN's methodology of working with the MOH from the initial phase, while also maintaining multisectoral collaboration. This approach should be endorsed by the other networks, although it is not currently used in Europe. In some countries this may not be easy as there are no counterparts within the MOHs to drive the initiative forward.

Further discussion is required on the economic estimates of activities. Information on cost can be sourced through the surveys, as in the case of STEPS, but it is important to further consider carrying out the programme with an eye to poverty reduction interventions, health insurance and the role of health professionals.

GROUP 2: Implementing the Global Strategy

This group considered the role of networks and the development of NCD policies. The element of integration was judged particularly important. Because of the wide diversity among countries, a single model would not be the answer, and policies and programmes again need to be tailor-made. The group felt that policy formulation should be considered as an action area, and observed that lessons can be learned in this field from the private sector. Networks such as CARMEN were considered the ideal format for getting feedback on policy matters.

It was noted that, while the tobacco initiative is well-developed, more efforts are required to focus on diet and nutrition. The issue of sustainability of the network was also addressed, and in this context it was judged important to win the involvement of professional and academic bodies at the national level.

One recommendation is to start with a situation analysis at country level and to provide guidelines to facilitate the process. The private sector needs to be included in the process in order to prompt the countries to accept the initiative. It is recommended that universal guidelines should be developed to further strengthen the process.

The issue of whether the MOH should lead the process was highlighted, and whether this was appropriate in view of the multisectoral and multifactorial nature of issues related to diet and nutrition, and indeed to NCDs in general. An open dialogue is recommended with the MOH as regards the global strategies, in order to establish links with the networks and avoid eventual isolation from the institutional bodies. Proper contact needs to be established between the parties involved, and WHO has a substantive and irreplaceable role in this.

Government involvement is also considered crucial to enhance knowledge-sharing, to ensure implementation and sustainability at country level, and to mobilize resources among others. CINDI has shown that it is possible to influence policy, and this success is benefiting other networks. The role of ministries other than that of health needs to be considered when mobilizing support at country level, and the academic sector should not be left out of the reckoning. The bottom line is that government support at policy and implementation level is fundamental.

GROUP 3: Partnership and Capacity Building

This group observed that demonstration projects are a useful vehicle for translating the global strategy into local action, even though the multiplicity of CINDI demonstration sites still faces the challenge of advancing to other developmental stages. By contrast, in CARMEN the demonstration process has created instruments and programmes that can readily be extended to other locations and other national levels. In countries where some projects have developed expertise, it would be useful to have WHO review those projects so as to produce generic recommendations that can be used as a planning model for others.

The major challenges identified relate to implementation in terms of scaling up from demonstration phase to national level, including moving global concepts to national concepts and from there to the local level. The difficulty of country implementation was recognized due to their diversity, the shortfall in experiences in demonstration areas that are largely not evaluated or have had only a small impact, and the need to strengthen local capacity.

Working with partners is much recommended, but partnerships require time to be built up. There are communication challenges when different groups bring to the table varying perspectives on the global strategy, and on ways of moving the agenda forward.

Networking is also difficult for Mega Countries, which have many more localities to cover, and where demonstration projects represent a minor percentage of the whole country output. The particular benefits of networking were recognized as: sharing experience, knowledge and expertise; the added value of the network as a good marketing tool; and its ability to exert pressure upon participating countries in the region.

Key questions raised by this group included: Have the networks done what they are expected to? How can the network be sustained and maintained from the financial and human perspective? How do we manage the Global Forum and each regional network? How can the links with WHO work plan and NCD be strengthened? How can country-level work plans be integrated and how can their effect be demonstrated?

It was suggested that more attention should be given to the potential of technology use (e.g. via the Internet) as an educational tool, for sharing mechanisms, advancing the network discussions and marketing the NCD programmes. Use of technology is also relevant for follow-up and historical reference for institutional purposes at national levels.

Among the challenges requiring solutions are:

- The poor availability of baseline data at country level;
- The need to document the ongoing process in the CARMEN countries;
- Finding qualified resource personnel sufficient for the needs.

Diversity between the member countries of CINDI is being addressed through training and capacity building, firmly integrated into current initiatives, by increasing research, and by showing and sharing results that highlight the added value of CINDI's work.

In the case of some Mega Countries, there were distinct benefits from participating in two networks, as this offered an additional opportunity to participate in various initiatives and utilize their experience, capacity building and health promotion activities. The delegate from Russia identified among the areas needing to be strengthened: systematic evaluation, data collection, and the documentation of experiences, including success and failure stories.

Summary of parallel sessions

A series of parallel sessions was held during the III Global Forum, and provided an additional platform for participants from the Region of the Americas to share information, knowledge and experiences with each other. Presentations at the sessions included:

NCD Prevention and Control and Health Promotion in Chile. Dr Branka Legetic from Chile described how Chile, like other developing countries, is undergoing an acute demographic transition, and NCDs have become a major health problem for the population. The National Health Plan for 2000-2010 is giving special priority to reducing cardiovascular diseases, cancer and prevailing NCDs.

Evidence-based Public Health Course. Professor True Ross Brownson, from Saint Louis University, USA, introduced the University's Evidence-based Public Health Course, which focuses particularly on health workers in the frontline of the battle to promote on-site NCD prevention.

Non-communicable Diseases in Central America. Dr Alberto Barceló, PAHO, Washington, described a study on the prevalence of diabetes in six countries: Argentina, Brazil, Chile, Cuba, Mexico and Uruguay. The highest prevalence was found in Mexico and Brazil, and the lowest in Argentina.

Public and private partnerships for better health. Dr Frances Taccone, from the US-based Produce for Better Health Foundation, said the 5 a Day programme was implemented 12 years ago in California and is fast becoming a national network. The objective is to disseminate the healthy concept of eating five or six portions a day of fruits and vegetables.

Field and Health. Mexico too has a *5 a Day* Fruits and Vegetables Programme. Dr Stéphanie Henzie told the parallel sessions that in Mexico seven out of ten women are overweight or obese; 27% of Mexican children are overweight; 17.1% of children under 5 are undernourished; and 27.2% of children and 26% of pregnant women are anaemic.

InterAmerican Heart Foundation. Dr Trevor A. Hassel, President of the InterAmerican Heart Foundation, USA described the Foundation's CARMELA programme (Cardiovascular Risk Factors Multiple Evaluation in Latin America). Its priorities are professional and public cardiovascular education, advocacy by influencing public policies in health care areas, research, and fund-raising to meet those needs. A primary goal of CARMELA is to determine the prevalence of hypertension, diabetes and other associated pathologies.

Salud te Recomienda (Health Recommends You). Dr Carlos Orengo, of the Puerto Rico Health Department, said that there was a 30% growth in overweight and obesity in adolescents in Puerto Rico between 1966 and 2001. *Salud te Recomienda* is a campaign to promote behaviour changes and healthy lifestyles in the population and to supply citizens with valuable information on healthy eating habits.

CARMEN Project, Colombia. Dr Celsa Sampson, PAHO, emphasized that cardiovascular diseases are the first cause of death in 72% of Colombia's regions and pose a serious public health problem. The strategies being implemented under the CARMEN initiative call for an increased political commitment towards NCD prevention and control, the regulatory development of NCD prevention, and the strengthening of intersectoral coordination to promote healthy lifestyles and NCD prevention.

Behavioural Risk Factors. Dr Valeska Figueiredo, National Cancer Institute (INCA) at the Ministry of Health, Brazil described the country's epidemiological transition over the period of 1930 to 2000 when infectious disease rates fell sharply and NCDs took on ever greater importance. The target population of a current study of behavioural risk factors consists of individuals aged 15 and over in 18 Brazilian cities. The study pinpointed tobacco use, low consumption of fruits and vegetables, insufficient physical activity, high alcohol consumption and risky behaviour by car drivers.

Primary Health Care: Hypertension and Diabetes. Dr Rosa Sampaio, Ministry of Health, Brazil, said the Hypertension and Diabetes Programme had undertaken prevalence studies on arterial hypertension in different Brazilian cities. Prevalence rates ranged from 10.1% in Volta Redonda to 25.5% in Araraquara.

National Nutrition Policy. Promoting a Healthy Diet: a Practical Guide. Dr Fátima Carvalho, Ministry of Health, Brazil, described epidemiological data on the prevalence of overweight and obesity in Brazil which showed that in 1989 25% of the population was overweight and 8.3% was obese. The National Food and Nutrition Policy (PNAN) advocated "10 steps to healthy eating," which include increasing and varying the consumption of fruits and vegetables and eating them five times a day, cutting down on alcohol and sodas, fatty foods, salt, sweets, cakes, cookies and other foods with high sugar content.

Research and Surveillance. Development of Research on Collective Health. Dr Gilma Azevedo Silva Mendonça, ABRASCO, Brazil, said that research on health in Brazil has been growing significantly in recent years. Research groups have designed 27 post-graduate programmes in virtually all the regions, excluding the North Region, and surveillance has been one of the most widely addressed themes.

Study on the Global Disease Burden in Brazil, 1998. Dr Joyce Schramm, ENSP/FIOCRUZ/MS, Brazil, explained how Disability Adjusted Life Years (DALY) are calculated by adding the Years of Life Lost (YLL) and the Years Lived with Disability (YLD). The worst indicators in Brazil were for the Northeastern Region, with YLL 133/1,000, YLD 117/1,000 and DALY 250/1,000. The best indicators are found in the Centre-West Region, with YLL 93/1,000, YLD 108/1,000 and DALY 201/1,000. The averages for Brazil are YLL 111/1,000, YLD 120/1,000 and DALY 232/1,000.

Epidemiology and Ageing in Brazil. Dr Maria Fernanda Lima Costa, NESPE/FIOCRUZ/UFMG, Brazil, said the country is facing a veritable explosion in the number of elderly individuals. There were 3 million inhabitants aged over 60 in 1960, 7 million in 1975, 14 million in 2000; by 2026 there

will be an estimated 32 million. Cardiovascular diseases are responsible for 38.3% of deaths among adults and neoplasia accounts for 13.3%. These data point to the need to invest in controlling arterial hypertension.

IV Global Forum on NCD Prevention and Control

It is important to acknowledge that the Forum has a series of objectives: marketing the work developed, seeking support to programmes, exchanging information, and attempting to achieve potential collaboration among the Networks. These are difficult objectives to be addressed in a standard format event. It is necessary to adapt mechanisms in different ways for the next meeting, which include recognizing the need for more capacity building, improving marketing, advocacy, and including other partners.

Canada has agreed to host the IV Global Forum, which will take place in Ottawa from 4-6 November 2004, with a programme developed jointly by WHO and PAHO. Another forum with special emphasis on the prevention of chronic diseases, will also take place around that date, starting on 7 November, and will be attended by important representatives from the political and technical fields. The host country is already closely involved in the preparations, which are starting immediately and which include the setting up of a planning committee.

Conclusion of the III Global Forum

The global control and prevention of NCDs is a long-term process that requires constant strengthening and steady leadership. The work carried out by the Networks has a homogeneous flow and can be compared to the movement of a large transatlantic ship, which turns slowly yet continues to sail forward. It is necessary to maintain the critical capacity and to face all challenges, keeping on a safe course, but always aiming at improving the work.

The task is clear, and progress can already be seen, but it is necessary to continue along the path of sustainable development, seeking to have an impact on NCD prevention. Priorities involve complex issues and a number of risk factors, particularly including tobacco, dieting, and physical activity. To carry out effective work, it is necessary to focus on a limited number of goals. The real work takes place in the Networks; the objective of the Forum is to strengthen and support them, by actively fostering the exchange of experiences.

It is important to recognize that at each meeting there are different needs expressed, and that not all have been addressed in this meeting. Priorities have to be established while at the same time not losing track of the main focus. It is thus increasingly important to have specific meetings at the global level.

At this meeting in Rio, several levels of work were discussed: community, national, regional and global. The proposal of a strategy with demonstration areas based on the community implies strong commitment to searching for evidence.

Community work has to be evaluated, since it is clear that in some situations it must be conducted more rigorously. Another important component is to carry out environmental work. Epidemiological surveillance is another key component.

The discussion on the institutional base was particularly intense. Ministries of Health need to actively participate in the Networks movement and in the entire NCD prevention and control process. Discussions with partners have been very productive, and the contribution of NGOs to the Forum is to be applauded.

It was unanimously agreed that the next meeting will be held in Ottawa, Canada, in November 2004.

Dr Elizabete Duarte, Chair of the meeting, pointed out that this Forum had been very important for the development of global policies, which is equally true of the work developed by the Networks to strengthen NCD prevention policies. The event had encouraged all concerned to reflect on the Networks' experiences, and hopefully it had been of value for all countries, NGOs and other participants at the Forum.

Finally, Dr Pekka Puska, on behalf of all the participants and WHO, expressed warm appreciation for the strong support that the Brazilian Government had provided to the meeting in terms of financial, human and administrative resources.

III Global Forum on NCD Prevention and Control
9-12 November 2003, Rio de Janeiro, Brazil

PROGRAMME

Venue: **HOTEL INTERCONTINENTAL**
Av. Prefeito Mendes de Moraes, 222
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SUNDAY, 9 NOVEMBER

18:00 – 18:10	Welcome <i>Dr Carissa Etienne, Assistant-Director of PAHO</i>
18:10 – 18:30	Launching the Global Fruit & Vegetable Programme <i>Dr Pekka Puska, WHO and Dr José Carlos Tubino, FAO,</i>
18:30 – 18:40	Launching of the Virtual Health Library on NCD Prevention and Control/PAHO, BIREME/PAHO <i>Dr Sylvia Robles</i>
18:40 – 19:10	Key notes <i>Dr Sylvie Stachenko</i> <i>Dr Jarbas Barbosa da Silva Júnior</i>
19:10 – 20:30	Opening remarks <i>Dr Catherine Le Galès-Camus</i>
20:30 – 22:30	Reception

MONDAY, 10 NOVEMBER

8:00 – 9:00	<i>Registration</i>
9:00 – 9:30	Welcome <i>Dr Pekka Puska</i> <i>Dr Jarbas Barbosa da Silva Júnior</i>
9:10 - 9:30	Introductions, approval of the agenda and election of the chairpersons and rapporteurs
9:30 – 10:00	Setting the Scene <i>Dr Pekka Puska</i>
10:00 – 10:30	<i>Coffee break</i>

PROGRESS REPORT OF THE REGIONAL NETWORKS

10:30-11:10	— CARMEN (WHO/AMR): <i>Dr Lucimar Coser-Cannon</i>
11:10-11:30	— CINDI (WHO/EUR): <i>Prof Helios Pardell and Dr Gudjon Magnusson</i>
11:30-11:50	— EMAN (WHO/EMR): <i>Prof Mustafa Khogali</i>
12:10-12:30	— MAOANA (WHO/WPR): <i>Dr Gauden Galea</i>
12:30 - 14:00	<i>Lunch</i>
14:00 – 14:20	— NANDI (WHO/AFR): <i>Dr Antonio Filipe Jr</i>
14:20 – 14:40	— SEAR Network (WHO/SEAR): <i>Dr Jerzy Leowski</i>
14:40 – 15:00	Discussion
15:00 – 15:30	<i>Coffee break</i>

GLOBAL INITIATIVES/ACTIVITIES

15:30 – 16:00	NCD prevention and health promotion (<i>Dr Pekka Puska</i>) – <i>Reports to the 113th meeting of WHO Executive Board</i>
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- *Diet, Physical Activity and Health: developing a global strategy and action*
- *Framework Convention on Tobacco Control (FCTC)*
- *Mega country health promotion network*

16:00 - 16:30 **NCD surveillance and WHO Global-Regional NCD InfoBase** (*Dr Kathleen Strong, Dr Jerzy Leowski*)

16:30 - 18:00 **Working groups I**

Parallel Session I

16:15 - 16:30 **NCD prevention and control and health promotion in Chile** (*Dr Branka Legetic - PAHO*)

16:30 - 16:45 **Public Health and Noncommunicable Disease**
(*Dr William True - St. Louis University, USA*)

16:45 - 17:00 **NCDs in Central America**
(*Dr Alberto Barcelo - PAHO*)

17:00 - 17:15 **Public and Private Partnerships for Better Health**
(*Dr Frances Taccone- Produce for Better Health Foundation, 5 A Day, USA*)

17:15 - 17:30 **Field and Health. 5 A Day Fruits and Vegetable Programme in Mexico** (*Ms Stephanie Hinze, Mexico*)

TUESDAY, 11 NOVEMBER

8:30 – 9:30 **Groups report and discussion**

IMPLEMENTING THE STRATEGY

8:30 – 9:10 **Translating Science into Integrated NCD Prevention: National strategy and the policy-building process**
(*Dr Ruitai Shao, Dr Sylvia Robles and Dr Satoshi Sasaki*)

9:10 - 9:50 **Implementing Chronic Disease Prevention in health services** (*Prof Aulikki Nissinen*)

9:50 – 10:30 **Campaigns & activities**
– *Fruit & Vegetable campaign (Ms Amalia Waxman)*
– *Move for Health (Dr Pekka Puska)*
– *Quit & Win 2004 (Prof Aulikki Nissinen)*

10:30 – 11:00 *Coffee break*

11:00 – 11:30 **Prevention of NCD across the life course: towards healthy ageing (Dr Alexandre Kalache)**

11:30 – 12:30 **Working groups II**

Parallel Session II

11:30 - 11:45 **Inter-American Heart Foundation (IAHF)**
(Dr Trevor Hassell, Barbados)

11:45 - 12:00 **Salud Te Recomienda (Health Recommends You)**
(Dr Carlos Orengo - MoH, Puerto Rico)

12:00 - 12:15 **CARMEN Project, Colombia**
(Dr Celsa Sampson - PAHO, Colombia)

12:15 - 12:30 **CARMEN in Argentina**
(Dr Enrique Vasquez - PAHO, Argentina)

12:30 – 14:00 *Lunch*

14:00 – 14:45 **Healthy communities and environmental changes: Community-based demonstration projects**
(Dr Gauden Galea, Dr Viliami Tau Tangi and Dr Ruitai Shao)

14:45 – 15:15 **Evaluation of NCD prevention and control initiatives for informed decision making: methods, models and pitfalls (Dr Kathy Douglas)**

15:15 - 15:45 *Coffee Break*

15:45 – 18:00 **Working groups III**

Parallel Session III

- 15:45 - 16:15 **Behavioural Risk Factors**
(Dr Valeska Figueiredo - INCA/MoH, Brazil)
- 16:15 - 16:45 **Primary health care: hypertension and diabetes**
(Dr Rosa Sampaio - MoH, Brazil)
- 16:45 - 17:15 **National Nutrition Policy. Promoting healthy diet: a practical guide**
(Dr Fátima Carvalho - MoH, Brazil)
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- 19:00 *Social Activity*

WEDNESDAY, 12 NOVEMBER

- 8:30 – 9:30 **Groups report and discussion**

PARTNERSHIP, CAPACITY BUILDING AND DEVELOPING WORK PLAN

- 9:30 – 10:00 **Partnership for global NCD prevention and control**
(IDF, ICN, WHF, UICC)
- 10:00 - 10:30 **Capacity building and training**
(CDC, KTL, Canadian CCDC)
- 10:30 – 11:00 *Coffee Break*
- 11:00 – 12:30 *Working groups IV*

Parallel Session IV

- 11:00 - 11:15 **Research meets surveillance: Development of Research on Collective Health in Brazil**
(Dr Gilma Azevedo Silva Mendonça - ABRASCO, Brazil)
- 11:15 - 11:30 **Study on the Global Disease Burden in Brazil, 1998. Selected results**
(Dr Joyce Schramm - ENSP/FIOCRUZ/MoH, Brazil)
- 11:30 - 11:45 **Epidemiology and Ageing in Brazil**
(Dr Maria Fernananda Lima Costa - NESPE/FIOCRUZ)

/UFMG, Brazil)

12:30 – 14:00	<i>Lunch break</i>
14:00 - 15:00	Group Reports and Discussion
15:00 – 15:30	<i>Coffee Break</i>
15:30 – 16:00	Recommendations and wrap-up session
16:30 - 16:45	IV Global Forum on NCD prevention and control
16:45 – 17:00	<i>Closing session</i>

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9 – 12 NOVEMBER 2003
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