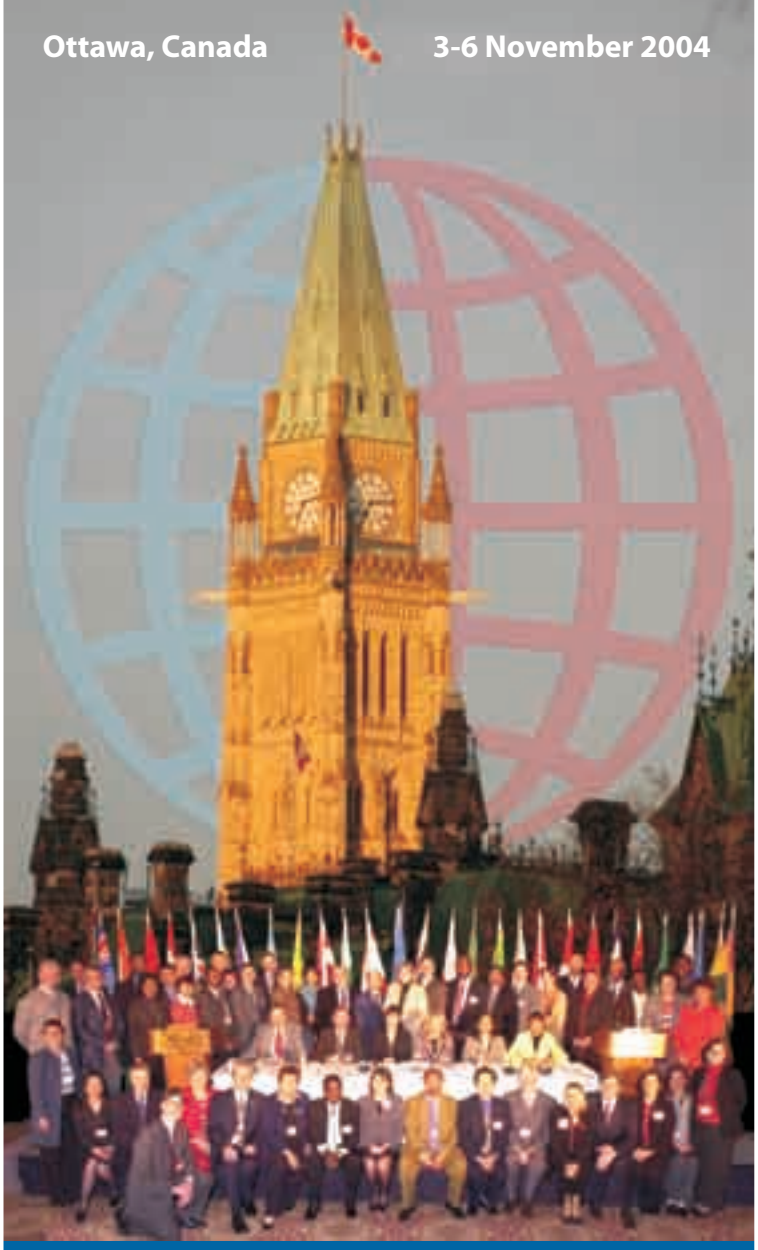
FINAL REPORT

WHO Global Forum IV on Chronic Disease Prevention and Control

Ottawa, Canada **3-6 November 2004**



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WHO Global Forum IV on Chronic Disease Prevention and Control

FINAL REPORT
of the meeting convened in Ottawa, Canada
3-6 November 2004

by

the Department of Chronic Diseases and Health Promotion, Noncommunicable Diseases and Mental Health, World Health Organization

and

the Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada

World Health Organization

Government of Canada Gouvernement du Canada

Acronyms

AFR	African Region
AFRO	World Health Organization Regional Office for Africa
AMR	American Region
AMRO	World Health Organization Regional Office for the Americas (see PAHO)
CARMEN (AMR)	Conjunto de Acciones para Reduccion Multifactorial de Enfermedades No Transmisibles
CD	Chronic Disease
CDP	Chronic Disease Prevention
CDPAC	Chronic Disease Prevention Alliance of Canada
CHP	Department of Chronic Diseases and Health Promotion, World Health Organization/ Geneva
CINDI (EUR)	Countrywide Integrated Non-Communicable Disease Intervention
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
EMAN (EMR)	Eastern Mediterranean Approach to Non-communicable Disease
EMR	Eastern Mediterranean Region
EMRO	World Health Organization Regional Office for the Eastern Mediterranean
EUR	European Region
EURO	World Health Organization Regional Office for Europe
FCTC	WHO Framework Convention on Tobacco Control
GF	Global Forum
GDP	Gross Domestic Product
HC	Health Canada
MDGs	Millenium Development Goals
MOANA (WPR)	Western Pacific Region NCD Network
MoU	Memorandum of Understanding
NANDI (AFR)	Network of African Noncommunicable Diseases Interventions
NCD	Noncommunicable Disease
NGO	Non-governmental organization
NMH	Noncommunicable Disease and Mental Health Cluster, World Health Organization/ Geneva
NPH	Department of Noncommunicable Disease Prevention and Health Promotion
PAHO	Pan American Health Organization (see AMRO)
PHAC	Public Health Agency of Canada
RO	World Health Organization Regional Office
SARS	Severe Acute Respiratory Syndrome
SEANET (SEAR)	South-East Asia Network for Non-Communicable Disease Prevention and Control
SEAR	South-East Asian Region
SEARO	World Health Organization Regional Office for South-East Asia
STEPS	World Health Organization STEPwise approach to surveillance
WHA	World Health Assembly
WHO	World Health Organization
WPR	Western Pacific Region
WPRO	World Health Organization Western Pacific Regional Office

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Meeting Summary

Chronic diseases are reaching epidemic proportions worldwide. The World Health Organization (WHO) Global Forum on Chronic Disease Prevention and Control provides a framework for international collaboration to fight these diseases. The fourth meeting of the Global Forum, Global Forum IV, was convened in Ottawa, Canada in November 2004 to provide an opportunity for participants to discuss collaboration and national action planning in the face of this global emergency. Three key themes were discussed at the Forum: policy, participation and planning.

To widen the scope for networking and learning, Global Forum IV also included a one-day collaborative International Showcase Day in association with the Chronic Disease Prevention Alliance of Canada. Showcase Day discussions focused on diet, physical activity and healthy weights in the following four areas:

- Getting Prevention on the Agenda
- Working with the Food Industry
- Bridging the Science-to-Policy Gap
- Risk Factor Surveillance.

Key outputs from Global Forum IV included a renewed commitment to advocacy for building political will among countries and regions in relation to chronic disease prevention and control. Participants clearly recognized the urgency for action and the importance of enabling tools to help countries and regions combat chronic diseases.

Products coming out of the Forum include a commitment to and strategies for increased information sharing and dissemination among participants; discussion and concrete action steps for the Forum's three key theme areas: policy, participation and planning; contributions to the development of two WHO 'prompter' tools: one to support partnership development and another for national action planning; review and refinement of an economic case for chronic disease prevention and control; and identification of key challenges and related actions for policy development in relation to diet, physical activity and healthy weights for each of four areas: Getting Prevention on the Political Agenda, Working with the Food Industry, Bridging the Science-to-Policy Gap and Advances in Risk Factor Surveillance.

In terms of previous Forums, Global Forum IV represented a transition event with respect to objectives, meeting format and outputs. Post-Forum evaluations indicated that participants appreciated this evolving format, in particular the focused and frequent opportunities for discussion with colleagues. They also commented on their increased commitment to action as a result of participating in this event.

Introduction

The purpose of the World Health Organization's Global Forum on Chronic Disease Prevention and Control is:

- to prevent the incidence of chronic diseases[1] by tackling the major risk factors and underlying determinants of health;
- to reduce premature mortality and morbidity caused by leading causes of death;
- to improve quality of life, with particular focus on developing countries, working through regional networks in line with the WHO Global Strategy for Noncommunicable Disease Prevention and Control approved by the 53rd World Health Assembly in 2000 and the WHO Global Strategy on Diet, Physical Activity, and Health endorsed by member states at the 57th World Health Assembly in 2004.

The initial meeting of the Global Forum (November, 2001 in Geneva, Switzerland) defined the goal and objectives, functions, key areas and methods of the Global Forum for chronic disease prevention and control and developed a broad framework for conclusions and recommendations. The second and third meetings of the Global Forum took place in China and Brazil and provided an opportunity to consolidate and advance the Forum's objectives.[2]

Global Forum IV

The fourth meeting of the Global Forum took place in Ottawa, Canada from Wednesday, November 3 to Saturday, November 6, 2004.[3] This transitional meeting carried on the work of the previous meetings in implementing the Global Forum's purpose and objectives in a format designed to encourage active participation and discussion among participants. The focus of Global Forum IV was on regions, countries and networks acting together in the best interest of national, integrated chronic disease prevention and control.

Objectives were:

1. To provide a global update on the current situation in integrated, chronic disease prevention and control
2. To promote and enable the development of international partnerships and inter-region collaboration for national, integrated chronic disease prevention and control
3. To encourage and develop national strategic action planning in member countries, including priorities and key action areas
4. To facilitate network building, knowledge translation and information sharing among regional networks, countries, collaborating centres and other stakeholders
5. To build on existing efforts to develop a coordinated platform for supportive policy development and implementation among member countries

Forum Themes

The Forum was structured around action in the following three theme areas:

Policy, e.g., to enable action through evidence-based advocacy;

Participation, e.g., to facilitate and enable implementation within member countries, networks, non-governmental oranizations (NGOs) and other stakeholders across the full spectrum of prevention through collaboration and partnership; and

Planning, e.g., to support action through identification of priorities, opportunities and barriers, and actions to address them.

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[1] For the purposes of this report, the terms "chronic disease" and "noncommunicable disease" are considered synonymous.

[2] Reports from previous Forums can be found at the following web sites:

World Health Organization. *Proceedings of the Global Forum on Noncommunicable Disease Prevention and Control.* November, 2001. (http://www.who.int/hpr/globalforum/meetings.shtml)

World Health Organization. *The Report of the Second meeting of the Global Forum on Noncommunicable Disease Prevention and Control.* November, 2002. (http://www.who.int/hpr/globalforum/meetings.shtml)

World Health Organization. *III Global Forum on Non-communicable Diseases Prevention and Control: Activities Report.* November, 2003. (http://www.who.int/hpr/globalforum/meetings.shtml

[3] The Global Forum IV agenda is included in Part 5.1 of the Global Forum Annex on Outputs and Resources.

Participants at Global Forum IV included representation from WHO regional offices, WHO Regional Networks for Chronic Disease, Member States, WHO Collaborating Centres, development agencies and donors, and international NGOs.

Outputs and Resources

Detailed Forum outputs (including records of discussions, tools, references, presentation summaries) can be found in the Annexes to this document on the WHO web site at www.who.int/hpr/globalforum/meetings.shtml.

Opening Session: A Global Context

Dr. David Butler-Jones, Canada's recently appointed Chief Public Health Officer, convened the Forum by welcoming participants and noting the wide range of perspectives on chronic disease prevention and control among the 27 nations represented in the room.

Dr. Jong-Wook Lee, Director General, World Health Organization, began his remarks by noting that with chronic diseases now accounting for 60% of deaths, there is an urgent need for more effective approaches to prevention and control. He acknowledged the role of the Global Forum in making major steps towards meeting this need and thanked Canada for hosting this 4th Forum and continuing its substantial impact in this area. Dr. Lee mentioned the benefits of strong Canadian support for the WHO Framework Convention on Tobacco Control, which is close to coming into force, and for the WHO Global Strategies for Noncommunicable Diseases and Diet, Physical Activity and Health. He also noted the importance of the Millenium Development Goals and that chronic disease prevention and control must be an integral part of every health system.

Dr. Lee stressed the importance of immediate action. The World Health Assembly has adapted landmark strategies on tobacco, diet and physical activity. There is an unprecedented opportunity to move ahead through effective cooperation among all sectors involved. In closing, Dr. Lee commented that the WHO is fully committed to chronic disease prevention and control and expressed his strong hope that ministers of health and other policy makers would support immediate action in this area.

Hon. Ujjal Dosanjh, Minister of Health, Canada, brought greetings from the Prime Minister of Canada. He emphasized that chronic diseases represent one of the major global health challenges of our time, taking a devastating toll both on the health of societies and on their economies. The recent establishment of the Public Health Agency of Canada and the appointment of the Chief Public Health Officer puts chronic disease prevention and control at the core of the public health system in Canada. Canada also has two decades of experience related to such issues as diabetes and tobacco control and is committed to aggressively promoting a chronic diseases prevention and healthy living agenda.

Hon. Dosanjh noted key areas of Canadian collaboration with WHO, including support of the FCTC, the development of new international health regulations and effective policy and programme interventions for noncommunicable diseases. Hon. Dosanjh also highlighted Canada's investment of $500K for the WHO Collaborating Centre on Chronic Disease Policy, as well as hosting the International Cancer Control Conference in Vancouver in 2005. In closing, Hon. Dosanjh took the opportunity to signal increased efforts to work with WHO regarding chronic disease by tasking Canadian officials with developing a framework for future cooperation related to this important issue.

Hon. Dr. Jorge José Santos Pereira Solla, State Secretary for Health, Deputy Minister of Health, Brazil, provided an overview of the current situation in Brazil, which has seen changes in its population strategy and the pattern of morbidity and mortality through increased urbanization and an aging population. Dr. Solla explained that the Global Strategy on Diet, Physical Activity and Health has been supported by Brazil's Ministry of Health as a significant opportunity to develop and implement an effective line of action to reduce death and improve quality of life. Of particular interest is the national programme for pharmaceuticals that involves 23,000 physicians, nurses and 200,000 community health agents working in family health. It is expected that this programme and its associated database will help to improve prevention and contribute to effective surveillance and control for noncommunicable diseases. In closing, Dr. Solla reinforced his message that chronic disease prevention and control is one of the priorities of the public health system in Brazil.

Dr. Maria del Rocio Saenz Madrigal, Senior Minister of Health, Costa Rica, welcomed participants to the Global Forum IV. She noted that noncommunicable diseases are the most serious problem for governments in this century– once diagnosed they become a daily, ongoing concern for the individual, the community and health services. She emphasized the need for intersectoral strategies to improve quality of life, with special attention to risk factors in the poorest members of the population. Dr. Madrigal recognized that primary health care requires an economic commitment and emphasized the importance of the Millenium Development Goals, information systems and the public policy observatories as strategies for implementation.

Dr. Butler Jones closed the opening session by quoting Benjamin Disraeli: *The health of the public is the foundation upon which rests the happiness of the people and the welfare of the state.* He encouraged Forum participants to work together in support of global public health to find effective strategies to prevent and control noncommunicable diseases that dramatically shorten the lives of people across the world.

Keynote Presentations

Dr. Catherine Le Galès-Camus, Assistant Director General, Noncommunicable Diseases and Mental Health, WHO, introduced the keynote presentations by noting the urgent situation related to noncommunicable diseases and how action by Forum participants is essential to drive the chronic disease prevention and control agenda throughout the world.

Hon. Dr. Carolyn Bennett, Canadian Minister of State (Public Health) noted that public health is undergoing a renaissance that includes not only infectious diseases but chronic diseases as well. She also noted the importance of applying the four "C"s of collaboration, cooperation, communication and clarity to best practices across jurisdictions to develop an effective "what-when-how" strategy based not on a shopping list of needs but on real, measurable, meaningful goals.

Dr. Bennett commented on the wealth of perspectives, information sharing and creativity that can result from the diverse experiences among country representatives in the Forum. She encouraged strategies focusing on common risk factors and also emphasized the important contribution of research in achieving the Millenium Development Goals.

Dr. Catherine Le Galès-Camus made the point that governments and the public must be reminded that we are faced with a global epidemic of chronic diseases that will have catastrophic social and economic impact in both rich and low income countries. Increasingly, chronic diseases are an obstacle both to development and to realization of the Millenium Development Goals.

Dr. Le Galès-Camus outlined the following four points that she hoped would be discussed at the Forum:

1. Strengthen efforts to take an integrated approach, e.g., common risk factors, diet, tobacco; national strategies must emphasize prevention
2. Enable cooperation at the international level
3. Act quickly on public health issues by targeting individuals at risk and implementing a general programme for overall national populations
4. Contribute to the development of national capacity through policies, strategies and actions, e.g., at the national level through public health institutes to help policy and decision makers and provide training programs and policies in line with the most recent research.

In closing, Dr. Le Galès-Camus noted that WHO recognizes the double burden of developing countries, which must deal with both communicable and chronic diseases. WHO is redoubling its efforts in chronic disease prevention and control, but what is needed now are resources and a strong commitment from Ministries of Health to ensure we have a coordinated approach. The Global Forum is a framework to enable this to happen.

Dr. Joxel Garcia, Deputy Director, Pan-American Health Organization, echoed his co-presenters' comments related to the global epidemic of chronic diseases and the need for a multisectoral approach to combat this epidemic. Although public health officials are acting to address these issues, the needs far outstrip the resources available to counteract them. Given the seriousness of the chronic disease challenge, Dr. Garcia emphasized the importance of bringing in as many influential people as possible to have an impact on chronic disease prevention and control, in particular industry, colleges, universities, policy makers, education and government. In closing, Dr. Garcia mentioned the epidemic of diabetes among Latino children in California, where for the first time in history, Latino parents will be burying their children.

In closing the keynote presentations, Dr. Le Galès-Camus thanked speakers and noted that it was now time for participants to get down to work to ensure the success of the Forum.

Forum Overview

Dr. Robert Beaglehole, Director, Department of Chronic Diseases and Health Promotion, World Health Organization, noted that it is an exciting and important time for public health, especially in Canada where as a result of SARS chronic diseases are now firmly on the agenda.

Dr. Beaglehole gave a brief update on discussions at the Regional Advisers meeting held November 3, which focused on how to best develop a truly global implementation plan for the Global Strategy on Diet, Physical Activity and Health. This was the second advisers' meeting in six months–an indication of the WHO commitment to strong leadership in this area. Dr. Beaglehole also mentioned the Global Report "Chronic Diseases–A Vital Investment" that will be published next year to make the case for investment and interventions that are affordable and effective. This report will provide STEPwise guidance for integrated national plans and set a quantitative goal for preventing deaths by 2015.

Dr. Sylvie Stachenko, Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, introduced the three Forum themes of policy, participation and planning, commenting on the importance of intersectoral approaches to addressing these themes in an integrated manner that recognizes their interdependence. She emphasized the importance of the wealth of diversity at the Forum from many backgrounds and countries, and that the Forum was designed to be both a good learning experience and a venue for action planning.

Dr. Stachenko acknowledged participants who, like herself, had attended all previous Forums: Dr. Ruitai Shao (WHO), Dr. Sylvia Robles and Dr. Lucimar Coser Cannon (PAHO), Dr. Sania Nishtar (Heartfile, Pakistan), Dr. Janet Voute (World Heart Federation), Dr. Jerzy Leowski (SEARO) and Dr. Srinath Reddy (WHO Collaborating Centre, India).

Thematic Presentations

WHO Regional Advisers were invited to present thematic updates on their activities and to propose challenges to the meeting in relation to chronic disease prevention and control. The following presentations were made:

Region	Topic	Presenter
MOANA (WPR)	Disease Prevention and Health Promotion	Dr. Gauden Galea
CARMEN (AMR)	Capacity Building and Training	Dr. Sylvia Robles
NANDI (AFR)	Surveillance	Dr. Antonio Filipe, Jr.
EMAN (EMR)	Policy Development	Dr. Oussama Khatib and Dr. Sania Nishtar
SEANET (SEAR)	Community-based Interventions	Dr. Jerzy Leowski
CINDI (EUR)	From Demonstration to Policy Development	Dr. Aushra Shatchkute Dr. Vilius Grabauskas

At the Forum, participants were provided with An Overview of Regional Networks as well as a copy of Forum presentations on a CD-ROM. Summaries of updates can be found in Part 1 of the Annex to this Document: "Forum Outputs and Resources" on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

Summary of Theme Discussions

The following discussion themes were identified during the Forum planning process:

- Policy, e.g., to enable action through evidence-based advocacy
- Participation, e.g., to facilitate and enable implementation within member countries, networks, NGOs and other stakeholders across the full spectrum of prevention through collaboration and partnership
- Planning, e.g., to support action through identification of priorities, opportunities and barriers, and actions to address them
- The economic case for chronic disease prevention and control.

Summaries of discussions follow. Detailed results of participants' theme discussions can be found in the Annex to this Document: "Forum Outputs and Resources" on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

1. Policy

Policy: *enabling action through evidence-based advocacy*

Forum participants discussed what their countries, organizations, networks, coalitions and alliances do well with respect to policy and then identified actions to improve policy development and implementation.

In terms of what is being done well, participants noted that policy-making is now done through a more consultative process; today many organizations and countries analyze why something doesn't work and then adjust policies based on what is learned. Policy development is happening at a variety of levels, including bottom-up, and this is essential to having an impact – a "top down" approach is not always appropriate.

There is growing recognition by many countries of the chronic disease burden and the requirement for related policies. However, the implementation and application of the policies and related frameworks is still weak. The importance of long-term strategies was recognized; countries with 10 and 20 year strategies (and therefore a long term view) are more likely to be successful, as is happening with food, nutrition and the involvement of the food industry. Civil society groups, coalitions and alliances are beginning to exert greater influence, as has been seen with the FCTC. In addition, the strengthening of public health systems in some countries has had a positive effect, e.g., Canada's newly developed Public Health Agency.

Regarding evidence and the burden of disease, there is more emphasis today on using science and surveillance data as a basis for action. Progress with STEPS and the availability of country data has been compelling in making the case for chronic disease prevention and control.

Forum participants had different perspectives about the impact of evidence: on the one hand,

the evidence about the increase of chronic disease in the total burden of disease seems to have a substantial impact on the development of public health policies. On the other hand, some participants thought that the evidence on burden of disease due to chronic disability has been available for some time, but the current investment in chronic disease prevention does not come anywhere near matching the burden. In addition, many people still do not accept the evidence about the burden of disease and the policies required to address this burden. Participants agreed that the current balance on this issue is inappropriate.

Issues specific to developing countries were discussed, such as challenges related to dealing with a double burden of disease related to both communicable and noncommunicable diseases. These challenges included effective use of resources (e.g., communicable and noncommunicable diseases are not in competition), partner mobilization across multiple NGOs and sectors, and implementation. Participants also noted that the development of all-encompassing chronic policies may not be appropriate in some countries where disease-specific models (such as diabetes) should be the focus. Another concern related to the evidence of burden of disease and the effectiveness of interventions: it is difficult to assess the effectiveness of population-based interventions on a scientific basis alone.

Suggested Actions

- Increasing political will and commitment through advocacy at all levels was a key action area for Forum participants. In particular, experience in the AIDS programs on evidence-based policy to support advocacy suggests that although epidemiological data is clearly important in advocacy, it needs to be augmented by: (a) a political argument through interest groups, (b) a human rights based argument about health as a human right through prevention of mortality, (c) an economic argument about the net future value of prevented cases to date, and (d) an emotional argument. It is important to make a case that is based on epidemiology, on economics, and on political arguments by appealing to political will as well as through appealing to the emotions.
- Advocacy should focus on health systems in the global sense rather than just health services, to ensure the inclusion of other sectors and a focus on systemic change.
- Participants emphasized that it is important to position arguments for chronic disease prevention in the context of competing priorities nationally and internationally. A failure to do so could result in losing sight of other priorities such as communicable diseases, mental health and injuries – the advocates for these issues are also making their arguments at the same time.
- Participants noted that the international community must show a strong commitment to the chronic disease agenda, just as they did for the Millenium Development Goals and other initiatives. A stronger commitment from the international community will stimulate action more quickly at the country level. One important result of the Forum, suggested by Dr. Anne Maryse Pierre-Louis of the World Bank is joint production of the report "Chronic Diseases: A Vital Investment" including joint dissemination at both international and country levels to increase the visibility of this document. This initiative could also be linked to other international disease-based organizations, along with the World Federation of Public Health Associations and the International Union of Health Promotion and Education.

  This is exactly the type of involvement that the WHO would like to have: high level international partners working together on key activities would be outstanding. We would also like to partner with organizations such as Health Canada and the Public Health Agency of Canada. (Dr. Robert Beaglehole, WHO).

- Development of solid policy frameworks for chronic diseases is essential, particularly in broader health and social sector policies; there is a need to update and improve strong existing policies in areas such as nutrition/food and transportation.
- Greater coordination at the country level among multisectoral international organizations can be achieved by working

closely with and consulting with country level teams to ensure that recommended strategies are congruent with the evidence on chronic disease prevention and control.

- Countries require the development of models, tools and curricula for intersectoral training to "infiltrate" systems, as well as differential strategies that aim to improve access to care, e.g., equipping disadvantaged groups with the information they require to address their health issues. This approach requires strategies that are contextualized to suit the needs of those at risk in terms of social issues.

Detailed results of group discussions related to this theme area can be found in the Annex to this report: "Forum Outputs and Resources" (Part 2.1: Policy – Group Discussions) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

2. Participation

Participation: *to facilitate and enable implementation within member countries, networks, NGOs and other stakeholders across the full spectrum of prevention through collaboration and partnership.*

Forum participants considered how to work together better in the context of a three-step process developed for discussion at the Forum. The three steps were:

Step 1: Clarify Common Ground

Step 2: Agree on Operational Arrangements

Step 3: Build Commitment and Trust.

In their discussions, participants noted that traditional disease-specific partnerships are easier to establish than non-traditional ones involving non-health sector partners. A large-scale chronic disease partnership including disease-specific NGOs and industry may not be achievable: a focus on smaller partnerships is more realistic. However, the Alberta Healthy Living Network and Integrated Pan-Canadian Healthy Living Strategy are two examples of chronic disease partnerships where use of the term "healthy living" has enabled non-traditional groups to find a shared role within the partnership.

Participants noted that partnerships are defined in terms of:

- Context: Collaboration and partnership are contextual; collaboration is generally easier to define. Partnerships do not need to be formal or "corporate;" they should be tailored to what mutually benefits partners in a local context, e.g., partnerships with the food industry to reduce the cost of lower cholesterol butter in Costa Rica; individual contacts with local media.
- Diversity: Partnerships can exist at any level for any purpose – what is important is similarity of goals, synchrony of efforts and synergy of effect. The focus is on establishing common ground, whether in private, public or private-public partnerships. It is important to differentiate between partnerships that have an emphasis on shared vision versus an alignment of interest and pooling of resources; unless this differentiation is clear it can negatively affect the credibility of the partnership.
- Level of Engagement: Start with engagements in which partners are independent at the operational level; then move to the level of cooperation and coordination where there is an agreement not to duplicate each other's work; then progress to the level of collaboration where a common vision is in place. Resource levels will often determine how many organizations can enter into a partnership; smaller organizations have to be more focused and make more choices.

The partnership process includes: clarifying perspectives, developing a shared vision or smaller objectives, determining the type of partnership, degree of collaboration and cooperation. These are complemented by mutual skill and knowledge development, sharing among partners and a conducive environment.

Participants noted that there are currently no generally accepted norms, principles, standards or guidelines for partnerships and suggested that one role of the Global Forum might be to look into facilitating the development of these norms and principles, which would lend impetus to country level initiatives to develop procedural

guidelines. This would also aid in producing an internationally conducive environment for chronic disease partnerships.

In terms of the flow of partnership development, participants emphasized that it is not linear but more iterative in nature.

As part of their discussions, participants identified challenges and actions related to participation.

Detailed results of group discussions related to this theme area can be found in the Annex to this report: "Forum Outputs and Resources" (Part 3.1) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

3. Planning

Planning: *to support action through identification of priorities, opportunities and barriers, and actions to address them.*

Forum participants discussed a draft framework for national strategic action planning. They agreed that such a framework is a useful tool/mechanism to engage governments for planning/implementation at the highest levels.

In discussing the key characteristics of this framework, they noted that it is intuitive, simple (i.e., involves a limited number of steps), multisectoral, multidisciplinary and includes additional determinants that affect success such as the political environment, social attributes, economic issues, public knowledge, attitudes and beliefs. It should have a logical flow (e.g., move from building of structures, to collection of information, planning and implementation) but also contain a cycle or an iterative model.

The framework's most important feature is that it is a national strategic action plan. Having Ministries of Health as a focal point for leadership and establishing partnerships for initiation of planning and action is generally appropriate, particularly in smaller countries. However, it is the responsibility of countries to identify institutional mechanisms or a focal agency. Leadership should not be top-down but tailored to the specific context, e.g., leadership by NGOs may be better in some circumstances.

Importantly, the application of the framework needs to be general to enable adaptation and buy-in by developing countries to meet special circumstances and issues. In addition, the framework needs to be sensitive to the availability of data in many countries to present the economic case for action, as well as to clarify the effectiveness of interventions. Cost-effectiveness data may not be available in some areas, but this should not prevent action.

The Ottawa Charter for Health Promotion was cited as an excellent document that could be complemented by a national strategic planning framework.

Interventions

Forum participants were also asked to identify interventions that should be acted on through comprehensive planning for chronic disease prevention and control. Their responses included:

- Advocacy to maintain the focus of the interventions
- Broad-based community mobilization, e.g., coalition building, intersectoral collaboration
- Capacity building, e.g., strengthening of NGO capacity and delivery systems outside the health sector
- Community participation and behavioural change, e.g., to create demand
- Development of strategies for scaling up an effective program before demonstration
- Enabling legislative actions
- Environmental change interventions outside the health sector that engage all sectors to create environments friendly to health (city, schools, restaurants, etc.)
- Integration of prevention in the chronic disease system, e.g., primary health care, medical school education, life-course approach
- Legislation to guide implementation, e.g., tobacco control
- Ongoing monitoring and evaluation, e.g., research integrated with implementation, data collection and analysis, testing effectiveness (what works and what doesn't)

- Partnership building, e.g., interventions to test tenets of effective partnership
- Policy development, e.g., healthy foods, tobacco control, including legislation, regulation, enforcement, fiscal measures and taxation
- Surveillance.

A revised Planning Framework can be found in the Annex to this report: "Forum Outputs and Resources" (Part 3.2) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

4. The Economic Case for Chronic Disease Prevention and Control

A group of Forum participants discussed the draft paper *"Making the Economic Case for Investments for Chronic Disease Prevention and Control: A Review of Current Published Information and Evidence to Address Critical Policy Questions"* prepared for the Forum by Dr. Clarence Clottey, Deputy Director, WHO Collaborating Centre on Policy Development, Public Health Agency of Canada and Dr. Jeff Johnson, Associate Professor and Fellow, Institute of Health Economics/University of Alberta. In their response, they first discussed the need for and inherent difficulties of preparing such a document, particularly with respect to the lack of data for making the economic case in developing countries.

The discussion group noted that the primary audience for the economic case is Ministers of Finance and Health, recognizing their primary need to identify the low-cost, short-term, high yield interventions in chronic disease prevention and control for investments during a given political cycle.

Basic economic questions to be answered by the document for the target audience are:

- Is it a public good, e.g., when there is no private demand does it require government intervention?
- Is it cost-effective, e.g., does it emphasize interventions which provide value for money?
- Is it costly, e.g., does it impoverish those who need to pay for it?
- Is it pro-poor, e.g., does it preferentially benefit the poor?
- What is the cost of inaction?

A summary of the results of group discussions can be found in the Annex to this report: "Forum Outputs and Resources" (Part 2.2) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

A revised version of the discussion paper is scheduled for January, 2005.

International Showcase Day

The final day of Global Forum IV was a Showcase Day for 160 international and Canadian delegates in connection with Canada's first ever Chronic Disease Prevention Conference organized by the Chronic Disease Prevention Alliance of Canada (CDPAC). CDPAC is a networked community of organizations and individuals whose mission is to foster and help sustain a coordinated, countrywide movement towards an integrated population health approach for prevention of chronic diseases in Canada through collaborative leadership, advocacy, and capacity building.

Showcase Overview

The focus of the CDPAC Showcase Day was to provide a forum for Global Forum IV (GF IV) participants and CDPAC members to interact, learn, share information and explore opportunities for working together on strategies for policy issues related to diet, physical activity and healthy weights. The Showcase Day consisted of Canadian and international presentations from key stakeholders followed by group discussions to explore issues related to real cases in the participants' communities.

Dr. Sylvie Stachenko, Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, opened the Showcase day by emphasizing how similar challenges are globally related to chronic disease prevention and control and the importance of this opportunity to pool collective resources and experience.

Ms. Donna Lillie, Chair, Steering Committee, Chronic Disease Prevention Alliance of Canada, gave a brief overview of the Showcase day and CDPAC. She echoed Dr. Stachenko's remarks about the opportunity represented by the presence of so many experts from around the world to share knowledge, actively increase professional networks and interactions, and challenge each other to find solutions.

Dr. Robert Beaglehole, Director, Department of Chronic Diseases and Health Promotion, World Health Organization, provided an overview of the WHO response to the chronic disease epidemic. He reassured participants that WHO is taking the pandemic very seriously, e.g., by responding to the mandate of 192 Member States through instruments such as the Framework Convention on Tobacco Control, the Global Strategies on Noncommunicable Diseases and Diet, Physical Activity and Health and the World Health Assembly resolution on cancer prevention. Dr. Beaglehole also noted the strong political support for chronic disease prevention and control that is being expressed in Canada and other countries. In closing, Dr. Beaglehole highlighted the importance of a full range of partners to build and strengthen partnerships. He hoped that by 2015 important and measurable impacts, particularly in developing countries, will be evident.

Part I: Showcase

Following opening remarks, the International Showcase Day focused on presentations from Canadian and international speakers in two formats:

- a Country Showcase Roundtable, consisting of presentations by representatives from Argentina, China and Colombia; and
- a Canadian Showcase focusing on collaboration for systems change, consisting of presentations from sectoral, provincial/territorial and national representatives.

Country Showcase Roundtable

Dr. David Butler Jones, Chief Public Health Officer, Public Health Agency of Canada, acted as moderator for the Roundtable. Presenters were:

- Dr. Lingzhi Kong, Director, Chronic Disease and Mental Health, Chinese Disease Control Department
- Dr. Ana Tambussi, Consultant, National Programme for Tobacco Control, Ministry of Health and Environment, Argentina
- Dr. Luz Elena Monsalve Rios, Ministry of Social Protection, Colombia

Each presenter was asked to speak on the key elements of their country's approach, as well as to provide one suggestion for working together collaboratively.

Summaries of presentations can be found in the Annex to this report: "Forum Outputs and Resources" (Part 1.2) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

Discussion

The following points were made during the question and answer period following the Country Showcase Roundtable:

- There is a lack of clarity between the terms "noncommunicable disease" and "chronic disease" and no apparent consensus on which is more appropriate. For individuals working in chronic disease prevention and control, the important point is to state clearly what is meant, i.e., chronic diseases include cancer, cardiovascular diseases, hypertension, diabetes, etc.
- In developing countries, the most significant challenge to increasing chronic disease prevention and control is to demonstrate to political leaders the depth of the problem and its impact on the country. The lack of political will may be due to difficulty in communicating with politicians who do not have the knowledge to be fully aware of the problems. Once political commitment is in place, change can be made relatively quickly, e.g., in Canada, SARS exposed weaknesses in public health but overall has led to changes that have strengthened the public health system.
- NGOs are important contributors to chronic disease prevention and control, as are other non-traditional partners.
- As well as "traditional" chronic diseases, developing countries such as Argentina, China and Colombia are also concerned with mental health and injuries. For example, China has published a strategic action plan for mental health.

Canadian Showcase Panel

The Canadian Showcase explored the Canadian experience in integrated chronic disease prevention related to systems change at the national, provincial and settings level. Presentations included:

Topic	Presenter
The National Perspective: The Chronic Disease Prevention Alliance of Canada	Ms. Bonnie Hostrawser, Executive Director, CDPAC (www.cdpac.ca)
The Provincial Perspective: The Alberta Healthy Living Network	Ms. Ellen Murphy, Co-Chair, Alberta Healthy Living Network (www.health-in-action.org)
Settings Perspective: School Health	Mr. Doug McCall, Executive Director, Canadian Association of School Health

A summary of the results of group discussions can be found in the Annex to this report: "Forum Outputs and Resources" (Part 1.3) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

In concluding the Canadian Showcase, Ms. Hostrawser noted that

- collaboration is happening and has demonstrated some early effectiveness for system change, but needs to be supported and sustained;
- continuing engagement at all levels is necessary;
- coordination and collaboration are essential to build on existing strengths; and
- there are serious capacity issues: for most organizations, collaboration and integration are not part of their core work responsibilities.

> *"There is strength in the chronic disease prevention and control movement because there is so much passion. However, we need to address capacity issues to ensure sustained action."*

Part II: Strategic Orientations

Following the Country and Canadian Showcases, four concurrent sessions were convened on the following themes:

1. Getting Prevention on the Political Agenda
2. Working with the Food Industry
3. Bridging the Science-to-Policy Gap
4. Advances in Risk Factor Surveillance

Each session consisted of a panel presentation followed by table discussions. During discussions participants were asked to identify challenges and actions related to the theme areas. Results were presented in plenary following the conclusion of the sessions.

A summary of the results of group discussions can be found in the Annex to this report: "Forum Outputs and Resources" (Part 2.3) on the WHO website: www.who.int/hpr/globalforum/meetings.shtml.

1. Getting Prevention on the Political Agenda

Panel Members:

Mr. Neil MacDonald, Provincial/Territorial Co-chair, Intersectoral Health Living Network (IHLN) from Alberta Health and Wellness, in collaboration with IHLN Co-Chairs Mr. Claude Rocan, federal representative from Public Health Agency of Canada, and Dr. Elinor Wilson, NGO Representative from the Chronic Disease Prevention Alliance of Canada

Dr. Sania Nishtar, President, Heartfile, Pakistan

Dr. Jill Farrington, WHO Regional Office for Europe, Denmark

Facilitator: Mr. Stephen Samis

Challenges identified in group discussions following the panel presentations included:

- How do we create a business case for health promotion and prevention?
- How do we develop a common language that crosses divisions existing within the disease treatment, chronic disease prevention and health promotion communities?
- How do we engage partners and line up mandates to focus on health?

- How do we know what is going on across Canada and internationally?
- How do we move beyond "preaching to the converted" to link with other non-health sectors?
- What do we need to do to get health prevention on the agenda?
- What is required to develop a sustainable process and support for intersectoral planning?

2. Working with the Food Industry

Panel Members:

Ms. Mary Bush, Director General, Office of Nutrition Policy and Promotion, Health Canada, Canada

Ms. Susan Roberts, Coordinator, Healthy Eating in Store for You Programme, Canadian Diabetes Association and Dieticians of Canada, Canada

Dr. Srinath Reddy, Director, WHO Collaborating Centre on Epidemiology and Prevention of CVD, India

Facilitator: Ms. Nancy Dubois

Challenges identified within this discussion area included:

- How can we educate consumers to enable consumer choice and advocacy?
- How can we develop a common vision among health sector and food industry partners? What do we need to do to build a strong partnership?
- How do we define relationships with the food industry that make nutrition and food safety everyone's business?
- What innovative approaches can help us promote health through policies and regulations that inform food purchasing, production and processing?

3. Bridging the Science-to-Policy Gap

Panel Members:

Dr. Diane Finegood, Scientific Director, Canadian Institutes of Health Research, Institute of Nutrition, Metabolism and Diabetes, Canada

Dr. Fan Wu, Director, WHO Collaborating Centre for Integrated Community-Based Programmes for NCD Prevention and Control, China

Dr. Clarence Clottey, Deputy Director, WHO Collaborating Centre for Policy Development in the Prevention of Noncommunicable Disease, Canada

Facilitator: Ms. Jane Farquharson

Challenges identified within this discussion area included:

- How can primary care physicians be encouraged to act as advocates for prevention activities within their practices?
- How can we address issues related to the interactions of scientists and policy makers, including language and timelines?
- How do we mobilize the political will to move funding to prevention?
- What can we do to lobby politicians based on the economic impact of chronic disease?

4. Advances in Risk Factor Surveillance

Panel Members:

Dr. Gauden Galea, WHO Regional Office for the Western Pacific, Philippines

Dr. Linda Van Til, Member, Surveillance Systems for Chronic Disease Risk Factors Task Group, Canada

Dr. Jerzy Leowski, WHO Regional Office for South-East Asia, India

Facilitator: Dr. Catherine Donovan

Challenges identified within this discussion area included:

- How can we advocate for and ensure sustainable funding for risk factor surveillance?
- How do we ensure dedicated, sustainable funding for surveillance activities related to chronic diseases?
- How do we increase the availability, validity and use of surveillance information in planning and evaluation?
- What is the best way to develop and make available standardized tools for use in a range of countries?

Closing Remarks

In closing the WHO Global IV Forum, Dr. Sylvie Stachenko thanked participants for their intense and energetic hard work. Dr. Stachenko was at the first Global Forum, which was a pioneering idea for developing this mechanism to advance the chronic disease prevention and control agenda. Over the years, the Global Forum has evolved to address more practical, specific areas such as systems issues related to policy, planning and participation. Dr. Stachenko emphasized the important role of Forum participants in making a difference to global and national chronic disease prevention and control.

Dr. Robert Beaglehole commented on the forthright, energetic and enthusiastic discussions that had advanced understanding and shared knowledge over the course of WHO Global Forum IV. He acknowledged the importance of the economic discussions and thanked NGO representatives for attending.

Dr. Beaglehole also noted that this Forum was at a transition point where it was important to think about the future of the event in advancing Global Forum objectives. He emphasized the importance of the six WHO Regional Networks that will continue to be a focus to support chronic disease prevention and control, as well as the need to reflect on how to build on these regional networks to advance the global agenda. In closing, he asked participants to reflect on how they can act in their countries to advance the Global Forum agenda in tandem with the Millenium Development Goals.

In their evaluations of Global Forum IV, participants described their experience as exhilarating, dynamic, interactive and focused. They indicated an increased commitment to future action on the three Forum themes: policy, participation and planning.

WHO Global Forum IV on Chronic Disease Prevention and Control

ANNEX

Department of Chronic Diseases and Health Promotion, Noncommunicable Diseases and Mental Health, World Health Organization

Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada

World Health Organization

Government of Canada Gouvernement du Canada

Part 1: Presentations

1.1: WHO Regional Office Thematic Presentations

MOANA (WPR): Disease Prevention and Health Promotion

Presenter: Dr. Gauden Galea, Regional Adviser, Western Pacific Regional Office

Dr. Galea posed the basic question: "What does a national response to chronic diseases look like?" and qualified it with the following challenges:

- How to develop a pragmatic model that integrates health promotion and disease prevention in developing country settings.
- How to avoid the problem of structures in countries mirroring the structures in development agencies.

Dr. Galea discussed high risk vs. population approaches and suggested that although they work well in different scenarios, one is not superior to the other. The challenge is to find a way to combine these approaches with respect to mix rather than a choice between them. Dr. Galea emphasized that there should be very clear priority setting systems and a planning system with a scientific approach to look at the most appropriate strategies for both the short and long term. In the WPR, they have tried to adopt the same approach as the STEPwise surveillance system by looking at interventions in the short, medium and long-term, finding that it is often useful to prioritize interventions in the same way as risk factors.

Dr. Galea concluded by describing two challenges: a) identifying the key interventions and the content of our national responses, and b) how these interventions can be used to track progress and evaluate effectiveness.

CARMEN (AMR): Capacity Building and Training

Presenter: Dr. Sylvia Robles, Regional Adviser, Pan-American Health Organization

To open her presentation, Dr. Robles presented the challenges for implementing integrated CDP programmes in PAHO, i.e.,:

- an institutional public health infrastructure that is not responsive to NCD; it was created for communicable diseases and maternal and child health
- an institutional context that is not conducive to participation of multiple stakeholders; fragmented and compartmentalized within governments with little participation outside the non-governmental sector
- the gap between academic institutes and public health services
- a lack of commitment for education in public health.

She noted that health sector reforms in the Americas have changed the roles of ministries of health and public sector agencies without strengthening them and that addressing these problems is a long-term proposition that requires tools, e.g., an observatory of human resources that can be used by countries to look at human resources and identify related issues. PAHO has a long-term partnership with schools of public health and has established a virtual public health campus. A virtual library for NCDs has also been developed in collaboration with CARMEN, which aims to reach everyone with appropriate scientific information either through the Internet or PAHO offices.

The CARMEN Network is an important collaborative tool for providing opportunities to share information among countries, promote cooperation and learn from successes and failures. The CARMEN School has been created to develop training and tools for the health sector to face the NCD epidemic and address issues related to lack of competencies. The school supports the need to train policy makers and health workers, as well as addressing the lack of availability of data on risk factors and the need for collaboration among different partners.

NANDI (AFR): Surveillance

Presenter: Dr. Antonio Pedro Filipe, Jr., Regional Adviser, African Regional Office

Dr. Filipe emphasized that most African countries are not facing an epidemiological transition – they are facing the reality of the double burden of infectious and noncommunicable disease. Nutrition is still the number one risk factor for diseases, but obesity is progressing rapidly. Unfortunately, data on chronic diseases is scarce; it is not generally regarded as a top priority by regional governments.

Among NCDs, CVD is the most important. Cancer and diabetes are growing problems in urban areas. Chronic obstructive pulmonary disorder (COPD) and diseases in the hemoglobinopathies group, including sickle-cell disease and thalassemia, are other important chronic disease groups.

Dr. Filipe noted that the WHO STEP approach to surveillance offers a good opportunity for most of the countries of his region, which tend to lack data and resources. Training in the STEPwise approach and collection of routine data is a priority, including screening programmes for cervical cancer, cancer registries and nutritional surveys. Risk factors are similar to other regions and include smoking, alcohol, obesity and blood pressure, as well as blood lipids and glucose.

Challenges for NANDI include extending the survey of risk factors; moving from surveys to surveillance; building in sustainability to improve routine data collection; integration of communicable and noncommunicable diseases surveillance system and integration of different risk factor surveys into STEP 1 of the STEPwise approach.

EMAN (EMR): Policy Development

Presenter: Dr. Oussama Khatib, Regional Adviser, EMRO and Dr. Sania Nishtar, Heartfile, Pakistan

Dr. Khatib provided an overview of the relatively new EMAN network, which operates in a region of 22 countries that are in the midst of an epidemiological transition, including increasing rates of obesity, smoking, diabetes, hypertension, and elevated rates of consanguineous disease. Twelve of these countries are officially enrolled in EMAN.

There is wide variation in terms of country incomes in the region, which makes equity of access to health care a major issue. There is also an emphasis on developing regional guidelines, which to date have been established for hypertension, diabetes and cancer. Demonstration areas have also been established in Kuwait (diabetes), Bahrain (cancer) and Iran (CVD). The Iran demonstration area has recently become a collaborating centre. There are also two collaborating centres for cancer in Saudi Arabia.

Surveillance is an important policy development tool: 10 EM countries are currently enrolled and using STEPwise as their national surveillance system to enable risk factor mapping.

One regional concern is a lack of training facilities; another (given that drug treatments are complicated and expensive) is the treatment of chronic conditions as an area of concern. In closing, Dr. Khatib highlighted the prevalence of rheumatic fever in Yemen and other countries in his region and the need to develop regional guidelines for this disease.

Dr. Sania Nishtar, Heartfile, provided information about the national action plan for chronic disease prevention and control in Pakistan. Heartfile's mandate is to develop an evidence-based strategy for chronic disease prevention and control and implement that plan in a private-public multi-stakeholder partnership. This is being achieved through a three phase process: planning across each disease domain; priority-setting within the proposed action agenda items; and development of an integrated approach for chronic diseases.

Challenges within this approach include: the need to be supported by strong political commitments; infrastructure and capacity building; as well as the need for procedural clarity in public-private relationships.

SEANET (SEAR): Community-based Interventions

Presenter: Dr. Jerzy Leowski, Regional Adviser, SEARO

Dr. Leowski noted that the SEANET charter is due to be formalized in 2005. The network's objectives are to facilitate and support member countries in relation to chronic diseases, sharing of experience and collaboration on knowledge generation and advocacy.

The network structure is based on activities of the national networks and includes associate members such as WHO Collaborating Centres and other institutions. Governance is through a Board of Directors guided by a high level steering committee. The role of the WHO is to provide secretariat support. Major components include political commitment, surveillance, health promotion programmes and activities, and integrated chronic disease prevention and control programmes.

Among the conclusions from recent pilot programmes is that a community-based approach for prevention is feasible and appropriate for implementation in the regions. The WHO STEPwise framework is suitable for estimating the level of risk factors in areas where community-based interventions are applied.

Areas that need strengthening include: identification of more stakeholders; more documentation related to the process of intervention; development of process indicators and methods of measurement; and criteria for determining success or failure. In closing, Dr. Leowski noted that SEANET has direction, commitment from local authorities and political support, and is making a concerted effort to advance chronic disease prevention and control in the region.

CINDI (EUR): From Demonstration to Policy Development

Presenters: Dr. Aushra Shatchkute, Regional Adviser, EURO and Dr. Vilius Grabauskas, Chair, CINDI International Management Committee

Dr. Shatchkute provided a brief overview of the CINDI initiative in the EURO region. CINDI includes 32 members and was developed to implement an integrated approach to chronic disease prevention and control. Two important components of CINDI are: monitoring and evaluation, including quantitative and qualitative databases; and capacity building mechanisms at national and international levels.

Important issues include continuation of multi-factorial intervention and capacity building. CINDI winter schools continue to be important because they combine international experience with training on programme implementation; other examples of capacity building include training the trainer courses on evidence-based chronic disease prevention. Additional issues include analysis of noncommunicable diseases policy development and continuing contribution to the European strategy on chronic disease prevention and control.

A key finding from a recent CINDI comparative study in 30 CINDI and CARMEN member countries was that an integrated approach to chronic disease prevention and control works, although a variety of models, approaches and methodologies for programme implementation is required. Another finding was that there are five key issues in the transition from demonstration to dissemination: political and policy supports, partnerships, information database, resource mobilization and closer health system links.

Dr. Grabauskas focused on the CINDI network initiative in developing a chronic disease strategy for a new and diverse Europe as described in the document "*A strategy to prevent chronic disease in Europe: A focus on public health action–The CINDI vision.*"

The burden posed by chronic diseases is high across Europe and there is a clear need for a shared vision in a changing Europe. In view of the gross inequities that exist, there is solid evidence related to chronic disease causation and at the same time a lack of integrated action.

Priorities for international collaboration in CINDI policy consultations include: policy development, legislation, coordination, marketing and organizational development, practice guidelines, public education and mass media involvement, monitoring and evaluation, and research.

In epidemiological and public health terms, the backbone of CINDI's strategy is evidence and the implementation of a high risk population strategy.

In practical terms, the major goal is the reduction of burden from four major chronic diseases: CVD, cancer, COPD and diabetes.

1.2: International Showcase Day– Country Showcase

Dr. Lingzhi Kong, Director, Chronic Disease and Mental Health, Chinese Disease Control Department, provided insights into epidemiological and health transitions in lifestyles, nutrition and social economics, commenting on the disparities in development between urban and rural areas, as well as a trend towards increasing overweight and diabetes, particularly in urban areas.

Dr. Kong also described the evolving Chinese chronic disease framework, whose goals include: to establish the NCD prevention system, to improve lifestyles, to control NCD prevalence and to reduce the NCD burden. Targets of the framework are the major risk factors (such as tobacco, diet, physical activity and blood pressure) and chronic diseases such as CVD, cancer, diabetes and COPD, which account for approximately 70% of mortality in China. These are being addressed through strategies such as improved information and surveillance; advocacy and awareness, especially for high level government and policy makers; development of priorities for integrated chronic disease prevention and control; partnerships; cooperation and coordination, especially in capacity building and international collaboration.

In terms of policy development, goals are to create a positive environment for chronic disease prevention and control, especially for political commitment; increasing resource mobilization; restoring health service; reforming the health system, e.g., medical insurance to include chronic disease prevention and control.

Dr. Ana Tambussi, Consultant, National Programme for Tobacco Control, Ministry of Health and Environment, Argentina, provided an overview of the situation in her country, which, like many countries, has become increasingly urbanized in recent years, with 45% of the population now living in the seven largest cities. This has placed stress on the social system, e.g., in greater Buenos Aires where the percentage of the population whose basic needs are not being met is in the range of 20-30%, and between 30-50% live below the poverty line in large parts of the country.

With respect to mortality, roughly five of every ten deaths are due to cancer or CVD. Among risk factors, tobacco, and hypertension are the most important, followed by obesity, sedentarism, alcohol and diabetes. There is great concern about risk factors among younger people in urban areas, particularly related to tobacco and alcohol abuse. In support of this, a national strategic system for risk factors surveillance is being developed. The survey is based on a PAHO instrument and will include: sociodemographic and household data, access to health care and coverage, self-perception of health, tobacco addiction, arterial hypertension, physical activity, weight, dietary habits, cholesterol, alcohol consumption, diabetes, preventive practices and accident prevention.

Intervention strategies focus on all levels; governments have a leading role and are the prime movers in collaboration with the private sector. An integrated, multisectoral, life-style based approach is used that looks at an optimal combination of measures. The priority is on poorer sectors of society with gender-sensitivity also being an issue. Finally, the strategies fully support international standards.

Various interventions are currently in progress, including tobacco control and working with the community and industry to look at the potential impact of reducing dietary intake. In closing, Dr. Tambussi noted that nutrition is a key area where organizations can work together collaboratively to support each other within the Global Strategy for Diet, Physical Activity and Health. She proposed an initiative to develop international legal instruments for nutrition that would regulate food production and advertising, as well strengthen technical capacities.

Dr. Luz Elena Monsalve Rios, Ministry of Social Protection, Colombia, described Colombia as a large country with a range of ethnic and climatic variation. The basic needs of approximately 40% of people are not being met with only 50% of people having access to social services. In recent years, there has been a massive move to urban centres. As life expectancy increases, the percentage of the aging population is also increasing.

There is recognition of the need for policy to move forward on chronic disease prevention and control. A recent survey has shown problems in areas such as metabolic diseases, nutrition, late diagnosis of cancer, rise in CVD and prevalence of tobacco abuse.

The chronic disease agenda is advancing: over the last five years political commitment has been strengthened; there is work on the development of institutional and regulatory mechanisms, as well as intersectoral efforts among the community at large. In addition, chronic disease prevention and control is now included within overall public health priorities and has received additional funding.

Achievements include: guidelines for mobilizing people from sedentary lifestyles; a variety of standards and treatment protocols for chronic disease prevention and control; and resource mobilization. An early detection system including guidelines for local activities is also in place in many areas of the country. Other initiatives include a new oversight and control model; a strategy focused on tobacco use in educational institutes; programmes for increased physical activity and FCTC ratification.

1.3: International Showcase Day– Canadian Showcase

1. National Perspective: The Chronic Disease Prevention Alliance of Canada

Ms. Bonnie Hostrawser, Executive Director, CDPAC, gave an overview of the history and development of CDPAC, which includes 53 member organizations representing hundreds of multisectoral stakeholders from twelve of thirteen Canadian provinces and territories.

The current climate in Canada is one of both opportunities and challenges for chronic disease prevention and control. Recent developments such as the creation of the Public Health Agency of Canada and appointment of a Chief Public Health Officer offer an opportunity for CDPAC to participate actively in comprehensive chronic disease prevention within a pan-Canadian Public Health strategy. A commitment to sustainable funding and resources and the erosion of public health organizations at the local level continue to be challenges. To address these, CDPAC works toward systems changes such as increased public health capacity on chronic disease prevention and health promotion issues, and increased municipal and local capacity to support chronic disease prevention and health promotion. Current activities include: development of a nutrition mobilization plan, identification of and action on policy priorities for obesity, and development of an integrated research agenda that will create a seamless network of research, policies and programs.

In closing, Ms. Hostrawser noted that CDPAC has been evaluated by its members as "the voice of influence for systems change in Canada," as well as a synergistic and dynamic network of intersectoral partners at all levels. She emphasized that the essence of CDPAC is its partners – the Alliance cannot succeed without collaboration.

2. Provincial Perspective: Alberta Healthy Living Network

Ms. Ellen Murphy, Co-Chair, Alberta Healthy Living Network (AHLN), updated participants on the situation in Alberta. The AHLN has 90 members from all sectors, both traditional and non-traditional. She noted how the network avoided terminology pitfalls related to use of terms such as health promotion, population health and chronic diseases prevention by packaging them together under the umbrella of healthy living. The network is based on two important assumptions: that it must work at all levels, including national and international, and focus on interventions related to coordination and integration.

The network has seven strategic priorities designed to facilitate a health systems and levels approach: partnership development and community linkages; awareness and education; surveillance; best practices; research and evaluation; health disparities and healthy public policies. Accomplishments include recognition by the WHO as a CINDI demonstration site in 2003, publication of an economic analysis of the cost of chronic diseases and a network mapping project.

In closing, Ms. Murphy noted that partners are continuing to build networks and have experienced considerable success at the community level, where three communities have received funding to establish their own

healthy living networks. The activities of other organizations, such as the Alberta Cancer Board, have also fit in well with the network approach.

3. Settings Perspective: School Health

Mr. Doug McCall, Executive Director, Canadian Association of School Health, described the historic opportunity for school health provided by the work on the Pan-Canadian Healthy Living Strategy and how it has acted as a catalyst for the Canadian system. The Council of Ministers of Education are organizing an intersectoral consortium with Health Canada and provincial stakeholders.

Research related to school health has considerable promise, as we are experiencing in Canada under the aegis of the Canadian Institutes of Health Research. In addition, the US Centers for Disease Control is an important source of knowledge that is often adaptable or applicable to other countries. What we know is that we should be talking not only about schools or chronic diseases but an overall integrated approach. The impact of schools is much more positive when instruction is coordinated with services, policy, social support and environmental change. Alignment of sectors is another important consideration, e.g., integrating schools not only with chronic disease issues but with other issues such as mental health and safe routes to schools.

Most importantly, school approaches must reflect the values of the community being served. Solutions must address the whole child, whole school and whole community, including the needs of education professionals.

In closing, Mr. McCall cited Canadian and international examples and opportunities related to the school setting and the nascent International School Health Network, which combines government, research and other stakeholders working from regional networks and thematic networks such as the Mental Health and Schools Network and which is benefiting from the support of the WHO Global School Health Program.

Part 2: Records of Discussions

2.1: Policy–Group Discussions

Participants provided policy feedback based on the following two questions. Responses are not in order of priority.

1. What do your countries/organizations/networks/coalitions and alliances do well with respect to policy, i.e., enabling action through evidence-based advocacy?
2. What are 2 or 3 actions that your countries/organizations/networks/coalitions and alliances could do to improve what they do with respect to policy, i.e., enabling action through evidence-based advocacy?

1. What do your countries/organizations/networks/coalitions and alliances do well with respect to policy, i.e., enabling action through evidence-based advocacy?

- International Level: broad policies have been developed, e.g., FCTC, WHO Global Strategy on Diet, Physical Activity and Health, the Ottawa Charter.
- Policy making is done through a more consultative process now, e.g., in the UK where community involvement is key to policy development. Today many organizations and countries analyze why something doesn't work and then adjust policies based on what is learned.
- Chronic disease is more integrated into a primary health care approach and national public health surveillance.
- The availability of data (e.g., NCD STEPwise) has strengthened evidence-based policy development and advocacy.
- Political commitment is increasingly combined with community effort.
- There is more emphasis today on using science and surveillance data as a basis for action.

- The strengthening of public health systems in some countries has had a positive effect.
- There is a need to strengthen across sectors, e.g., Ministries of Health, Agriculture and Transportation as well as Health.
- There needs to be support of NGO capacity.
- Linkages among public health and disease-based organizations at the international level have improved.
- Policy has improved generally in terms of legislation and at community, schools and work sites.
- WHO contributes significantly by, e.g.,
  - providing international connectivity to promote chronic disease prevention policies as part of its global mandate
  - collecting evidence through demonstration databases
  - developing policy frameworks for chronic disease prevention and setting policies in broader health and social sector policies
  - developing materials for global advocacy
  - providing technical assistance for capacity building and program development.
- The Chronic Disease Prevention Alliance of Canada (CDPAC) combines the largest NGOs in an alliance that is developing a powerful voice for advocacy and fostering innovative thinking in civil society.
- The Canadian Intersectoral Healthy Living Network is a consortium of organizations working on integrated chronic disease prevention, health promotion and nutrition that facilitates networking for policy development and implementation.
- The International Council for Nurses builds capacity for nurses to participate in the national decision making processes and works with nurses to make their roles more proactive in chronic care and therefore chronic disease prevention.
- Heartfile is an NGO that has developed a national policy on chronic diseases in an integrated multi-stakeholder partnership-based model that uses country-wide evidence to develop national policies and plans of action.

- The PAHO nutrition unit is advocating through governments to improve transportation policies that support physical activity, e.g., bike paths.
- WHO Collaborating Centres provide operational research to generate evidence for policy action.
- There is an improved process of policy development, starting with evidence, then advocacy, action planning and strategies.
- Advocacy is used to initiate consensus with stakeholders and get the attention of policy builders and to prioritize chronic disease prevention in the public health agenda.
- Formulation and initiation of policy development is being done well and easily; however, implementation and application of chronic disease policy is still weak.
- There is a growing recognition by many countries of the burden of chronic disease and the need for policies to address it.
- Networks show enthusiasm and commitment.
- Civil society groups are more active in advocacy.
- Canada has drawn attention to the determinants of health and set up frameworks and models for action, although implementation is problematic.
- Tanzania has developed guidelines for chronic disease prevention and control involving different sectors.
- Thailand is good at creating national level campaigns (e.g., physical activity), but less effective at the people/community level.
- In China, the government has asked each province to set up a unit to take responsibility for chronic disease prevention and control and to give resources to it. A long-term national strategy is being developed,

including an action plan with financial support. A multisectoral cooperation committee has been set up for tobacco issues, working towards ratification of the FCTC and a national strategy for tobacco control. There is a wealth of experience at the provincial and local level with community-based interventions. There are also food and nutrition guidelines as part of a national long-term strategy with a 10-20 year timeline.

- In Europe, cities exert local influence on national policy development related to implementation.

Developing Countries

- Developing countries such as Ghana are dealing with a double burden of disease related to both communicable and noncommunicable diseases, which poses different challenges, e.g.,
  - how do you use evidence of increased NCD to put resources into chronic disease prevention without taking away from communicable diseases?
  - how do you mobilize partners in multiple NGOs (such as World Bank, UNICEF, etc.) to move the agenda forward
  - who will put plans and resources in place to implement them?
  - how do we bring in partners from outside the health sector?
- Developing countries may not want to develop all encompassing policies on chronic disease prevention and control; they should focus on models for specific diseases (such as diabetes) that are an increasing priority.
- We need evidence of the burden of disease as well as about the effectiveness of interventions. It is difficult to assess the effectiveness of population-based interventions – the science is not sufficient to answer all the questions we have.
- There is a need to introduce changes in approaches by agencies in developing countries – CD and NCD can complement each other.

2. ***What are 2 or 3 actions that your countries/ organizations, networks, coalitions and alliances could do to improve what they do with respect to policy, i.e., enabling action through evidence-based advocacy?***

All Levels

- Advocate, advocate, advocate and raise awareness. Many countries do not feel that chronic disease prevention is on the political agenda yet. In particular, we need more evidence-based advocacy with respect to diet, physical activity and health. There is not as big a need for evidence in tobacco.

  "Let's not preach to the choir; we need to focus on the unconverted."

Country Level

- Develop a strong economic rationale for country benefits related to chronic disease prevention. However, instead of talking about cost savings (which won't work), tie the rationale to quality of life issues, productivity and to the dependency ratio.
- Develop national committees on tobacco control and national planning.
- Establish processes and structures to implement strategies based on and/or integrated with existing structures.
- Develop better tools for (a) policy impact assessment, (b) health impact assessment of policies put forward by other parts of government, and (c) marketing the impact of successful policies.
- Provide country-specific evidence to advocate and influence policy development.
- Develop differential strategies that aim to improve access to care, e.g., equipping disadvantaged groups with the information they require to address their health issues. This approach requires strategies that are contextualized to suit the needs of those at risk in terms of social issues.
- Analyze existing agricultural, trade and transportation policies to learn what works and what doesn't.
- Look at health insurance benefits for medication.

- Develop a health equity policy that enshrines health as a basic human right.
- Change health professionals' curriculum and education so that they are more aware of population-based prevention and the determinants of health.
- Develop models for interdisciplinary training and approaches to building capacity in integrated ways so that ultimately we can infiltrate systems.
- Support public education as a precursor to policy change, including more research on linkages between education and change.
- Encourage more cross-talk and interaction between chronic disease approaches to surveillance and integrated risk factor approaches.
- Recognize that policy and advocacy are multidimensional, including
  - epidemiological data
  - political/interest groups
  - economic externalities, e.g., productive losses
  - rights based access
  - health as a human right
  - emotional impact on women, poor people, children's future health.
- Make strategies more implementable at the country level, e.g.,
  - FCTC: Develop structures such as a ministers' committee at the national level. Have a strong consultation process; build coalitions that involve NGOs, government agencies, enforcement; develop clear action plans that focus on resource mobilization. Put in place a monitoring mechanism.
  - WHO Global Strategy on Diet, Physical Activity and Health: Include physical activity at the country level. Consider alcohol as an additional strategy both in-region and in-country. Put in place an action plan with defined targets, objectives and a timetable for implementation. Develop high level advocacy at every level, including where there is resistance.

- Develop a combined multi-stakeholder governance mechanism.
- Foster capacity development at the local level and enhance sustained capacity development at the country level.
- Start with the determinants, not the disease.
- Address power struggles among sectors.
- Focus more on how we can work together and not as much on differences. Acknowledge the importance of customizing various approaches to different stakeholders and situations. Establish when to use approaches and for whom,
  e.g., high risk vs. population approaches or a combined approach; disease prevention vs. health promotion or a combined approach. Recognize similarities between chronic disease prevention and health promotion.
- Bring the legislators on board: ultimately, on some issues, we need high level decision makers to create the legislation required to support our key values.
- Through organizations such as WHO and the World Bank, strengthen the commitment of the international community to send a strong signal that there is a link between health and poverty to support action at the country level.
- Establish partnerships with sectors outside health, e.g., agriculture, finance.
- Prioritize chronic disease prevention and control in national health agendas and subsequently allocate both human and financial resources.
- Improve existing policies on nutrition and food, transportation, etc., to re-orient them to chronic disease prevention and control.
- Collect better information and improve the information base through surveys and surveillance.

- Tie the talk to action, e.g.,
  - move from demonstration of the importance of the determinants of health to addressing them
  - communicate with different departments when developing health policies and ensure they consider the impact of their own policies on health
  - relate interventions to poverty reduction strategies
  - use social marketing principles in chronic disease prevention and intervention
- Start some activities for health screening for employees, involving trade unions.

Organizational Level

- Involve regulatory bodies to ensure their potential contributions are realized.
- Regarding the WHO: avoid a compartmentalized approach to policy around chronic diseases: "integration" is a term that is over-used but under-done. Strengthen high level advocacy for policy development and the capacity for identifying and addressing priorities.
- Develop better research methodologies and value other dimensions of decision making.
- Have international organizations advocate at high political level for policy formulation and by sharing country experiences within networks.
- Have international organizations coordinate, communicate and streamline a concerted policy, plan and approach to prevent conflicting positions among organizations.
- Ensure that national organizations critically review evidence and use evidence better in policy development.

Network Level

- Establish a multisectoral approach at the network level, which tends to be inward-looking.
- Foster sharing among networks to ensure the same multisectoral approach is used at the member country level.
- Assist with the development of national goals and intersectoral targets for chronic disease prevention and control.
- Share experiences more frequently and communicate more regularly among networks.
- Network with the media. Communicate with the public through language and approaches that they will understand, e.g., not just complex statistics but plain language.
- Ensure that network members share experiences to support country development rather than keeping it "in the club."

Coalition/Alliance Level

- Regarding the WHO, FCTC and other documents: clarify and better define roles of each partner and make them more action-oriented – currently everyone seems to be doing the same thing.
- Advocate for mobilization of resources to chronic disease prevention and control, including raising awareness.
- Explore opportunities for combined funding mechanisms with other programs, e.g., HIV/AIDS.

- Ensure better coordination and collaboration for an integrated approach.
- Create multi-sectoral partnerships.

2.2: The Economic Case for Chronic Disease Prevention and Control

Group members discussing this draft document concluded that the document should be an advocacy text covering the burden of disease, effectiveness of interventions, and the costs and consequences of non-intervention. Some suggested that it could be a semi-prescriptive guide, e.g., identifying which cost-effective intervention should be done when. The paper should also be part of a wider argument recognizing that a health impact assessment on its own (however high quality) does not change political behaviour. The writers could benefit from reviewing the document on the basis of similar, successful advocacy documents, e.g., AIDS advocacy.

The primary audience for the economic case is Ministers of Finance and Health, recognizing that their primary need is to identify low-cost, short-term, high yield interventions in chronic disease prevention and control that can be invested in during a given (usually short) political cycle.

Basic economic questions to be answered by the document for the target audience are:

- Is it a public good, e.g., when there is no private demand does it require government intervention?
- Is it cost-effective, e.g., does it emphasize interventions which provide value for money?
- Is it costly, e.g., does it impoverish those who need to pay for it?
- Is it pro-poor, e.g., does it preferentially benefit the poor?
- What is the cost of inaction?

The argument must recognize the UN MDGs and address chronic diseases in that context, e.g., address chronic diseases in advocacy even if MDG do not specifically include chronic diseases. Recognizing that short-term funding increases for chronic disease are unlikely to be major, focus on obtaining small short-term increases and putting chronic diseases on the table for the longer-term. Key MDG related messages include emphasizing the links to:

- Poverty, e.g., chronic diseases are causing impoverishment (health care costs; decreased earning from disability); threaten economic development (dependency ratio, disability rates); and result from poverty of opportunity (health illiteracy leading to chronic disease; disability as consequence)
- Granularity, e.g., MDGs do not relate uniformly to all regions; document could broaden the MDGs by analyzing the impact of MDGs in different parts of the world and the implications for action; the MDGs must be broadened to address the needs of specific regions with specific actions.
- Women's health, e.g., loss of power (victims of diseases, earning losses due to disability, paying for treatment of family) and opportunity
- Double burden of disease, e.g., addressing communicable diseases while ignoring noncommunicable diseases will allow the latter burden to grow and eventually siphon resources from infectious diseases and maternal and childhood health that would weaken the MDG strategy.

Document conceptual issues including the humanitarian argument, immediacy of returns, focus on determinants, and "cautious" presentation of immediate (injuries) vs. long-term savings (cancer).

Other potential argument pathways include review of the cost of diseases reviewed, identification of priority burdens (e.g., tobacco), linking these to the determinants and then linking the determinants to economic sectors, and research knowledge, including dissemination of knowledge outside the scientific community.

Participant Comments

In discussions following the group's presentations, Forum participants identified the following key issues:

- Limiting the audience to ministers is a concern, as is emphasizing short-term impacts. Chronic diseases by their nature are not short-term. The critical issue is: how do we convince political leaders about the long term effects of not addressing chronic disease prevention and control?
- The cost-effectiveness issue is difficult because it has been argued on grounds of cost-effectiveness that it is better to apply secondary prevention to treat a person who has had a stroke than to prevent it through control of hypertension.

  In terms of cost-effectiveness, there are instances where measurement of effectiveness is not there or is based on various assumptions, particularly when cost structures vary from setting to setting. In addition, the Macroeconomic Commission acknowledges that any intervention that is equivalent to the GDP per capita of a country is very cost effective. However, it is difficult for chronic disease prevention to make such a case; it may be possible for short-term interventions, but not longer-term ones where there is a reliance on models with a number of intermediate assumptions rather than data.
- The aim of the document is to develop a reasonable set of general and broad assumptions regarding cost structures, looking at what should be targeted for investment and also at how to make the best

argument for resources that would advance the cause. We are looking for the reasonable not the ideal. There is still no consensus on which cost structures are the most useful. Interventions are challenged by the question of attributability; when you are intervening one way, there is a whole variety of potential side effects that may or may not accrue and some that are not intended. As well, there is a need to examine how you factor opportunity costs into the whole equation.

- Economics related to chronic diseases are complicated and inexact. While there has to be some sort of economic analysis or argument to make the case for chronic diseases, there are not many good examples of chronic disease costs, which will mostly accrue in terms of opportunity costs or outpatient treatment in terms of efficiencies rather than prevention. There are conflicting values and issues.
- Some regions refer to low cost/high yield interventions rather than cost effectiveness. The important point in making a case for use of public money for chronic disease prevention and control is to address economic factors affecting the public good that will influence Ministers of both Finance and Health.

2.3: Showcase Day Challenges and Actions

1. Getting Prevention on the Political Agenda

Challenge A: The Meaning of Health

The challenge is to get health prevention on the agenda by changing the perception that health refers solely to the treatment of diseases within the health care system and shifting the focus towards individual lifestyles and disease prevention.

Actions

- Build capacity for prevention in the treatment sector (e.g., primary health care) including knowledge, skill and perspectives.
- Build resources for health promotion.
- Shift health perceptions through stories and case studies, media coverage, etc.
- Identify, inform and collaborate with allies and build coalitions of the committed.
- Develop and roll out demonstration projects.
- Generate a public long-term agenda (e.g., similar to the environmental agenda of the last twenty years) to help shift the political agenda.

Challenge B: Linkages

The challenge is to move beyond "preaching to the converted" to link with other, non-health sectors.

Actions

- Have the health sector assume a catalyst role to bring sectors together.
- Identify early leaders and bring them together around an issue; use existing "tables" to influence actions at various levels.

Challenge C: Language Issues

The challenge is to develop a common language (for disease treatment, chronic disease prevention and health promotion) that crosses divisions existing within communities.

Actions

- Develop more inclusive, action-oriented language.
- Get over language issues and get on with actions!

Challenge D: Sustainable Intersectoral Planning

The challenge is to develop a sustainable process and support for intersectoral planning.

Actions

- Develop clear priorities with visible, measurable short-term outcomes and assessment/evaluation components.
- Identify and develop best practice models as a guide for action.
- Establish collective commitment to intersectoral action that crosses silos.

Challenge E: Awareness

The challenge is to know what is going on across Canada and internationally.

Actions

- Mandate an agency to act as a central repository for dissemination of evidence and surveillance (similar to Canada Census).
- Identify and develop best practice models that guide peoples' actions.

Challenge F: Partner Engagement

The challenge is to engage partners and line up mandates to focus on health.

Actions

- Develop intersectoral partnerships.
- Advocate and create awareness.
- Develop a focused message to politicians and policy makers.

Challenge G: Health Promotion/ Prevention Business Case

The challenge is to create a business case for health promotion and prevention.

Actions

- Build an effective cost-benefit analysis to demonstrate the positive economic impact of health promotion.
- Use the analysis to generate support from politicians and heads of state and build public support.

2. Working with the Food Industry

Challenge A: Common Vision

The challenge is to develop a common vision among health sector and food industry partners.

Actions

- Find a way to make partnership attractive to industry partners.
- Work together to develop a vision.
- Allow time for decision makers to obtain their Boards' approvals.

Challenge B: Building the Partnership

The challenge is to decide on partnership membership.

Actions

- Create a collaborative multi-stakeholder group to work together with industry.
- Develop a sample terms of reference for the partnership.
- Build relationships with care over time, recognizing the distinct roles and interests of each partner.

Challenge C: Defining Relationships

The challenge is to define relationships with the food industry that make nutrition and food safety everyone's business.

Actions

- Promote health through policies and regulations that inform food purchasing, production and processing.
- Consult with and educate consumers to enable consumer choice and advocacy.
- Include food safety and nutrition in policies and education.
- Explore examples from countries that have worked with global food industries, e.g., success stories, documenting and sharing learnings on how to influence change.
- Anchor issues related to food labeling in broader partnerships and advocate for government legislation using sound criteria.

Challenge D: Nutrition and Food Safety

The challenge is to make nutrition and food safety everyone's business.

Actions

- Build a common agenda based on policies and guidelines that work toward collaboration among industry, governments and NGOs.
- Consult with and educate consumers.
- Work with industry (through NGOs and academia) in situations where industry is not comfortable with government involvement to change norms related to food production and processing, e.g., convince industry to help pass public health messages related to healthy food choices.

- Include food safety and nutrition in policies and education.
- Change the social environment related to the marketing of unhealthy products, e.g., sugar, transfats.
- Continue to develop and collect scientific data related to food and health.

3. Bridging the Science-to-Policy Gap

Challenge A: Issues Related to Professional Cultures

The challenge is to address issues related to the interactions of scientists and policy makers, including language and timelines.

Actions

- Promote operational research, including policy research and knowledge transfer.
- Develop more efficient and scientific policy-making procedures.
- Create a new type of knowledge broker to link and act as liaison among communities.
- Communicate in plain language.
- Establish a consultative process from the outset.
- Identify and communicate benefits for each party clearly.
- Ensure shared responsibility for program delivery.

Challenge B: Political Will

The challenge is to mobilize the political will to move funding to prevention.

Actions

- Lobby based on the economic impact of chronic diseases.
- Model impacts on funding of pharmaceuticals, beds, etc., i.e., indicators that decision makers care about.
- Apply evidence to local jurisdictions.

Challenge C: Advocacy by Primary Care Physicians

The challenge is to have primary care physicians act as advocates for prevention activities within their practices.

Actions

- Convince physicians that they can make a difference in health prevention.
- Develop health prevention information packages for physicians.

4. Advances in Risk Factor Surveillance

Challenge A: Surveillance Data

The challenge is to increase the availability, validity and use of surveillance information in planning and evaluation.

Actions

- Bring surveillance experts and policy makers together, e.g., to network, develop a strategic plan, fund data analysis, dissemination and observatories.
- Use and make available standardized tools.
- Build capacity to utilize tools.
- Allocate resources to fund and disseminate surveillance data.

Challenge B: Surveillance Funding

The challenge is to obtain dedicated, sustainable funding for surveillance activities related to chronic diseases.

Actions

- Advocate for more sustained funding.
- Make the case for surveillance and lobby governments for appropriate resources.
- Share experiences, strategies and success stories.

Part 3: Tools

3.1: Partnership Prompter

This guide is intended as a prompt to support the implementation of organizational, country, regional and global partnerships for chronic disease prevention and control. It is designed around six questions for initiating and sustaining partnerships:[1]

Benefits and Barriers:	What are the benefits and barriers of working in partnership?
Common Ground:	Is the purpose of the partnership clear and realistic?
Ownership:	What is the level of commitment to the partnership?
Trust:	How can we develop and nurture mutual trust?
Operations:	Are operational arrangements among partners clear and robust?
Review:	What do we need to do to enable monitoring, measuring and learning?

While areas are listed in a general sequence, partnerships unfold in different ways depending on unique circumstances.

This tool is meant to prompt users to consider important questions: not all questions are important to all partnerships and most questions will need to be customized to suit specific situations.[2]

[1] These questions have been adapted from the six partnership principles outlined Assessing Strategic Partnership: The Partnership Assessment Tool. UK: © Crown copyright, 2003.

[2] For an electronic version of this tool go to the WHO website: www.wholint/hpr/globalforum/meetings.shtml

Benefits and Barriers

Rationale: Without an understanding of the benefits and barriers involved in a partnership, a genuine partnership is unlikely to develop.

What are the benefits and barriers of working partnership?

Clarifying partnership benefits and barriers includes identifying:

a. What has been and can be achieved jointly.

b. Factors that contribute to or support the achievement of partnership outcomes.

c. Barriers to success and what it will take to minimize their influence on achieving outcomes.

d. How and to what extent partners are involved, e.g., are partners:
   - involved as full or partial participants?
   - involved voluntarily, under pressure from others?
   - involved to fulfill a major or minor aspect of their mandate?

e. Areas where partners need to work together, i.e., the extent that partners are interdependent.

f. Areas where partners need to work separately to achieve goals established for the partnership, i.e., the extent that partners are independent.

Common Ground

Rationale: Partners need to consider whether there is common ground for a partnership, both in terms of a broad understanding and specific, realistic goals and objectives.

Is the purpose of the partnership clear and realistic?

Establishing common ground among partners includes:

a. An explicit vision statement and key principles to guide partnership activities.

b. Goals and objectives that provide an operational framework for moving forward, e.g., to provide a focus, help clarify boundaries, clearly define the scale and scope of work.

c. Taking a second look at the goals and objectives in terms of how realistic and attainable they are, e.g., in terms resources, commitments, autonomy, flexibility, etc.

d. Identifying how partnership programs and initiatives are linked to clear outcomes.

e. A clear statement of why each partner is involved, e.g., motivations and purposes.

f. Identifying areas where early success is most likely to occur.

Commitment

Rationale: To achieve the benefits of partnership, partners need to ensure that there is widespread commitment to working in partnership, especially at senior levels.

What is the level of commitment for the partnership?

Ensuring ownership and commitment includes:

a. Senior personnel within each partner organization appreciating that the partnership is fundamental to achieving their organizational objectives.

b. Operational personnel using their discretionary, day-to-day power to implement and support shared arrangements.

c. Partners resisting pressures to make unilateral changes and/or withdraw from mutually developed agreements.

d. Partners recognizing the importance of and encouraging the ongoing development of networking skills.

e. Partners anchoring relationships in organizational structures and processes rather than depending on key individuals who may move on.

f. Clarifying resistance to working in partnership and addressing these challenges on an ongoing basis.

Trust

Rationale: Trust is the most elusive area of partnership and, although partnerships are possible with little trust among those involved, the more trust there is, the the chances for a healthy partnership.

How can we develop and nurture mutual trust?

Developing and nurturing mutual trust includes:

a. Ensuring that partnership arrangements recognize and value each partner's contribution, irrespective of resources or capacity to contribute.

b. Providing all partners with opportunities to lead.

c. Distributing the benefits derived from the partnership among partners on a 'win-win' basis, e.g., with respect to recognition, achievement of outcomes.

d. Accepting changes in a partner's ability to participate, e.g., as a result of staff turnover, changing finances.

e. Encouraging risk-taking by individual partners in pursuit of shared outcomes, e.g., individual loss in the short term for the sake of longer-term collective gain.

f. Basing the partnership on robust performance management: the right people are in the right place at the right time to support successful outcomes.

Operations

Rationale: Operational arrangements can become mired in cumbersome, elaborate and time-consuming working arrangements. They should be as lean as possible with time-limited inputs, task-oriented joint structures and a clear understanding about processes and outcomes. Clarity about areas of responsibility and lines of accountability is essential.

Are operational arrangements among partners clear and robust?

Creating clear and robust operational arrangements includes:

a. Clarifying partners' financial contributions, e.g., amounts, length of commitment, limiting conditions imposed by sponsoring organizations.

b. Understanding and valuing the nature and importance of in-kind contributions, e.g., staff support, endorsement, networks, office space and equipment.

c. Being able to demonstrate (i.e., to one another and to parent organizations) how responsibilities are shared among partners.

d. An understanding among partners about how they are singly and collectively accountable for deliverables (outputs) and the achievement of outcomes.

e. Making ongoing operational arrangements simple, task-oriented and time-limited.

f. Having partners' primary focus be on meeting commitments and achieving outcomes rather than on perceived status or creating new structures.

Review

Rationale: Partners can have doubts about levels of commitment or the costs and benefits of being involved. Monitoring, measuring and learning are essential parts of assessing performance and cementing commitment and trust.

What do we need to do to enable monitoring, measuring and learning?

Enabling monitoring, measuring and learning includes:

a. Agreeing on clear success criteria for outcomes and the partnership itself.

b. Making arrangements to monitor and review the extent to which the partnership is achieving its goals and objectives.

c. Making arrangements to monitor and review how the partnership process is working, e.g., with respect to items included in this tool.

d. Disseminating review findings among partners and at all levels within parent organizations.

e. Effectively communicating partnership successes to others outside the partnership.

f. Making arrangements and a commitment to revise partnership agreements in light of reviews.

3.2: Planning Prompter

This guide is intended as a prompt to support national strategic action planning for country- and region-specific initiatives related to the implementation of (a) integrated, disease-specific and risk-factor approaches to Chronic Disease Prevention and Control (CDPC) and (b) global strategies such as the Framework Convention on Tobacco Control (FCTC) and the WHO Strategy on Diet, Physical Activity and Health.

This prompter builds on extensive work on CDPC-related planning by WHO Geneva. It addresses a range of planning challenges such as:

- What is involved in developing a national strategic action plan?
- Where is a good place to begin?
- How can we build on global and regional strategies and initiatives?
- Who should be involved and how?
- What kind of information do we need?
- What are the basic components of an action plan?
- How can the strategy be expanded over time as more resources become available?

A draft version of the prompter was reviewed by participants during WHO Global Forum IV on Chronic Disease Prevention and Control, Ottawa, Canada, November 3 to 6, 2004. This version integrates participants' feedback during the Forum.

Global Context

National planning can be supported through the formation of strategic alliances at global and regional levels.

WHO Geneva can facilitate and enable global coordination for implementing regional plans, i.e.,

- provide a planning framework, methods, tools and training
- provide funding to support regional inter-country efforts
- provide technical support to regions
- provide vision and coordination for CDPC strategic action planning
- support regions through country efforts in CDPC planning.

WHO regions in collaboration with WHO Geneva can facilitate overall support and guidance, training and a focal point for technical support with the aim to build capacity at region and country levels, e.g., regional CDPC advisers can:

- coordinate regional training workshops; identify funding for workshops and implementation
- develop a Strategic Regional Plan for CDPC
- ensure country plans meet main criteria, e.g., phases, representation, strategic areas, evidence-based actions, partnerships
- identify countries with capacity (and need) for national strategic action planning
- liaise with WHO representatives, ministries of health.

Learning from Experience

During the Forum participants from a range of countries offered the following considerations based on their national planning experiences.

When developing a national strategic action plan for chronic disease prevention and control:

- Be aware that a document-based approach to planning may not be sensitive to national political cultures and processes.
- Build on experiences gathered at sub-national and local levels.
- Ensure broad dissemination of the plan prior to implementation and following official adoption.
- Ensure that implementation and evaluation processes are fully delineated.
- Include both top-down and bottom-up approaches to facilitate leadership from non-government organizations.
- Include political, social and personal impacts and perspectives to ensure that civil society is engaged at the level of human rights, i.e., morals and values.
- Make the strategic action plan operational by developing a clearly defined implementation strategy.
- Many countries may lack cost-effectiveness data for CDPC; this should not prevent action.
- Recognize that the role of WHO is as a facilitator and enabler.

- To gain buy-in and support, involve a broad range of stakeholders (including operational-level personnel) in planning and consultative processes.

National Strategic Action Planning

This prompter is organized around three key aspects of national planning. All three aspects are fundamental to the planning process, but are not necessarily sequential. Users are encouraged to adapt the guide to their unique circumstances.

Establish a National Mechanism for Planning	*Gather Relevant Information*	*Draft a National Strategic Action Plan*

Establish a National Mechanism for Planning

There are three main tasks involved in establishing a national coordinating mechanism:

a. Officially designate a national focal point for integrated CDP.

It is the responsibility of each country to define the lead institution or agency, e.g., the Ministry of Health, or a non-government organization.

Responsibilities include:

- coordinating the planning process
- developing baseline information to inform the planning process, e.g., an environmental scan
- developing training programs
- mobilizing other ministries, agencies and groups
- providing technical and secretariat support for a national steering committee
- setting up implementation, dissemination and evaluation mechanisms.

b. Create a multi-sectoral, leadership and/or consultation mechanism, e.g., through a stakeholder consortium or a national steering committee.

Steps for creating a leadership mechanism could include:

- defining the terms of reference, e.g., purpose, objectives and roles and responsibilities
- identifying operational and other resource requirements
- identifying members.

Membership could include:

- academics
- health professionals
- Non Government Organizations, e.g., disease and risk factor organizations
- operational staff
- other government ministries and regulatory agencies, e.g., agriculture, transportation, etc.
- private sector, e.g., media, business, food industry
- related professions, e.g., legal, economic, administrative.

c. Explore options with (a) and (b) above for developing coordinated policy platforms and securing resources—essential elements for implementation.

Gather Relevant Information

In CDPC policy-making, information is power. The right information can provide a basis for influencing policy makers, communicating with the public, identifying policy interventions and measuring progress. Once a national committee is in place, the next step is to bring together information relevant to national planning. This includes:

a. The 'political' environment, e.g.,
- current initiatives, networks, alliances, etc.
- current state of relevant policies, laws and regulations
- historical context for regional and country social and health policy development
- surveillance data (in many cases from the WHO STEPwise approach[3]) and other burden of disease data
- who's who in integrated chronic disease prevention.

b. Economic impact of chronic diseases.

c. Effectiveness of current interventions.

d. Public knowledge, attitudes and beliefs.

[3] Noncommunicable Diseases and Mental Health. Summary: Surveillance of risk factors for noncommunicable diseases The WHO STEPwise approach. WHO Geneva. 2001.

Draft a National Strategic Action Plan

A national strategic action plan includes:

a. A **vision** for what the national committee believes is the ideal condition for the country.

b. A **mission statement** that clearly describes what the initiative is trying to accomplish.

c. A summary of **key findings** from Step 2 and a **rationale** for the initiative.

d. **Goals** and **objectives** and corresponding **strategies** required to achieve the goals.

e. **Activities** within each strategy, e.g., how each strategy will be implemented, expected **results**, **potential barriers,** identify and addressing capacity gaps, who is **responsible** for what, by when and the **resources needed**.

f. **Indicators** to measure progress.

g. A **broad-based consultation** to establish ownership among those involved in implementation.

h. **Formal recognition** of the plan, granting it official status.

i. The identification of **key implementation challenges** such as resources, existing policies, dissemination and **actions** to address these challenges.

j. A mechanism for **monitoring and evaluating** progress.

A Realistic Stretch

Develop a plan that will enable a "realistic stretch", i.e., it will challenge your organization or country but you know it can be done. Planning for each phase can become more comprehensive in three ways:

- **Encompassing more organizations, initiatives and sectors**: involving more health organizations and networks and reaching out to organizations beyond health to build a multisectoral component.
- **Developing a broader information base:** broadening and deepening information gathering and consultation processes as more and more interests are included in the strategy; this also includes establishing ongoing systems (e.g., disease and risk factor surveillance) and ongoing evaluation processes.
- **Becoming more rooted in authority structures:** progressively integrating all three steps into the existing infrastructure and/or establishing a separate organization or unit with independent and sustainable funding.[4]

Expanding the phases with respect to the above approach can be organized into a STEPwise framework with three levels:

Core:	initiatives that can be successfully initiated using existing resources and completed within a two-year time frame
Expanded:	initiatives that require additional resources for successful implementation over two to five years
Comprehensive:	initiatives that require external funding and a timeframe longer than five years for successful implementation.[5]

Appendix: Planning Terms[6]

Vision:	Describes an ultimate state or condition where all outcomes are achieved. A vision statement should be: (a) understood and shared by members of the community, (b) broad enough to include local perspectives, (c) inspiring to everyone involved and (d) easy to communicate (e.g., short enough to fit on a T-shirt).
Mission:	Describes the overall purpose of the plan. It should be (a) concise, (b) outcome-oriented and (c) inclusive.
Goal:	A long-term general aim or aspiration.
Objective:	Frequently used interchangeably with the term goal; usually more specific and can be partly achieved during the planning period.
Policy making:	Making choices to bring about change. Regardless of the approach and methods used, policy making is a political process.

Policy: Agreement or consensus on the (a) issues, (b) goals and objectives to be addressed, (c) the priorities among those objectives and (d) the main directions for achieving them.

Strategy: Broad lines of action to achieve the goals and targets, including:

- identifying suitable points of intervention
- ways of ensuring involvement of relevant partners
- a range of political, social, economic, managerial and technical factors
- constraints and how to deal with them.

Target: An intermediate result towards the achievement of goals and objectives, that is:

- more specific than an objective
- has a time horizon
- frequently, but not always, quantifiable.

[4] These three ways to expand a National Strategic Action Plan have been adapted from the WHO STEPwise approach to surveillance.

[5] Ministry of Health, Tonga. National Strategy to Control and Prevent Non-Communicable Diseases in Tonga. Report on the National Workshop 24th -28th October, 2003. Nuku'alofa, Tonga. Adapted.

[6] Building Blocks for Tobacco Control: A Handbook. WHO: France. 2004. pp 68-69. Adapted.

Part 4: Resources

4.1: Key Terms

General Terms[7]

Accountability: accountability results when decision makers at all levels fulfill their obligations and are made answerable for their actions. Setting explicit objectives and defining how progress towards them will be monitored makes it easier to achieve accountability.

Advocacy: the action taken by health professionals and others with perceived authority to influence the decisions of communities and governments.

Assessment: the obligation of a public health agency to monitor the health status and needs of its community regularly and systematically; one of the three core functions of public health.

Attributable: the quality or characteristic that can be assigned to the element of interest.

Behavioural change: an intervention approach that uses public information and education to promote behavioural patterns favourable to the population as a whole; also includes interventions (e.g., counseling) at the group or individual level for the same purpose.

Behavioural patterns: habits of living that influence health. (e.g., diet, physical activity, smoking).

Burden of disease: the loss of health in populations due to disease and injury. It is measured using the Disability Adjusted Life Year or (DALY) which combines the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of 'healthy' life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability.

Capacity-building: the development of the technical expertise to plan, implement and evaluate interventions aimed at preventing or controlling non-communicable diseases in a variety of settings. Areas of expertise in capacity-building include problem identification, epidemiological and behavioural risk factor analysis, coalition-building, programme implementation, knowledge of intervention methodologies, process, impact and outcome evaluation, and the ability to obtain ongoing support and funding through administrative and legislative means, beyond the life of any particular source of funding.

Coalition-building: the establishment of a temporary alliance of fractions, parties, individuals or groups for a specific purpose.

Collaboration[8]: is a process through which parties or sectors who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own visions of what is possible. Collaboration involves joint problem solving and decision making among key stakeholders in a problem or issue.

Four features are critical to collaboration:

1. the stakeholders are interdependent
2. solutions emerge by dealing constructively with differences
3. decisions are jointly owned
4. stakeholders assume collective responsibility for the future direction of the domain.

In collaboration it is common to have:

- lack of clarity about who is a stakeholder
- disparity of power and/or resources among stakeholders
- complex problems that are not well defined
- scientific uncertainty
- differing perspectives that lead to adversarial relationships
- dissatisfaction with previous and existing approaches and processes.

[7] Many of these terms are adapted from two sources: (a) WHO document appendices, (b) Ministry of Health, Government of Pakistan; World Health Organization, Pakistan office, and Heartfile. National Action Plan for Prevention and Control of Non-communicable Disease and Health Promotion in Pakistan. Appendices.

[8] Barbara Gray. Collaborating: Finding Common Ground for Multiparty Problems. Jossey-Bass Publishers, London, 1989, 5. Adapted.

Community: a specific group of people, often living in a defined geographical area, who share a common culture, values and norms and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms, which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them.

Community mobilization: a process aimed at enabling communities to understand and control the circumstances affecting their lives. It acknowledges that agents of change can be found wherever the decisions that affect people's ability to influence their lives are made and implemented.

Comprehensive public health strategy: an approach to a major health problem in the population that identifies and employs the full array of potential public health interventions, including health promotion and disease prevention.

Disease prevention: disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences, once established.

Effectiveness: a measure of the extent to which a specific intervention, procedure, regimen or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population.

Efficiency: the capacity to produce the maximum output for a given input.

Endemic: the constant presence of a disease or infectious agent within a given geographical area or the usual prevalence of a given disease within such area.

Epidemiology: the study of the causes and prevention of disease in populations or communities, making it the main source of evidence for public health decision making.

Evaluation framework: a description of how a programme is to be evaluated.

Evidence-based public health: the use of agreed-upon standards of evidence in making decisions about public health policies and practices to protect or improve the health of populations.

Fiscal: measures related to tax and tax policies.

Generalizability: the level at which the findings of a result can be attributed to a bigger population or the whole population of concern.

Guidelines: systematically developed statements traditionally used to reinforce best practices.

Health: a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity.

Health disparities: differences in the burden and impact of disease among different populations, defined, for example, by sex, race or ethnicity, education or income, disability, place of residence, or sexual orientation.

Health education: health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy. It includes improving knowledge and developing life skills that are conducive to individual and community health.

Health promotion: the combination of educational and environmental supports for action and conditions of living conducive to health. The actions may be those of individuals, groups or communities, of policymakers, employers, teachers or others whose actions control or influence the determinants of health. The purpose of health promotion is to enable people to gain greater control over the determinants of their own health. In health promotion, health is seen as a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capabilities.

High-risk approach: an intervention strategy that targets only people with the highest levels of recognized chronic disease risk for the purpose of reducing their level of risk to that of the most favourable level in the population; distinct from and complementary to the population-wide approach.

Impact: the total, direct and indirect effects of a programme, service or institution on the health

status and overall health and socio-economic development.

Implementation plan: a list of activities to be organized or carried out, in a set order and according to a schedule, to accomplish a certain goal. The plan stipulates who does what and when, and may include information on the costs associated with each phase of the work. Implementation is also the act of converting programme objectives into actions, such as through policy changes, regulation and organization.

Incidence: the number of new cases of disease occurring in a population of a given size within a specified time interval.

Indicator: a variable with characteristics of quality, quantity and time. It is used to measure, directly or indirectly, changes in a situation and to appreciate the progress made in addressing it. It also provides a basis for developing adequate plans for improvement.

Individual approach: see *high-risk approach*.

Integrated chronic disease prevention:[9] although a marked elevation of a single risk factor significantly predicts an individual's ill health, the societal burden from chronic disease results from the high prevalence of multiple risk factors related to general life-styles. Therefore, community-based activities are required with an integrated public health approach that is targeted to populations, in addition to those at high risk.

> *"No longer can 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."*

- Within the context of *chronic disease prevention and control*, the term *integration* has several meanings. The classical definition involves determination and confrontation of common risk factors, rather than the process of attacking many individual diseases separately.
- *Integrated* chronic disease prevention programmes aim at interventions that address common risk factors through the health system and other existing community structures, rather than an outside prevention programme.
- Another meaning of the term *integration* for chronic disease prevention and control denotes *a comprehensive approach* which combines varying strategies for implementation. These include policy development, capacity building, partnerships, and informational support at all levels.
- *Integration* calls for intersectoral action to implement health policies – another aspect of integration needed to address the major determinants of health that fall outside the remit of the health system.
- *Integration* also refers to efforts to combine population and high risk approaches by linking prevention actions of various components of the health system, including health promotion, public health services, primary care and hospital care.
- *Integration* does not preclude meeting the *unique needs* of particular populations. However, when chronic disease prevention and control programmes have been established by addressing different diseases, eventually a balance among them should be achieved.

Intersectoral action: when the health sector and other relevant sectors collaborate to achieve a common goal. For practical purposes, intersectoral and multisectoral actions are synonymous.

Intervention: an activity or set of activities aimed at modifying a process, course of action or sequence of events, in order to change one or several of its characteristics such as performance or expected outcome.

Life expectancy: the number of years of life that can be expected on average in a given population.

Lifestyle: a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions.

Living conditions: the everyday environment of people, where they live, play and work. These living conditions are a product of social

[9] http://www.who.int/hpr/globalforum/integrated.ncd.prevention.shtml
(adapted, e.g., with NCD changed to chronic disease)

and economic circumstances and the physical environment – all of which are largely outside the immediate control of the individual.

Malnutrition: any disorder of nutrition. It may be due to unbalanced or insufficient diet or defective assimilation or utilization of food.

Modifiable characteristics: factors that are amenable to change (e.g., diet, physical activity, and smoking), in contrast to those that are intrinsic to the individual (e.g., age, sex, race, genetic traits).

Monitoring: regular observation of changes in some condition, either in a population or an individual, such as health status, or in an environment, such as levels of pollution, in order to determine whether an initiative is proceeding according to plan. Monitoring includes keeping track of achievements, staff movements and deployment, supplies, equipment, and money spent. The information gained from monitoring is used in evaluating the initiative.

Morbidity: knowledge of the illness or diseased condition in a population. Various ratios are calculated to ascertain the morbidity level.

Mortality: rate of death expressed as the number of deaths occurring in a population of a given size within a specified time interval.

Network: the number and types of social relations and links between individuals and/or institutions that may provide access to or mobilize social support.

Obesity: usually defined in terms of body mass index (BMI), which is calculated as body weight in kilograms (1 kg = 2.2 lbs) divided by height in meters (1 m = 39.37 in) squared; definitions of obesity may differ by region and specific groups.

Opportunistic screening: the presumptive identification of unrecognized disease or defect by tests, examinations or other procedures which can be applied rapidly to sort out apparently well persons who probably have a disease from those who probably do not. This is done in a passive way in a health setting without having to go out to look for cases.

Outcome: a change in current or future health status or health-related behaviour that can be attributed to an intervention. In the field of health, the desired result or impact of a policy measure or other health intervention would be a positive change in health status or health behaviour.

Outcome assessment: an outcome assessment is used to determine the short-term effects of an intervention on an identified population.

Output: the products, services and other items, such as clinical preventive guidelines, regulations, tax law provisions, directly produced by a programme or organization.

Overweight: see *obesity*.

Passive smoking: inhaling cigarette, cigar, or pipe smoke produced by another individual. It is composed of second-hand smoke (exhaled by the smoker), and side stream smoke (which drifts off the tip of cigarette or cigar or pipe bowl).

Physical inactivity: lack of habitual activity sufficient to maintain good health, resulting in an unfavourable balance between energy intake and expenditure and fostering the development of overweight or obesity and other risk factors for chronic diseases.

Policy: an agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies needed to deal with the issues.

Policy and environmental change: an intervention approach to reducing the burden of chronic diseases that focuses on enacting effective policies (e.g., laws, regulations, formal and informal rules) or promoting environmental change (e.g., changes to economic, social, or physical environments).

Policy framework: a conceptual structure based on consensus among major stakeholders that shows the relationship.

Population-based data: health data that pertain to a defined, usually large, population (e.g., vital statistics, surveillance, results of population surveys).

Population-wide approach: an intervention strategy that targets the population as a whole with regard to the risk levels of various subgroups; distinguished from and complementary to the *high-risk approach*.

Prevalence: the frequency of a particular condition within a defined population at a designated time

(e.g., 5.5 million men living with hypertension in 1994 or 34% of the population found to use tobacco in a survey conducted in Pakistan).

Prevention: approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability.

Primary prevention reduces the likelihood of the development of a disease or disorder. Secondary prevention interrupts, prevents or minimizes the progress of a disease or disorder at an early stage. Tertiary prevention focuses on halting the progression of damage already done.

Preventive dose: the intensity and duration of appropriate public health interventions needed to achieve goals; similar to the dose and duration of medical treatment sufficient to control or cure an illness.

Primary health care: essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable.

Primary prevention: a set of interventions, including the detection and control of risk factors, designed to prevent the first occurrence of noncommunicable diseases among people with identifiable risk factors.

Priority populations: groups at especially high risk of chronic diseases (e.g., those identified by sex, race or ethnicity, education, income, disability, place of residence, or sexual orientation).

Process evaluation: an assessment of how a programme achieves its effects. This includes evaluation of the amount of resource inputs used, as well as a description of activities implemented and of outputs (intermediate outcomes, proximal impacts) of the programme.

Programme: a set of projects designed to achieve common, long-term goals.

Programme evaluation: a periodic review and assessment of a programme to determine, in light of current circumstances, the adequacy of its objectives and its design, as well as its intended and unintended results. This assessment addresses how a programme achieves its effects, including evaluation of the amount of resource inputs used, as well as a description of activities implemented and of outputs (intermediate outcomes, proximal impacts) of the programme.

Project: a group of planned activities linked by common short- to long-term objectives and managed by a single centre of responsibility.

Qualitative data: qualitative data are categorical rather than quantifiable observations, and often involve descriptions of attitudes, perceptions, intentions and activity.

Quality of life: individuals' perceptions of their positions in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept.

Risk: the likelihood of incurring a particular event or circumstance.

Risk assessment: a measure to determine the chance or probability of acquiring a disease. The excess risk caused by exposure to a given factor is calculated by incidence rates of disease in exposed and non-exposed populations.

Risk behaviour: a behavioural pattern associated with increased frequency of specified health problems; for example, high salt intake, smoking, and binge drinking are all associated with CVD.

Risk factor: an individual characteristic associated with increased frequency for specified health problems; for example, high LDL cholesterol, high blood pressure, and diabetes are all associated with CVD.

Risk factor detection and control: an intervention approach that targets people with identifiable risk factors; includes both screening or other methods of detection and long-term disease management through changes in lifestyle, behaviour and medication, when necessary.

Screening: the identification of unrecognized disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly to sort out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic.

Secondary prevention: a set of interventions aimed at survivors of acute NCDs events (e.g., heart attack, cancer, diabetes, etc.) or others

with known NCDs in which long-term case management is used to reduce disability and risk for subsequent NCDs events.

Social marketing: the development and implementation of programmes aimed at influencing people's ideas through the use of techniques and approaches similar to those employed in the marketing of goods and services, such as market research, product planning, communication and distribution.

Stakeholders: parties who have a common interest in a project and have agreed in principle to support it. Depending on their affiliation, they may provide assistance with conceptual, technical, material, financial or human resources.

Strategy: a plan of action that is designed to achieve long-term goals, taking into account the resources available and barriers anticipated, as well as possibilities for collaboration among relevant stakeholders.

Surveillance: a regular collection, summarization and analysis of data on a continuous basis.

Symptomatic: feeling and showing the discomfort and complaints of disease.

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Part 5: General Information

5.1: Agenda

Wednesday, November 3, 2004

4:00 pm Registration

5:30 pm Reception

6:30 pm **Welcome & Opening Remarks**

Master of Ceremonies:
Dr. David Butler-Jones, Chief Public Health Officer, Canada

Dr. Jong-Wook Lee, Director-General, World Health Organization

Hon. Ujjal Dosanjh, Minister of Health, Canada

Dr. Jorge José Santos Pereira Solla, State Secretary for Health/Deputy Minister of Health, Brazil

Hon. Dr. María del Rocío Sáenz Madrigal, Senior Minister of Health, Costa Rica

7:30 pm Dinner

9:30 pm Closing

Thursday, November 4, 2004

6:45 am Registration

6:45 am Guided Walk, Guided Run

8:15 am Breakfast Buffet

9:00 am **Keynote Presentations**

Hon. Dr. Carolyn Bennett, Minister of State (Public Health), Canada

Dr. Catherine Le Galès-Camus, Assistant Director-General, World Health Organization

Dr. Joxel Garcia, Deputy Director, Pan American Health Organization

9:30 am **Part I: Meeting Overview**

Dr. Robert Beaglehole, Director, Department of Chronic Disease and Health Promotion, World Health Organization

Dr. Sylvie Stachenko, Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada

Objectives, Introductions, Pre-Forum Questionnaires: *Dorothy Strachan, Facilitator*

10:40 am Refreshment Break

11:10 am **Part I (continued)**

11:30 am Thematic Presentations by Regions and Regional Networks

MOANA/WPR: Dr. Gauden Galea - Disease Prevention and Health Promotion

CARMEN/AMR: Dr. Sylvia Robles - Capacity Building and Training

NANDI/AFR: Dr. Antonio Filipe Jr. - Surveillance

12:30 pm Lunch

1:30 pm Thematic Presentations (continued)

EMAN/EMR: Dr. Oussama Khatib - Policy Development

SEANET/SEAR: Dr. Jerzy Leowski - Community Based Interventions

CINDI/EUR: Dr. Aushra Shatchkute and Prof. Vilius Grabauskas – From Demonstration to Policy Development

2:30 pm **Part II: Policy Theme – Enabling Action Through Evidence-based Advocacy**

Small Group Work

3:00 pm Refreshment Break

4:15 pm Plenary Reports on Group Work

Feedback on the Day

5:00 pm Free Time (optional tour of National Gallery of Canada)

6:30 pm Reception and Dinner: National Gallery of Canada

Master of Ceremonies: *Ms. Janet Voûte, Global Forum IV Programme Committee*

Friday, November 5, 2004

6:45 am Registration

6:45 am Guided Walk, Guided Run

8:15 am Breakfast

9:00 am Welcome and Agenda Overview

9:10 am **Part III: Participation Theme**
Small Group Work

10:30 am Refreshment Break

11:00 am Plenary Reports on Group Work

12:00 pm Lunch

1:30 pm Agenda Overview

1:40 pm **Part IV: Planning Theme**
Small Group Work

3:00 pm Refreshment Break

3:30 pm Plenary Reports on Group Work

4:45 pm Free Time

6:30 pm Reception and Dinner: Canadian Museum of Civilization

Master of Ceremonies: *Ms. Madeleine Dion Stout*

INTERNATIONAL SHOWCASE DAY

Saturday, November 6, 2004

6:45 am Registration

6:45 am Guided Run/Walk

8:00 am Breakfast Buffet

9:30 am **Welcome and Opening Remarks**

Dr. Sylvie Stachenko, Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada

Ms. Donna Lillie, Chair, Steering Committee, Chronic Disease Prevention Alliance of Canada

10:00 am **Part I: ShowCase**

Dr. Robert Beaglehole, Director, Department of Chronic Disease and Health Promotion, World Health Organization

WHO Response to Chronic Disease Epidemic – WHO Global Strategy for Diet, Physical Activity and Health

10:10 am Country Showcase Roundtable

Chair: Dr. David Butler-Jones, Public Health Agency of Canada

Dr. Kong Lingzhi, Disease Control Department, China

Dr. Ana Tambussi, Pan American Health Organization, Argentina

Dr. Luz Elena Monsalve Rios, Ministry of Social Protection, Columbia

11:10 am Refreshment Break

11:30 am Canadian Showcase: Collaboration for Systems Change:
The Canadian Experience in Integrated Chronic Disease Prevention

Panel Presentation:

1. National Perspective: The Chronic Disease Prevention Alliance of Canada
   – *Ms. Bonnie Hostrawser, Executive Director*
2. Provincial Perspective: Alberta Healthy Living Network
   – *Ms. Ellen Murphy, Co-Chair, Healthy Living Network*
3. Settings Perspective: School Health
   – *Mr. Doug McCall, Executive Director, Canadian Association of School Health*

12:30 pm Buffet Lunch

1:30 pm **Part II: ShowCase**

1:40 pm Concurrent Panel Presentations and Discussion

1. Getting Prevention on the Political Agenda

   Mr. Neil MacDonald, Provincial/ Territorial Government Co-chair of the Intersectoral Healthy Living Network (IHLN) Coordinating

Committee (from Alberta Health and Wellness), in collaboration *with Federal Government Co-Chair Mr. Claude Rocan (from the Public Health Agency of Canada) and NGO Co-Chair Dr. Elinor Wilson (from the Chronic Disease Prevention Alliance of Canada)*

Dr. Sania Nishtar, Founder and President, Heartfile, Pakistan

Dr. Jill Farrington, WHO Regional Office for Europe

1:40 pm Concurrent Panel Presentations and Discussion (continued)

2. Working with the Food Industry: Challenges and Progress

Ms. Mary Bush, Director General, Office of Nutrition Policy and Promotion, Health Canada, Canada

Ms. Susan Roberts, Coordinator, Healthy Eating in Store for You Programme, Canadian Diabetes Association and Dieticians of Canada, Canada

Dr. Srinath Reddy, Director, WHO Collaborating Centre on Epidemiology and Prevention of CVD, India

3. Bridging the Science-to-Policy Gap: Research and Evidence

Dr. Diane Finegood, Scientific Director, Canadian Institutes of Health Research, Institute of Nutrition, Metabolism and Diabetes, Canada

Dr. Fan Wu, Director, WHO Collaborating Centre for Integrated Community-Based Programmes for NCD Prevention and Control, China

Dr. Clarence Clottey, Deputy Director, WHO Collaborating Centre for Policy Development in the Prevention of Noncommunicable Disease, Canada

4. Advances in Risk Factor Surveillance

Dr. Gauden Galea, WHO Regional Office for the Western Pacific, Philippines

Dr. Linda Van Til, Member, Surveillance Systems for Chronic Disease Risk Factors Task Group, Canada

Dr. Jerzy Leowsky, WHO Regional Office for South-East Asia, India

2:10 pm Small Group Discussions

3:00 pm **Part III: Showcase**

3:05 pm Plenary Reports on Group Discussions

3:30 pm Refreshment Break and Exhibits

4:00 pm **Vision and Leadership: Getting It Together**

Remarks
Dr. Robert Beaglehole, World Health Organization
Dr. Sylvie Stachenko, Public Health Agency of Canada
Moderator: Allan Gregg

Discussants
The Honourable Marc Lalonde, Past Federal Minister of Health and Welfare
The Honourable Jean Rochon, Past Minister of Health and Social Services, Quebec
Dr. Maureen Law, Former Federal Deputy Minister and Co-Chair, Canadian Coalition for Public Health in the 21st Century
Dr. John Millar, Executive Director, Population Health Surveillance for the Provincial Health Services Authority, BC

5:20 pm **Closing Remarks**

Dr. Elinor Wilson, Chair, Chronic Disease Prevention Alliance of Canada Conference

5:30 pm Reception

7:30 pm Free Evening and Dinner at Local Restaurants

5.2: Participants

Global Forum IV

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Part 6: Feedback from Participants

Summary of Forum Evaluations

1. Overall, how was this Forum from your experience?

Poor				Excellent	Average
1	2	3	4	5	**4.0**
N = 29					

2. What are the first words that come to mind to describe this Forum?

- Workshop process (19), e.g., it was:
  - a new approach, innovative, integrative
  - action-oriented, interactive and dynamic
  - collaborative—discussions were open and inclusive
  - focused and efficient
  - good background documents
  - more policy- than technically-based
  - well planned, organized and facilitated.
- Results (8), e.g., it:
  - advanced the political agenda for NCD prevention and control
  - encouraged global partnerships
  - was mind enriching, productive, useful.
- People and networking (7), e.g.,
  - a fascinating group of people
  - an opportunity to speak with people and learn from senior players with international experience
  - stimulating exchanges took place among people from different backgrounds and professions on a core topic.
- Personal impact, (7), e.g., it was
  - enjoyable; I was happy to be present
  - exciting, exhilarating, stimulating, awesome
  - wonderful with all the ideas put forward, informative, a learning experience
- There was not a lot new. (1)

3. Please rate, from your perspective, how successful we were with respect to the Forum objectives.

Not Successful			Successful	
1	2	3	4	***Average***

a. To provide a global update on the current situation in integrated, non-communicable disease prevention and control.
(N=31) _____ **3.1**

b. To promote and enable the development of international partnerships and inter-region collaboration for national, integrated chronic disease prevention and control.
(N=31) _____ **3.4**

c. To encourage and develop national strategic action planning in member countries, including priorities and key action areas.
(N=30) _____ **3.2**

d. To facilitate network building, knowledge translation and information sharing among regional networks, countries, collaborating centres and other stakeholders.
(N=31) _____ **3.4**

e. To build on existing efforts to develop a coordinated platform for supportive policy development and implementation among member countries.
(N=31) _____ **3.1**

4. Please rate the following:

Poor			Excellent	
1	2	3	4	***Average***

Registration Kit (N=30) _____ **3.5**

Forum Organization and Logistics (N=31)_____ **3.8**

Accommodation (N=30)_____ **3.8**

Meals (N=31) _____ **3.4**

Speakers (N=31) _____ **3.3**

Opportunities to Interact with Colleagues (N=31)_____ **3.8**

Main Forum Room (N=31) _____ **3.7**

Comments

- Include a technical session, e.g., on diet, physical activity and tobacco
- Make small group discussion topics less theoretical and more focused around real-life cases, e.g., actual programs implemented at the country levels would have given a more concrete orientation to the forum.
- Provide more information on Ottawa (e.g., a map) and its attractions; some of the restaurants listed were not available.
- Take concrete steps to support countries in developing and implementing strategic action plans.
- The bag structure was awkward as papers were not three-hole punched.

5. As a result of this Forum I will –

Start doing:

- building effective partnerships, especially with non traditional partners and other agencies
- collaborating more with Canada; initiating partnerships with the Canadian Public Health Agency and NGOs involved in chronic disease prevention
- collecting more international links and data
- developing/initiating a national action plan e.g., in a more organized way, if resources are available, refining current plans and future planning mechanisms
- discussing the concept of chronic disease prevention and control more fully within my agency and understanding people's views on support for chronic disease integration and global cross talk
- documenting ideas on prevention; playing a more active role in my regional network
- doing more policy advocacy, e.g., for integrated chronic disease prevention and control, risk factor surveillance
- engaging regional networks
- focussing more activities on chronic disease prevention
- following-up on people and their ideas
- interacting with and building on the work of the six regional WHO networks, looking to WHO for possible joint activities
- intervening in community health in my home district
- looking more carefully at partnership styles
- proposing to my organization the need to develop a policy statement on chronic disease prevention and for shifting the nursing curriculum towards a chronic care model
- strengthening partnerships and coalitions at national, regional and local levels
- supporting the implementation of the Global Strategy on Diet, Physical Activity, and Health.

Stop doing:

- being passive and pessimistic about not attaining my goals
- complaining.

Continue doing:

- advocating for the chronic disease prevention agenda, for risk factor surveillance, for increasing resources and policies and for exercise and healthy diets
- building and developing regional networks
- building partnerships and networks
- developing evidence-based policy, documenting progress, sharing information
- integrating perspectives
- introducing the CARMEN approach to the areas in my region
- national planning for action for the prevention of CVD
- promoting policy development
- shifting from an acute care to a chronic care model
- strengthening partnerships with WHO
- surveillance
- working on integrated chronic disease prevention at the national level.

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