MIP/01/APR.NMH
28 May 2001

WORLD HEALTH ORGANIZATION

# MEETING OF INTERESTED PARTIES

**GENEVA, 18 TO 29 JUNE 2001**

# Noncommunicable Diseases and Mental Health

## Progress report, 2000

### NONCOMMUNICABLE DISEASE PREVENTION AND HEALTH PROMOTION (HPS)

1. As economic development and globalization proceed, threats to public health change. Unfortunately, while globalization may bring with it many important advances, the benefits are not universal and those currently most at risk are least likely to benefit. Increased tobacco consumption, decreased physical activity, and unhealthy diets are typically associated with the early years of economic advancement. These same factors are also primarily responsible for the transition in the burden of disease from infectious to noncommunicable diseases in developed countries. This same transition is now rapidly taking place also in the developing world, hindering economic development and contributing to poverty.

2. Given this development, sustained and major improvements in public health will most likely be achieved through comprehensive programmes that build national capacity to conduct evidence-based health promotion and disease prevention programmes in order to establish supportive public policies. WHO will provide global leadership in the development and diffusion of innovative and effective health promotion and disease prevention programmes so as to help ameliorate some of the expected adverse sequelae of globalization, and to prevent the dire noncommunicable disease burden projections from becoming a reality. Current work aims to reduce the incidence of noncommunicable diseases by tackling the major risk factors, and underlying determinants of health, in order to reduce premature mortality and improve quality of life, with particular focus on developing countries.

3. In 2000, WHO's health promotion efforts focused on advancing school health globally, regionally and nationally, emphasizing the importance and feasibility of healthy ageing, assessing the prevalence of risk factors in the largest countries, determining the best ways of increasing physical activity, and facilitating the development of effective national health promotion programmes.

## School health

4. Primary prevention is the key to cost-effective health promotion programmes, and schools are the ideal setting in which to start. Towards this end, WHO collaborated with UNESCO, the World Bank and UNICEF to foster school health programmes as an important strategy for achieving Education for All (EFA). WHO's Thematic Study on School Health and Nutrition served as the basis for ensuring that health in general, and HIV prevention in particular, was included in EFA's framework for action. As a commitment to the EFA goal, WHO, UNESCO, UNICEF and the World Bank launched the Focusing Resources on Effective School Health (FRESH) initiative as a common vision for focusing resources.

## Healthy ageing

5. Ageing is an active, vital and healthy period of life, rather than one of gradual deterioration. To change the perceptions and the reality of ageing, WHO has prepared a policy paper on health and ageing in preparation for the Second United Nations World Assembly on Ageing in April 2002. It has strengthened the Global Movement on Active Ageing through continued advocacy, such as the annual intergenerational walk event – Global Embrace. WHO has also reviewed the inclusion of the life course perspective in medical curricula and published training materials for primary health care workers.

## Risk factor assessment

6. Year 2000 activities emphasized collaboration with partners and building risk factor surveillance capacity. WHO implemented several activities in the surveillance component of the Mega Country Health Promotion Network, which involves the 11 largest countries in the world, constituting approximately 60% of the world's population. These activities included providing technical assistance to individual countries. Additionally, along with the Centers for Disease Control and Prevention, United States of America, and the National Public Health Institute of Finland, WHO co-sponsored a series of three global surveillance meetings that focused on building capacity, comparability, and analysis, interpretation, and use of behavioural risk factor data.

## Physical activity

7. In 2000, WHO collaborated with global partners in the development of an international physical activity questionnaire, tested in 12 countries. The questionnaire is designed to assess physical activity among the adult population in various cultural settings. In cooperation with 14 countries, WHO and the Centers for Disease Control and Prevention, Atlanta, launched the Pan-American Network on Physical Activity with the global purpose of sharing experience and knowledge, strengthening programmes and developing policy. WHO co-sponsored with UNESCO the International Olympic Committee (IOC) 8th World Sports for All Congress on Sport for All and Governmental Policies, (Quebec, 18 to 22 May 2000). It also participated in the Pre-Olympic Congress, organized by Australia and the International Council for Sport Sciences and Physical Education (Brisbane, 7 to 13 September 2000). WHO cooperated with IOC in organizing a technical session on promoting women's health through physical activity at the IOC 2nd World Conference on Women and Sport (Paris, 6 to 8 March 2000).

## National capacity

8. Bridging the equity gap – the 5th Global Conference on Health Promotion (Mexico, June 2000) provided the catalyst and focus for action throughout 2000 and stimulated intercountry activities (Nairobi, September 1999 and Pretoria, November 2000). A ministerial statement on health promotion, which

pledged support for the development of countrywide plans of action, was signed by 87 ministers of health, or their delegates and a framework for countrywide plans of action for health promotion was approved at the Conference.

## Next steps

9. The Health Assembly passed a resolution on noncommunicable disease prevention (WHA53.17) emphasizing integrated programmes at national levels and WHO's global leadership. After the reorganization of the cluster, a new department was formed and the work along these lines is being strengthened.

10. Future efforts in prevention of noncommunicable diseases will place emphasis on the importance of nutrition, along with physical activity and increased support to countries to implement effective and sustainable health promotion. Thus, six collaborative programme areas are envisioned: (1) school health and youth health promotion; (2) ageing and life course; (3) physical activity; (4) nutrition (as it relates to the prevention of noncommunicable diseases); (5) national and community programmes, and (6) behavioural risk factor surveillance.

11. WHO will play a major role in preparing for the Second United Nations World Assembly on Ageing in April 2002. In support of the first consultation on elder abuse to be conducted in September 2001, a plan of action will be devised.

12. In addition, WHO will advocate for the development of "age-friendly" standards; continue work on incorporating ageing and life course perspectives on training of health professionals, and examine the impact of the AIDS epidemic on older adults in Africa. The first meeting of experts on life course and prevention of noncommunicable diseases will be held, leading to a plan of action focused on the research agenda that is needed and exploring policy development.

13. A database on physical activity benefits, best practices and policy guidelines will be developed. Ongoing and new physical activity international and regional networks, including relevant collaborating centres and nongovernmental organizations, will be mobilized in support of country programmes. An emphasis will be put on global initiatives/campaigns to increase young people's involvement in physical activity and related healthy practices through cooperation with relevant organizations of the United Nations system (e.g. UNESCO), the IOC, the International Federation of Football Associations and other partners.

14. Developing a programme in chronic disease nutrition will be a priority. Experience in Finland and elsewhere has demonstrated that changes in dietary practices, increases in physical activity and decreases in smoking, can have a profound positive impact on cardiovascular disease and overall mortality rates. The plan is to collect the evidence base, to establish critical global and regional partnerships to outline recommended action for community-based and national programmes.

## MANAGEMENT OF NONCOMMUNICABLE DISEASES (MNC)

15. The rapid rise of noncommunicable diseases, mainly cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, represents a major health challenge to global development in the new century. Low and middle-income countries suffer the greatest impact. A global strategy for the prevention and control of noncommunicable diseases has been developed and endorsed by the Fifty-third World Health

Assembly (resolution WHA53.14). This strategy focuses on assessing the pattern and trends and risk factors of major noncommunicable diseases, as well as the national capacity for prevention and control; promoting the development of evidence-based strategy to reduce unhealthy behaviours and major risk factors; and implementing cost-effective and equitable interventions for the management of common noncommunicable diseases.

16. In 2000, an instrument was developed for assessing national capacity for noncommunicable diseases prevention and control that was circulated to all Member States. Completed questionnaires are being received through the six regional offices and a preliminary report will be developed in May 2001.

17. A document on evidence-based interventions for secondary prevention of coronary heart disease and stroke has been developed. The objective is to assist Member States in strengthening health care for people with major cardiovascular diseases by developing public health policies for the implementation of sustainable cost-effective secondary prevention interventions with emphasis on primary care and community-based action.

18. Updated general principles for screening for common noncommunicable diseases in health systems were developed and discussed in a consultation.

19. A new methodology for the development of guidelines was developed in July 2000. This methodology is based on current best practice with explicit, transparent use of systematic reviews of evidence to develop recommendations. It also includes cost-effectiveness considerations of key recommendations. A multidisciplinary group on guideline development has been established to update existing hypertension guidelines produced by WHO and the International Society of Hypertension, and to present them as a case study.

20. The development of the global forum and regional network for noncommunicable diseases prevention and control in four regions was discussed at an interregional meeting organized in May 2000. Two meetings in the African and Eastern Mediterranean regions are being organized during the first half of 2001 in collaboration with the Regional Office for Africa and the Regional Office for the Eastern Mediterranean.

21. A protocol on community-based noncommunicable diseases prevention programmes was developed and implemented in three countries.

## Cardiovascular diseases (CVD)

22. A guideline development group has been constituted and is working on updating the WHO guidelines on hypertension management. The rheumatic fever/rheumatic heart disease prevention programme is ongoing in 21 countries. Technical assistance has been provided to various interested countries and work is in progress for updating the Guidelines on prevention and treatment of rheumatic fever/rheumatic heart disease. A monograph on the multinational monitoring of trends and determinants of cardiovascular diseases (MONICA) is under preparation and the third edition of the Cardiovascular Diseases Survey Methods was sent for publication. A consultation on air travel and venous thrombosis was organized and specific recommendations on key areas of research required were made.

## Cancer control (PCC)

23. International experience in implementing the national cancer control programme strategy was reviewed. An updated publication is in preparation and will be launched in collaboration with the International Union Against Cancer in 2002. A report will be published in 2001 on a consultation held to develop guidelines on management and palliative care of HIV-related cancers in Africa.

## Chronic respiratory diseases initiative

24. One main priority is to develop a comprehensive strategy for lung health. Based on a consultation, an action plan is being developed.

## Disability and rehabilitation

25. Intercountry consultations on strategies for improving rehabilitation services were held. An international conference on appropriate orthopaedic technology was organized in the United Republic of Tanzania. A report on disability and rehabilitation status in 25 African countries has been finalized. A joint position paper on community-based rehabilitation has been reviewed with ILO, UNICEF and UNESCO. One comprehensive report and six regional progress reports on the implementation of the four United Nations Standard Rules related to health have been finalized. Work to finalize WHO's policy on disability has been completed. The international conference on rethinking care for the disabled was conducted in Oslo, Norway in April 2001.

## Human genetics

26. Guidelines on integrating public health approaches for the prevention of common genetic and congenital disorders were developed. A protocol for implementing pilot projects in selected countries was also prepared and published.

27. An expert consultation on new developments in human genetics was held in July 2000 to review WHO's activities in genetics. The experts recommended that WHO develop an agenda in ethical, legal and social issues in genetics with special emphasis on developing countries. In coordination with other clusters, an international planning group was established. A meeting of the group and representatives of relevant organizations of the United Nations system (FAO, UNESCO, WIPO and WTO) was held in February 2001. A draft plan of action was developed for discussion with regional offices and experts from developing countries.

## Diabetes

28. National, regional and global estimates for diabetes prevalence and case numbers for the years 2000 and 2025 have been revised during 2000. Regional and global estimates for diabetes-related mortality were prepared in collaboration with evidence for health policy during 2000 and a report has been submitted for publication in the WHO Bulletin. National, regional and global estimates for diabetic complications are being prepared during 2000-2001. Guidelines for diagnosis and classification of diabetic complications will be distributed during 2001.

## Oral health

29. A model for introducing affordable means of oral disease prevention and control at an early stage was developed and implemented in the People's Republic of China, the Russian Federation and Senegal. A method for monitoring total fluoride exposure to prevent dental caries and fluorosis was developed and tested. Five-year milk fluoridation use in community preventive programmes was completed and evaluated. Training modules and guidelines for introducing atraumatic restorative treatment of dental caries in communities with no pressurized water and electricity were developed and tested.

## Prevention of blindness and deafness

30. An economic analysis of sensory disabilities, planning protocols and instruments for data collection and analysis was initiated. Global planning and coordination continued within the Vision 2020 framework and a global monitoring system (including data bank) was developed. Technical cooperation with Member States increased and disease-specific activities included assessment of cataract surgical services, promotion and coordination for onchocerciasis and trachoma control and development of strategies for other blinding conditions. Population-based surveys on deafness took place in South East Asia and Nigeria. Guidelines were developed for hearing aids services and expert recommendations for primary ear and hearing care. Technical support was given to four prevention of deafness projects in southern India.

## Next steps

31. In 2001, a report on assessment of national capacity for noncommunicable diseases prevention and control, based on the findings obtained from the questionnaires received from Member States will be developed.

32. A set of cost-effective, evidence-based interventions for secondary prevention of coronary heart disease and stroke will be identified. Community trials to incorporate these interventions in health systems of selected countries will be initiated in 2001. Two regional networks for noncommunicable disease prevention and control programmes in the Regional Office for Africa and the Regional Office for the Eastern Mediterranean will be established in 2001. General principles for screening for noncommunicable diseases in health systems will be published.

33. Evidence-based guidelines on the management of hypertension will be developed. A report on national, regional and global estimates for diabetes prevalence and estimates for the years 2000 and 2025 will be finalized. A report on the classification and diagnostic criteria for the major long-term diabetic complications will be completed.

34. Disease-specific programmes will move forward. These approaches include the development of feasible strategy for prevention and control of hypertension and rheumatic heart disease; a strategy for improving national rehabilitation services and updated review of community-based rehabilitation. Implementation of the global strategy for Vision 2020 – the Right to Sight; WHO's agenda on the Ethical, Legal and Social Implications in genetics, and a protocol for integrating prevention of common genetic disorders into primary care will continue.

## INJURIES AND VIOLENCE PREVENTION (VIP)

35. Violence and unintentional injuries due to traffic, burns, falls or drownings are an important public health problem, causing more than five million deaths annually. The number of deaths is small in comparison to the number of survivors of violence and injuries, many of whom remain permanently disabled. Although people from all social classes are affected, the poor suffer injuries more often and have less chance of survival when they are injured.

36. The traditional view of injuries as "accidents" or "random events" has resulted in the historical neglect of this area of public health. Injuries are preventable. Many prevention strategies, including the use of child car seats, seat belts, designated drivers, flame-resistant clothing, smoke detectors, fenced-in pools and water areas, and early childhood and family-based strategies to prevent violence, have proven successful.

37. Public health agencies have a crucial role to play in addressing the problems of violence and injury.

38. To date, most injury prevention efforts have focused on developed countries. Yet low- and middle-income countries have a higher injury mortality rate compared to high-income countries in all regions of the world. It is urgent to develop strategies which are appropriate, cost-efficient and effective in low- and middle-income countries.

### Surveillance

39. In 2000, WHO developed tools to facilitate data collection and analysis on injuries and violence. Guidelines on landmine injury surveillance were published and widely disseminated; guidelines for injury surveillance for less-resourced environments were drafted. In addition, WHO has provided technical support to several countries, including Afghanistan, Ethiopia, Mozambique and Nicaragua, for data collection. A multi-country study on alcohol and injuries was initiated in collaboration with Mental health and substance dependence. An injury epidemiology course was prepared in collaboration with the Injury prevention initiative for Africa for representatives from eight African countries.

### World report on violence and health

40. In mid-1999, work was initiated on the World report on violence and health, the first global publication of its kind. The goals of the report are to raise awareness worldwide about the public health aspects of violence and to highlight the public health responses and solutions to the problem. Nearly 100 authors and peer reviewers from around the world contributed to the preparation of the first draft of the report, completed in October 2000. Based on comments received during a series of six regional consultations with an additional 70 violence prevention experts, two final documents are being prepared for release in 2002. The technical background report will be written for public health practitioners and researchers, while a concise summary report will be produced for policy and other decision-makers.

### Violence prevention

41. A two-fold approach to strengthen country capacity for the prevention and combat of violence has been adopted: (1) the development of tools for the prevention and management of the consequences of violence, and (2) the provision of technical support at country level. Pilot-testing of the framework was initiated in Mozambique. Within the framework, guidelines for the prevention of child abuse and neglect are in preparation with external partners. Collaboration with Gender and women's health on a global

initiative on sexual violence, a research agenda on HIV/AIDS and violence, and a multi-country study on violence against women. Background work for a consultation on medico-legal management of cases of sexual violence was also conducted in 2000. Technical support has been provided to Burundi and Rwanda to improve accessibility to health services for women and girls affected by violence, and to facilitate the development of a national plan of action on violence prevention in Algeria and Mozambique.

### Traffic injuries prevention

42. A network of researchers from developing countries was created in collaboration with the Global Forum for Health Research. The purpose of the network is to facilitate South-South and North-South partnerships to conduct research on traffic injury prevention in developing countries. During 2000, the network met twice, in Uganda and Thailand, to develop protocols for three studies. In addition, a consultation to develop a WHO strategy on road traffic injury was held in headquarters from 26 to 27 April 2001.

### Small arms

43. In view of the growing threat to public health posed by small arms and the lack of reliable data on this topic, the planning for a multicountry study has been initiated. The study will assess the impact of small arms on health and provide data that will inform policy-making. Planning and fund-raising took place in 2000; the study will be conducted from 2001 to 2004.

### Landmine victim assistance

44. Input to the Ottawa process on landmines and to the implementation of the joint ICRC-WHO strategy has continued. In addition to the development of standards for data collection, a framework for victim assistance was developed. Technical assistance was provided to Afghanistan, Bosnia and Herzegovina, Mozambique and Nicaragua.

### Pre-hospital care

45. Appropriate pre-hospital care can save hundreds of thousands of lives every year. A consultation on pre-hospital care, held in 2000, resulted in the creation of a network of experts who will draft guidelines for the development of pre-hospital care systems. Training in pre-hospital care was conducted in a number of countries including Angola, Iran and Mozambique.

### Next steps

46. The World Report on Violence and Health will be finalized for publication in 2002. The WHO strategy on traffic injury prevention will be launched and research will be initiated. A number of normative documents will be drafted or released in 2001 in the areas of injury surveillance, pre-hospital care, medico-legal management of cases of sexual violence and the prevention of child abuse. A report on deaths due to small arms will be released at the United Nations Conference on the Illicit Trade in Small Arms and Light Weapons in All Its Aspects in July 2001 and will lay the groundwork for a larger study that will follow.

## Mental health and substance dependence (MSD)

47. Some 400 million people in the world suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. At least one of every four people who turn to health services for help is troubled by these disorders. Often, they are not correctly diagnosed and thus not treated. Groups at special risk of being affected by the burden of mental health problems include children and adolescents experiencing disrupted nurturing, abandoned elderly, abused women, those traumatized by war and violence, refugees and displaced persons, many indigenous people and persons in extreme poverty. The department of mental health and substance dependence seeks to reduce the burden related to mental and neurological disorders, and to alcohol and drug abuse. Two major events marked the nature and the content of activities in 2000; namely, the merger of the cluster (with the concomitant merge of Mental health and Substance abuse) and the choice of mental health as the theme for World Health Day 2001, *The world health report 2001* and the ministerial round tables during the Fifty-fourth World Health Assembly in 2001.

## World Health Day and *The world health report 2001*

48. Awareness-raising activities about mental health targeted at the general public have been initiated around the world. A global school contest on mental health has been supported by six First Ladies and includes schools from over 70 participating countries. Advocacy materials (brochures, posters, stickers) were developed to support mental health activities based on the World Health Day strategy and message: Stop exclusion, dare to care. Public events and media activities organized by governments, WHO collaborating centres and nongovernmental organizations in over 75 countries took place on or around World Health Day, 7 April.

49. An outline of *The world health report* was prepared and submitted for extensive consultations both in-house and to mental health experts selected by the six WHO regional offices. A media strategy for launching *The world health report* was initiated and activities organized in the six WHO regions.

## Information production and dissemination

50. Suicide trends, alcohol use and related harm, and injected drug use were monitored. Global reports on suicide mortality and the first global status report on alcohol were published.

51. Information from 172 countries has been obtained on country resources for mental health. This information has been used for *The world health report 2001*. The data will also be compiled, analysed and produced as an atlas of mental health resources before the end of 2001.

52. For the research community, a protocol including instruments for a multi-site intervention study on suicidal behaviours was finalized and distributed, and a drug abuse epidemiology guide was prepared and disseminated.

53. For policy-makers, a draft mental health legislation manual was completed and is part of an overall advocacy package for governments as well as nongovernmental organizations at the national and local levels.

54. For primary health care staff, a behavioural science-learning module on immunization was published, and a review of best practices for the care of people with substance dependence and living with HIV/AIDS was prepared.

## Awareness raising

55. Awareness-raising activities on mental health issues have taken place in China and in Mozambique. Global campaigns for the prevention of suicide and about epilepsy were launched. Regional and local awareness campaigns about depression and priority neurological diseases were prepared and information materials for the general public on depression, suicide and epilepsy were produced and distributed.

56. Examples and case studies on protecting and promoting the rights of people with mental health problems, stigma and human rights violations, special provisions for vulnerable groups, the role of nongovernmental organizations and governments, and strategies for promotion and implementation of international standards and conventional norms were obtained from several countries.

## Training

57. Training on evaluation of mental health care services was provided to 10 countries in all WHO regions. Materials have been prepared for training nongovernmental organizations in primary prevention of substance abuse and are being field tested in three WHO regions. A training manual for the prevention of substance abuse among street children was finalized and disseminated to Member States. Training materials on screening and brief interventions for alcohol use problems were updated and similar materials on problems of drug use are being developed and updated.

## Guidelines production/dissemination

58. Guidelines on the identification and management of priority mental disorders, substance dependence and epilepsy at primary health care level, on the prevention of suicide, and of mental retardation, on the management of child and adolescent mental disorders, as well as on service evaluation were developed and disseminated to Member States. A rapid assessment guide to substance use and sexual behaviour was developed and is currently being field-tested. In addition, guidelines for the treatment of opioid dependence were prepared.

## Support to countries

59. Training programmes are being run for mental health professionals and health professionals on the importance of integrating mental health into primary health care in four developing countries.

60. Community-based mental health projects, covering areas such as non-hospital based psychosocial care and rehabilitation, quality assurance, training centres and the involvement of nongovernmental organizations in reduction of stigma and discrimination, were implemented in six countries. Technical assistance was provided to another three developing countries for the development and/or improvement of mental health plans with emphasis on intersectoral collaboration.

61. Support was given to 17 Member States for the assessment of the extent and impact of injected drug use on health, particularly the transmission of HIV and hepatitis B and C, as well as for the development of appropriate interventions.

## Special issues

62. The mental health policy project was created, and several evidence-based documents on service delivery, national level planning and management and on mental health financing were drafted, internationally reviewed and revised.

63. A document on Women's mental health: an evidence-based review (WHO/MSD/MHP/00.1) was published and training materials (text, videos, slides) were drafted. A rapid assessment protocol for mental health problems in complex emergencies was developed. An international consultation was organized in October 2000 that led to the Declaration of cooperation: mental health of refugees, displaced and other populations affected by conflicts and post-conflict situations (Geneva, January 2001).

## Next steps

64. In 2001, activities will relate to World Health Day, the ministerial round tables during the Fifty-fourth World Health Assembly and the release of *The world health report*. Activities for the release of *The world health report* have also been planned in all six WHO regions.

# TOBACCO FREE INITIATIVE (TFI)

65. A cigarette is the only consumer product that, when used as recommended by manufacturers, kills half of its regular consumers. Today, four million people die every year from tobacco-related causes. If current trends continue, twice that many are expected to die by 2020, over 70% of whom will be in developing countries. In response to the global increase in tobacco use, WHO created the tobacco free initiative in 1998, a cabinet project whose mandate is to focus international attention, resources and action on the devastating public health impact of tobacco.

66. The centrepiece is the framework convention on tobacco control (FCTC) – WHO's first public health treaty. The FCTC is currently being negotiated by WHO Member States, with May 2003 as a projected date for adoption. Once the convention has been ratified, the FCTC will have a significant impact on global tobacco control, saving millions of lives in the process.

## FCTC negotiations

67. Negotiations on the FCTC began in October 2000 when representatives from 148 countries travelled to Geneva for the first session of the Intergovernmental Negotiating Body. The second meeting of the Intergovernmental Negotiating Body took place from 30 April to 4 May 2001.

68. The nongovernmental organizations have a key role to play in ensuring a strong and meaningful convention, and many countries have supported their extended participation in the negotiation process. At its last meeting, WHO's Executive Board agreed that nongovernmental organizations wishing to participate in the work of the Intergovernmental Negotiating Body may be admitted provisionally into official relations with WHO for the duration of the negotiations, subject to certain conditions.

## Public hearings on the framework convention

69. The first negotiating session was preceded by two days of public hearings. The hearings marked the first time that an agency of the United Nations system publicly sought and secured views from all parties interested in a proposed convention. The hearings highlighted the key differences between the positions of tobacco companies and public health organizations on the role of taxes on tobacco products; the risks of second-hand smoke; and the contribution of advertising to smoking, especially among youth. A total of 514 written submissions were received, and speakers representing 144 organizations took the floor over a two-day period to express their views on the convention. The hearings were broadcast live on the internet, on a site where both the written submissions and the audio/video archives continue to be consulted.

## Report of a committee of experts on tobacco industry documents

70. In August, WHO released the report of a committee of experts appointed by the Director-General to investigate how and to what extent tobacco companies had influenced and undermined tobacco control work at WHO and other organizations of the United Nations system. The report revealed that tobacco companies considered WHO one of their leading enemies, and planned and implemented global strategies accordingly to discredit and impede WHO's efforts to carry out its mission – including placing their own consultants in positions at WHO, paying them to serve the goals of tobacco companies while working for WHO. As a result of this inquiry and the recommendations of the committee, Switzerland and Egypt have already conducted their own inquiries and released reports on similar tobacco industry activities. Other countries are planning and carrying out inquiries. WHO has now introduced a declaration of interest form to be signed before staff are appointed.

## United Nations Inter-Agency Task Force on Tobacco Control

71. The 15-agency task force is currently the only system-wide group chaired by WHO. It also includes the World Bank, IMF and WTO. Substantial progress has been made in working with other organizations of the United Nations system in the formulation and promotion of tobacco control initiatives.

## Country support

72. A roster of experts has been established who form the basis of rapid response teams in the areas of legislation, price interventions, economic impact of tobacco control, and epidemiology. As the FCTC continues to develop, formal demands from Member States are likely to increase substantially.

73. Projects in five pilot countries (China, India, Kenya, Senegal and Ukraine) seek to use legislation, economics and possibly litigation as tools for tobacco control. Projects being piloted in Benin, Burkina Faso, Cameroon, Côte d'Ivoire and Mali, use legislation and price interventions as tools for preventing children and young people from using tobacco or for promotion of cessation of tobacco consumption. The World Bank is supervising economic analysis in at least five countries in collaboration with WHO.

74. A global youth tobacco survey, a school-based tobacco-specific survey aimed at 13-15 year olds, has been completed in 30 countries and is under way in another 30. The information yielded will be used to help countries design, carry out and evaluate tobacco control and prevention programmes targeting youth.

75. A global health professional survey, which monitors and documents the prevalence of tobacco use among health professionals and assesses knowledge, attitudes and behaviours (including whether they advise patients on cessation) has been piloted in five countries and will be expanded to include 15 more in the first half of 2001.

### Communication

76. The “Tobacco Kills – Don’t be Duped” global media and nongovernmental advocacy campaign, active in 17 countries, aims to strengthen the role of health communicators in advocating the effective tobacco control policies in their countries and regions as they prepare for the framework convention. The logic of the campaign reverberated far beyond its original scope and became the leitmotif for World No Tobacco Day 2000. The campaign will stretch to 30 countries in 2001.

### Scientific Advisory Committee on Tobacco Product Regulation

77. WHO’s Scientific Advisory Committee on Tobacco Product Regulation, composed of scientists and tobacco control experts from around the world, advises WHO on the regulatory framework, policy development and dissemination of scientific information for tobacco products. The Committee, established in 2000, collates and assesses information on the impact of different national tobacco regulatory frameworks; evaluates how regulatory approaches developed for cigarettes could be adapted to cover all forms of tobacco; and advises WHO on how governments and international agencies could encourage the development of substantially less harmful tobacco products and other nicotine delivery devices. The Committee also serves as the mechanism through which selected tobacco companies provide WHO with information on their perspective on product modification, and their efforts to reduce the harm caused by tobacco products.

### Next steps

78. TFI will continue to organize and provide the Secretariat support for the negotiations on the FCTC. The third session of the Intergovernmental Negotiating Body will take place in November 2001. Depending on progress made, either one or two more sessions will be convened in 2002. In parallel, WHO will work with countries to strengthen their capacity to implement and enforce the FCTC by organizing training workshops in the areas of economics, legislation and other aspects of tobacco control. The media and advocacy team will focus on working with key nongovernmental organizations to raise public awareness around the FCTC. Research will be funded on effective tobacco cessation strategies.

## CROSS-CLUSTER INITIATIVES

79. There are three cross-cluster initiatives in the Noncommunicable Diseases and Mental Health Cluster, on surveillance, health care and long-term care. The products and activities of these initiatives are described below for each specific area.

## SURVEILLANCE (CCS)

80. Surveillance is a major function as it underpins disease prevention and health promotion efforts. The surveillance initiative coordinates common surveillance functions across the cluster.

81. Key activities in 2000 included the establishment of a common approach to surveillance of major noncommunicable diseases and their risk factors, to strengthening of headquarters regional and country infrastructure for information exchange, including coordinating work with regional offices, collaborating centres and other partners on developing country assessments and strengthening health information systems. Steps have been taken towards a unified approach to link work on trend analysis, health systems development and surveillance of diseases and other conditions, including communicable diseases.

82. Specific surveillance products led by the initiative include the following: world report on current patterns and trends in risk factors for major noncommunicable diseases; WHO STEPwise packages for surveillance (development, testing and dissemination) of major noncommunicable diseases risk factors and selected diseases; WHO-recommended surveillance standards for noncommunicable diseases and mental health; collaboration with community-based prevention programmes; guidelines for monitoring alcohol consumption and harm; simplified stroke surveillance system using the WHO STEPS approach.

### Next steps

83. Obtaining resources, regional office input, and collaborating centre support in training to test and implement tools and methods at the country level will be a priority. A report, which summarizes the current status of the major noncommunicable diseases risk factor assessment at the country level, will provide the baseline against which to measure improved country capacity in surveillance.

## HEALTH CARE

84. Health care systems have been traditionally designed to deal with acute, episodic cases. Chronic diseases, both communicable and noncommunicable, require a different kind of health care. In most countries, health care for chronic diseases is fragmented and its quality is addressed within the usual hospital-focused quality perspective. Health care systems, which have been traditionally built around curative approaches, need to adapt to face the burden of chronic illness care. Most developing countries need to organize their health care system to cope simultaneously with the double burden of disease. The mission of the health care initiative is to improve health care for noncommunicable diseases and mental health, and to provide technical support to countries in the preparation of their health care systems to deal with the double burden of disease.

85. In collaboration with Evidence and information for policy, a project was initiated on transforming primary health care to address the challenges of chronic conditions. An issue-raising report for the regional workshops and a protocol for the region-specific reviews were prepared. The outcome of both activities, along with validation workshops, will provide a clear description of good practices and articulation of WHO policy in primary health care.

86. A project was initiated on tackling chronic care in health systems: reorganizing health care for chronic diseases. A report on chronic care in the world that presents models and best practices in health care for chronic diseases was prepared. The report will be validated and used as a reference in adapting existing models for different settings.

87. A project on gender and noncommunicable diseases was initiated. Key activities included research on the evidence on gender and noncommunicable diseases with emphasis on lung cancer, cardiovascular diseases and arthritis; an overview of the international policy background on gender and health

considering the implications on noncommunicable diseases; and a reworking of a WHO document on gender and health from the perspective of noncommunicable diseases.

### Next steps

88. In 2001, six regional workshops and region-specific reviews as part of the primary health care project will be conducted. A project on adherence to long-term therapies has been initiated. A preliminary report on the subject will be the basis for a meeting between WHO experts and other main stakeholders (physicians, industry and nongovernmental organizations). The meeting is expected to define the structure and process for further development of the project. A second meeting will take place at the beginning of 2002 to develop WHO policies on adherence to long-term therapies. In addition, future work will also comprise the development of a framework for how health care systems should/could handle gender issues in relation to noncommunicable diseases.

## LONG-TERM CARE

89. The long-term care initiative anticipates and responds to the growing double burden of disease in developing and industrialized countries alike, to be found in the re-emergence of infectious diseases, (AIDS, tuberculosis), chronic non-infectious diseases (cardiovascular diseases, cancer, diabetes), mental illnesses and debilitating diseases (e.g. epilepsy, dementia) and chronic disability as consequences of violence (e.g. road accidents, war). The objectives are to expand existing knowledge for long-term care policy.

90. The work has three major foci, evidence for policy, national capacity building and family and community care. Evidence for policy involves legislation, financing, management, human resources, projection of needs/resources and ethics; health systems reform and continuity of health and social care are key elements of national capacity building; and family and community care entails both quality of care and quality of life.

91. Key activities in 2000 were the publication of the report of the WHO Study Group on Home-based and Long-term Care (WHO Technical Report Series, No. 898, 2000), a report on long-term care laws, the initiation of a long-term care policy initiative, and the issue of a document[1] on Community home-based care: family care-giving; caring for family members with HIV/AIDS and other chronic illnesses, a Botswana case study. A comparative country analysis on community home-based care was begun and a report based on research in Kenya on this same topic is about to be released. A report on HIV/AIDS and family care in Haiti is in preparation.

### Next steps

92. The long-term care policy initiative will review policy components and will examine health systems interface, human resources strategies, role of the family and informal support, and case management and quality of care. Nine national long-term care case studies and a conceptual framework for comparative analysis are being developed. A meeting is planned where industrialized countries and developing countries will exchange experiences.

[1] Document WHO/NMH/CCL/00.1, Geneva, 2000.

## COMMUNICATIONS

93. The rapidity of the shift of the burden of disease from infectious to noncommunicable diseases, injuries and violence will seriously challenge health care systems. Difficult decisions about policy options and resource allocation will be taken. Arguments must be able to extract value for life at every step of the cycle. In order to communicate meaningfully, considerations of poverty and equity must be incorporated into thinking and messages.

### Next steps

94. In the area of health communications, the overall public information role of WHO will be enhanced and greater emphasis will be given to supporting Member States. In addition, efforts will continue to strengthen the applications of behavioural sciences and health promotion knowledge within health systems, particularly in terms of adherence to therapies and treatment regimens for chronic diseases.

95. Coordination of health promotion is being improved throughout WHO; and in collaboration with the International Union on Health Promotion and Education, a global forum for health promotion dialogue is being established to bring together bodies of the United Nations system, nongovernmental organizations, and the private sector to work more effectively on health promotion issues.

= = =