

2009 AMR e-discussion on Global Public Health
Part II: Emerging and future health challenges

Responses in Full by Contributors: Part Two

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1. Formulating guidelines for controlling and preventing cardiovascular disease (CVD): Ten principles

Formulation of guidelines and community involvement

The World Heart Federation believes that although the causes of the global epidemic of cardiovascular disease (CVD) involve the same risk factors, a one-size-fits-all approach is neither appropriate nor adequate when it comes to developing guidelines for a specific country. It is essential that governments work in partnership with national societies of healthcare providers and foundations to develop guidelines that reflect national priorities and resources. The approaches to CVD control and prevention can differ because of cultural, social, medical and economic imperatives in a particular country or region.

The most cost-effective approach is to treat patients at high short-term risk while encouraging those at lower short-term risk to be more physically active, adopt healthier diets and avoid tobacco. Healthcare budgets ought to determine the specific benefits of primary and secondary prevention programs based on local epidemiological factors. Every effort should be made to address the financial constraints placed on the healthcare system.

Countries should formulate national and regional guidelines using the **ten principles** developed by the World Heart Federation. These are:

- 1) Governments, national professional societies and foundations should collaborate to develop clinical and public health guidelines for CVD prevention that targets risk factors.
- 2) Evidence-based guidelines should incorporate professional judgment on the translation of such evidence into effective and efficient care, addressing all areas of CVD risk.
- 3) The assessment of total CVD risk should be based on epidemiological risk factor data appropriate to the population to which it is applied.
- 4) Policy recommendations and guidelines should emphasize the importance of a total risk reduction for CVD prevention.
- 5) The intensity of interventions should be a function of total CVD risk, with lower treatment thresholds for higher-risk patients than for low-risk patients.
- 6) National cardiovascular societies and foundations should promote routine, prospective collection of validated national vital statistics on the causes of CVD and outcomes of patients with CVD for use in the development of national policies.
- 7) National professional societies should inform policy makers of risk factor targets and drug therapies for CVD prevention that are culturally and financially appropriate to

their country, and ask their government to incorporate CVD prevention into legislation wherever relevant.

8) National professional societies and foundations should facilitate CVD prevention through education and training programs for healthcare professionals.

9) National professional societies should assess the achievement of lifestyle, risk factor and therapeutic targets defined in the national guidelines.

10) Healthcare professionals should include CVD prevention as an integral part of their daily clinical practice.

Close collaboration with a range of organizations is a critical element of success. A case in point is the pioneering North Karelia Project in Finland (see link provided below). Its Director, Professor Pekka Puska, is the World Heart Federation's current president and Director-General of the National Institute for Health and Welfare in Finland.

The North Karelia Project emphasizes the important role played by primary healthcare, voluntary organizations, the food industry and supermarkets, schools, and the local media. Annual cardiovascular mortality rates among working-age people are now some 80 per cent lower than at the outset of the project in 1971, with an overall increase in life-expectancy and a greatly improved public health system. Although the North Karelia Project focused on cardiovascular disease, its impact on the health system is summed up by a public health nurse in North Karelia: "The North Karelia Project transformed the activities of public health nurses in many ways. Previously they had worked largely with children and pregnant women.....but nowadays preventive and health promotion services [with adults] are an integrated, routine feature of life in the province."

In the first part of this e-discussion, the World Heart Federation emphasized the need for an integrated approach to healthcare. It is such an approach that is central to the success of the North Karelia Project. The risk factors for CVD are risk factors for many other chronic diseases. Thus, an integrated approach targets the main common behavioral risk factors for a range of chronic diseases.

For more information on the North Karelia Project, please follow the following link:

<http://www.thl.fi/thl-client/pdfs/731beafd-b544-42b2-b853-baa87db6a046>

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2. Tobacco control strategies: An essential tool for global public health

1. What are the essential elements of national strategies to address the growing magnitude of non-communicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) and social determinants? What sectors besides the health sector must be involved in designing and implementing the strategies? How can we raise the priority accorded to non-communicable diseases in development work at global and national level?

Tobacco use is a major risk factor for six of the eight leading causes of death in the world (trachea, bronchitis and lung cancers, chronic obstructive pulmonary disease, ischemic heart disease, cerebral-vascular disease, lower respiratory infections and tuberculosis). Tobacco use is classified as the second major cause of death in the world and the fourth most common risk factor for disease worldwide. Estimates show that in the 20th century, the tobacco epidemic killed 100 million people worldwide. Evidence-based strategies to curb tobacco use exist and have proved to be effective in reducing the burden. These measures have been laid out in the global treaty, the WHO Framework Convention on Tobacco Control (WHO FCTC) (<http://www.who.int/fctc/en/index.html>), adopted in 2003 and with more than 160 Parties committed to implementing tobacco control in their countries. As part of WHO's technical assistance package for implementing the WHO FCTC at country level, the Organization released the **MPOWER** package of strategies aiming at reducing demand for tobacco. **MPOWER** stands for **m**onitor tobacco use and prevention policies, **p**rotect people from tobacco smoke, **o**ffer help to quit tobacco use, **w**arn about the dangers of tobacco, **e**nforce bans on tobacco advertising, promotion and sponsorship, **r**aise taxes on tobacco (<http://www.who.int/tobacco/mpower/en/index.html>).

Tobacco use represents a multifaceted problem because it is not only limited to health but also affects a large number of sectors, including development. Disability and death in early age due to tobacco use mean fewer resources for growth in countries. Also, personal expenditures on tobacco consumption can represent high opportunity costs for families taking away essential resources that can otherwise be spent on education, health-care or good nutrition (<http://www.who.int/tobacco/communications/events/wntd/2004/en/index.html>, http://www.who.int/tobacco/research/economics/publications/mdg_book/en/index.html).

Tobacco control can only become effective if it is implemented through the collaboration of the different sectors of the government and the input of the different intergovernmental specialized agencies. For example, the successful implementation of the MPOWER package will need the active involvement of a number of Ministries in addition to the Health Ministry, such as Ministries of Finance, Customs, Education and Communication, etc.

Patterns in tobacco use can be clearly seen from a social-determinants perspective. Evidence shows a differential distribution in tobacco use is based on income, gender, age, ethnicity and place of residence. Efforts to prevent and control tobacco consumption among disadvantaged groups will need to focus on an integrated approach that seeks to reduce the underlying social inequities that prompt tobacco consumption among these groups and confer on them a relative disadvantage in accessing cessation services.

2. In the wake of the financial crisis, how can we maintain and enhance the favorable policy and resource trends for global health of the recent past? How can we better define the roles different stakeholders can play (including through collaborative inter-sectoral efforts) towards the achievement of public health goals?

Tobacco control work is geared towards ensuring that the tremendous progress made during the good times is not lost during the bad:

- by continuing to make the economic case that senseless loss of 5.4 million people this year alone – people in the prime of their productive years – cannot be good at a time when we need as much human ingenuity as possible to overcome the challenges ahead.
- by focusing on the potential benefits of tobacco control policies on economic growth, not least on the potential of tobacco tax increases to at once decrease consumption of an addictive product while increasing tax revenues that can then contribute to financing much needed economic stimulus packages as well pro-poor social policies. Tobacco taxes are a mode of taxation more easily accepted than others and in a time when governments are suffering from "revenue hunger"; such taxes are a notable source of revenue. Tobacco tax increases therefore represent a win-win situation: saving lives and generating revenues.
- by engaging ever more broadly and deeply with non-health sectors, especially the Ministries of Finance on the issue of tobacco taxation mentioned above, but also with Ministries of Agriculture. In the context of the current global food crisis, diversification from tobacco growing should be seriously considered to free up valuable land for more beneficial crops.

3. What further innovations should be incorporated into global health partnerships and collaborative arrangements to improve their performance, reduce transaction costs and increase synergy of action aligned to country priorities? What other innovative ways of working can be considered that strive for greater coordination and collaboration of all actors in health?

The UN Ad Hoc Interagency Task Force on Tobacco Control, established in 1999 by the UN Secretary-General, is an important forum to intensify a joint UN response and global support for tobacco control (http://www.who.int/tobacco/global_interaction/un_taskforce/en/index.html). This Task Force is a very useful platform for multi-sectoral collaboration and effective implementation of the WHO Framework convention on Tobacco Control at country level.

Another novel way of working for improved public health (which is being increasingly promoted) is the public-private partnership. The WHO Tobacco Free Initiative department has been working for two years now with the Bloomberg Philanthropies for scaling up of tobacco control efforts in developing countries where the health burden from tobacco use is highest (<http://www.who.int/tobacco/communications/highlights/bloomberg/en/index.html>). This project, implemented in collaboration with four other partners, has led to concrete improvements in tobacco control in a number of countries.

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1. Call for greater integration of mental health and psychosocial support into efforts to achieve the MDGs and humanitarian responses

One of the most neglected but important noncommunicable diseases is mental health and psychological problem. WHO says 450 million people suffer from mental health and neurological problems such as depression, anxiety disorders, drug abuse among others, and almost 1 million people die due to suicide every year. In fact, suicide is the 3rd leading cause of death in young people.

At least 1 out of 5 patients at the primary health care settings have mental disorders. In addition, mental health problems are shown to be a risk factor for physical morbidity and even mortality. Mental health problems occur as a consequence of physical health problems, too. Further, mental health and psychological problems affect health seeking behaviours and can prevent patients from adhering to treatment regimens, which are often crucial, not only to their health, but to ensure that medicines remain effective and to reduce the likelihood of drug-resistant strains from emerging. These problems can also increase health related risky behaviours such as excessive alcohol use and drug use, violence and risky sexual behaviour. However, we tend not to include mental health into our discussion related to primary health services or health systems while health systems and services should integrate both physical and mental aspects since they are inseparable.

According to the latest Update of the Global Burden of Disease (GBD) by WHO (http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html), "depression" is the leading cause of years lost due to disability. Mental health problems including Alcohol abuse are among the 10 leading causes of disability in both rich and poor countries. It is sad the depression is already ranked 3rd in GBD, and is projected to be the top cause of GBD in 2030: We need to take action now.

Health is a "state of complete physical, MENTAL and social well-being and not merely the absence of disease or infirmity" as the WHO definition. As all of us know, human beings are emotional beings.

If we face death of children, complication during/after pregnancy, HIV infection, pandemic of flu or any noncommunicable diseases, we are often psychologically affected by these morbidity or mortality. Needless to say, war/conflict, natural disaster, displacement, sexual and gender-based violence, discrimination and human rights violation, and poverty can have strong impact on mental health and psychological well-being of people. As stated in the UNESCO Constitution,

"since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed." This shows how mental health and psychosocial aspects are critically important not only for health, but also for the society and our future. I think mental health and psychological well-being is one of the most paramount indicator of human security.

UNFPA Executive Director called on "all governments and partners to include measures for mental health in efforts to achieve human development and respond to humanitarian crises." (<http://www.unfpa.org/news/news.cfm?ID=1195>) She says "mental health must be a key component in efforts to achieve MDGs 4 and 5" and calls for "greater integration of mental health and psychosocial support into humanitarian responses and efforts to achieve the MDGs" and "making mental health a global priority." She closes the Statement with saying "mental health is central to human dignity."

The UN SG is also calling for "more integration of mental health awareness into all aspects of health and social policy, health-system planning, and primary and secondary general health care" with saying "there can be no health without mental health." (<http://www.un.org/News/Press/docs/2008/sgsm11843.doc.htm>)

UNFPA and WHO have established the WHO-UNFPA Joint Programme on Mental Health, and have started to develop mental health packages to integrate into maternal health, sexual and reproductive health and HIV and AIDS, gender-based violence and adolescent health. It is part of the WHO Mental Health Gap Action Programme which will develop mental health essential intervention package. Hope we will have more partners in this.

I think now is the time to pay appropriate attention to and promote integration of mental health and psychological aspects in the UN system for better social and human development and human security.

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2. Prospects of virtual integration model for healthcare systems in developing countries

The emerging disease pattern in developing countries with predominant chronic medical conditions accounting for over 60% of the disease burden has exposed the weaknesses inherent in the current delivery system. In these countries, chronic medical conditions such as diabetes, hypertension, tuberculosis, HIV/AIDS, cancer etc; present mainly at the primary care level and have to be dealt with at these settings. Nonetheless, most primary health care is oriented toward acute health problems and the urgent need of patients. Patients with chronic medical conditions need broader support that goes beyond biomedical interventions^[1]. These patients need planned care that anticipates their needs, and care that is integrated cutting across time, settings and providers as well as self-care skills for managing problems at home. In addition, patients and their families also need support from policies that would help them effectively manage and prevent chronic conditions from within their communities. The present health care

delivery system in developing countries is therefore not suitable for dealing with chronic health problems, which require long-term therapies along side on-going support and provision of appropriate information and ancillary services to enhance the quality of patients' life.

Secondly, there is fragmentation of care - both among similar providers and between different levels of care. As noted by the World Health Organisation (WHO)^[2], in the public sector in developing countries, nearly all hospitals provide a wide range of patient care that could have been taken care of effectively by General Practitioners or primary healthcare workers operating from simple premises - health centres, out-patient or walk-in clinics, maternity homes, dispensaries or even at home. Private medical practitioners in urban and semi-urban areas have large quantity of modern medical equipment that is rarely used. A considerable proportion of all sickness is managed at home, yet households have the least healthcare information among care-givers. Some public health programmes such as Tb and malaria control provide a wide range of basic health services rather than having linkages with appropriate clinic facilities. This situation creates duplication and wastage of resources leading to disintegration of health care services for a defined population of patients.

There have been attempts in the past to strengthen the referral system between the different levels of care. But this has been unsuccessful mainly due to inefficient transport or communication systems, which are outside the core functions of the health sector. In addition, costs other than the cost of medical treatment are also directly borne by individuals and households. Similarly, there have been efforts at 'vertical integration' of publicly provided health care services at sub-national levels – mainly districts. This too has encountered great difficulties largely due to administrative and organisational structures (Hierarchies) that prevent various actors within the healthcare system from working towards a common goal – improving health status of a given population.

Parallel to public sector provision of health care services is the poorly regulated private sector that engage in short – term or contractual interactions between patients and providers leading to exposing individuals especially the poor to financial risk of illness. This sector (Markets) does not also respect priorities among interventions and patients that the public sector is trying to target – and therefore may not be producing enough public health goods and services that lead to better health outcomes for majority of the population.

In order to overcome noticeable failures of traditional governance mechanisms – hierarchical bureaucracies and fragmented markets – in providing effective coordination of health care organisations that deliver improved outcomes – an alternative governance structure (integrated health networks) has been suggested^[3]. This approach strikes a balance between avoiding the inefficiencies and unresponsiveness that occur with the hierarchical traditional model of civil service administration of public health services on one hand and the loss of financial protection and strategic coordination perpetuated by the private sector. But 'vertical integration' has some limitations because of its provider perspective – relating to integrating levels of care, where the availability of services defines the kind of care provided. As opposed to 'virtual integration', which has a patient outlook - where health service units form alliances or partnerships based on a common vision, shared information and incentives to provide the sort of care as defined by the needs of the patients.

The concept of a 'virtual health system' is further supported by two powerful ideas working in synergy - a notion of health as a 'knowledge economy', and the shift to a contextual structure and process of medical care. As explained, this new perspective sees health as a 'knowledge economy' and health systems as "ways of organising access to expert knowledge or expertise (defined as information plus interpretation and best judgment), embodied in both people and products, and in which multiple types of power relations are embedded"^[4]. By conceptualizing health systems as knowledge economies, one would argue strongly that a virtually integrated service delivery model – using modern communication systems for sharing information without cumbersome controls but having a shared vision for meeting patients needs, has a much better potential for the production and organisation of access to expert knowledge and the technologies, which are obtained from it. This is a clear departure from the prevailing idea, where health systems are seen as complex technical systems through which specialized health services – protection, prevention, diagnosis and treatment, and health products – drugs and equipment are produced and distributed to populations.

Again following the pattern of the development of 'virtual corporations', where a major shift away from production, distribution, and sale of products to a concern over controlling the processes that deliver the products has been made – virtual health networks could emerge by coordinating the systems that provide access to expert knowledge and its technologies rather than controlling the ways and means of organising health producing services and goods as in bureaucratic hierarchies or markets. Thus virtual health networks set up for cancer or diabetes care; could theoretically lead to the break down of hospital walls, linking specialist and generalists doctors (whether they are in public or private service), along with members of home care teams, and using information technology for virtual as well as real time communication – providing a seamless service for patients while focused on delivering better patient health outcomes.

Aside from an informed population of consumers, some of the other conditions necessary to hold together such a 'virtual health network' have been identified as shared vision and information, and a variety of regulatory and incentive systems, which are designed to reward organisational goal achievement or otherwise punish capture, incompetence and fraud^[5]. Meanwhile, given the current situation in most developing countries – weak economies, poor infrastructure, unstable political climate, lack of technological know-how etc – are the conditions necessary for creating such a virtual health network obtainable? While many of these features of under-development may appear as major obstacles to the emergence of virtual health systems in developing countries, they are counterbalanced by huge opportunities inherent in the emerging global political, economic, social and technological arena. These include 'globalisation' and its effects on health - the growing link between pandemics such as AIDS with economic development and global security – prompting the UN General Assembly on HIV/AIDS in June 2001 ; the advent of the 'network society' - where people have a strong desire to be connected to several other persons in a complex globalizing world; information and communication technologies (ICTs) revolution especially the prevalence of the internet and mobile telephones – making inter-personal interactions quite possible; and public policies in favour of collaboration between the public and private sectors (public/private partnerships - PPPs), which allow greater cooperation among various actors in health. On this basis, it is believed that developing countries can actually 'leap-frog' some of the development challenges that faced many advanced countries on their path of progress.

But for this to take place, the international community must be ready to support this innovative idea (virtual health networks) for improved coordination and collaboration of all actors in health, by re-aligning their activities towards enhanced 'global health outcomes'. This calls for renewing of international cooperation for health that is focused on the systems that deliver care through better synergy of efforts both at the national and global levels.

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3. Alcohol and NCDs: Need for evidence-based alcohol policies

One of the essential elements of a national strategy to reduce the burden of noncommunicable diseases is a key policy target to reduce population-wide alcohol consumption. That target should rely on evidence-based policies that can help to reduce the fallout from heavy drinking. Together with tobacco use, unhealthy diets and physical inactivity alcohol use make up a quartet of modifiable risk factors for an increasing burden of noncommunicable diseases (NCD). Together with the existing health challenges this creates a double burden of disease in many societies.

Alcohol constitutes a double-sided problem: On one hand drinking is a severe and additional burden to the poor and underprivileged. On the other hand we see new drinking habits and increasing consumption levels among a growing middle-class in many developing countries. Worldwide, 1.8 million deaths (3.2 percent of total) and a loss of 58.3 million (4 percent of total) of Disability Adjusted Life Years (DALYs) are attributable to alcohol use.

Unintentional injuries alone account for about one third of the 1.8 million deaths. The report from the Commission on Social Determinants of Health is accurately pointing out that a society without effective alcohol policies is likely to experience a sharp rise in alcohol problems during economic development (p. 135). The obvious owner of a national strategy is the state. Often the responsibility is placed in the Ministry of Health and/or Social Welfare. Developing or implementing evidence-based alcohol policies will need to involve several state actors, including law enforcement, the judiciary, and the Ministry of Finance. While the various companies of the international alcoholic drinks industry and their front organizations often portray themselves as partners in reducing harm, we would state along with the WHO Expert Committee that the contribution the alcohol industry can make to the reduction of alcohol-related harm is only in the context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion. (WHO Technical Report Series, Recommendation no. 9)

As for the other three NCD risk factors there is strong evidence of cost-effective interventions in the alcohol field. Taxation as a measure to influence the price of alcohol, limits on physical availability (for example age limits, restriction on hours and days of sale, outlet density etc.), and drink driving countermeasures are all proven effective. The research evidence on the impact of alcohol advertising, particularly on youth, has become much stronger in the past six years. Given this evidence base restriction on advertising is also a measure that should be considered. The policy option best practices are nicely laid out in Babor et. al. Alcohol: No Ordinary Commodity and the already mentioned report of the WHO Expert Committee.

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1. National strategies to assess healthy habits in the population

As other contributors were mentioning, there are many risk factors for non-communicable diseases, one of them is obesity. Unhealthy habits and physical inactivity are part of this result. To solve this, it is necessary to address an integrated and coordinated work in the government and the society.

- 1) Health sector: Should not only focus on healing and treating diseases but start offering preventive and healthy attitudes of the people towards health. People need to get educated on healthy habits in the primary health centers in their community by visiting doctors. Most of the medical staff are used to offering medicaments and treatments to sick patients at the health center but are not used to giving preventive measures to maintain healthy habits or to have those. Education and promotion of health are the most important for current needs in the community.
- 2) Government at all levels should increase its participation in the society by improving and offering new options to have healthy habits.
 - a. Increase the spaces to do exercise. Many developing countries have the largest cities in the world and completely forgot to coordinate cement and green areas. There is a reduced amount of green areas where people can exercise daily.
 - b. Municipalities think that providing a large amount of buses and taxis in downtown is progress while spaces for biking and walking inside downtown were practically eliminated for street vendors or parked cars. So, increase the path spaces to motivate back the people to walk and bike through downtown.
 - c. Tax more on unhealthy products and reduce tax in healthy daily products as milk, meat, vegetables or fruit. People in developing countries have to buy

water and is cheaper to buy coca-cola for example. Or, is cheaper to get junk food rather than any healthy food.

d. Municipalities have different nursery gardens to breed the plants they will use in the gardens of the city and sell to the population. They may be pushed to also produce vegetables there to make it easier available for the people in their zone.

e. Municipalities, together with schools and primary health centers should provide the children with better healthy habits as part of their main education. Children have a great influence on the family habits because they want to apply what they learn in school (Cordova K. (ed), 2008. Salud Comunitaria en Bolivia, chapter 3).

f. Municipalities should forbid candies, gas drinks or unhealthy products in the break of schools (at least the public schools).

g. Municipalities should increase the provision of cleaner water so that people start drinking water instead of gas drinks.

As we can see, there are many strategies that can be followed by the government and local communities to have better healthy habits. It would be impossible to think that health sector can do it alone or that the community itself could change their habits without the support of their government and a real change in the basic management of social health.

To achieve these objectives, it is important to coordinate work between initiatives of the government and other sectors to provide the society with the option to change their unhealthy habits for healthy ones. International cooperation should probably focus more on cooperating coordinated activities and not too isolated ones to achieve better results.

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2. Chronic diseases: Make our children a priority in society

Many of the chronic diseases have risk factors which begin in childhood or in the travails of childhood: risk factors such as smoking, obesity, hypertension, hypercholesterolemia, diabetes, allergies, physical inactivity and others. Work done by Vincent Felletti suggests that adverse childhood events (ACEs) if properly dealt with in early childhood, may help us to avoid or at least decrease the incidence of many chronic conditions. Adverse Childhood Events include physical, emotional or sexual abuse, physical or emotional neglect, loss of a parent (by divorce, death or abandonment), an addicted parent, a mentally ill parent, an incarcerated parent, or seeing your parent abused. Treating these conditions entails implementing many of the recommendations in the UN Social Determinants of Health document. It implies making our children a priority in society, and ensuring that children are protected, nourished, loved, educated, cherished,

stimulated, encouraged, and celebrated, not exploited, abused, ignored and left to fend for themselves. It means that our communities have to jointly care for the children in our midst, that no-one "owns" the children, that corporal punishment is never used against children, and that our societies put the most emphasis and resources into our children - and for them, into mothers and families. We could then avoid many scourges of today: fetal alcohol spectrum disorder, many addictions, many mental illnesses, much social dysfunction, much unemployment, and vastly decrease rates of violent crime, addiction, incarceration, and rates of cancer, COPD, CVD and others. Combined with a respect for the environment, which would also contribute to a healthy environment for children and workers, there is high likelihood of lower chronic disease rates within just a few years.

These ideas are reinforced by much of the neurodevelopmental science of the past decade whereby we have learned how very malleable and also vulnerable early childhood really is and what a wonderful opportunity we have if we actually invested in our children. But children don't vote so it won't happen unless we reset our societal and health priorities. This is the ultimate in preventive health policy but of necessity, it involves departments of health, education, environment, justice, community development and others. It requires a government-wide commitment to screen all new investments and policies through a child-supportive lens.

I know that many of you dealing with chronic diseases believe that this does not apply directly to your area, but without a broader view of health risks in society, chronic diseases will continue to grow in prevalence. And each of us working on our individual chronic disease or body part, will not make a healthier individual overall. If we want to prevent rather than just treat chronic diseases, we must start early and deal with the child as a whole.

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1. Mainstreaming Mental Health into MDGs and Humanitarian Responses

Following up Dr. Izutsu's important contribution, I would like to join him to call for mainstreaming mental health, psychological and emotional aspects into efforts to achieve global health, advance broader development and respond to humanitarian crises.

It is wonderful that UNFPA and WHO have started working together in this critically important area. As stated in a WHO-UNFPA meeting report on maternal mental health ([maternal mental health report](#)) and a UNFPA fact sheet ([UNFPA Fact Sheet](#)), mental health and psychological problems are closely related to achieving MDGs 4 and 5. These say:

1 in 3 to 1 in 5 women in developing countries have a significant mental health problem (such as depression) during pregnancy and after childbirth.

Suicide is a leading cause of pregnancy-related death in some countries.

Some of risk factors include poor socioeconomic status, less valued social/ender roles and status, unintended pregnancy especially among adolescents, and gender-based violence.

Link with MDG5: Maternal mental health problems are associated with increased maternal physical morbidity (more obstetric complications, preterm labor, and more pain, etc) and increased maternal mortality (including suicide).

Depressed women are less likely to seek and receive antenatal or postnatal care.

Link with MDG4: Maternal mental health problems are associated with lower infant birth weight, higher rates of malnutrition/stunting, diarrheal disease, infectious illness and hospital admission, reduced completion of immunization in children; also, associated with adverse effect on physical, cognitive, social, behavioral and emotional development of children.

These indicate that it is inevitable to integrate mental health into maternal and child health services and policies. As Dr. Izutsu mentioned, it is true not only to MDGs 4 and 5, but also for overall global health, and broader development and humanitarian response. For example, due to stigma, fear and the symptoms of AIDS, many persons living with HIV/AIDS (and other illnesses) suffer from depression and other mental health problems. Mental health problems (Which include drug dependence) can also make people more vulnerable to HIV infection and more likely to transmit HIV through possible increased risky behaviors. Mental health is an important factor for keeping adhesion to treatment regimens, too.

Screening can detect mental health problems. Medication and psychological interventions, most of them deliverable through primary health care services, can prevent and address these problems. Primary health care and health system should include mental health as a key component since mental health problems are both causes and consequences of physical problems and physical and mental health are closely inter-related to each other. Many patients come with both.

As we pay attention to human emotion when we have communication with individual persons, it is a "must" for all the development and humanitarian response programmes to pay good attention to, consider and integrate mental, psychological and emotional aspects of people on the ground. UN considers and integrates gender, cultural and other social perspectives in its programmes and policies. The next issue to integrate is mental, psychological and emotional aspects, I believe. Our well-being and quality of life owe a lot to mental health.

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2. Raising the priority of non-communicable diseases (NCDs) by valuing health: International agreement on methods of accounting for health

We need to establish clear and realistic measures of the cost of illness to society and hence the benefits of investments that improve health and reduce risks of non communicable diseases. Currently burden of disease studies show the impact of non communicable diseases and lifestyle risk factors but offer no accepted method for valuing the impact of a Disability Adjusted Life Year. Of course this is difficult, the value must reflect the long term impact on each level of society including family, community, employers and all public services. The measure should be specific to each society and economy and by showing the benefits to each sector should provide the basis for engaging all in reducing health risks. It should also provide a clear measure of the economic and social case for investing in improved health and clarify discussion of national priorities for health improvement. Where vertical global health partnership programs focus on specific health targets it should be possible to evaluate their economic and social impact and balance this against national health improvement targets.

Placing a value on health and setting such values alongside other economic investments raise difficult ethical questions but ignoring the value of health simply avoids the issue and means that health loses out. In the UK we are trying to build a consensus on methods for valuing the societal impact of illness and hence to value health prevention measures, it would be useful to build an international consensus on this issue.

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3. The impact of the global financial crisis on the MDGs and on health

The global financial crisis poses particular challenges for development goals and targets. It is widely assumed that its impacts on health, through increases in poverty and decreases in growth, will be felt first and most strongly in low-income countries least responsible for the crisis. A February, 2009 World Bank policy note, 'The Global Economic Crisis: Assessing Vulnerability with a Poverty Lens,'^[1] estimates that over 40% of developing countries are at high risk for rising poverty, and that the numbers living in extreme poverty would rise by almost 50 million in 2009, while the number of children needlessly dying would rise by 400, 000^[2]. Those estimates would magnify as the crisis deepens and persists. The World Bank, echoing the concerns of the World Health Organization, global civil society and many public health organizations worldwide, is calling on rich nations to increase their support to poorer countries through grants or low-interest loans.

Yet it is also increasingly expected that development assistance will stagnate and possibly decline due to the financial crisis. Much of the current aid discussion is focusing on improving its effectiveness and efficiency rather than its quantity^[3]. Effectiveness and efficiency are laudable

goals, as is the intent of the International Health Partnership H8 and bilateral donor country partners to implement the Paris Declaration on Aid Effectiveness through better health-aid harmonization (amongst donors and external agencies) and alignment (of donors to recipient country priorities). While many donor countries are re-affirming their earlier aid pledges, it remains to be seen if they will follow through; the G8, as one indication, are behind on their 2005 Gleneagles commitments^[4], and Italy, while claiming its commitment to reach the 0.7% GNI aid target, is cutting its aid levels next year. More importantly, if more than 5 trillion dollars can be committed to support the high consumption economies and failed banking systems of donor nations there is something morally repugnant in a lack of similarly ambitious commitments to assist those paying the highest price for the rich world's deregulated excesses.

Such an ambition is far from being unaffordable. The global financial architecture has allowed the persistence, if not expansion of low-tax/no-tax offshore financial centers, variously estimated to hold between \$8 and \$11.5 trillion in untaxed wealth. A nominal tax on growth alone would raise at least \$160 billion a year. The persistence of such centers, and the capital flight they encourage, cost developing countries between \$40 and \$50 billion in lost tax revenues annually^[5]. Yet little action has yet been spurred to ensure transparency in the financial dealings of such centers with the November G20 meeting on the global financial crisis stopping short of advocating for their regulation. A currency transaction tax, long a source of civil society advocacy and occasional intergovernmental conversation, could raise between \$33 and \$60 billion a year at a rate that would have no dampening effect on market transactions^[6]. Such a tax is not being mooted to finance bank bail-outs or IMF coffers; why not global aid transfers, building on the UNITAID model? If we accept that economies have become inherently global, and so a high-income world financial crisis is toppling the health capacities of low-income nations, should not the mitigating, countercyclical policies be similarly financed through global taxation schemes?

Finally, there is the matter of trade and tariffs. A large number of low-income countries still rely on tariffs for 20% to 40% of their overall general revenue. They remain under pressure of loan conditionality or World Trade Organization negotiations to lock-in and progressively lower such tariffs. The economic theory is that resulting growth would allow a broader base of taxable sources to replace, if not expand, the lost tariffs revenue. But empirically, this has not been the case for the majority of low-income, and even many middle-income, countries whose tariffs were reduced consequent to structural adjustment programs^[7]. That is one reason why the WHO Commission on Social Determinants of Health, following on from the evidence provided by the knowledge network on globalization which I chaired, recommended that no such reductions be undertaken or demanded in negotiations unless and until low- and middle-income countries have been provided sufficient assistance to develop institutionally adequate and transparent systems of public revenue generation. Otherwise the market gains for high-income countries (or for other low- and middle-income countries) arising from easier access into low-income country markets would likely be paid for by reduced health and welfare access by the poorest citizens of those countries.

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4. The United Nations Decade for a Healthy World, 2011-2020: Global Mobilization, Civil Society Action, Individual Participation, and National Implementation

A United Nations Decade for a Healthy World, 2011-2020, is proposed to the 2009 UN Economic and Social Council (ECOSOC) as an innovative framework to mobilize public opinion and strengthen the collective commitment of all nations to the health of their peoples as a first priority. The UN Decade, 2011-2020, would be a catalytic worldwide call for "Health" (in its broadest definition) to become the global common cause and shared responsibility of all humanity. By developing such a universal action plan to build consensus about the goals for our common future, the UN could then implement a program that would enlist and involve 7 billion individuals ("We the peoples of the United Nations") in working together for a healthy world.

In the *World Health Report, 2008*, "Health is no longer seen as being limited to survival and disease control but as one of the key capabilities people and societies value." This wider concept of "Health" could become a rallying point for all levels of society to work together for the common good.

The WHO Commission on the Sustainable Determinants of Health has recently called for "governments, civil society, WHO, and other global organizations [to] come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it."

The *United Nations Decade for a Healthy World, 2011-2020* is a proactive global opportunity available to us (now) at just this "right time." The Decade will need a framework enabling all sectors and all levels of humanity to join in a comprehensive strategy of sustained and meaningful activities, including:

Global Mobilization for public awareness of the relevant, complex and essential issues involved.

Opportunity for cohesive Civil Society Action (across sectors) to strengthen and reinforce all their extensive global efforts.

Unprecedented opportunity for Individual Participation, a significant long-term agenda for many millions of concerned citizens, to become actively involved in achieving a "Healthy World."

Worldwide expectation for National Implementation (by all UN Member States) to make health a top priority (within national policies and laws) for their citizens and for all humanity.

First, this ***United Nations Decade for a Healthy World, 2011-2020*** can become an innovative framework to incorporate global health partnerships and collaborative arrangements to improve performance, reduce transaction costs and increase synergy of action aligned to country priorities.

Second, this *UN Decade, 2011-2020*, can actively involve everyone contributing to the “healthcare” sector.” This can include highlighting activities addressing the growing magnitude of non-communicable diseases (such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their modifiable risk factors (such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol). This *Decade* can thus raise the priority which needs to be accorded to non-communicable diseases in development work at global and national levels.

Third, the *UN Decade, 2011-2020*, can encourage and strengthen all needed activities to support birthing, healing, recovery from injury, the treatment of all infectious diseases (including HIV / AIDS) and bringing compassion and support to the dying. The *UN Decade for a Healthy World, 2011-2020* can encompass innovations which strive for greater coordination and collaboration between all actors in health. At the same time, this *Decade* can be a focused framework where the roles different stakeholders play are better defined (including through collaborative inter-sectoral efforts) towards the achievement of public health goals.

Fourth, an encompassing agenda for the *UN Decade, 2011-2020*, would establish significant links connecting “Health” with its critical social determinants including social justice, education, peace from violence and trauma, as well as all environmental considerations. Mandates to achieve economic, social and cultural development (through democratic governance structures empowering civil society initiatives and innovation) would also be enabled.

Fifth, the *UN Decade, 2011-2020*, can encompass all sectors besides the health sector. It can be a global arena (where all stakeholders are involved cohesively around a comprehensive theme) in designing and implementing relevant strategies to influence the well-being of people across the human lifespan. The *UN Decade for a Healthy World, 2011-2020* can include everyone working to bring the following:

- human rights, gender, childhood and elderly equity
- national, provincial, state and municipal governance
- ethical, sustainable commerce and economics, banking and financial prosperity
- human security based on justice and transparency

- faith-based and ecumenical activities arising from all spiritual traditions
- re-emerging indigenous culture, knowledge and wisdom, traditional healing practices
- international, national, regional, community and citizen diplomacy and relationships

- “green” technologies and employment
- non-toxic, non-polluting environments
- sustainable-energy supply, recycling, land use, renewable resources and mining
- nutrition, bio-culturally-sensitive food supply and security, including indigenous herbal remedies, clean water and sanitation engineering
- natural and wildlife ecosystems

rural and urban planning, architecture and landscape and interior design
tourism and transportation

early-childhood, primary, secondary, pre-post graduate education
vocational and human development, including lifelong learning
nutrition, sustainable agriculture, fishing and food production
safe, equitable, productive workplaces, homes and communities

information, communications and entertainment technology
multi-media including journalism, broadcasting, filmmaking, advertising, public
relations, print and online publishing, internet development
music, art, theatre, dance, heritage, history and culture.

And, sixth, the ***United Nations Decade for a Healthy World, 2011-2020***, provides a global opportunity to swell the ranks of civil society (beyond the millions of people active now) to proactively involve hundreds of millions of concerned citizens, across the earth. Active participants in the ***UN Decade for a Healthy World, 2011-2020***, can include:

youths who are seeking global relevance in their activities
retirees (from all the above sectors) with experience and wisdom to contribute

everyone working to strengthen the trans-disciplinary principles of the Earth Charter
everyone working on the achievement of the United Nations Millennium Development Goals
all stakeholders who see their own health, the health of their families and communities as a priority in their lives.

Dr. Margaret Chan, World Health Organization Director General, sees “health as the driver” of all sustainable development, including economic, social and cultural advances. She notes that humanity’s health can no longer be addressed by Health Ministers alone. “They need help” from all government Ministers, including from Finance Ministers, and from all sectors of society. In the wake of the global financial crisis, proactive investment in “Health” must now be seen as the strategic investment in overall human progress. As Dr. Chan has observed, if Health is seen as the key driver of all economic and social advances, this change in the way we appreciate Health's significance can maintain and enhance the favorable policy and resource trends for global health that have been established in the recent past.

United Nations Secretary General Ban Ki-Moon recently said, “I am determined to push... global health as one of my key priorities... not only because global health is an enormous challenge, but because we can do something about it. New actors and resources are pouring into the global health space as never before...But this won't amount to much if we don't ensure coherent and decisive action.”

To have healthy peoples on a global scale involves teamwork worldwide. This requires developing many interlinked factors of individual and community well-being such as equity, justice, collaboration, understanding, appreciation and respect. As a universal plan of action, the ***United Nations Decade for a Healthy World, 2011-2020*** will establish a framework for all

sectors of society and all levels of humanity to cooperate, worldwide, in common concern and shared commitment.

UNICEF's *State of the World's Children 2009* has noted that "in parallel with the 2008 G8 Summit, a G8 Health Experts Group was established.... pledging to take comprehensive action to address the health-related Millennium Development Goals [MDGs].... emphasizing the need for a longer-term perspective that extends beyond the 2015 MDG deadline, and the imperative of mobilizing a wide range of stakeholders."

The *United Nations Decade for a Healthy World, 2011-2020* would strengthen this pledge and answer this longer-term need. This proactive program for 2011 to 2020 would provide the world community with a sustained opportunity to reshape and reform global systems around the life-affirming ideals held in common by all societies, regardless of creed or culture.

Just imagine a world without needless suffering and sickness, where everyone seeks to be healthy, to contribute creatively to society and with active concern for the health of others. What a dynamic world it would be if our own good health and the health of others become the first priority for each of us and for our communities and our nations. This could happen in a decade—the *United Nations Decade for a Healthy World, 2011-2020*.

Respectfully submitted on behalf of more than 19,000 individual "nurses and concerned citizens" from 87 UN Member States, including many leaders who represent organizations with millions of constituents worldwide

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5. The critical need for multi-sectoral attention and collaboration on non-communicable diseases (NCDs)

It appears certain that we are about to repeat our mistakes of the past (e.g., HIV) by not taking strong multi-sectoral action now to address the growing non-communicable disease epidemics worldwide.

As pointed out by WHO and others, the human and economic costs of chronic diseases are staggering. Because low and middle income countries are and will be more affected than the wealthier nations, NCDs will become a major factor in increasing the "wealth divide". NCDs will move families into poverty and make it even more difficult for countries to achieve their MDGs. What are the reasons for the delay in action? Why (knowing that we have many affordable tools for primary and secondary prevention) are we still not acting forcefully to contain this threat to health and well-being?

As a Swiss NGO, Partnerships in Health has been committed to chronic disease prevention and care. Over several years now, we have sent out many requests for funding, have attempted to

build partnerships, and are actively promoting the involvement of NGOs in this topic here in Switzerland and in our partner countries.

From potential donors, we have encountered little more than mild acknowledgement, “yes, maybe it is important, but...” Just like during the initial years of the HIV epidemic, those affected are not so “worthy”. When looking at the issues superficially, it appears as though the “victims” of NCDs are to blame; that it is the problem of an individual, and not of critical importance to public and global health. However, when analyzing the situation in more depth, it becomes clear that we are all affected, and that we are paying through increased health care costs, loss of productivity, opportunity costs, and family or personal illness and death.

Are the victims really to blame? New evidence already implicates processes of “maternal-to-child-transmission” of diabetes related to excessive weight gain during pregnancy. And preceding that, there is the unique genetic makeup that makes some people gain weight more easily or support alcohol only in small quantities. What makes cigarette or food addiction different from being addicted to hard drugs? And how can children and adults choose healthier foods without access to such foods or without positive role models in environments that advertise healthy choices?

Solutions require joint efforts to create health-promoting environments, involving WHO and other international agencies, the public and private sector, the for- and not-for-profits, donors and implementing agencies, academia and media. We must stop missing opportunities and start to:

- Broadly share the accumulated knowledge-base on modifiable risks factors and successful strategies and pilot approaches

- Learn from past delays in addressing HIV and the resulting human and financial costs

- Gain a better understanding of the successful advocacy efforts that overcame the strong discrimination against those infected with HIV and resulted in a move forward in prevention, treatment and care

- Advocate and support the elaboration of supportive legislation and policies

- Build and strengthen health systems to meet the health needs of the populations they serve in a comprehensive rather than focus on a selective group of diseases

- Look for successful approaches elsewhere and see how they can be adapted to NCDs

- Forge new partnerships at the community, national, regional and global level and focus on identifying win-win situations for the agencies involved

- Utilize the many opportunities to integrate chronic disease prevention education into existing programs of governments, civil societies, and businesses. Examples include:

- Prenatal care and breastfeeding promotion
- Early, primary, and secondary education
- Health services delivery
- Adult literacy
- Education of micro-entrepreneurs
- Workplace policies and health promotion
- Urban/community planning
- Media
- Special interest groups (women, political groups and so on)

- Highlight and share regionally and globally successful examples of the integration of chronic disease prevention, treatment, and care efforts into ongoing activities

In May 2008, the World Health Assembly passed resolution WHA61.14, endorsing ***The Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases***¹. The **WHO 2008 -2013 Action Plan for the Global Strategy for the Prevention and Control on Non-Communicable Diseases** provides guidance and asks for results. We now urgently need champions and donors that come forward and work with willing agencies to contain and prevent NCDs and create healthier and stronger societies.

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[1] <http://siteresources.worldbank.org/NEWS/Resources/WBGVulnerableCountriesBrief.pdf>

[2] World Bank wants G7 to address rising poverty in crisis, *The Age*, February 13, 2009; [here](#)

[3] IHP+ Ministerial Communiqué February 2009 [here](#)

[4] [DATA REPORT 2008](#)

[5] See Labonté et al, *Towards health-equitable globalisation: Rights, regulation and redistribution*. Final Report of the Globalization Knowledge Network, World Health Organization Commission on Social Determinants of Health, 2008. Available online:

<http://www.globalhealthequity.ca/electronic%20library/GKN%20Final%20Jan%208%202008.pdf>

[6] The Currency Transfer Tax, A presentation by David Hillman of Stamp Out Poverty at the UN Financing for Development Conference - Doha, Qatar, 29 November 2008 - at the side event: Innovative Financing to serve development: from Monterrey to Doha towards a scaling up; [click here](#)

[7] See Labonté et al, *Towards health-equitable globalisation: Rights, regulation and redistribution*. Final Report of the Globalization Knowledge Network, World Health Organization Commission on Social Determinants of Health, 2008. Available online:

<http://www.globalhealthequity.ca/electronic%20library/GKN%20Final%20Jan%208%202008.pdf>

Dated: February 23, 2009 – Vol. 5

1. Essential elements of national strategies to improve people's health

Education

I think that educating the masses on preventative measures is one of the most effective ways of addressing this issue. In my country Kenya, when the President declared AIDS a national issue and enough resources were directed towards educating people even in the most remote areas, a marked change has been felt, the spread of the disease stalled

and more and more people have come to realize how detrimental some of their practices could be (e.g. wife inheritance and lack of circumcision in some communities). This same strategy of educating on proper diet, physical activity etc can be very effective in helping people from the grassroots up understand and change their behavior accordingly.

Good health policies

Health policies that consider the regular individuals rather than some big companies that are out to sell products that may be detrimental to people's health. We know that governments need money to fulfill their goals, but the cost of these diseases in terms of human, monetary, and medical resources is much greater than the money given by some of those big firms. Enforcing those policies is also very essential because there's no need to, for example, ban smoking in public without enforcing that ban for the good of the citizenry.

P. Karue (a private citizen)

2. National strategies to assess healthy habits in the population

Qs: What are the essential elements of national strategies to address the growing magnitude of non-communicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) and social determinants? What sectors besides the health sector must be involved in designing and implementing the strategies? How can we raise the priority accorded to non-communicable diseases in development work at global and national level?

I have been monitoring the responses related to the essential elements of national strategies to address the growing magnitude of non-communicable diseases and their modifiable risk factors. I am not in the medical field but have been involved in a unique partnership with the BC Children's Hospital in Vancouver. I am an elementary school teacher that was asked to work with a "medical team" comprised of pediatric endocrinologist, a psychologist, an eating behavior specialist, an assessment coordinator and two educators.

8 years ago we set out to test the question, *Can children teaching children have a measurable impact on their health?* The intervention was indeed a success and has been published in *Pediatrics*, the journal of the American Academy of Pediatrics (<http://pediatrics.aappublications.org/cgi/content/abstract/120/4/e1059>). The focus was on non-communicable health issues and modeled, what I strongly believe, was an effective and empowering partnership: a true collaboration of health and education sectors.

On the basis of the initial study our Provincial Health Authority awarded us a grant to publish and disseminate the Healthy Buddies program (<http://www.healthybuddies.ca/>) to selected schools in British Columbia. The impact of our program was further tested on this larger scale. To date, the preliminary data appears to confirm our earlier findings that early intervention, in a

school setting, (designed for all children based on a buddy teaching model) has a significant impact on students' health.

As the intervention was designed with input from educators, it was structured to meet the needs of the students and teachers. A children's book illustrator created engaging graphics and the materials were prepared with the intention of meeting the curriculum. This was not an add-on. The topics addressed in the three program themes (activity, nutrition and mental health) are common to most areas of the world.

In September 2007 we were invited to present Healthy Buddies in Damascus, Syria at the W.H.O, the first Regional Conference on Health Promoting Schools in the Eastern Mediterranean Region. The focus was on "Partnership for Health, Education Achievements and Human Development". The intention at the time was to explore options for adapting and translating the program into Arabic. This reinforced our belief that a partnership, either locally or globally (one between health and education) can truly reach children at a time when lifelong health behaviors are beginning to form.

"Healthy Buddies" is now being used in 4 provinces in Canada and is available for any jurisdiction on a cost-recovery basis. The investment has been made in British Columbia and our hope is that we can form new partnerships around the world with the common goal of addressing children's health. I believe what we have to offer is an innovative framework based on an empowering relationship between health and education authorities.

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3. Making health a top priority: Commitment from all of us is needed to convince the rest of us

What is missing from this debate so far that is essential to achieving a healthy world? Nowhere is there a document addressing the problem represented by those political leaders and billions of ordinary citizens who consider priorities other than health as being more important, except perhaps, when their own health deteriorates.

Those millions who work in the health field may consider health as the most important social goal for themselves, their community and their nation. But they are a minority and not always a persuasive minority. Because they are so preoccupied with the health problems confronting them, they are not spending time convincing the vast majority of the world's policy-makers and opinion-molders that health should be the first common cause of humanity. Nurses, doctors, other health workers and ordinary citizens concerned with health have yet to persuade others — who are not concerned with and committed to health — that they should be.

The UN General Assembly, in 1969, adopted a Resolution (the first to be unanimous in 20 years) calling for "Mobilization of Public Opinion for Economic and Social Development." This Resolution led to collaborative action by the UN family of Agencies and Programmes (joining with government information leaders of UN Member States and communication strategists of business and civil society) to promote the goal of universal economic and social development to be accepted throughout the world community. In the subsequent year, the UN General Assembly declared a "Development Decade" and launched a worldwide multi-faceted effort to raise the level of human prosperity everywhere.

These strategic approaches are needed again now for the subject of health. WHO's Director General, Dr. Margaret Chan — while leading the global actions of all those devoted to improving health conditions in the world — is also calling for health to be the priority of everyone else, including leaders of government and every citizen who has a vote and a voice and who is able to speak up for the health of the world.

So, where do we go now? Do we need a Resolution for adoption by the UN/GA 2009, launching a campaign in 2010 that will mobilize public opinion worldwide in support of health as the priority goal of every Member State? Yes, such a Resolution well-implemented could bring about a unity of purpose and campaign to convince non-believers that health should be humanity's first priority. Without a worldwide public campaign to persuade those who have priorities other than the health of their family and community, the world health sector will continue to be underfunded, understaffed, undervalued and unable to achieve the needed goals.

Declaring and effectively implementing **a UN Decade for a Healthy World, from 2011 to 2020**, could advance our present slow progress in helping millions of people to become stronger, healthier citizens. But, such a **Decade** would fail to reach the billions of people who need to be involved in the improvement of health in their own communities and nations, unless those now committed actively convince and persuade those who do not yet treat health as a personal priority of their heart and mind.

The Nightingale Initiative for Global Health (NIGH) seeks to inform and involve nurses and other health workers in celebrating 2010 as the International Year of the Nurse. They intend it as a global celebration of commitment to launch the **UN Decade for a Healthy World, 2011-2020** (See: www.NightingaleDeclaration.net).

Nurses are the backbone of global health, and more than 15 million of them working wherever there is suffering in today's world. They are busy, dedicated people. Their caring talents are respected and legendary. Until now, their time and talents for public persuasion have not been so strongly focused.

Nurses, other health workers and those convinced that health should be humanity's new first priority are actively seeking to persuade the United Nations ECOSOC and General Assembly to debate, decide, adopt and implement a program of action to raise public awareness and mobilize opinion to achieve a healthy world. This is paving the road for the adoption of a "**UN Decade for a Healthy World, 2011-2020**," including a World Summit for Global Health producing a universal action plan to improve the health of all citizens, further enlisting everyone's positive contributions to the global community on the road to 2020.

So, "yes!" we need an International Year of the Nurse in 2010 to help nurses bring humanity's most serious health problems to the attention of the global community. These then can be addressed by the united actions of UN Member States and resolved in the ensuing Decade for a Healthy World. However, the nurses of the world should not be left alone to this task, although they are accustomed to lonely vigils. All persons who see the need can also do the deed and work to persuade the whole world that health is both a global responsibility and the responsibility of every citizen.

A UN Resolution to Mobilize Public Opinion for Universal Human Health is now needed and so is the UN General Assembly's endorsement of the International Year of the Nurse in 2010 to be the launching pad for a UN Decade for a Healthy World, 2011-2020. But (unless it is a decade that impinges on the conscience and actions of every citizen in the global community) raising consciousness, increasing awareness, releasing resources and mobilizing personal commitment to a healthy world — it will fail to deliver the maximum needed and many will die who could otherwise have made the earth a better place.

With the upcoming session of the 2009 UN ECOSOC, now is the time to put these steps in place: Recommend a ***UNGA Resolution to Mobilize Public Opinion for Universal Health, Endorse and Participate in a UN International Year of the Nurse, 2010***, and ***Adopt and Implement a UN Decade for a Healthy World, 2011-2020***.

Kind regards,

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4. Integration of mental health promotion in education programmes

Before considering what needs to be done about the growing burden of non-communicable diseases when the world is facing a grave economic crisis, we should endeavor to learn from the past and set our priorities right socially, economically and politically.

The new/current economic order has stressed upon economic gains at national, regional and international level thereby undermining health/well being. Nations flourished economically while the population's health and well being remained much like the fringe benefits. Had health/ well being of people been the core concern of any social, economic or political agenda things would have been different. So at the macro level — international, regional and national; there is dire need to **put people's health and well-being first**. Environmental scientists will also

agree to this idea since the economic development in the past years has posed great challenges to the sustainability of environment and human race.

On the other hand, things also need to change at the micro/individual level. Individuals have problems-within and outside, but only those who can overcome setbacks and cope with internal and external threats. By coping I do not mean learning to live with what we have – coping in effect is a way of dealing with challenges. I agree with contributors who mentioned the need for mainstreaming mental health and would like to add that in the current circumstances **promoting mental health would be the key to achieve overall wellbeing in individuals**. I would like to stress upon the integration of mental health promotion strategies in schools and other educational program so that our education system produces healthy individuals who can contribute to other's wellbeing not mere financial outcomes. I see mental well being not merely as state for adhering to medical treatment or avoiding suicide and substance abuse but also as a concrete base for physical, emotional and social health as it may change health seeking behaviors, social interactions and ethical considerations.

This may seem like a theoretical and idealistic vision but this is where I see principles of mental well being, empowerment and leadership coming together. If education systems can groom emotionally intelligent individuals capable of coping intelligently with internal and external challenges then the outcome will be a race of empowered people who have self-control and compassion, the more compassionate of this race will take up the task of leadership and empower others.

Regards,
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The Aga Khan University
Karachi-Pakistan

5. Chronic diseases: Need a broader view of health risks in society and make our children a priority in society

As already mentioned by Dr. Ruth Collins-Nakai «many of the chronic diseases have risk factors which begin in childhood or in the travails of childhood.»

Over the past three decades science and prenatal and perinatal psychology have shown the long term effects of the **prenatal period** on the health as well as emotional and mental well being and creative potential of each individual.

It is during this vital prenatal period (very early childhood) that the foundations of physical, emotional and mental health are established. During this time the child develops the basis of his/her health, emotional sensitivity, as well as intelligence, brain development, and the creative capacities as well as the ability to relate to others and the environment.

By educating and informing future parents we are offering them the chance to participate consciously in giving the very best materials so that the child may thereby optimise the genetic capital he/she receives from the parents.

Health and vitality of the preborn are favoured by the mother eating a healthy varied diet, deep breathing, and sufficient rest and exercise, whilst avoiding or greatly diminishing things like, alcohol, smoke, drugs, chemical toxins, stress, violence, dehydration... all these are known to have long term effects on the individual throughout life.

The development of the pre-born child's senses, for example the taste for beauty are awoken by the stimulus received when the mother herself nourishes herself with beautiful sounds, images, forms, colours, artistic creations and nature itself.

The sound emotional development is largely influenced by what the child lives through her mother's emotional states transmitted through hormones which traverse the placenta reaching the prenatal child and amplifying the state. If the mother avoids prolonging negative (fear and stress) or other painful emotional states whilst encouraging positive harmonious emotions and happiness, the child will receive the happy disposition and acquire «a taste» for happiness. The mother should favour the internal secretion of «love» hormones such as endorphins and oxytocin which are antagonistic with «stress hormones» such as catecholamins and adrenaline. These latter send vital energy to the limbs (fight or flight) leaving less energy available for the healthy overall development of the pre-born. Whilst the mother is secreting «stress hormones» the body naturally lowers the immune response, digestion and absorption are impaired as well as the growth and repair of the cells.

Every easy, natural and free methods of «endorphin release» should be taught to every family as an effective stress management programme.

When parents communicate their love to the unborn child it creates a loving relationship and awakens in the child his/her own capacities to love. This sets the basis of self confidence, confidence in others and in life itself.

The beliefs held about life, the desires and fears that the parents, especially the mother, hold in her mind and emotions as well as creative imagination impact the child's development and therefore their entire life.

It is vital to inform, encourage, empower and support a shift in the general awareness of this fundamental process, in keeping with actual scientific discoveries, and make this the basis of health empowerment, as opposed to fighting disease. The implications on all sectors of society are immense. Far more economical, will considerably lower the rate of violence and greed as people will be born feeling safe and nurtured and will naturally seek out the strong hormones of well being that they will have been bathed in in-utero.

This approach is fundamentally a «preventive approach» and would involve all stake holders and sectors of society.

The United Nations Decade for a Healthy World, 2011-2020:

Yes, an excellent idea I would word it slightly differently: **The UN Decade of Health and Wellness for All**. This unites the factors of emotional and mental health which are an integral, and inseparable, factor to overall health.

I look forward to increased collaboration with ECOSOC and with the NGO's who have submitted proposals as we have many common insights and approaches.

Julie Gerland

Chief Administrative Officer

OMAEP Organisation Mondiale des Associations pour l'Education Périnatale (World Association for Prenatal Education Associations)

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Dated: February 25, 2009 – Vol. 6

1. Combating non-communicable diseases: The Danish Heart Foundation and its project in Kenya

Thank you for the invitation to join this extremely relevant debate about emerging and future health challenges. I have some suggestions and remarks to the questions in item 3:

What sectors besides the health sector must be involved in designing and implementing the strategies?

How can we raise the priority according to non-communicable diseases in development work at global and national level?

My background for joining the debate is that I am the CEO at the Danish Heart Foundation (DHF) which is a NGO aiming at prevention of CVD, patient support and improvement of treatment through a comprehensive support to research. DHF has more than 100.000 members and an active network of volunteers counting more than 1000 people in Denmark.

The Danish Heart Foundation has been closely involved in combating cardiovascular diseases in developing world as an active player under the World Heart Federation's Twinning programme. The DHF has for the last 4 years supported the development of a heart foundation in Kenya. Focus in the initial phase has been on combating rheumatic heart disease in the Nairobi Eastlands slum area. Our work in this project has given us a lot of experiences in and positions on how to meet the future health challenges. This is what I want to share with you.

Briefly about the African project: With financial support from Danidas Small Project Fund and the Danish Heart Foundation, we have had success in building up the heart foundations capacity as a volunteer organisation and in developing a successful model for combating heart disease in urban slum. The project has an educational and a popular approach built on groups of volunteers.

With support from school authorities in Nairobi, the subject, prevention of rheumatic heart disease, has been integrated into the curricula of the public schools in the Eastlands. It has been supported by a training programme for headmasters and teachers conducted by Kenyan Heart

National Foundation who also has developed a booklet, posters and a system of talking walls inside the schools.

The headmasters and teachers, who have been trained, have formed a group of volunteers as part of the member structure in Kenyan Heart National Foundation (KHNF) so that they, as a part of this NGO, can participate in further development of the programme. In the schools, groups of children have been organised in heart groups, who are also a part of the KHNF structure.

The Children's Heart Groups keep attention to the subject so that the students both learn about it from the teachers and from their peers. The Children's Heart Groups are very creative in developing means of education. They make theatre plays, songs like rap songs, posters and many other things in order to teach their peers how to avoid the disease. In addition to that, they also collect money for treatment of children who are sick, as an act of solidarity. Clinic staff is of course also trained so that they can give the right preventive medication.

Apart from focussing on primary schools, the project also has a strong popular approach and during the last 2 years we have succeeded in establishing about 8 local committees (with 5 -10 members in each) in the slum. They work actively to inform the public about prevention of the disease and they play an important role in advocating local authorities about the importance of prevention.

Thanks to these local committees there has been a remarkably raised awareness about rheumatic heart disease in the area, and they have initiated to create a patients club with a focus on patient support and secondary prevention. Also, faith-related organisations have been involved in the project and have received education from KHNF.

An external evaluation dated back to 15 November 2008 has been conducted by Professor B. Mayosi (South Africa) and Doctor F. Bukachi (Kenya). In their conclusions and recommendations, they point out the following:

1. This is a unique and leading project on RHD prevention without parallel comparison in the country, and perhaps in the East African region.
2. Significant achievements have been made in sensitising school teachers and children on all aspects of RHD prevention.
3. Healthcare providers will benefit more from continued workplace support in the form of regular follow-up through peer group seminars.
4. The growing community support for the project from parents, local administrators, faith leaders and volunteers is important and also a sign of great promise of the project, which needs continued support for long-term sustainability.

With reference to above project, I will stress that it is essential to integrate the following sectors in our future efforts to combat cardiovascular diseases:

- **Educational system**

Education (primary schools, secondary schools, vocational schools and universities) is an essential sector to integrate in the prevention of NCDs. Prevention of NCDs should be integrated in schools curricula, teachers must be trained, and training materials should be developed and

made available for all. The students should be included as active players and there must be support for their activities.

- **Civil Society**

Another crucial partner in combating NCDs is the civil society. NGOs and their volunteers have played a leading role over the years in the prevention of cardiovascular diseases in Denmark as well as in other European countries. Our project in Kenya has confirmed that there are huge resources in civil society and that civil society can contribute to a popular approach, which represents opportunities that can not be found anywhere else.

- **Funding**

It is a major problem that combating NCDs (especially in low and middle income countries) lacks both international and national attention and that it is extremely under-funded. There is no special funding for the prevention and treatment of NCDs like for AIDS/HIV, malaria, tuberculosis and so on and there is very little political attention to these diseases. International and national aid agencies should use burden-of-disease indicators as one metric for allocating resources so that they can address the conditions that have the greatest economic and social impact on low-income countries.

Besides this, an approach built on research and optimized healthcare sector is also important to achieve successful prevention of diseases such as non-communicable diseases. The condition of health care has changed over the last years. Diseases which formerly were connected to our part of the world are now emerging tremendously in the poor countries. New equipment for diagnosing and medical care has to be adapted to the needs in these countries.

So, I have no doubt in my mind that prevention and treatment of non-communicable diseases need to be mandatory in all relevant policies in order to develop a new common NCD-prevention strategy adjusted to the needs and based on the networks already established in the individual countries. Sustainable interventions are the only ways to combat the biggest killer in the world, namely, cardiovascular diseases.

Best regards,

Susanne Volqvartz

CEO, Danish Heart Foundation

2. Improving health care: the importance of education, inclusive policy and computer information technology (CIT)

Education, comprehensible inclusive policy and its implementation are the most important elements. Accountability and transparency are the keys to success.

Healthcare has two phases: prevention and treatment. Prevention is more important than treatment. Healthy diet and physical activity are two key elements for diseases prevention, especially cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Legumes such as beans and peas can lower the risk of heart disease and type 2 diabetes. Physical activity

plays a very important role in keeping human body healthy. Environmental health, mental health and social activity also contribute to the quality of life. Educate people about nutrition and healthcare. Tell low-income people to eat legumes and nuts instead, if they can not afford meat. Teach them about clean water and proper hygiene to prevent infection.

Governments need to set up a good Health Care system. A working system requires the involvement of all sectors. People are more willing to cooperate if they are involved in system setup. It is a system for all people and it requires the involvement of all sectors. Government officials, healthcare practitioners, nutritionists, information technology (IT) specialists, philanthropic foundations, insurance specialists, private sectors, citizen representatives, religion group, international NGO are to be involved. The key tasks are:

- 1) **Build a good IT system:** The database is so perfect that there is no duplicated data entry required: It cuts down patients' waiting time, it gives doctors more information about patients, and it requires less clerks.
- 2) **Build a service credit system:** In this global financial crisis, a lot of people lose job. After proper training, they can help take care of patients and build service credit for their future service required.
- 3) **Build good volunteering system:** Give incentive to attract volunteers.
- 4) Give responsibility and enforce accountability. Implement the policies and don't abuse the financial aids. NGOs can use their expertise to input ideas in policy-making and oversee the policies implementation.
- 5) Use IT system for global information exchange.

Encourage people with awards and discourage them with higher price or punishment through the following:

1. Pay school tuition for doctors and nurses for the exchange of service years in rural areas after graduation.
2. High sale tax on tobacco and alcohol to discourage consumption. Impose regulation of higher medical fee for smoker and alcohol abuser.
3. Punish the environment hazard polluters and require them to take the responsibility.

Shiuho Lin
Gray Panthers

Dated: February 27, 2009 – Vol. 7

1. Mental health provision: The important role of telemedicine

I have been reading the suggestions in the phase II of your discussions. Much emphasis has been placed on how **mental health** needs can be taken care of. As already mentioned in our previous document (Feb 9-14 Telemedicine: Serving for rural areas), we believe Telemedicine can be a great cost saver and provide relief to many persons in Rural areas who find the cost of travel and access to the healthcare practitioner a major impediment.

We would like to add here that **Mental Health Provision** is specially suited for such an online and distant provision wherein very few psychiatrists, counselors as well as other therapists can serve a large number of areas and repeatedly.

We did it very successfully during the Tsunami (see www.sathi.org/healingtouch.pdf). More importantly, the caring organization SCARF (see www.scarfonline.org) has been continuing this online Mental Health Support project on its own accord although the mandate (of treating the Tsunami survivors) had already been achieved. It even extended the same methodology to fresh areas.

Recent advances in Broadband and now 3G means that more and more persons in rural areas have access to technology, and telecommunication facilities like video conferencing can create an immediate connection to therapists. Yes it is possible, far cheaper than arranging therapists for every village or town. The same methodology can be extended to tertiary care provision for the disabled, spastics and autistics, etc by providing training and support to the immediate care givers like parents.

We from SATHI are very willing to share this experience along with our technological and implementation expertise worldwide, especially the under-developed countries.

Regards,

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2. Growing cancer crisis in developing countries: 12 steps to take in order to help developing countries control cancer

Dear Dr. Alwan and Mr. Ross: You invited recommendations as to which aspects of NCDs we think require the most attention, and arguments that address the trade-off between NCD policies and other priorities of national health systems. At their meeting in June, the Ministers must (finally) address the growing cancer crisis in developing countries.

WHO data shows that 7.9 million people die from cancer every year and that 72% (5.7 million) of those cancer deaths occur not in the high income countries but in the low and middle income countries where cancer is now killing more people than malaria, TB and HIV/AIDS combined. This is largely because (despite the relatively low cancer incidence compared to the high income countries) cancer patients in developing countries face the same barriers and obstacles that confront other patients with NCDs: poverty; public and professional ignorance; poor access to treatment facilities; and the overall lack of an adequate healthcare infrastructure.

As a result, 80% of cancer patients present with cancers that are too far advanced (Stage III/Stage IV) to be curable and are usually sent home without any palliative care. Children are particularly vulnerable. In some countries, pediatric cancer survival is lower than 20% compared with more than 70% in Europe. By 2030, WHO has projected that there will be 12 million cancer deaths worldwide (i.e. an increase of 50% in mortality) and a predicted escalation in cancer incidence in low- and middle-income countries caused by increased longevity and the adoption of Westernized lifestyles with their attendant risk factors.

Ironically, the improvement in treating AIDS patients with antiretroviral drugs has helped raise cancer incidence. In industrialized countries where HAART has been extensively used to treat AIDS, although the incidence of many AIDS-related malignancies (e.g. Kaposi sarcomas, cervical cancers) may have decreased, malignant diseases overall have become the most frequent cause of death for HIV-infected patients (around one third of patient deaths). Thus, in regions such as Africa, where the AIDS incidence is higher, both AIDS-related cancers and non-AIDS-related cancers will grow in significance as more and more HIV positive people gain access to HAART due to the major efforts in this area that are presently ongoing. Given the World Health Assembly's resolution on Cancer in 2005 and the International Union against Cancer (UICC)'s Global Cancer Declaration adopted by the World Cancer Summit and subsequently endorsed by the World Cancer Congress in 2008, it is reasonable to suppose that Ministers and ECOSOC are already aware of the gravity of the cancer situation. However, with a few notable exceptions there has been little or no action on the part of Government in the developing countries, and even less vision and material support (again with a few exceptions) offered by governments in the developed countries.

Because cancer control experiences many of the same barriers and obstacles confronting other NGDs (and indeed, communicable diseases), it will also benefit from the capacity-building solutions that have been previously proposed in Parts One and Two of this consultation. The following list outlines twelve steps that developing countries should be helped to take in order to make headway in cancer control.

1. Improve cancer registration coverage by establishing strategically sited population-based cancer registries to collect cancer incidence and mortality coverage.
2. Formulate a National Cancer Plan based on a realistic assessment of available resources with expert consultation and peer-review.
3. Improve conditions of professional service thereby retaining skilled healthcare staff and preventing human capital flight.
4. Raise public awareness about cancer through public health campaigns and formal education.
5. Train non-oncology healthcare professionals (especially GPs) to recognize the symptoms of prevalent cancers in order to improve early detection rates.
6. Encourage Knowledge transfer and skills-sharing through 'twinning' partnerships that offer telemedicine and visiting experts.

7. Build diagnostic capacity by training and retaining pathologists and skilled lab technicians and providing adequate lab facilities.
 8. Build treatment capacity (surgery, drug therapy, radiotherapy) and involve general/regional hospitals in cancer care to the extent possible.
 9. Initiate long term research-based treatment programmes so that patients are not only cured but also produce data on the efficacy and toxicity of therapeutic interventions in the local context.
 10. Use this information and other existing data to build a context-relevant accessible evidence base that can be reviewed for quality, summarized where accurate conclusions are possible, and used to identify gaps in knowledge.
 11. Provide coordinated palliative care services at institutional and community levels and ensure access to opioids.
 12. Reduce risk factors by the active discouragement of smoking and the use of other tobacco products, the prevention of cancer-related infection and measures to forestall the growing epidemic of obesity that is already spilling over into developing countries.
- In conclusion, although hard choices do have to be made, the argument that NCD control policies will necessarily require a trade-off against other priorities of national health systems should not be used as a pretext for avoiding this increasingly important cause of ill-health even in the poorest countries. Improving the knowledge and capabilities of existing primary healthcare facilities and educating the public should ensure that cancers are detected earlier, and therefore require shorter, less expensive and less toxic therapy.

Building accessible treatment capacity in secondary care, training and retaining skilled staff, forging and maintaining productive working relationships with centers of care and expertise in other countries (both North-South and South-South) will lead to improved survival rates, and therefore assist in putting cancer on the map; a crucial step as WHO has projected that by 2010, cancer will account for more deaths than any other disease category. Because of differences in the cancer patterns and resources of developing countries, it will be essential to establish and nourish an active healthcare research community so that patients are diagnosed and managed more efficiently. Adequate provision for the terminally-ill will always be necessary, but hopefully these needs will be reduced as more patients are prevented from getting cancer or are cured.

What should be appreciated is that around 11 people are dying every minute in developing countries from cancer, and that in some countries it is probably going to take more than a generation (over 20 years) to provide an adequate cancer service for their descendants. The challenge before us, therefore, is enormous but if, as should have been the case, the original MDGs agreed by governments had included cancer we might already be halfway way to our goal. Not to address the cancer crisis fully as part of the ECOSOC meeting in June 2009 would, I believe, be unforgivable.

Mark Lodge
Executive Director

3. The American Cancer Society to the UN: Integrate non-communicable diseases into the MDGs

The American Cancer Society strongly urges the United Nations to integrate non-communicable diseases, which now surpass infectious diseases as the leading cause of death in the world, into the UN Millennium Development Goals. Efforts to prevent and control non-communicable diseases, which are among the leading threats to human health, will help reduce disparities and increase the quality of life for more than one billion people living in low-resource nations. These diseases, which include cancer, accounted for 60 percent of all deaths globally in 2005. ACS supports the six-year-action plan endorsed by the World Health Assembly in 2008, which calls for the WHO to map emerging epidemics of non-communicable diseases and analyze their social, economic, and political causes, using this information to formulate guidance on effective policies and financial measures to tackle these diseases. As populous regions experience economic growth, they are also experiencing a greater burden of the non-communicable diseases associated with "Western lifestyle" factors. Non-communicable diseases pose a deadly threat to people in each geographic region of the world, including people with all socioeconomic backgrounds. We strongly encourage the UN Millennium Development Goals to formally recognize the non-communicable disease burden so that it can be addressed more effectively and comprehensively.

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4. Emerging and future health challenges

1) Under the provision of essential drugs – anti cancers, anti asthmatics and anti diabetics, anti-tuberculosis anti malaria anti retroviral at the grass root and mounting effective health awareness campaign in the 774 local government authorities, along 36 states of the federation council of state by using materials that can go a long way to address the growing magnitude of non-communicable disease infections and reducing the risk factors age, sex, height, weight body mass index (obesity) thereby improving the health indices in the country. Besides the health sector, the education, information

and communication sector can collaborate to design programmes with ministry of financial and implementation strategies encompassing the NGOs, community-based organizations and faith-based organizations. Priorities should be given to adult to prolong their life span using the global health system at international and national, state and local levels of government.

2) In the light of global financial crisis, we need to take a look at the previous national policies and integrate them into the present policies while forecasting the future rule in global health. The goals of public health can be achieved through multi sectional approach to stake holder in health system with the patients at the center of the field.

3) Innovations such as taking campaigns to schools, churches, mosques, market places and town union meeting should be incorporated into global health partnership and collaborative arrangement to improve their performance and reduce transaction cost (exchange rates) and increase synergy of action aligned to country priorities.

Other innovations such as conferences, seminars, workshops and public lectures can also be considered to strive for greater coordination and collaboration of all actors in public health.

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5. Essential elements of national strategies to address the growing magnitude of non-communicable diseases: A bottom-up approach and the role of communities themselves

Global and national strategies are largely ineffective unless they are informed and owned 'bottom up'. No matter how much resourcing is pumped into a national strategy, it will not change heads (let alone hearts) unless there is grassroots ownership. Modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) are not usually about how people have to live but about how they choose to live; a leaflet, a broadcast, a mass teaching programme will not affect change. There is worldwide evidence for this with HIV/AIDS, teenage pregnancy rate and obesity, to name a few.

Dr Margaret Chan, World Health Organisation Director General, sees "Health as the driver of all sustainable development, including economic, social and cultural advances". At Links International, we see this statement come alive in the micro, real people in dire poverty being empowered and encouraged to take control of the health of their community. Firstly, they are taught to carry out a simple needs assessment, to prioritise the need, we then teach where the need is the greatest and help them link the teaching to a practical project which they can undertake. For example, no matter how poor a community is, they can dig a pit latrine and removing the human waste from a community does save lives. We have an example of a

community in Uganda where death from simple diarrhoea in infants has reduced dramatically just because the community, led by a core group of influencers, has addressed the sanitation and rubbish problem themselves. Micro enterprise is now flourishing in this village, the whole place is clean and tidy, there are crops growing where there was rubbish. This project has crossed a cultural and social divide.

At Links, we have projects like this blossoming in Africa, India and the Philippines, the simple teaching is transforming hundreds of communities and there are measurable outcomes. These projects do need to involve medical people but it is not a clinical model and is looking at health in its widest sense, rather Shalom, a sense of well being. The projects should reach up to mesh with the clinical, economic, educational and the financial strategies but sadly, in most areas where we work those national policies and strategies are so far removed from local people as to be unheard of or thought to be unattainable. We can raise the priority accorded to non-communicable disease at global and national levels by acknowledging the need to engage and value the work being carried out at grassroots levels.

Linden Boothby

Primary Health Care Manager
Links International

6. The role of the Global Alliance against Chronic Respiratory Diseases (GARD) in supporting the Action Plan for the Global Strategy for Prevention and Control of Non-communicable Diseases (2008-2013)

What is GARD?

GARD is a voluntary multi-sectoral alliance working towards the common goal of reducing the global burden of chronic respiratory diseases (CRDs). Its vision is a world where all people breathe freely. Collaborating parties are professional associations, medical societies, foundations, patients' associations, WHO collaborating centers, governmental agencies and private companies. The World Health Organization provides technical leadership and secretariat support to the Alliance (www.who.int/gard). GARD was launched in 2006 and has a comprehensive approach for the surveillance, prevention and control of CRDs.

Chronic respiratory diseases: burden and mortality

CRDs are non-communicable diseases (NCDs) with increasing prevalence numbers. Around 300 million people suffer from asthma, 210 million from chronic obstructive pulmonary disease (COPD), and millions of others from other CRDs, including sleep apnea syndrome, rhinitis, rhino sinusitis, occupational diseases and pulmonary hypertension. In 2000 people died of asthma and 3 million of COPD, which is expected to 2005, 250, become the third leading cause of death in the world by 2030. Asthma is the most common chronic disease in childhood, the major cause leading to emergency room, in hospital treatments and school absenteeism. Most of deaths and burden occur in low and middle income countries, meaning an enormous problem for public health and the societies. For these reasons, in 2008, the 61st World Health Assembly endorsed the Action Plan to support the implementation of the Global Strategy for Prevention and Control of NCDs, including CRDs.

GARD Action Plan 2008-2013

The GARD Action Plan 2008-2013 is an instrument of the Action Plan for the Global Strategy for Prevention and Control of Non-communicable Diseases 2008-2013. The Plan sets out the vision, goal, purpose and strategic objectives of the Alliance, in order to guide the work of GARD collaborating parties. GARD pursues four strategic objectives:

1)**ADVOCACY:** To raise the recognition of the importance of CRDs at global and country levels, and to advocate the integration of prevention and control of such diseases into policies across all government departments.

2)**PARTNERSHIP:** To promote partnering for the prevention and control of CRDs.

3)**NATIONAL PLANS ON PREVENTION AND CONTROL:** To support WHO in assisting countries to establish and strengthen national policies and plans for the prevention and control of CRDs using WHO-endorsed approaches and methods.

4)**SURVEILLANCE:** To support WHO in monitoring CRDs and their determinants and evaluate progress at country, regional and global levels.

GARD at the country level

GARD focuses on the needs of countries fostering country-specific initiatives tailored to local conditions. Interested parties may constitute a country alliance with the aim of pursuing GARD goal and objectives at the country level (GARD Country). This GARD Country would provide local coordination, momentum and capacity to improve surveillance, prevention and control of CRDs. Among the priority goals of GARD Countries are tobacco ban in public places and training of primary healthcare professionals to recognize and treat CRDs in an integrated way with other NCDs.

Dr Jean Bousquet, Dr Ronald Dahl, Dr Eric Bateman and Dr Carlos Baena-Cagnani

Members of the Executive Committee

The Global Alliance against Chronic Respiratory Diseases (GARD)

7. Preventing preventable diseases: A realistic approach in the context of Nigeria

My contribution to this discussion at this point will be precise. It may be short, but on the long run if government and funding bodies take notice of this important point, it will go a long way to benefit the health system, the under-served population and our entire population as a whole.

Students in primary and secondary schools are my major target for this paragraph. First, I would like the government to equip teachers in local primary and secondary institutions with

information on health and environment that applies to daily life. I have learnt from the project my organization is currently undertaking (which is aimed at educating students on issues concerning health and environment that are applicable to their daily life) that although many teachers know the definitions of health, climate and environment, they do not know how those definitions can be applied to their own life or their students' life. I have discovered that although most of these students have been thought environmental protection, their schools do not have a good waste management system. Many students playing on the street during school hours expose themselves to health threats.

I would like to say that if this area is not well monitored; funding bodies and the government will have to face the consequences of the problem. This solution may seem unrelated but with the establishment of school clubs to educate students on health and environment applicable to daily life, our organization has seen a lot of positive changes. The good news is that many teachers now are involved and they have realized that depending only on school curriculum will not help them go far in terms of achieving health. Governments of developed countries should also join in supporting of this great idea because it will go a long way to prevent many preventable diseases killing people in developing countries.

Local NGOs should be encouraged to undertake community-based efforts. I will also suggest that more than one NGO should be involved to undertake a project since this will bring about competition which will in turn produce better effectiveness. Traditional rulers and cultures should also be taken into serious consideration, as there are many locations in Nigeria that still have unhealthy lifestyles as a culture. I will also suggest the establishment of local health clubs be monitored by local NGOs, whose duty will be provide personnel to anchor the club meeting. The role of fathers has for long been overlooked on issues concerning children and mothers, but it is noteworthy that in Africa, if a father advises a mother on issues that can affect her and the child negatively, she will listen. So I will suggest that health campaigns should not be restricted to only women because we have so many mothers that say they can't bring their children to have immunization because the father resented it.

Finally, I would like to advise funding organization and the government to promote works of individuals, groups and NGOs that provide solution or explanation to a health issue/problem. For example, there should be a means to review books published by individuals or NGOs and sponsor them, if they are found worthy of distribution, most of these people have ideas but they don't have funds. In addition, music, drama and short stories should also be open for sponsorship in order to distribute them. A website could be established to achieve collection purpose and review, and this will go a long way to encourage people to use their talents to benefit their community in a healthy way.

Robinson Rhoda

Secretary General

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8. Basic Development Needs (BDN): Case studies from Egypt

To improve quality of life and Primary Health Care, WHO /EMRO (World Health Organization / Eastern Mediterranean Regional Office) initiated Basic Development Needs (BDN) in diverse countries of the region (Sudan, Pakistan, Egypt among others).

The objectives of BDN are as follows:

- Organising the community and building its capacity
- Promoting self-management and self-reliance
- Building relationships with different stakeholders

Partnership is established among the community leaders and representatives, governmental officials, stakeholders, and a technical support team (TST). A community development committee (CDC) empowered the community.

Community representatives (CRs) volunteered. Their functions include the following:

- link to families in their neighbouring houses (street)
- implementation of BDN needs assessment survey
- dissemination of health and environmental education
- follow up on micro-credit projects loans

The BDN experience in an informal community in Egypt showed that their community needs and problems were:

- No water / sanitation
- No primary school
- Insufficient transportation
- No street lightning
- Unpaved streets
- No health services provision in their community
- No pharmacy
- Others

Although a health unit was 2 km away, the community knew little about the services provided by it in their area. BDN reached interface between community and health unit:

- CRs could use the premises of the health unit for their training.
- They get to know the services provided by the health unit.
- They helped the health unit in making a community surveys e.g. under five years children for vaccination, diabetic patients.
- Some CRs helped during the TB campaign and vaccination.

Few health indicators could improve after a year but many others after years. Poverty elevation is most difficult to attain. During my work at WHO HQ from 2004 to 2004, little attention was given to the BDN approach at EMRO although it addresses a comprehensive way of PHC.

Dr. Salma Galal

9. National strategy to address NCD: Vietnam's case

In Vietnam, national strategies to address the growing magnitude of non-communicable diseases have been mainly developed by MOH in collaboration with contributions and supports of different stakeholders. It seems that this process needs more involvements of life-witnesses, the people who have benefited or have been suffered from the previous strategies or developing strategies. The beneficiaries (most inhabitants) will benefit if developed strategies have been based in real circumstances with available experiences on economic status. And moreover, these strategies have had a positive aspect with beneficiary's life. They will suffer if these strategies may conflict with private development economic for basic need survive, especially in world financial crisis since last year.

It is not so difficult to imagine several examples that relative to non-communicable diseases like tobacco use or unhealthy diets that conflict of health economic and economic development of the most people in both remote/mountainous areas and urban of Vietnam that linking with strategies of tobacco control (lung diseases) or strategies on preventive avian influenza with farmstead /chemical & industrial foods (of course, this is communicable diseases), additional, with mental health in economics crisis.

With tobacco, the WHO has strategy on reducing burden by tobacco. I won't discuss the WHO's strategy as it protects people from tobacco with evidence-based strategies to curb tobacco use exist. The WHO estimated that in the 20th century, the tobacco epidemic killed 100 million people worldwide. But there are no data on how owners/millionaire of tobacco factories may take benefit, or how many workers in world wide/each country can get income from these factories and how many farmers could get rice from raising tobacco for the factory. Moreover, it seems the percentage and proportion of tobacco used with its burden has not been mentioned enough to effectively preventive new potential tobacco-user from youth. Today, in world financial crisis, when a lot of people are losing their jobs and most of them may have to back their native at mountainous are, where the weather and land is suitable for traditional herbals or tobacco raising what do they do when the land for raising rice/maize are limitation while available land and its weather are suitable for tobacco. How the most people at poor place can deal with economics crisis for survive with empty stomach before they can die or make other die by raising tobacco. So, food security with sustainable development program would be considered during developing harm reduction national strategies of tobacco burning.

With Vietnamese mental health, I perceived that national strategies that suit in conflict or crisis place/duration are still in ideas or papers. All people may have problem with mental health but they have not recognized that they are in pre-delitescence of mental diseases. Students have too much pressures of lessons/learning overtime, additional with pressure of the family to university etc. Workers suffer not only from workload in office but also with homework as well as costly for learning of children etc. However, these issues have not much focused during develop national strategies for non-communicable diseases.

In this world economic crisis, to maintain and enhance the favorable policy and resource trends for global health of the recent past, awareness raising and communicable practice on MDG relative to non-communicable diseases is very important. Community Based Approach would be considered in completing strategy penetration (Global level/National level/community apply). All departments of the country should collaborate and integrate rather than in separating activities. Coordination of global health would be considered as regulate holder and targeting also to civil society organization, non government offices with BCC methodology (rather a beautiful policies but in paper only).

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10. Missing link between research, policy making and information campaigns

The poverty, illiteracy and disease are great obstacles for developing countries. There is need to incorporate ingredients of healthy living and good practices in school curriculums at all levels, promote sensitization through video features in waiting areas (e.g in hospitals), pamphlets and radio programs in different languages. For example the vegetarian diet and herbal plants being popularized in the streets of Nairobi and its environs may not achieve great success! Worse still local research or published data on these issues among other health areas are hard to find. Therefore, there little research and if any there is missing link between research (even on non-communicable diseases, their modifiable risk factors and social determinants) educators, policy makers among others. It is prudent for governments and international community to support active and collaborating national institutions like national hospitals and medical schools, etc. to undertake such studies and disseminate the results. Inclusions of their recommendations in teaching curriculum, publications, policy development and reduction of disease incidences are a few impact indicators. Institutions achieving this level of implementation should attract more support (financial, equipment, capacity) especially on identified areas; broadening their research, implementation, evaluation of benefits, costs, appropriate technologies and in overall improvement of health care.

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11. Health-promoting schools

What sectors besides the health sector must be involved in designing and implementing the strategies? How can we raise the priority accorded to non-communicable diseases in development work at global and national level?

Innovative partnerships for a more effective health sector

Education improves health and health improves learning potential. Education and health support, complement and enhance each other. Neither is possible alone. Together, they serve as the foundation for a better world. Being able to read, write and calculate has been acknowledged as a human right. Schooling in itself has been shown to be a powerful way to influence health everywhere. Its impact is clearly seen in benefits to maternal and child health. Literate women tend to marry later and are more likely to use family planning methods. Mothers with even primary education tend to take better care of their babies; they are also more likely to seek medical care for their children and to have them immunized. Learning should not be restricted to school age, nor to any other age. The connection between education, health and earning capacity is better understood. Ensuring that our surroundings are conducive to good health thus means directing effort at all levels, within and between all sectors of society. In so doing we can make healthier choice and lay the foundations for true social and economic development.

Health-promoting schools: If we consider what it takes to create health, the school emerges as an ideal setting for action. Schools can help young people to acquire basic skills needed to create health. Such skills, sometimes called life skills, include decision-making, problem-solving, critical-thinking, communication, self-assessment and coping strategies. When people have such skills they are more likely to adopt healthy lifestyle. Each new generation of children faces health challenges, but those faced by today's school-age group seem particularly daunting. Children are confronted at an early age by situations that require knowledge for decision-making skills and for preventive action. Very often adolescents find themselves under strong peer pressure to engage in highly risky behavior which can have serious implications for their lives.

The spread of HIV/AIDS among adolescents is a more recent phenomenon, but is growing in importance, while the traditional problem of sexually transmitted diseases among adolescents continues to increase. It is possible to introduce some of the most important concepts in the areas of reproductive and sexual health without arousing controversy. These include respect for others (especially persons of the other sex), self esteem, the possibility of planning families and understanding that children are ideally born as the result of a conscious decision by loving and responsible parents, the importance of postponing the first pregnancy, and the ability to withstand peer pressure.

To imagine what a school can do to become health-promoting is an excellent starting point. Just as physical health creates an image of strength and vitality, mental health should be associated with strength of mind and vitality in the way that individuals interact with others and as they deal with the challenges of everyday life. As witnessed by the scale of mental health problems of both children and adults, the "how to" of life is often a rather weak component of human competence. Life skills education in schools enables children to protect and promote their own health and well-being. Teaching methods therefore need to be interactive for learning such skills, rather than just acquiring knowledge. When schools are health-promoting in this way, a major improvement is anticipated in the mental health status of children, and of the adults that they will become. By that time, "Mental Health" should lose its negative image and the real significance of mental well-being for human societies will be acknowledged.

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12. Samoa's national health campaigns and findings

In Samoa, Non-Communicable Diseases (NCDs), including obesity, diabetes, heart diseases, high blood pressure, strokes and cancer, are a top health priority. The prevalence of these diseases is high and increasing: obesity is currently 52.7%, diabetes 23.3% and high blood pressure 21.4%. NCDs are now appearing in younger age groups and complications from these diseases are more common (Health Sector Strategic Plan, 1998-2003). One of the most successful strategies to address NCDs is the involvement of key people in the country mainly politicians and different professionals in health promotion activities like physical activities, healthy diets and restricted use of tobacco and alcohol in public places especially around young children.

For physical activities in particular, Samoa strongly promoted a national health campaign last year where all villages and communities can sign up with the National Organising Committee to participate in the daily 30-minute exercise program for their own benefit. The village can choose their own jazz-leaders (youth or adult) from their own community to lead the 30-minute exercise daily. "This health promotion initiative through the practice of physical movements such as simple but creative aerobics is a move by the Ministry of Health in partnership with the Ministry of Women, Community & Social Development, to encourage community responsibility over their own physical wellbeing. This specific component is part of a national health campaign that uses a strength-based community approach whereby the community Partners and Network of the **Government, Women Representatives, Village mayors and Church Ministers** are being tapped into organizing and mobilizing everyone (regardless of their age, status and ability) in the village to exercise for at least 30 minutes everyday, in their own village grounds and in whatever dress they are comfortable in.

This method also, encourages the use of traditional Samoan dance movements such as the sasa, mauluulu, faatau pati and traditional rhythm and beats to make it more 'all inclusive of the aging population' but uppermost is for all to have fun" (sportsamoa.com/news.html)

The above photo shows the current Prime Minister of Samoa enjoying the slow movements exercise with some of the local women enjoying physical movements in their own local style. (Photo source: www.samoalivenews.com/Health/Get-Moving-Samoa.html).

The message is clear: not only should we preach health risks and ways to prevent NCDs, but we also need to lead by example in our own communities. Simple and enjoyable activities can go a long way in preventing NCDs. I am witnessing the large positive impact of this community-based approach in my own village in Samoa.

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13. Emerging and future health challenges

It is people who make the difference so long as it is the right people. If we are to address the explosion of NCDs, and also address the key MDG objectives, we need to re-orientate an element of the medical school curriculum. Back in 1978, Primary Health Care was launched at the famous Alma Ata meeting. It failed, largely because it did not get 'buy-in' from physicians and other senior health professionals. There was no civil society as we have today, and the community health workers and other cadre ended up being suffocated through the lack of support and materials. Africa remains very hierarchical in its societal structure and unless 'seniors' buy-in to something, it is unlikely to work.

The world is now very different, and the biggest change is the emergence of civil society. It means that community initiatives have a chance of working. But if we are to defeat both the growing non communicable burden of disease as well as the range of other diseases linked to poverty, the environment or simple lack of knowledge, we must also harness the support of the 'seniors'.

But here we still have a problem and have got to take a very realistic viewpoint. Public sector salaries are poor and doctors quite understandably have aspirations for their family members. As such they choose a specialty that provides an opportunity for private practice to supplement their income. This means obs and gynae, surgery, medicine, pediatrics. It doesn't mean public health for instance. A major feature in Africa since the turn of the millennium has been the increase in private practice as Africa's economic growth has nurtured a thriving middle class once again. Many doctors and teachers who might otherwise have emigrated have stayed at home and done well in the traditional specialties though most have not ventured beyond the confines of their busy consulting rooms and theatres. Nonetheless, that they are content to stay at home is a big positive.

Family Medicine or General Practice (US/UK nomenclature) has arrived, though has had to fight its way through to reluctant acceptability against often quite fierce competition from the super specialties. But the public sector doesn't seem to know what to do with them. In one West African country, I recently found that the Family Medicine specialists had been put to work in the outpatients of a teaching hospital. They did a job, but it wasn't the broader outreach that their training had equipped them for.

What we need to do is to put significant resource into developing a new physician. Part GP, part Public Health specialist, part Community Surgeon, and part Community Physician. Build a curriculum, instill a commitment (don't forget to also provide them with opportunity to have aspiration for their family and to have a private income to supplement the public sector salary), and then empower them to care for their community, teach them to work with civil society to be the mentors of the primary care workers within their area (maybe manage little revolving funds so that PHC posts can dispense essential medicines), carry out essential surgery, raise

awareness of the risk factors for hypertension etc, oversee local maternity centers or indeed build trust and teach traditional birth attendants of the indicators for when they must refer patients, and last but by no means least, provide holistic family care.

The innate conservatism of the super specialties will be a problem. This new specialty must be accorded equal footing. Systems don't change much but people will. However, we need the right people.

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14. Ten demands for a healthy India

The following was adopted at the two day workshop on community health in Ranchi, Jharkhand (India) on 15-16 February 2009:

1. Make Right to Health a fundamental Constitutional Right and enact a Right to Healthcare Act under which all Indian citizens can get easily accessible, quality healthcare services;
2. Stop privatisation of healthcare and abdication of the state's responsibility for health of citizens in the country;
3. Raise budget allocation for health to 5 percent of GDP by 2012 and to 10 percent of GDP by 2015; Allocate adequate portion of the health budget to traditional healthcare systems also
4. Provide a minimum of 2000 balanced calories per day to all Indian citizens and take all necessary measures to ensure this;
5. In compliance with the Supreme Court directive ensure quality and universal service provision in anganbadis to all girl children, women and all those in the age group 0-6.
6. Provide pregnant and lactating women daily financial support equivalent to the daily minimum wage for a period of six months (three months before and after child birth);
7. Provide emergency interest free loans to all citizens for meeting non-health related expenditures during illness;
8. Enact a Rational Drug Policy that allows the sale of only generic drugs and also limit the patent holding rights on all drugs to a maximum of five years;

9. Cancel the licenses of all industries causing pollution and recover full damages to the affected people as also to the environment;

10. Protect the basic human rights of all citizens guaranteed in the Indian Constitution and prevent violation of these rights by both state and non-state agencies, including in times of natural or man-made disasters;

Start nutrition rehabilitation centers for malnourished children.

Enact a nursing home regulation act immediately.

Provide financial support equivalent to the prevailing daily minimum wage to those who undergo de-addiction therapy, for the entire period of the treatment.

15. Wellness-based vision

Leverage the best innovations in family health plans. In developing countries where a shrinking pool of workers is expected to support the pensions of an increasing numbers of retirees, innovative ways to contain health care cost is receiving a lot of attention nowadays, particularly where increased per capita spending reduces little or no measurable gains in health.

Shift from a focus on sickness to a wellness-based vision: This is an approach to health care that is becoming popular in the literature. What does this shift entail? If we focus on the supply side of the care, this shift means that families should subscribe to a plan that is underpinned by healthy behavior rather than worry about health care when one becomes sick. Another interpretation of this idea is to persuade healthcare users to move away from the notion that "more is better" to "only the care I need". Health systems could also move away from offering options that have added little or no proven value to performing wellness health plans.

New knowledge is acquired every day. Absence of knowledge is no longer an issue when it comes to health care and thus, why not deploy this information so as to involve clients and create "smart patients"? Combining evidence-based disease management and self-reported assessments with promising strategies can facilitate this shift.

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16. Community Participation in Palliative Care: 28 years of experience with HOME Hospice Inc.

In the World Health Report, 2008, "Health is no longer seen as being limited to survival and disease control but as one of the key capabilities people and societies value." This wider concept of "Health" could become a rallying point for all levels of society to work together for the common good. This statement prompts me to share briefly from my many years of work 'on the ground' with an organization I co-founded, namely HOME Hospice Inc. I can offer observations as to the strength and capacity of people in community rallying together around their dying ones in the home. What I have observed epitomizes the 'new' public health approach in palliative care whereby community participation in caring for their own dying ones in the home leads to significant health enhancing benefits. Community coming together in this community participation model builds social capital.

In essence, the work of HOME Hospice facilitates a vital shift needed in health systems from doing things 'to' and 'for' society in the area of health programs and initiatives, to opening out to the immense opportunities and benefits that arise when people change to working 'with' one another at all levels. HOME Hospice is an example of the efficacy of this approach, when the caregiver, their family, friends and neighbors (their personal community) are educated and supported by the program to come together around a dying person and their family. This enables them to stay together at home until death occurs. There are benefits across all levels of society by this small event occurring time and time again in the home.

There is a relatively new world movement with a significant literature already about the public health approach to palliative care, stimulated by the Ottawa Charter (1986) and various leaders in the field throughout the world, notably Professor Allan Kellehear (Compassionate Cities: Public Health and Palliative Care, 2005 London: Routledge). I want to make these comments because I have worked as the Director and Co-founder of HOME Hospice Inc. over these 28 years in Australia. The organization's mission is 'to aid families and their communities in caring for their terminally ill at home and restoring the role of community in compassionate caring for their own dying'.

What has been achieved over the years with HOME Hospice is a small example of the potential for social change. Community participation, people caring for one another, being bonded together in the face of life's deepest mystery, yields significant benefits for the caregiver, their family, the dying loved one and most especially, their personal community. I have witnessed again and again a palpable transformation of the people in that personal community, having reached out in a compassionate response to friends in need. Now, enriched by the relationships they have formed, the dignity of service they have discovered, there is new depth and meaning in their company and in their communication. People now know how to respond and this is lasting as its ripple effects reach into the wider community.

People involved in taking up this program is a classic example of the 'new' public health approach. Palliative care is but one small example in terms of the needs for sustainable global health policy. Especially in these financially challenging times, there are urgent concerns for sustainable health initiatives. I contend that if community involvement is restored or enhanced globally, there is hope of a way ahead to collectively work together 'with' all levels of society to address health problems and the many desperate inequalities that exist. I am simply one person working on the ground over all these years and these are reflections on the ability and power of community to affect change, to drive towards what they want. Is there a possibility of this model of community participation in health generally a way for the future?

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