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Regional framework for action

In 2013, WHO focused on putting into action the regional framework for action, endorsed by the Regional Committee in 2012, to scale up the implementation of the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. This meant sustaining high-level commitments by Member States, supporting them in the implementation of strategic interventions agreed in the four priority areas of the framework, and building capacity to respond to the needs in each country.

The World Health Assembly endorsed, in May 2013, the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, along with a global monitoring framework with a set of nine voluntary targets and 25 indicators. All countries of the Region included noncommunicable diseases as a priority in their planning for the 2014–2015 collaborative programme with WHO. WHO also focused on developing partnerships with international and regional partners, such as the International Diabetes Federation, the International Union for Cancer Control and the World Heart Federation, all of which play an important role in advocacy for noncommunicable diseases.

The following represents an outline of the progress made in the four areas of the regional framework.

Governance

WHO focused on building national capacity and providing technical support in reviewing and updating the national plans for noncommunicable diseases through regional meetings and country assessment missions. Currently 20 countries have units and focal persons in place to manage programmes for noncommunicable diseases at the level of the ministry of health or equivalent. As part of a multi-region global WHO initiative, four countries are developing national multisectoral plans for noncommunicable diseases, including guidance on how to develop national targets and indicators and prioritize interventions, and these plans will be finalized early in 2014. 2013 also witnessed activities to build capacity and train national professionals including programme managers in ministries of health in the technical and managerial aspects of noncommunicable disease prevention. However, the need for such training is considerably higher than what has been offered. A plan for establishing a regular regional training seminar is being considered in order to accommodate a larger number of professionals involved in programme development and monitoring.

Prevention and control of risk factors

WHO accelerated its policy work on the shared risk factors for the main noncommunicable diseases, particularly aiming at scaling up the implementation of the best buys for prevention. These include interventions on tobacco use, physical inactivity and unhealthy diet.

Tobacco control continues to face important challenges with stagnation or reversal of prior gains in some countries, while some forms of tobacco use, such as waterpipe smoking, are showing an alarming increase. Fig. 1 shows the prevalence of smoking among adults compared to other WHO Regions. WHO implemented a series of advocacy activities to stimulate national action in the two countries where the WHO Framework Convention on Tobacco Control (FCTC) has not been ratified (Morocco and Somalia). This will remain a priority and action will be sustained in 2014. A regional multisectoral meeting addressed the challenges relating to tobacco and trade and a follow-up meeting for GCC countries is planned for 2014. Technical support was provided to several countries in the areas of tobacco taxation and development of tobacco control legislation. National capacity to support implementation of article 5.3 of the WHO FCTC on tobacco industry interference was strengthened in two countries, with participation from a range of sectors. The number of countries that are now signatories to the first WHO protocol to the FCTC, the *Protocol to eliminate illicit trade in tobacco products* has increased to eight.

The promotion of physical activity is a strategic priority. In preparation for a high-level multisectoral regional forum on a life course approach to promoting physical activity in 2014, a regional mapping of policies and programmes on physical activity was conducted. The challenges identified include a lack of data on the prevalence of physical activity, limited leadership support and lack of multisectoral collaboration from the different sectors concerned. The forum, which took place in February 2014, brought together policy-makers at the ministerial level from a range of sectors, such as health, youth, education, sport, transportation, urban planning and information, to discuss ways to address these issues.

With regard to addressing unhealthy nutrition, policy statements and recommended actions for reducing salt and fat intake were developed. Two countries have started salt reduction in bread, and the Gulf Cooperation Council drafted standards and specifications on elimination of *trans*fat in food and edible oils.

A regional protocol for measurement of population salt intake, developed in collaboration with WHO Collaborating Centre for Nutrition of the University of Warwick, was released in October 2013. Technical support and capacity-building were also provided for the development of food-based dietary guidelines and salt and fat reduction strategies, and several countries initiated implementation of these strategies.

A regional mapping study of progress in the implementation of the WHO recommendations on the marketing of foods and nonalcoholic beverages to children, conducted in collaboration with Liverpool University, showed limited awareness of the recommendations, poor development of legal frameworks to control such marketing, and lack of attention to cross-border marketing. An expert consultation, attended by representatives from consumer groups, child health protection groups, nutritionists, lawyers and media networks, recommended Member States to adopt a comprehensive approach to regulate marketing, and made key recommendations to accelerate the implementation of the WHO recommendations, including the establishment of a national multisectoral working group in each country led by the Ministry of Health. This work will be carried forward in 2014 with focus on building the capacity of consumer protection groups in this area, and on advocacy development and enforcement of marketing regulation.

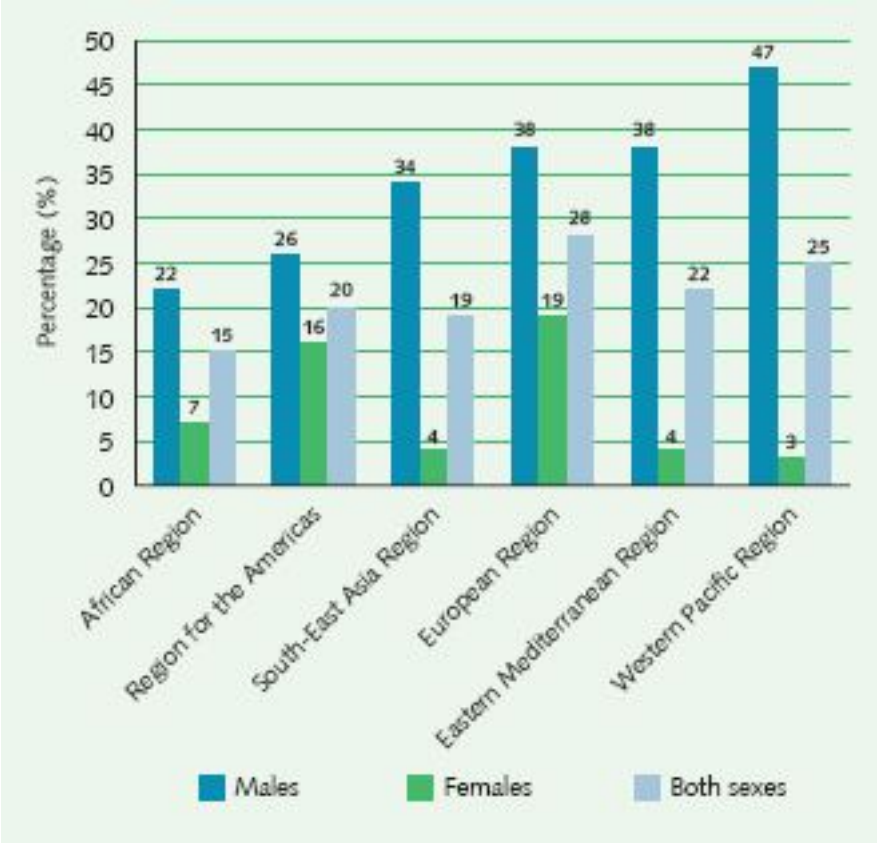

Fig. 1. Tobacco use among adults (15+ years) in the Eastern Mediterranean Region compared with other WHO regions

Source: WHO report on the global tobacco epidemic 2013. Geneva: World Health Organization; 2013

Surveillance, monitoring and evaluation

All countries participated in a survey to develop country profiles for capacity and response to noncommunicable diseases and a regional report is being prepared. Five countries conducted the STEPS survey during 2013. Reporting of cause-specific mortality for noncommunicable diseases is a challenge in most countries. It is expected that the regional strategy to strengthen civil registration and vital statistics systems will help to address this. WHO continues to provide support to countries to strengthen cancer registries, in collaboration with the International Agency for Research on Cancer (IARC). Countries have started developing national targets and indicators and reporting on progress in line with the global monitoring framework. WHO has initiated collaborative work with the Eastern Mediterranean Public Health Network (EMPHNET), to study surveillance gaps and to develop a programme for capacity-building in surveillance in order to expand the network of regional experts who can provide high-quality expert advice to countries.

Tobacco surveillance continued to receive attention. The *WHO report on the global tobacco epidemic 2013,* which includes profiles of all countries of the Region, was published. Support was provided to five countries to carry out the fourth round of the Global Youth Tobacco Survey. The Global Adult Tobacco Survey was completed in Qatar, the first self-funded country to do so in the Region, and preliminary results were released. Three other countries are in different phases of the survey.

WHO also supported and/or conducted surveys and research to generate evidence to support policy work in priority areas. Research on economic evaluation of the priority interventions and ‘best buys’ for noncommunicable diseases – interventions that are expected to provide a high return on investment in terms of health gains – is being conducted in four countries, in collaboration with the Disease Control Priorities Network and the University of Washington. Regional capacity in this area was strengthened with a view to developing a core group of regional researchers. A multi-country study is under way to generate evidence in three areas to inform policy interventions for salt reduction: population level salt intake through 24-hour urinary sodium excretion; salt content of commonly consumed foods; and patterns of intake of such foods. The results of both these studies will be available in 2014.

Health care

WHO sustained its support to countries to strengthen integration of noncommunicable diseases

into primary health care, including through implementation of the WHO package of essential noncommunicable disease interventions for primary health care in low-resource settings and nationally approved guidelines. Tobacco cessation also received attention as a priority health care intervention, with support provided to several countries in the area of treatment of tobacco dependence.

Of the four main groups of noncommunicable diseases, cancer received particular attention in 2013. The national cancer control programmes in five countries were assessed, in collaboration with the International Atomic Energy Agency (IAEA) and IARC. To establish a clear roadmap for countries in the areas of cancer surveillance, research and early detection, a regional meeting on cancer control and research priorities was held jointly with IARC. The recommendations of the meeting were translated into an action plan that will be implemented with IARC in the areas of cancer registration, causation of cancer, and early detection/screening for common cancers. Qatar became the first country in the Region to join IARC's Executive Board, reflecting its commitment to cancer research and surveillance. With the support of regional experts, two palliative care training modules were established to build national capacities and support training of trainers in low resource countries.

Mental health

Mental, neurological and substance use disorders continue to exact an important toll in the Region, especially in countries with acute and/or chronic humanitarian emergencies and large-scale displacement of population within and across borders. Both the public health response and the service provision show important gaps. For example, 40% of countries do not have mental health policies, 30% do not have plans, and 65% do not have more recent legislation than the past 20 years. There is a large variation in availability and access to mental health professionals and services. The Region has half the global rate of outpatient facilities, and only 1% of outpatient facilities offer follow-up community care. Almost 60% of the mental health workforce is working in institutional settings and community-based mental health services are therefore scarce. Countries have made variable progress in the integration of mental health into primary care. Despite the burden and economic impact of mental, neurological and substance use disorders, the median investment in mental health care of US$ 2 per person annually in the Region is below the US$ 3–9 needed for a selective package of cost-effective mental health interventions in low-and middle income countries. This has translated into a treatment gap in countries ranging from 76% to 85%.

In 2013, WHO focused on five areas. With regard to the first, the development of policy, legislation and strategy, a comprehensive global mental health action plan 2013-2020 was endorsed by the World Health Assembly. Technical support was provided to countries in reviewing, formulating and finalizing national mental health policies, in drafting mental health legislation, in development of national substance use policies and strategies and in developing

national action plans for reducing harmful use of alcohol.

In the area of service development, WHO focused on scaling up implementation of the mental health gap action programme (mhGAP) to bridge the treatment gap though integrated service delivery. This was launched in several countries where capacity-building for integrating mental health and substance abuse in general health care using the mhGAP tools was initiated.

Mental health and psychosocial support is key in the response to humanitarian crises and emergencies. Technical capacities were strengthened in several countries, including international nongovernmental organizations operating in these settings. WHO also supported the development of a psychosocial intervention package to be delivered through non-specialized health workers in emergencies, which is currently being field tested in Pakistan. WHO is collaborating with Johns Hopkins University in setting up a capacity-building programme for psychological interventions by mental health professionals.

Guidance was developed to support countries in setting up a substance use treatment information system and for setting up a suicide registration system. ,

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