

The UN High-level Meeting on the Prevention and Control of NCDs (New York, 19–20 September 2011) and associated side-events

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Important disclaimer:

This independent report, written by C3 Collaborating for Health, is wholly based on notes taken by C3 and others at the plenary sessions, roundtables and side-events. Every effort has been made to reproduce the discussion as it happened, but accuracy cannot be guaranteed as we do not have access to hard copies of the texts of the various events.

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Contents

The UN HLM on the Prevention and Control of NCDs.....	3
Introduction to the UN HLM and the Political Declaration.....	3
This report.....	3
Next steps	3
Plenary sessions and roundtables: thematic presentation	4
Plenary speeches	4
Themes of the plenary and roundtables.....	5
Side-events.....	11
a) Partnership and multi-sector working	11
What's next? How can countries lead the way and engage cross-sectoral partners in the control of NCDs?	11
NCD Alliance briefing – from advocacy to action.....	12
Global Diabetes Symposium: Finding the way to global action	13
Exploring the intersection of agriculture, nutrition and health	14
Working together: collaborating to fight NCDs	15
b) Prevention of NCDs, particularly addressing the risk factors	16
NCDs in urban settings: a call to action in low- and middle-income countries	16
Physical activity and NCDs	17
c) The scale of the problem, data and targets.....	18
From burden to ‘best buys’: reducing the economic impact of NCDs	18
Monitoring NCDs, targets and indicators: what gets measured, gets done	19
d) Synergies with other areas	20
Achieving health equity: uniting around a common agenda to address NCDs and HIV	20
Climate change and non-communicable diseases – creating a climate for health	21
e) Tackling NCDs for all: a lifelong, gendered approach	22
Integrating NCDs: the next frontier in women’s health.....	22
Gender-responsive approaches to NCDs	23
Adolescent health and an opportunity for action.....	24
Innovating for Every Woman, Every Child: towards sustainable partnerships and business models	25
f) Universal coverage and putting people at the centre	26
The role of universal health coverage in tackling non-communicable diseases.....	26
Patients as catalysts for change.....	27
g) New technologies	28
Mobile phones and social media in the response to NCDs.....	28
Communicating the noncommunicable.....	29
h) Looking to the future.....	30
NCD Alliance debrief	30
Appendix 1: The Political Declaration.....	31
Appendix 2: Some useful links	32

The UN HLM on the Prevention and Control of NCDs

Introduction to the UN HLM and the Political Declaration

The United Nations High-level Meeting on the Prevention and Control of NCDs (the 'UN HLM') took place on 19 and 20 September 2011 at the New York headquarters of the UN. It is only the second time that the UN has held a meeting of the General Assembly on an emerging health crisis, the first being HIV/AIDS in 2001. 34 heads of state attended the NCD meeting, compared with 25 at the HIV/AIDS meeting in 2001 – and there were 133 statements made by country delegations at the plenary sessions, which had to be extended to accommodate the unexpected interest.

The main output of the meeting was the **Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases**, which had been negotiated prior to the UN HLM and which was adopted unanimously by member states during the opening plenary. (A précis of the Political Declaration is in Appendix 1, below.) It sets out the scale of the problem of NCDs, and calls for 'a whole-of-government and a whole-of-society effort', that reduces risk factors and creates health-promoting environments, strengthens national policies and health systems, and encourages international cooperation and partnerships, with more research, monitoring and evaluation (including the preparation of recommendations for a set of voluntary global targets for the prevention and control of NCDs, before the end of 2012). Follow-up will include a report on achievements in 2012 and a comprehensive review in 2014.

No major new sources of funding were pledged – although Australia has donated A\$4 million towards the implementation of the WHO Action Plan for the Global Strategy on the Prevention and Control of NCDs, and Russia is allocating funding to help to monitor NCDs and risk factors in Africa, Asia and Eastern Europe.

This report

This report is based on notes taken by C3 Collaborating for Health and others attending the UN HLM and the many side-events that took place over the few days of the UN HLM.

- The plenary and roundtable sessions were all broadly similar in format – namely, statements from senior country representatives – and are here presented by theme. The roundtables were: Roundtable 1 – The rising incidence, developmental and other challenges and the social and economic impact of non-communicable diseases and their risk factors; Roundtable 2 – Strengthening national capacities, as well as appropriate policies, to address prevention and control of non-communicable diseases; and Roundtable 3 – Fostering international cooperation, as well as coordination, to address non-communicable diseases.
- The side-events are also presented by theme, each beginning with a list of the topics that C3 has identified as being key themes in that event.
- The Appendices are a précis of the Political Declaration, and some useful links to documents, websites and media reports.

Next steps

It was made very clear by numerous delegates at the UN HLM that NCDs have now reached a 'tipping point', with no time to waste in taking aggressive action – action that is to be led by member states. Strong statements were made on the need to establish targets, and a process to do so is established by the Political Declaration. The high-level review that is also required by the Political Declaration will help to mobilise action: states can be held accountable for the progress that they have made. All UN member states must have NCD plans in place by 2013 – and many will need help from civil society and others to achieve this. Partnership and cross-sector working are essential for delivering all aspects of the Declaration.

The awareness and momentum created by the UN HLM is also timely, in that the Millennium Development Goals are due to expire in 2015, and ensuring that NCDs are incorporated in any successor goals will help to raise NCDs further up the development agenda. The MDG review meeting is in 2013.

Plenary sessions and roundtables: thematic presentation

This section summarises the plenary sessions and the three roundtables that made up the United Nations High-level Meeting.

- The opening plenary began with five short addresses by the president of the General Assembly, the UN secretary-general, the WHO director-general, the Union for International Cancer Control and the president of the International Olympic Committee. The closing plenary also saw a speech by the mayor of New York. All these are briefly précised here.
- The rest of this summary takes the form of a thematic rendering of the rest of the plenary sessions and the roundtables, all of which took the form of senior representatives of government (and, in the roundtables, civil society) stating some of the main challenges that they face, and action they have taken, on NCDs.

The UN HLM is ‘a historic opportunity to set a new global agenda and to advance the protection of the world’s vulnerable populations’ – President of the General Assembly

Plenary speeches

- The **president of the General Assembly, Mr Nassir Abdulaziz Al-Nasser**, noted that this was only the second time in its history that the General Assembly had met at the level of Heads of State and Government to address an emerging health issue. There have been important developments in our understanding of NCDs, but there is much more that can be done to identify and implement solutions. Cooperation, both between sectors within countries and at international level, is essential.
- **Ban Ki-moon, UN secretary-general**, described the UN HLM as a ‘landmark meeting’. He spoke particularly strongly on the need to involve the private sector in finding solutions, just as the private sector has been intrinsic to efforts to tackle HIV/AIDS. Public–private partnerships are needed, paired with political vision and resource mobilisation.
- **Dr Margaret Chan, the director-general of the World Health Organization**, then spoke passionately on the need for urgent action, including full implementation of the Framework Convention on Tobacco Control, which is often under threat from tobacco companies.
- **Princess Dina Mired (representing the UICC)** contrasted the sometimes ‘vague’ language in the Political Declaration with the very real impact that NCDs have on human lives: ‘We have the opportunity and the moral responsibility to muster the political will to deliver the right punch.’
- Finally, the **president of the International Olympic Committee, Jacques Rogge**, talked about the role of sport and physical activity in preventing NCDs.

The Political Declaration was then formally, and unanimously, adopted. It is summarised in Appendix 1, below.

The closing plenary included a speech by **Mayor Michael Bloomberg** of New York. He set out some of the achievements of the city in recent years in tackling NCDs and their risk factors – life expectancy has risen faster than in the United States as a whole over the last decade, and there are now 450,000 fewer smokers in New York than in 2002, which is saving 1,500 lives a year. He noted that changing the physical and social environment is much more effective than trying to change individual behaviour – and, crucially, that healthy solutions (such as a smoking ban) are not necessarily costly. Cooperation across sectors is necessary, and government action, while not sufficient on its own, is ‘absolutely essential’.

Themes of the plenary and roundtables

Note: There was little differentiation between the themes of the plenary and the roundtables, and no opportunity for discussion – this lack of interaction in the roundtables was criticised by Sir George Alleyne (director emeritus of PAHO) in roundtable 3, and the delegate from Kuwait in the first roundtable commented that he was disappointed to have come all the way just to hear country delegations talking about their own achievements or problems. However, key themes clearly emerged, and are summarised here.

The scale of the problem

The sheer scale of the burden of NCDs, worldwide, was reiterated throughout the plenary and roundtables – 63% of deaths worldwide are due to NCDs, 80% of which are in developing countries, and 9 million of which each year are among those aged under 60.

‘NCDs do not have to spell inevitable doom for our countries and people’ – Desi Bouterse, president of Suriname

Delegates, including Princess Dina Mired (who spoke on behalf of the UICC), the Peruvian minister of health and the delegate from Mauritius, stressed that this is now a global epidemic, even though it is not formally identified as such in the Political Declaration (which refers instead to a ‘challenge’), and it is even beginning to threaten global socioeconomic security.

Many provided startling statistics from their own countries: half of all patients with diabetes die from it in Guinea (many have limbs amputated); in Tonga, where 90% are overweight or obese, 40% of adults have pre-diabetes or diabetes; in Tanzania, 21.8% of the population are overweight, and 5.3% have diabetes; in Suriname, 73% of children aged 13–18 do less than an hour a week of physical activity, and 90% have used tobacco; and in France smoking among young women continues to rise. But there was also good news – smoking has fallen in countries such as Israel (from 45% to 22% since 1983) and Canada (from 25% in 1999 to 17% today).

Partnership and multi-sector working

The Political Declaration heavily stresses the need for a ‘whole-of-government’ and ‘whole-of-society’ approach to NCDs – and this was the theme that was most taken up by the statements in the plenary and roundtables, led by the UN Secretary-General in his call for public–private partnerships. Many delegates mentioned the need for multi-sector working and for partnership, and many have in place national plans that aim to take this approach forward. While individual responsibility certainly plays an important role, consumers and citizens cannot always make the healthy choice – making this easier will require efforts by all parts of society, and many different areas of government. NGOs also have an important role to play in the fight against NCDs, as stressed by Margaret Chan in the third roundtable.

‘In coordinated fashion, we can win!’ – President of Slovenia

As the Mexican roundtable delegate put it, ‘We’ve done all that we can, with limited resources, with public policy’ – it is time to work with the private sector and civil society groups.

Prevention of NCDs, particularly addressing the risk factors

One of the main themes both of the Political Declaration and the UN HLM was the need to take urgent action to prevent NCDs: ‘prevention is the cornerstone’ of what needs to be done, according to the EU delegate in the first roundtable. Particularly important in prevention is addressing the four major risk factors: tobacco use, poor diet, lack of physical activity and the harmful use of alcohol. Many examples were given of the extent of these risk factors around the world, and actions that are being taken to counter them.

- **Tobacco use** was frequently mentioned – both successes (often catalysed by the Framework Convention on Tobacco Control) and failures. The insidious nature of the tobacco companies was pointed out by some delegates – in Nauru, for example, children are 3–4 times more likely to use tobacco than their peers in developed countries. And struggles are under way: Uruguay explained that it is currently facing a lawsuit from Philip Morris over the country’s tax policies, and the Australian health minister explained how her country is the first to pass laws on plain packaging of tobacco

products – a move that is being fought by the industry: ‘The more that tobacco companies fight, the more we know we are on the right track!’

- Jacques Rogge (International Olympic Committee) highlighted sport as ‘the gateway to **physical activity** and healthy lifestyles’, while others focused on active living (including active transport – encouraging walking and cycling rather than car use) as a lifelong way to get enough exercise. In Mongolia it is currently the ‘year of physical activity’. The Swedish secretary of state noted that physical activity is now prescribed for some patients in place of drugs.
- Many countries noted efforts being made to improve **diets** – for example, working to eliminate trans fats (e.g. Brazil), reduce salt (e.g. Barbados, Argentina), and improve labelling (e.g. in restaurants in New York City, as described by Mayor Bloomberg).
- **Alcohol** misuse was also noted – for example, Botswana has a programme to reduce alcohol consumption, and Namibia is working to limit the sale of alcohol to over-18s and to restrict when it can be sold. Enforcement of these laws is often challenging, especially in rural areas.

A key part of prevention is tackling **health inequalities**, raised by several delegates and highlighted in the final plenary feedback from roundtable 1 – we need to look at the bigger picture: what drives the prevalence of disease: the ‘causes of the causes’.

The role of government

Although a whole-of-society approach is needed, there is an essential role for governments: ‘Governments may not be the whole solution, but they can lead the campaign’, as Ban Ki-moon put it. Governments need to adjust their thinking to recognise that investing in prevention and health care is worthwhile, even in a challenging financial climate. Establishing indicators and collecting data is a role for government – something that many countries, such as Israel, noted that they are in the process of establishing – and countries including Chad are planning screening for the risk factors and public-education programmes.

Policies need to be reorientated towards public health, with a ‘change of mindset’ and ‘sustained political commitment before the consequences catch up with us all’ (president of Switzerland), and with ‘health in all policies’ (Norwegian minister of health). The current policy failures were highlighted by Dr Chan: ‘obesity is a signal that something is terribly wrong in the policy environment’. Some efforts already being made were highlighted – for example, a National Exercise Taskforce has been established in Barbados to tell people about the importance of getting active.

‘Governments must make healthy solutions the default social option’ – Mayor Bloomberg

Whether and how much government should regulate was raised by some delegates, with suggestions that a ‘fat tax’ could be instigated on foods high in fat, sugar and salt. There is certainly a clear role for legislation in some areas – notably tobacco – but, as the UK’s health minister put it, ‘In a free society we cannot just legislate these problems away. The Elimination of Obesity Act 2011 does not exist.’ The International Development Law Association delegate commented that more legal measures are needed, but can be resisted by industry – there is a need for capacity building in this area.

The role of the private sector

Many delegates raised the role of the private sector in the ‘whole-of-society’ approach – and most regarded business involvement as being positive, indeed essential.

Businesses can take a strong role in workplace health, as noted by the delegate from Russia. A delegate from the World Bank commented that in central Asia, NCDs reduce productivity by between 7 and 30% – a drain both on the companies themselves and on the national economy.

The failure of some companies to act responsibly was noted by several delegates, with some fears about conflicts of interest being expressed in the third roundtable from Thailand and Consumers International. The tobacco industry was very strongly criticised, particularly for its ‘despicable efforts’ to subvert the Framework Convention on Tobacco Control. Margaret Chan also commented in the third roundtable that we need to be on the lookout – ‘even an old dog like Big Tobacco can learn new tricks’.

As part of civil society, the private sector (although not, of course, the tobacco industry) had a voice at the roundtables. The International Food and Beverage Association, for example, spoke in the first roundtable, highlighting efforts that its member companies have made. The IFBA representative also made a plea for member states to ‘consult with a willing business sector’ when planning how to implement the Political Declaration.

The costs of NCDs

Several countries noted the costs of NCDs to their economies – in Barbados, 1 in 4 people has an NCD, which is currently costing 6% of GDP, and the proportion is set to go up to 1 in 3 by 2025. Health spending is heavily skewed towards the developed world – 60% of cancer deaths occur in developing countries, but only 5% of the global spend on cancer treatment is spent there. But even in the developed world, relatively little is spent on prevention – in the EU, for example, less than 3% of the health budget is spent on prevention. As Ban Ki-moon noted, ‘Treatment must be affordable – but prevention is cheaper.’

A recent report on the costs of NCDs was cited by many delegates – compiled by Professor David Bloom at Harvard University, it estimates the loss in economic output due to the four major NCDs will be around \$30 trillion between 2011 and 2030. The report also undertook a cost-benefit analysis and found that the benefits of taking action now outweigh the costs of inaction three-fold.

Identifying which interventions are the most cost-effective was highlighted by many delegates – this evidence is needed to ensure that limited budgets are spent to best effect.

‘We must bring NCDs into the broader health and development agenda’ – Ban Ki-moon

The impact of NCDs on development

Given the huge costs of NCDs to national economies, individual families and communities, it is not surprising that many delegates stressed the need for NCDs to be central to the development agenda, as without this they ‘will scuttle progress towards the Millennium Development Goals’ in countries that are least able to cope (President Robert Mugabe, Zimbabwe). As pointed out by the delegate from Trinidad and Tobago at the first roundtable, as soon as there is an upward trend in development, lifestyles change and more salt, sugar and fat is consumed, fuelling the NCD crisis – and, indeed, malnutrition and obesity can be ‘at the same table’ in Mexico and elsewhere.

Financial strains do not just come about because of health-care costs (although these can be catastrophic for poor families) – the price of healthy lifestyles is also problematic. In Nauru, for example, the cost of a head of lettuce is the same as a packet of cigarettes: ‘Vice is more affordable than virtue.’

The Mauritian prime minister stated that ‘NCDs are one of the greatest challenges to development of our time’, and stressed that the UN HLM must be seen in the context of working towards the successors to the MDGs. Guyana has been calling for an ‘MDG Plus’ on NCDs since 2001, and Barbados also commented that NCDs ‘must’ be in any future development goals.

Finally, the failure of truly sustainable development – including the links of NCDs with climate change – was noted by some delegates. The president of Nauru noted that climate change and ocean acidification are contributing to a shortage of healthy food in his country, and the vice president of the Maldives stated that preventing NCDs is inextricably linked with climate change – and that we have an obligation to future generations to tackle this dual problem.

‘Where are the targets? How do we know we are on the right path without a well-defined finishing line?’ – minister for public health, Botswana

The need for data and targets

Many delegates, such as those from Jamaica and Yemen, called for much more surveillance on NCDs and their impact, particularly in low- and middle-income countries, where current capacity is often inadequate. Without accurate data it is not possible to allocate resources to best effect, or to track progress. As the UN Population Fund delegate noted, targets are necessary for accountability. The Political Declaration sets in motion a process to establish targets, and this was welcomed. South Africa has recently adopted its own targets, and commented that the UN HLM added to the impetus for that move.

There was also a call for international assistance in establishing surveillance frameworks and collecting data.

Putting people at the centre

What can be lost in all the talk of statistics and costs is that there are people at the centre of the NCD crisis – the UICC called on everyone to think not in terms simply of lives lost, but instead count the survivors. Some delegates talked about patients and individuals – notably the International Association of Patient Organisations, whose delegate at the first roundtable stressed that patients are an important part of the solution, as they can offer responsible citizenship around NCDs, and provide information that is essential to improving management of illness. Denmark particularly noted the importance of self-management of NCDs.

Bringing health care closer to home was also called for by the Red Cross/Red Crescent society – moving health from clinics to communities and into the home.

Universal access to care

The International Covenant on Economic, Social and Cultural Rights includes ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ – and the importance of universal, equitable access to care was raised by many delegates: ‘access to health is a right, not a luxury’. The need for more, better treatment and management is obvious: for example, half of all public hospital beds are occupied by people with NCDs in the Bahamas, and 80% of drug costs are for hypertension and diabetes, according to the prime minister. Late diagnosis is often a particular problem – in Swaziland, 39% of heart disease is only diagnosed in tertiary care facilities.

‘Where you live shouldn’t determine whether you live – Nancy Brinker, World Health Organization

Countries’ efforts to improve care were highlighted, and the Rwandan health minister commented that efforts to date are ‘a beginning: we want to go further’. Great strides have been made in Rwanda in HIV – where there is now universal access to treatment, such that mother-to-child HIV transmission rates are now less than 2% – and this success needs to be replicated for NCDs. Inequalities within countries are also important, stressed by countries including Denmark – as the International Union against TB and Lung Disease noted, ‘fair distribution of health is a human right’. The needs of vulnerable populations were also noted as being of particular importance.

Tackling NCDs for all: a lifelong, gendered approach

NCDs do not only affect older people – premature death and disability are major issues, but tackling the risk factors begins in childhood, and even before birth, as increasing evidence shows that the health of the mother during pregnancy can affect the long-term health of the child. The early origins of health are key (and linking NCDs to maternal and child health would be of benefit, noted by Russia and the League of Arab States), and a life-course approach – or ‘womb to tomb’, as the president of Fiji put it – is needed.

‘We are not just adding years to our life, but life to our years’ – UK health minister

The NCD burden can fall particularly hard on women, whose health has major social and economic consequences. Women are often the primary carers, and may, in some cultures, have restricted access to care. The need to empower and educate women was highlighted by New Zealand, for example, and the delegate from the Commonwealth Secretariat and others also noted the need to ensure that the impact of NCDs on women is fully recognised and dealt with.

Synergies with other areas

Particularly in an era of particularly stiff competition for limited resources, seeking out synergies with other areas, and ensuring economies of scale, is essential – as the minister of health from Mozambique noted, the country has no possibility to treat these new diseases, and only an integrated policy of fighting the risk factors will work.

Working across silos with other disease areas (notably HIV, TB and malaria) is essential – indeed, the Zimbabwe delegate at the first roundtable commented that the emphasis on HIV has allowed the NCD epidemic to spread. As the South African health minister noted, HIV is now itself a chronic disease, being treated over a long period of time – and there are many valuable lessons that can be learned from the

experience of access to HIV medicines. A delegate from Guyana commented that existing immunisation programmes are life-saving, and could be used as a model for NCDs, particularly cancer.

Strengthening health systems across the board, with a particular emphasis on primary care, is essential.

International action

Several ways in which the international community can come together to tackle NCDs were highlighted.

Intellectual property (IP) rights, particularly in relation to essential medicines, were raised by delegates – Zimbabwe’s delegation voiced a fear that the human face of NCDs can get lost in efforts to conform with TRIPS. Several delegates – such as the president of Kenya – called for the enabling of local manufacture of medicines, which would improve access. There needs to be ‘constructive dialogue’ with the commercial sector to ensure trade practices protect and promote health – the feedback from roundtable 2 noted that many wanted to tackle perceived pressure from the pharmaceutical industry. But, as the feedback from roundtable 3 noted, there needs to be the right balance between cost to consumer and ‘reasonable profits’.

The ‘brain drain’ of experienced health professionals was noted as a problem – for example, by Hungary’s president and by Guyana’s delegate in the first roundtable.

Other areas that would greatly benefit from joint national action include information sharing (called for by India), research cooperation (for example, a scientific technical working group to look at what research is needed and measure the efficacy of interventions, called for by Trinidad and Tobago), regulatory harmonisation, and technical support (such as help for small countries in setting regulatory measures, as noted by the International Development Law Association).

The delegate from St Lucia particularly applauded organisations that are looking into reducing fat, sugar and salt, because (as is also the case in countries such as Botswana) St Lucia imports most of its food, so international action in this area will affect the diet of its people. The minister of health from Papua New Guinea also called on wealthy countries to stop subsidising unhealthy agriculture.

Sir George Alleyne commented that ‘There must be some place of authority that will facilitate [international] cooperation’ and that ‘We must undertake to strengthen WHO to undertake what it needs to perform.’ Some suggestions were made, including the appointment of a UN Secretary-General special envoy representative on NCDs, called for by the prime minister of Trinidad and Tobago and minister of health for Guyana, among others.

‘We are entering a new frontier in public health, for which international collaboration and cooperation are quite vital’ – prime minister of St Kitts and Nevis

New technologies

A few delegates (such as the League of Arab States representative in the third roundtable) noted the rising importance of new technologies – social media and mobile technology. In Gabon, for example, mobile technology will soon be used to disseminate messages about diabetes, and social media was noted as being a good avenue to explore in the future in the feedback from roundtable 2.

National realities

Taking national realities into account was also a theme. Countries vary greatly in terms of their rural/urban populations, cultural norms and attitudes (for example, in Comoros only 13% smoke and 80% never drink alcohol, but 80% do not eat five-a-day).

Other diseases

The main focus of the Political Declaration is the four main NCDs: cardiovascular disease, cancer, chronic lung disease and diabetes. However, there are many other non-communicable diseases, and delegates highlighted some that should also be taken into account – the World Medical Association delegate, for example, called for a ‘more complete’ approach.

Countries including Kenya, India, Grenada and Tanzania particularly noted the impact of mental health disorders – the report from Harvard on the costs of NCDs between now and 2030 puts the economic burden of mental health at around \$17 trillion (compared with \$30 trillion from the main four diseases in the Political Declaration).

Other diseases that were specifically mentioned include musculo-skeletal disorders, oral diseases, accidents and sickle-cell disease.

Looking to the future

Although some delegates expressed disappointment with some aspects of the Political Declaration – particularly the lack of clear goals and a roadmap – Ban Ki-moon described it as ‘an excellent foundation from which to bring NCDs onto the broader global development agenda’. Many delegates focused instead on the positive: on the need for the Political Declaration to be the start of something new and urgent. The UN HLM ‘must be a watershed event with a clear before and after, with ignorance, complacency and inertia replaced by awareness, shock and the right actions straight away’ (Margaret Chan). Ideas included agreeing a minimum package of care available to everyone everywhere (Guyana), global standards on trans fats and salt, creating a roadmap (Kuwait), and identifying more champion countries that can lead by example (NCD Alliance).

The urgency of the growing epidemic was stressed throughout: there is no time to waste in putting the commitments unanimously adopted in the Political Declaration into action.

Side-events

This section presents the 20 side-events attended, which are categorised broadly by theme.

Please note that **all the events covered multiple themes, so the choice of category is largely subjective.** Themes such as partnership/cross-sector working, the scale of the problem, prevention and interventions were common to almost all of the events.

Themes:

- a) Partnership and multi-sector working
- b) Prevention of NCDs
- c) The scale of the problem, data and targets
- d) Synergies with other areas
- e) Tackling NCDs for all: a lifelong, gendered approach
- f) Universal coverage and putting people at the centre
- g) New technologies
- h) Looking to the future

a) Partnership and multi-sector working

What's next? How can countries lead the way and engage cross-sectoral partners in the control of NCDs?

This event was held on 19 September, hosted by the Institute of Medicine and FHI 360 (www.fhi.org), and moderated by Johanna Ralston (World Heart Federation) and Peter Lamptey (FHI 360).

Key themes were:

- the **problems posed by NCDs** in developing countries – Grenada, Rwanda, Bangladesh and Kenya; and
- **solutions**, particularly from the private sector.

The event began with representatives of a number of developing countries highlighting **particular issues posed by NCDs**. In Kenya, where Article 43 of the Constitution states that every Kenyan has the right to affordable health care, 50% of hospital beds are occupied with people with NCDs, which are more complicated and take longer and are more costly to treat. In Rwanda, progress has been made with infant diseases – the death rate of under-5s used to be 20%, but it is now 6% – but there is still a long way to go. Rheumatic heart disease and cervical cancer are particular problems among adults in Rwanda, and Bangladesh, too, noted its high rates of cancer among women. Grenada is now focusing particularly on workplace wellness.

The private sector was represented by **Renuka Gadde** (global health at BD – Becton, Dickinson & Co.), who focused on partnership working and access pricing, and by **Maureen Harrington** (Standard Bank of South Africa). Standard Bank has 40,000 employees in Africa, and has put in place a comprehensive wellness programme, tackling issues such as high blood pressure and cholesterol, HIV/AIDS and diabetes. There are 600 'wellness champions' in the company, and an Employee Assistance Programme (the top two issues being crime and vehicle accidents).

In particular, the event called for the recognition that NCDs are a global problem, that strong national leadership is required – and that appropriate resources be committed.

NCD Alliance briefing – from advocacy to action

This event was held prior to the UN HLM, on 17 September. It was hosted by the New York Academy of Medicine, organised by the NCD Alliance, and took the form of a general briefing about the NCD Alliance and the UN HLM.

Key themes were:

- the achievements that have been made in putting **NCDs on the political agenda**;
- the **practicalities of the UN HLM** itself;
- the launch of some **new publications**; and
- the need for more to be done, with the **UN HLM forming part of a longer-term commitment**.

Cary Adams (UICC) set out the aims and achievements of the NCD Alliance since its formation in 2009. Its aims were the HLM on NCDs, inclusion of NCDs in the MDGs and their successors, access to essential medicines, and better integration of NCDs into health systems. He highlighted the **achievements, not only of the actual HLM, but also the mushrooming effect of advocacy**, with national and regional NCD alliances, support from other movements and greater levels of influence and access. Australia, for example, has committed A\$25 million over four years to preventing NCDs.

Eduardo Cazap (an oncologist from Argentina and UICC member), **Mirta Roses** (PAHO/AMRO), **Dr Ashley Bloomfield** (WHO) and **Joop Theunissen** (UN NGO Office) updated attendees on the **practicalities of the UN HLM**. Over 100 countries have signed up to speak, so the plenary sessions have been extended – initially there was only time for 65 [and in the end over 130 spoke]. The level of civil-society involvement is unprecedented – normally only 20 tickets are given to NGOs, but 283 civil-society representatives are expected. Expectations management is also important – there may be many empty seats, but protocol demands that every member state has the right to a seat at any time.

There is still much to be done. There is little ‘outrage’ about NCDs – we need to foster a rights-based approach, with greater involvement of people with the diseases, as well as prominent government or celebrity champions. More funding is required: suggestions include using the expertise of the HIV community (‘they know how to pressurise governments to open their wallets!’), asking for existing resources to be reallocated, and for countries to remove taxes on essential medicines, as well as producing medicines themselves.

‘Lack of recognition and visibility is the largest risk factor, including lack of data and surveillance systems’

The issue of private-sector involvement was also discussed: **Jean-Claude Mbanya** (International Diabetes Federation) spoke of the need to work together in a ‘public-private-people’s partnership’, and **Pekka Puska** (World Heart Federation) noted that the determinants of the NCD epidemic are related to commercial interests, so we need to be strong on public-health objectives. Team Type 1 (<http://teamtype1.org/>) was mentioned (cyclists travelling across the United States to raise awareness about type 1 diabetes). Teenagers with type 1 are dying of CVD complications – such complications need to be prevented, and the private sector should be part of this initiative.

The lasting message of the event is that **this is just the start**. Mirta Roses urged everyone to ‘keep the hope, keep the strength, and keep the enthusiasm: it can be done’, and **Karen Sealey** (PAHO/WHO) warned of the danger of losing momentum, urging all to keep pushing for NCDs to remain on the development agenda.

‘We are in it for the long haul!’ – Cary Adams, UICC

Several new publications were also launched: a *Collaborative Framework for Care and Control of Tuberculosis and Diabetes*, a *Global Asthma Report*, *Global Diabetes Figures 2011* and the *IDF Global Diabetes Plan 2011–21*, and the *Global Atlas on CVD Prevention and Control*.

Global Diabetes Symposium: Finding the way to global action

This event was held on 18 September, co-hosted by the Albert Einstein College of Medicine of Yeshiva University and the International Diabetes Federation, with funding support from Novo Nordisk and Bristol-Myers Squibb.

Key areas covered include:

- the **scale of the diabetes epidemic** – and its impact on development;
- the **early origins of health**, and childhood; and
- the need for **solutions from many different (non-health) sectors**.

'The fight is global – solutions can emerge from anywhere!' – Venkat Narayan

Following introductions from Louis Weiss and Allen Spiegel, from the Albert Einstein College of Medicine, **Venkat Narayan** (Emory University) presented on **'NCDs: where the worlds meet'** – NCDs, and diabetes in particular, are not diseases of the developed world. While blood pressure and 'bad' cholesterol have declined in developed countries, levels have increased in LMICs, and there are now increases in BMI – and diabetes: in some LMICs diabetes has quadrupled. The costs are unsustainable even in the United States – \$1 in every \$5 spent on health care (and \$1 in every \$4 in Medicare) is spent on diabetes. And beyond these costs, diabetes is linked to productivity – it will not be possible to achieve the MDGs on poverty reduction without addressing diabetes. All past projections of diabetes have proved to be underestimates – the latest figures from the IDF suggest that there are 366 million people with diabetes worldwide, 4.6 million deaths annually, and that this costs US\$465 billion.

The **early origins of health** were discussed by **Meredith Hawkins** (Global Diabetes Initiative, Albert Einstein College of Medicine), **Judy Fradkin** (NIDDK) and **Richard Deckelbaum** (Institute of Human Nutrition, Columbia University Medical Centre). The intra-uterine environment is important – maternal glucose tolerance increases in the third trimester risks type 2 diabetes in the child, so this is a vital time to intervene (and the NIH/CDC has a programme aimed at families with GDM), and maternal overweight correlates with high BMI when the child is aged five. Richard spoke about the double burden of children with over- and under-nutrition, and noted that the most common type of childhood diabetes in Japan is type 2.

Meredith presented on a form of diabetes ('malnutrition diabetes'), which presents in young people following a childhood of malnutrition. Anil Kapur (World Diabetes Federation) noted that this type of diabetes is not, in fact, new, and that it used to exist in India but is less prevalent today.

In addition to using the health sector (for example, encouraging health professionals to ask people about their family history of diabetes, which helps them to understand the risk), speakers stressed the need to **involve other stakeholders**, particularly the business community. Venkat Narayan said that food and agriculture policies are essential – that federal subsidies are often in opposition to health policy, and that advertising tends to be of the foods of which we should be eating the least. The concern with food and farming was echoed by **Derek Yach** (PepsiCo), who called for policies and incentives to make healthy food affordable, and for energy density and portion size to be reduced. For him, 'farmers and town planners hold the key to diabetes prevention', with a need for integrated urban design to include walking and cycling, and a coalition to address the intersection of aesthetics, the environment and health.

The remaining speakers were: 'Promoting self-management behaviors: challenges and opportunities' (Elizabeth Walker, Albert Einstein College of Medicine), 'Behavioral interventions in global diabetes' (Edwin Fisher, Global Director, Peers for Progress), 'Initiatives used in diabetes prevention/management program in NYC' (Shadi Chamany, New York City Department of Health and Mental Hygiene), 'HIV infrastructure-the key to comprehensive healthcare systems – The AMPATH story' (Sonak Pastakia, AMPATH Chronic Disease Management Program), Launch of the International Diabetes Federation Global Diabetes Plan (Ruth Colagiuri, IDF) and 'Managing diabetes in a low-resource country and concluding remarks: IDF vision for the future of global diabetes' (Jean Claude Mbanya, IDF).

All presentations and video are available online at www.einstein.yu.edu/gds.

Exploring the intersection of agriculture, nutrition and health

This event was held on 19 September, and was co-hosted by PepsiCo and the Chicago Council on Global Affairs, attended by about 100 people. It presented the results of a new report, *Bringing Agriculture to the Table: How Agriculture and Food can Play a Role in Preventing Chronic Disease* (available at http://www.thechicagocouncil.org/UserFiles/File/GlobalAgDevelopment/Report/Bringing_Agriculture_To_The_Table.pdf), followed by a panel discussion.

Key themes were:

- the **role of agriculture in NCDs**; and
- **partnership working** for solutions.

‘NCD in low- and middle-income countries looks like it does in high-income countries, but it has a younger face and emptier pockets’ – Rachel Nugent, Chicago Council on Global Affairs

Rachel Nugent (The Chicago Council on Global Affairs) began by setting out the burden of NCDs globally – everywhere except Somalia and Haiti has an increasing problem with the diseases, which are in danger of overwhelming health systems (spending on NCDs in Brazil is the equivalent of 10% of GDP, for example). What is recommended in the report is clearly going to be less expensive than the alternative. The **role of agriculture in fuelling – or stemming – the epidemic** was discussed by all speakers: there is too much effort going into making too much food, and not enough into making healthy food, such as fruit, nuts and wholegrains. 2 billion people are currently suffering from a lack of micronutrients such as zinc, iron and vitamin A. There have been successes – in the United States, consumption of added sugar has fallen by about a third in a decade – 2/3 of which is due to changes in consumption of soda.

And yet, despite the obvious links between the agriculture and health agendas, as **Shenggen Fan** (International Food Policy Research Institute) pointed out, there is a lack of a common language between the two worlds, with health the worst offender for incomprehensible acronyms. The first priority should be to do no harm. For example, the Rockefeller Foundation’s new global health lead should have an interest in agriculture, as part of the need to shift from siloed into cross-sector thinking. (Brazil is leading the way on this, with a ‘super agency’.) In an era of hunger and food insecurity, as well as over-consumption, joined-up working will be essential.

The discussion turned to the different **roles of the multiple stakeholders in the food supply chain**, ‘from farm to fork’, namely: production (agriculture), primary food storage/processing, secondary food storage/processing, food retail and food marketing. All these stakeholders need to be involved if health is to be improved, along with five main groups of actors: national governments (who, it was suggested, could tax unhealthy food if the market does not work), international institutions, donors, the agrifood business and consumers.

The concept of ‘value chain’ was discussed, with the UN’s David Nabarro preferring ‘benefit chain’ as a more accurate description of what needs to be done. In particular, agriculture can: encourage production of healthy foods such as legumes; put in place policies to support the marketing of fresh foods, and protect local farmers; improve the nutritional content of staples; encourage school gardening; and ensure genuinely sustainable development by assessing the health impact of environmental projects.

In an example of a new initiative by the private and public sectors, **Derek Yach** (PepsiCo) described the company’s announcement on the day of this meeting of a partnership with the Chinese Ministry of Agriculture to promote sustainable agriculture projects: building and operating demonstration farms using the most advanced irrigation, fertilisation and crop-management techniques, and working together to promote best practice to improve yields, increase income and raise living standards for farmers.

Marketing healthy foods in an attractive way is also key, as pointed out by both Derek Yach and Shenggen Fan – the first vitamin A-enriched rice, for example, was initially marketed under the name Yellow Endosperm rice, which (unsurprisingly) was not a big seller until it was relaunched as ‘golden rice’.

As Shenggen Fan stressed, there is no time to waste in taking action.

Working together: collaborating to fight NCDs

This event was held on 19 September, and was organised by the International Food and Beverage Alliance, which is made up of 10 of the largest food and beverage companies in the world, who came together to support the implementation of the WHO's Global Strategy on Diet, Physical Activity and Health.

Key themes were:

- the **scale of the challenge** requires **partnership**;
- the **positive role that can be played by the food companies**; and
- the role of **regulation**.

'Healthy offerings and healthy profits are not mutually exclusive' – Secretary Sibelius

The US Secretary of Health, **Kathleen Sibelius**, set out the **scale of the challenge** facing the United States, with adult obesity having doubled and childhood obesity tripled in just one generation. The First Lady's 'Let's Move It' campaign (the new CEO of which was also present at the meeting) was described, including 1,500 childcare centres that are committed to taking part, and the 'million hearts' campaign to prevent 1 million heart attacks and strokes over the next five years, using the message ABCs (aspirin, blood pressure, cholesterol, quit smoking). **Despina Spanou** (European Commission) also commented on the rise in obesity in the European Union (with obesity now between 7% and 24% in EU countries, and ¼ of people doing no physical activity). NCDs are spread in new ways – transmitted through social networks, making them, as **Julio Frenk** (Harvard School of Public Health and former Mexican health minister) described them, 'communicated diseases'.

A major theme of many of the speakers was the **need for partnership** in overcoming the challenge of NCDs, which Secretary Sibelius began by highlighting the CDC's work with PAHO and the WHO to train health-care professionals in 40 countries in physical activity, and that food companies are working together to reduce salt. Dr Spanou noted that the EU and OECD are working together on legislation that will govern health claims on food labelling.

The **role of the food companies** was introduced by **Derek Yach** (PepsiCo) by way of explaining that food insecurity, climate change and agriculture are inseparably linked with health. The food industry has good consumer insights and a deep knowledge of consumer behaviour that can be used to market healthy products – Julio Frenk noted that we need to move away from the idea that 'if it's good for industry it's got to be bad for people'.

Whether formal **regulation** should be imposed was then discussed by Dr Yach, noting that this is not simply about the multinationals – we need to ensure that SMEs and local food companies can also meet any new standards. There are some advantages to self-regulation by the industry (costs are borne by the companies, not the public purse; the onus is on the companies themselves to stop cheats), but some self-regulation is weak. However, most developing countries do not have the capacity to regulate – or at least not to enforce regulation once it is on the books. Dr Spanou noted that legislation/self-regulation it is not an either/or – they can run concurrently, or follow on from each other, as happened with GDA labelling in the EU, when companies began labelling before the EU required it. Julio Frenk commented that regulation should enable greater transparency, and also cautioned against using the same measures for all the risk factors – tobacco is a simple issue, whereas food is much more complex. He also noted that good regulation should be about creating an enabling environment, whether that is an improved built environment, or an environment that encourages competition and innovation in delivery of services and other fields.

Finally, the **significance of the UN HLM** was strongly stressed by both Dr Frenk and Dr Yach, with the latter commenting that the world of global health will never be the same again after this week. We need 100% of us to die of NCDs, rather than from infectious or reproductive diseases: what is crucial is the quality of life with which we live, and the age at which we die.

b) Prevention of NCDs, particularly addressing the risk factors

NCDs in urban settings: a call to action in low- and middle-income countries

This event was held on 18 September, and was hosted by the New York Academy of Medicine, introduced by Jo Ivey Boufford and with discussion facilitated by Gloria Sangiwa. The aim of the meeting was to assess the growing urban NCD epidemic, and give policy-makers, stakeholders and advocates the opportunity to assess the evidence base for existing urban NCD interventions. Key themes fell clearly into two categories:

- **evidence** on the increase in NCDs and its particular relevance for urban areas; and
- **interventions** – including a case study of Bangladesh.

‘You cannot make a difference in addressing the risk factors unless you have effective mechanisms for engaging the non-health sector’ – Ala Alwan

Dr Ala Alwan (World Health Organization) **set the stage**, describing the rapid increases in urbanisation over recent decades (33% of the global population lived in urban areas in 1950; in 2009 50% was reached; by 2030 it will be 60%, and 70% by 2050), which has led to a triple threat of infectious disease, injuries/crime and NCDs. The bulk of premature deaths from NCDs (90% of the 9 million a year among under-60s) are in low- and middle-income countries – 56% of NCD deaths in Sierra Leone are in the under-60s, compared to just 7% in Sweden. Surveillance of data – integrating NCD data into national health systems – is essential to measuring and tackling the diseases.

But NCDs are not only a threat to health: ‘they are also emerging as a major socioeconomic threat, and are a threat to urban development’, with many families being forced into poverty following catastrophic spending. He focused particularly on encouraging new ways of working, especially at the municipal level.

Professor Srinath Reddy (World Heart Federation) then introduced some **successful risk-factor interventions**, commenting particularly on New York City’s own achievements, including a recent 500,000 drop in the number of smokers and a successful campaign against transfats from 50% of restaurants in 2006 to just a few percent today. He noted that ‘we need to distinguish evidence for policy and evidence on policy’ – in other words, we can no longer use lack of evidence as an excuse for inaction, but we must assess interventions to identify which are the most successful. He referred frequently to the WHO’s *Interventions on Physical Activity and Diet: What Works* report (2009): <http://www.who.int/dietphysicalactivity/whatworks/en/>

Interventions on diet can include reducing the use of transfats (Denmark was the first country to do this) and promoting the consumption of fruit and vegetables through increasing availability – if they are available within 100m of residences, purchases have been shown to increase. Effective physical activity interventions include improved public transport, encouraging healthy commuting and trips to school, and point-of-decision prompts to encourage stair use. Cities need ‘smart growth’ urban planning, with mixed land use and open space. Specific projects include Agita Sao Paulo in Brazil (a ‘poster-child’ for promoting community-based physical activity), the ciclovias that began in Bogota (where 120km of roads are closed to motorised traffic on Sundays), the Steps Forward project (Pasos Adelante) on the US/Mexico border, and Chennai’s PACE programme (313% increase in participants exercising more than three times a week).

The final speaker was His Excellency **Dr Ruhul Haque** (Ministry of Health and Family Welfare, Bangladesh). Bangladesh is fast urbanising, from just 5.1% in 1960 to 27.6% in 2009, and NCDs are rising in tandem – by 2000, 5.3% had diabetes, up from 1.1% in 1980 (the rate of diabetes in urban areas is double that of rural areas). However, he commented that it is not just about living in cities: ‘urban’ means nothing – rather, it is the ‘urban poor’ who are most at risk. He described some responses, including implementation of the Framework Convention on Tobacco Control, and noted that the way forward is to scale up NCD models, but that more coordination is needed to prevent the diseases. He also called on the world community to find more money to help poor countries to treat conditions, and hoped that the UN HLM will give the courage and strength to find solutions.

Dr Alwan noted that the Political Declaration meets many of WHO’s expectations. Particularly important is the ‘health-in-all-policies’ approach it takes, that NCDs are part of the development agenda (with the socioeconomic impact repeatedly emphasised), and that work is beginning on global targets.

Physical activity and NCDs

This was held on 18 September, and was a five-hour event, attended by seven ministers of health and their representatives, including the minister of health of Aruba and the US Surgeon General, Dr Regina Benjamin. It was hosted by the American College of Sports Medicine and PAHO. It brought together many stakeholders from the physical activity and sports arenas and elsewhere to discuss physical activity as an instrument of action on NCDs at policy, worksite, community and individual levels, with the aim of fostering national physical activity policies across the ‘whole of government’ and ‘whole of society’.

Themes of the day fell into three broad categories:

- a **snapshot of physical activity** in a number of countries;
- **making the case** for physical activity, including in the workplace; and
- **the best buys** – building on examples of successful existing projects from around the world.

‘The bottom line is that we should make it fun!’
– Regina Benjamin, US Surgeon General

The event began with presentations on the **ways in which a number of countries are promoting physical activity**. In the US, **Regina Benjamin** noted that it is part of the movement to solve childhood obesity in a generation, including policies such as the Safe Routes to School programme and Putting Prevention to Work grants (used in LA to improve an outdoor public park and playground). In Brazil, **Deborah Carvalho** noted that \$100 million has been spent on local physical activity promotion projects – the World Cup 2014 and Olympics 2016 are being used to catalyse sports in the country. **Dr Alberto Tejada** (minister of health, Peru) used the example of making public spaces more enjoyable, not for physical activity per se – but it has made physical activity much easier, with 350,000 people now using the space in Lima. **Richard Visser** (Aruba’s health minister) talked about ‘sports for all’, combining education, physical activity and sport, but noting that including sport at school requires an extension of school hours. Some of the speakers focused on sport rather than physical activity; others more on general physical activity.

A major theme of the day was how best to **make the case for physical activity**, given how clear the benefits are for health. Making the case is not possible without knowing the data and where best to take action, and **Eva Jané-Llopis** (WEF) used examples of employers’ realisation that physical activity can improve worker health and productivity – and noted that, often, data from these programmes are not captured, which is a missed opportunity as they are then not reproduced elsewhere. **Caitlin Morris** from Nike presented a physical-activity systems map on which Nike is working, to ascertain how physical activity initiatives can impact on different sectors and stakeholders (particularly among young people, where data is weakest). She warned not to be overwhelmed by perceived barriers, as working across sectors can have great impact.

‘[Physical activity] should be viewed as a driver of performance, not just health’ – Jack Groppe, author of *The Corporate Athlete*

In one of the most engaging talks in any side-event, these benefits were given a human face (so often lacking at such events): **Priscilla Farrell** is a 71-year-old from Maine, who used to be in a battle with obesity and type 2 diabetes, on oxygen 24 hours a day. Now, following the ‘Healthway Silver Sneakers’ programme, she has lost 115lb, has her diabetes under control, and is off oxygen – as the chair, **Jim Whitehead**, put it, ‘What a proof of concept!’ A session was also devoted to elite athletes (both able-bodied and disabled), who talked about the programmes with which they are now involved to encourage physical activity.

Many examples were given of **successful physical-activity initiatives**: the ciclovias (a ‘healthy epidemic’) in South America, Caribbean Wellness Day, the Exercise is Medicine movement (prescribing physical activity), schools programmes (notably a short and engaging presentation from **Jayne Greenberg** about work in Miami schools), a programme bringing soccer to young people in Africa, the Unplug and Play social marketing project, and a guide for interventions in Brazil and Latin America (the GUIA project).

The event ended with delegates giving their views on the most important next steps – of which reaching consensus on the ‘best buys’ in physical activity was central. Physical activity needs to be worked into urban planning, and there should be a focus on youth and the rights of the child. If the private sector is to fund initiatives, it must be listened to, and there was a call to action to PAHO for an ‘Americas’ Regional Summit on Physical Activity and NCDs to be held in January 2012.

c) The scale of the problem, data and targets

From burden to 'best buys': reducing the economic impact of NCDs

This event was held on 18 September, jointly hosted by the World Economic Forum and the World Health Organization at the New York Academy of Medicine. It was held to launch two major reports:

- *The Global Economic Burden of Non-communicable Diseases* (WEF and Harvard School of Public Health – available here: <http://www.weforum.org/reports/global-economic-burden-non-communicable-diseases>) and
- *Scaling Up Action against Noncommunicable Diseases: How much will it Cost?* (WHO – available here: http://www.who.int/nmh/publications/cost_of_inaction/en/index.html).

The two reports are also summarised in a précis document, *From Burden to 'Best Buys': Reducing the Economic Impact of Non-communicable Diseases in Low- and Middle-income Countries* (available here: http://www.who.int/nmh/publications/best_buys_summary/en/index.html).

Key themes were:

- estimating the **economic impact of NCDs on economies and businesses**; and
- the **cost of interventions** – population-based and individual – to tackle NCDs.

The **economic burden** posed by NCDs was clearly set out by **Professor David Bloom** (Harvard School of Public Health, and primary author of the first report). He described the motivation for compiling the report as having been the fact that although the burden in terms of human health has been calculated, this has not been translated into hard numbers to set out the very significant threat to economic progress. NCDs are truly a global issue. The report (which includes mental health in its calculations) calculates costs in three different ways: the 'cost-of-illness' approach, the 'value of lost output' approach (which uses the WHO's 'EPIC' tool to relate projected NCD mortality rates to current and future economic output), and the 'value of a statistical life' approach. The projected costs are staggering whichever system is used – for example, the value of lost output approach leads to an estimated loss in economic output of \$46.7 trillion between 2011 and 2030 (\$16.3 trillion of which is from mental illness; \$1.7 trillion of which is from diabetes; and \$15.6 trillion is from CVD). The cost-of-illness approach (estimating direct and indirect costs of ill health) estimates losses of \$745 billion in 2030. Professor Bloom noted that the main takeaway message is simply that NCDs matter a great deal!

Jean-Pierre Rosso (WEF) spoke both about the impact that NCDs can have on businesses, and the impact that businesses can have on NCDs. Businesses understand consumer behaviour and can therefore influence consumption choices, and businesses can also play a key role as employers, encouraging healthier behaviour in the workplace – for example, as members of WEF's Workplace Wellness Alliance. There was also brief discussion about conflicts of interest, which **Dr Ala Alwan** (WHO) noted is contained in the Political Declaration [note: it is explicitly mentioned with regard to the tobacco industry in para. 38].

The second report estimates **what it will cost to fix the epidemic of NCDs**, and Ala Alwan, **Dr Dan Chisholm** and **Dr Shanthi Mendis** (WHO) presented on its list of population-based and individual interventions, selected by WHO as being 'best buys'. The best buys are in five categories: tobacco use (e.g. tax increases); harmful alcohol use (e.g. restrictions on marketing); unhealthy diet and physical activity (e.g. replacement of trans fats); cancer (e.g. hepatitis B immunisation to prevent liver cancer); and CVD/diabetes (e.g. multi-drug therapy including glycaemic control for those who are at high risk). The report estimates how much these interventions would cost to implement in 42 low- and middle-income countries: a total price tag of US\$11.4 billion (\$2 billion of which is the population-based best buys) per year from 2011 to 2025 (a total of \$170 billion). The cost per head is \$3 in upper-middle income countries and \$1.50–2.00 in lower-middle income countries. 'All countries can do something.'

Finally, Hungary's health minister, **Miklos Szocska**, spoke about Hungary's efforts to tackle the NCD epidemic, including a total ban on smoking in public places, and earmarked taxes on some foods with high sugar or salt content. He noted, however, that as a small country Hungary feels very exposed to the actions of multinationals, and expressed a hope that new business models will be developed.

Monitoring NCDs, targets and indicators: what gets measured, gets done

This was held on 19 September and was hosted by the WHO. Its goal was to ‘strengthen the surveillance and monitoring of NCDs, risk factors and determinants as an integral part of national health information systems’.

Key themes were:

- the vital **importance of surveillance**, and what areas it should cover (including the social determinants of health); and
- once surveillance is in place, **what targets can and should be set**.

‘What gets measured can get managed’ –
Tom Frieden, CDC

The director general of the WHO, **Margaret Chan**, began by setting out why surveillance is so essential – it is key to accountability of governments, as without accurate data countries are left to build strategies based on crude estimates, and there are major gaps in the information available. **Dr Ala Alwan** (WHO) reiterated the message that **surveillance is a crucial first step** – ‘we cannot advocate for appropriate interventions without having surveillance’. This message has been put forward by the WHO for some time (surveillance is the first of the three major components of the WHO Global Strategy, for example), particularly in the last three years – the Moscow report (April 2011) proposed a surveillance framework. Any such framework should monitor: exposures, risk factors and social determinants of health; health outcomes; and health-systems capacity and response.

Professor Michael Marmot (University College, London) provided more details on the need to measure social determinants. There are increasing social inequities, which are driving the risk factors – for example, the differential in smoking prevalence between high and low socioeconomic groups, and the inequality in male death rates by level of education. **Dr Tom Frieden** (CDC) commented that more investment in accurate and timely surveillance is needed (including reliable statistics on cause of death, risk factors and environmental exposure such as air quality), including investment in capacity-building and public health institutions. The issue of capacity and the brain drain was picked up on by a Kenyan delegate, however: ‘over the past few years, we have been losing our personnel to richer countries ... what is the strategy of WHO to deal with this phenomenon?’

The panel discussion and questions stressed the need for surveillance – **Pekka Puska** noted that health monitoring can be a useful tool in influencing people’s lifestyles: the information supplied to individuals can spur them into become healthier. The deputy minister of health and social development from the Russian Federation, **Veronika Skvortsova**, noted that Russia has introduced a universal ‘health card’ to encourage better surveillance and action. One thing that can relatively easily be measured is age – but, as Dr Chan put it, ‘the linkage between NCDs and age is important, but you can be old in terms of years, but still have a dignified and healthy ageing process’.

Once surveillance is in place, **targets should be set** so that governments can report on their progress and set out their achievements. Dr Frieden set out key criteria for any targets – that they be measurable (i.e. including a baseline and status over time), that the interim and final targets are ambitious and aspirational, that they are achievable, and that they are relevant and important. He noted that a global task force should be set up to establish targets, building on the WHO’s preliminary proposals for targets, which included: 25% reduction in premature mortality for NCDs; 10% relative reduction in diabetes prevalence; 40% reduction in daily tobacco smoking; halve the risk in obesity; reduce salt intake to <5g a day; and reduce alcohol use by 10% in per-capita consumption and prevalence of heavy episodic drinking.

Michael Marmot also commented on the UK’s indicators for the social determinants of health that could be adapted globally, including: an indicator of early child development across interconnected health issues; an indicator of young people’s involvement in education; and indicators on the resources available to live a life with dignity and participate fully in society. **Anne-Grete Strøm-Erichsen** (minister of health and care services for Norway) noted that she is particularly in favour of specific exposure targets for obesity, smoking and alcohol.

d) Synergies with other areas

Achieving health equity: uniting around a common agenda to address NCDs and HIV

This event was held on 20 September, and was co-hosted by the WHO, UNAIDS, South Africa and the United States. It was moderated by Laurie Garrett (global health at the Council of Foreign Relations). The event was to discuss the calls that are increasingly made to work with, rather than in competition with, the HIV world, drawing on the many similarities and synergies between the two epidemics. A discussion paper is available online: http://www.who.int/nmh/events/un_ncd_summit2011/discussion_paper_hiv.pdf

The main themes were:

- the **key lessons that can be learnt from HIV**;
- the benefits of **moving out of silos** and towards integration;
- putting **people at the centre**; and
- **collective action** – and strong leadership.

‘[Integration] is smart, it is the right thing to do for the patient, and can save an extraordinary amount of resources’ – Ambassador Eric Goosby

WHO’s director, **Margaret Chan**, gave a strong introductory presentation that set out the **key lessons to be drawn from the HIV epidemic** – an epidemic in which, like NCDs, ‘prevention is by far the best option’. She noted that initial complacency can give the diseases the space they need to get bigger and more costly, with serious dangers of denial at political level and misinformation at societal level (countries without education campaigns are ‘dreamland’ for tobacco companies). It is essential to innovate in resource-constrained settings, and HIV also brought unprecedented attention to the issue of fair access to medicines. **Michel Sidibé** (UNAIDS) agreed that many of the challenges are very similar, with social justice at the centre. **Dr Tokugha Yeptthomi** (a Chennai doctor who has lived with HIV for 17 years) also urged all political leaders to take advantage of TRIPS flexibilities in protecting public health in tackling NCDs as well as HIV.

A central message from all speakers was the need to **move out of disease silos** and establish integrated, rather than parallel, systems to tackle NCDs and HIV. **Aaron Motsoaledi** (minister of health from South Africa) explained how his country is moving towards an integrated model, which is being monitored carefully for scale-up. **Nancy Brinker** (WHO goodwill ambassador for cancer control) highlighted the links between cervical cancer and HIV (the ‘Pink Ribbon, Red Ribbon’ campaign) – when HPV is present in an HIV+ woman, it is particularly virulent, but this can be interrupted through good screening. **Ambassador Eric Goosby** (US global AIDS coordinator) noted that PEPFAR is currently working on this, including training healthcare professionals (notably nurses) to use simple screening and treatment of areas of the cervix that are at risk.

Another reason for breaking out of disease silos is that **disease-specific programmes fail to put the individual at the centre of care**. As Minister Motsoaledi put it, it simply does not make sense only to deal with HIV at a clinic – his country has made great strides in HIV testing (now reaching 14 million people with HIV testing, up from just 2 million), but he hopes to test for diabetes and hypertension at the same time. Michel Sidibé noted that if you prolong someone’s life through treating HIV, they should not then simply die young from NCDs. Ambassador Goosby commented that this is a natural evolution – that infectious disease, when under control, shifts to NCDs, so we must align with the way in which disease moves through individuals. The main driver should be people’s needs – and the individual is, as Dr Chan noted, the best person to know if there is something wrong and, as Dr Yeptthomi put it, those whose lives are affected should be involved as equal partners. It is also important to avoid stigma and overcome cultural taboos: for example, classifying a clinic as specifically an ‘HIV clinic’ can have major privacy implications for those attending, and women in South Africa avoided going to clinics on ‘family planning day’. Minister Motsoaledi noted that this is why ‘integration is so extraordinarily important’.

Finally, there were calls both for **strong political and community collective action** – and for strong leadership. The moderator commented that, to date, the only NCD community that has come close to the activism of the HIV community is those involved with breast cancer – though the youth rally prior to the UN HLM was also highlighted by an audience member as a sign of progress.

Climate change and non-communicable diseases – creating a climate for health

This event was held on 19 September, and was hosted by the Public Health Institute, moderated by its president, Mary Pittman. Further information (including links to presentations) is available: <http://dialogue4health.ning.com/profiles/blogs/phi-holds-climate-change-and-ncds-panel>.

The event was held to fill in what was regarded by those attending as a serious gap in the conversation in the Political Declaration and the UN HLM itself. Key themes were:

- the wide **range of impacts of climate change on health**, and the need to **measure these impacts**;
- the urgent need to identify synergies and to **bring together the global agendas for health and for climate change**, as well as other areas such as gender and the early origins of health; and
- **nutrition and diet** – both the food that we eat, and how it is produced (including local production, trade and supply-chain issues).

‘The rich will find their world to be more expensive, inconvenient, uncomfortable, disrupted and colorless – in general, more unpleasant and unpredictable, perhaps greatly so. The poor will die’ – Kirk R. Smith, University of Berkeley, 2008

Dr John Balbus (NIH’s National Institute for Environmental Health Services) set out **the range of impacts that environment has on NCDs**, with about 40% of COPD and 20% of heart disease due to environmental factors. The global epidemics of NCDs are creating populations with increased vulnerability to climate change – but policies can be found that have co-benefits for both, such as moving away from meat consumption. **Dr George Luber** (associate director for climate change at the National Centre for Environmental Health, CDC) commented that ‘the bad news is that health is very late to the game’. He particularly encouraged the development of a data system that links climate, neurological and NCD data so that data-driven approaches can be developed for vulnerable populations.

Several speakers, including **Dr Cristina Tirado** (PHI’s Center on Climate Change and Health), noted that the global agenda for health is totally separate from that for climate change, and there is an urgent need to **build a platform** to discuss with stakeholders how tackling these two areas together can be better achieved.

Nutrition is one area where there are obvious connections between climate change and NCDs, but, for example, the agriculture chapters in the last IPCC report did not mention the health sustainability aspect of diet (for example, the need to eat many fruit and vegetables). **Dr Denise Costa Coitinho Delmue** (UN Standing Committee on Nutrition) noted that there are two sides to the ‘malnutrition spectrum’ – undernourishment of young children, coupled with over-nutrition, creating a ‘double burden’. Climate change can also, of course, affect food production – and current projections to 2080 are that this will become increasingly problematic. She focused on the need to take a multi-sectoral approach (Dr Egal, too, later picked up on the need to partner, not confront), and noted the importance of the ‘developmental origins of NCDs’, powered by inadequate foetal development and lack of breastfeeding.

The nutrition ‘value chain’ was the subject of **Dr Florence Egal’s** presentation (Food and Agriculture Organization) – we need to be systemic when looking at diets, not just look at single ingredients such as oil. There is currently a disconnect between producer and consumer, and locally available food is needed, with consumers able to make informed, local choices, building on traditional diets and knowledge. In the discussion, driving demand through regulation was also noted: 30% of school-meal ingredients in New York now have to be locally sourced, creating a market for the products.

Some new **solutions** were also highlighted, including:

- the work of the International Cookstove Alliance, which is seeking to improve cookstoves, a major source of disability in women in the developing world;
- telling the story of climate change from the perspective of human health, not just for its impact on wildlife. There is a new project at the CDC to source individuals’ stories (the Faces of Climate Change project) to develop this narrative – a new departure for the CDC; and
- taking a grassroots approach (not just fighting ‘city hall’) that creates a new movement in this field – this will take energy and persistence, but ‘we can really be powerful’.

e) Tackling NCDs for all: a lifelong, gendered approach

Integrating NCDs: the next frontier in women's health

This event was held on 19 September, and was co-hosted by the American Cancer Society, GAVI Alliance, the Partnership for Maternal, Newborn and Child Health, PATH, UNFPA, the World Heart Federation and Women Deliver. The event was to highlight the need to achieve better health outcomes for women by leveraging existing resources, policies, and programmes to create a lifecycle approach to women's health. In particular, it hoped to take further steps towards the achievement of the health MDGs and to ensure women's rights to health care by expanding synergies with global efforts to prevent and control NCDs. A press release on the event is available here:

http://www.who.int/pmnch/media/membernews/2011/20110919_integrating_ncds_pr/en/index.html

In addition, it was to highlight new technologies – such as HPV vaccines and early screening and treatment tools to prevent cervical cancer cases, and new gender-focused models for NCD programmes and policies – that make possible major breakthroughs in women's health. **Dr Agnes Binagwaho**, minister of health in Rwanda, described a partnership to bring the cervical cancer vaccine to the 96% of girls who are in school at age 11 in the country – the aim is to reach more than 95% of them in a campaign driven by the first lady.

Key themes of the event were:

- taking a lifecycle approach, beginning in the very earliest origins of health and
- women's role in economic development.

'We must not only see women as patients ... but as great change agents'
– Srinath Reddy

Dr Asha-Rose Migiro (deputy secretary general of the UN) set the scene, noting that women's empowerment is key to NCDs, as with all development issues, and commented that advocacy by NGOs makes it easier for governments to take bold action.

Australia has been taking strong action on tobacco smoking and exposure to smoke, on which the **Hon Nicola Roxon** (Australia's minister for health and ageing) spoke – though there is still some way to go, as, although tobacco use has fallen from 30.5% in 1988 to 15.8% today, many young women still smoke. Just as the tobacco industry has tailored its damaging messages to a female audience, so Australia is now updating health warnings specifically designed for women (for example, it damages your teeth and can cause bladder cancer, as well as messaging about harm to unborn children), and introducing plain packaging.

Several commentators, particularly **Dr Srinath Reddy** (World Heart Federation), highlighted the need for an **integrated, lifecycle approach**, without the artificial separation of maternal/child health and NCDs. Women often receive diagnosis of illness at a late stage, and may then be denied treatment – this 'continuous cycle of neglect continues across a life-span' for women, so access to services is essential throughout life. **Jill Sheffield** (founder/president of Women Deliver) also stressed this problem – that women are, in some societies, considered to be disposable. Empowering girls and women (for example through the use of microfinance schemes, mentioned by **Dr Christopher Elias**, CEO of PATH), and strengthening health systems, as noted by **Ms Purnima Mane** (deputy executive director of UNFPA), are essential to speed progress towards the MDGs and to tackle the NCD epidemic. As well as access to a strong health system (fundamental to improvements in NCDs), a lifecycle approach should take into account the creation of an 'enabling environment', with investment in healthy living for all.

A particularly important aspect of the lifecycle approach is that, as several speakers stressed, the very **early years of life** are critical in setting down markers for future health of mother and child. Not only do we need to work to tackle NCDs in childhood, young women and expectant mothers must be helped to improve their own health to give long-term advantage to them and their children, including bringing NCD prevention and control into maternal health programmes. Jill Sheffield suggested identifying the 'sweet spot', the point at which NCDs and maternal health can work together.

Dr Asha-Rose Migiro noted that when acting on NCDs among women, 'we do more than cure individual people: we strengthen societies'. This theme of women as key to the progress of society was reiterated by Purnima Mane, who stressed the huge potential for development afforded by working with women, and Jill Sheffield, who commented 'women are the economic drivers in the developing world ... They are an economic force that many have failed to recognise.'

Gender-responsive approaches to NCDs

This event was held on 20 September, and was co-hosted by PAHO, the NCD Alliance, the Commonwealth Secretariat and the Partnership for Maternal and Newborn Health. It highlighted aspects of NCDs (both risk factors and the diseases) that are specific to women, stressed that a gender-responsive approach is critical – and demonstrated that there is plenty of good practice that would benefit from being brought together.

Key themes were:

- aspects of NCDs that fall hardest on women;
- taking a **lifecycle approach** to women's health;
- overcoming **barriers to health**, including culturally specific issues; and
- **tailoring messaging** to the needs of both women and men.

Ann Keeling (NCD Alliance) began by commending the Political Declaration for its strong commitment to taking a gender-based approach – 'a positive base to move forward' – and, as all the discussion showed, this is an urgent need. **NCDs tend to fall hardest on women**, who are often among the poorest with the least access to health care, and who tend to prioritise the health of their families over their own wellbeing. Women face a range of specific NCD-related health issues – for example, obstructive labour due to gestational diabetes, lack of access to the cervical cancer vaccine, and deaths due to COPD following years of cooking with solid fuels. **Yvonne Lewis** (Health Education Division, Ministry of Health, Trinidad and Tobago), for example, noted that more women are overweight than men in Trinidad and Tobago, as they are more sedentary – and that diabetes is now the third-leading cause of death among women in the region (compared to the fifth-leading among men).

Many of the speakers focused on taking a **lifecycle approach** to women's health – not just for their own health needs ('women deserve to be healthy'), but also to protect the health of the next generation: 'Women's health offers the solution to NCDs, but while doing this we must be sure that it doesn't become another tool of victimisation' (Anil Kapur, World Diabetes Federation). In Trinidad and Tobago, for example, guidelines on healthy pre-pregnancy weight have been developed, and the country is hoping to campaign around the issue, particularly targeting adolescent girls.

There are many **barriers to women's health** – from the 'outrageous' targeting of women by tobacco companies, to gender stereotypes that label active girls as 'masculine', and the poor quality of food often eaten on the run by busy women. Researcher **Katherine Rock** presented a study that is addressing how to overcome barriers to physical activity in schools in Nicaragua, a country in which there is a strong gender and sport law, but where, in practice, only 21% of girls take part in extra-curricular sport (compared with 68% of boys). It recommends that safe spaces be found, parental support obtained (through informing them of the benefits to their daughters), girls are educated to understand the issues, and suggests strengthening of physical activity programmes for girls and women, perhaps including participation quotas.

Dr Aurora del Rio (Ministry of Health, Mexico) also cited lack of time as key – and suggestions to women now include giving themselves 30 minutes to relax and spending some of this time doing physical activity, for example putting on their favourite music and dancing in the living room. Community dance groups – 'jazzercise' – are being run in Samoa, according to The **Hon Leao Talalelei Tuitama** (minister of health), with women supplied with music and instruments, and competitions between the villages.

A final barrier to women's health is lack of information, with one discussant noting that it should be 'unacceptable' if NCD data is presented in a way that cannot be disaggregated by gender.

It was also stressed that **messaging needs to be tailored to women** – for example, ensuring that women know why physical activity is good **for them**, as a natural antidepressant or as a way to improve body image. Although the main focus of the discussion was women and NCDs, the discussion also noted the need for strong messaging in men's health, as men are often late to seek diagnosis. Creating gender-specific educative brochures (Mexico) or establishing men's health clinics (Trinidad and Tobago), which are more attractive to men, can improve men's health, and in Samoa Health Fairs have encouraged the (primarily male) village chiefs to persuade men in their villages to give up smoking.

Adolescent health and an opportunity for action

This event was held on 21 September, hosted by AstraZeneca in partnership with the Johns Hopkins School of Public Health and Plan International. It was a discussion on addressing adolescent health risk factors, including those for NCDs, and marked the launch of a new commitment by the Young Health Programme (a partnership between AstraZeneca, Plan International and Johns Hopkins) given at the Clinton Global Initiative to ‘combat NCDs through integrated global research, advocacy, education and health-skills training that will benefit a quarter of a million adolescents across 15 countries’.

Key themes were:

- children and adolescents are neglected in this area – but **the start of life is a big determinant of later health**; and
- a **description of the Young Health Programme**.

‘If we wait for government, we’ll wait for ever –
Robert Blum, Johns Hopkins School of Public Health

Robert Blum of the Johns Hopkins Bloomberg School of Public Health spoke about the importance of **tackling NCDs among children and adolescents**, stressing how much he wanted to get this issue into the Political Declaration. Adolescents comprise one-fifth of the world's population, but are among the most neglected in the healthcare system – including a lack of data on their lifestyles and health habits. This requires immediate action at both a community and policy level, as it is largely children’s environments (not genetics) that determine future health. Much of our unhealthy behaviour starts at a young age: about ¾ of people who are obese in adolescence will remain obese in adulthood, and 90% of smokers take up the habit in adolescence – and around 75% of people who suffer from mental illness begin to suffer from it before the age of 24. Clearly, it is essential to take action early, and yet this relationship between young people and NCDs is often overlooked.

However, there are examples of interventions that work – although data tend to be very poor. When enforced, minimum age purchasing is very effective, for example, and there is also a strong role to be played by schools and communities. No one has yet done a proper evaluation on the differences between community and targeted initiatives, however.

Caroline Hempstead (AstraZeneca) spoke on **the Young Health Programme**, which intends to reach 500,000 young people between the ages of 10 and 24, and was launched in Zambia in the week before the UN HLM and is already active in Brazil, India, Sweden, the United Kingdom and Canada. She highlighted the advantages corporates can give, such as in harnessing innovation and taking grassroots experience into evidence-based policy and action. The Programme will enhance young people’s understanding of risk behaviour through peer education, and provide a safe space in which they can discuss the issues. The initiative also has a two-part research component called WAVE – Well Being of Adolescents in Urban Environments – which will set the stage for health interventions using cell phones and other social media to communicate with young people at risk of NCDs, working with community youth workers and young people to ensure accurate survey methods, intends to collect robust data around adolescent health care access, resources and services. Dr Blum noted that this partnership is the first time that a major corporation has focused on youth in this way.

More on the Young Health Programme is available at <http://www.younghealthprogrammeyhp.com/>.

The discussion included the barriers to getting medicines to market (e.g. how regulation of drugs takes time), how paediatricians can be very influential – there are 5,000 in India, for example – and the need to commit more resources to translating research.

The meeting was committed to putting youth health higher up the agenda.

Innovating for Every Woman, Every Child: towards sustainable partnerships and business models

This high-level, roundtable discussion was held on 21 September, the first anniversary of the UN secretary-general's launch of the Global Strategy for Women's and Children's Health (Every Woman, Every Child), and timed to coincide with the publication of a new report, *Innovating for Every Woman Every Child*:

http://www.who.int/pmnch/activities/jointactionplan/innovation_report_lowres_20110830.pdf. The event was co-hosted by Merck, GSK, Intel, The Wellbeing Foundation, the UN Foundation, the government of Norway (NORAD) and the Partnership for Maternal, Newborn and Child Health. The aims of the meeting were to learn from one another, to be a forum for dialogue between global health stakeholders and industry on effective implementation of the Global Strategy, and to identify shared value propositions and focus on moving from pilots to sustainable partnership models.

The key themes were:

- **innovative business approaches to development**;
- **how to be a responsible corporate citizen**; and, crucially,
- **partnership working** and **sharing information**.

The innovation that was discussed is largely around different ways of working, primarily through partnerships. This is particularly important when incentivising in-country implementation of projects – ground-level implementation and the role of the government are often both contingent on infrastructure development, so both the public and private sector are needed to make initiatives succeed. It was felt that business needs to improve its efforts to **align philanthropic and social investments and long-term core business strategies and investments**: strategies that associate progress in development with success as a company can be more sustainable than traditional philanthropic or 'transactional' efforts. In particular, the private sector has unique strengths (for example, Research & Development, Marketing & Sales, Communications, Supply & Distribution, Financial Management, Data Management) – working out the best way to use and integrate these strengths into the public sector is a fruitful way to assist in development. Using the 'untapped potential' of mobile technology to improve access to health and financing is critical, and is a shared interest of both public and private sectors. This can and should be pursued, including through strategic impact-investments, incentives and policies.

Another insight was to view **women as consumers/customers**. Business should recognise that the very things that they want in a customer – education, empowerment, equity, access, information – are some of the same things that are needed in development. Finally, engaging employees was seen as important – namely, engaging them in the important women's and children's issues at local, national, regional, and global levels.

Being a responsible corporate citizen means doing business in a way that is good for the company's bottom line, but which is also sustainable. **Partnership** is an ideal way to achieve these win-wins, whether it is seeking a common understanding between public and private sectors (which is often lacking, so bridges need to be built and mistrust overcome), or working with partners in other companies in the private sector. For example, there is an opportunity in Every Woman, Every Child to establish a cross-industry, joined-up, private-sector advocacy and communications strategy to provide consistent messages.

The need to be willing to **share information** was also stressed. Data is critical in measuring the success of development and of health programmes, as well as in understanding market dynamics and opportunities in the private sector. Where NGOs have better access to, collect and generate local data on health and other community realities, the private sector might be more willing to be involved if data were strategically shared to address the needs through sustainable business approaches aimed at long-term success, rather than being asked to invest in 'reactive' philanthropic initiatives.

Participant feedback from the event suggested that Every Woman, Every Child will repeat this style of event (encouraging substantive dialogue among a small group of high-level leaders) in different regions of the world, focusing on specific themes of women's and children's health such as maternal mortality, health workers, vaccines and mHealth.

f) Universal coverage and putting people at the centre

The role of universal health coverage in tackling non-communicable diseases

This event was held on 19 September, hosted by the Permanent Missions of Brazil and Thailand, the Rockefeller Foundation and the World Health Organization. Its aim was to consider the development of health financing systems for universal health coverage and how this can contribute to meeting the costs of preventing and treating NCDs and other health goals.

Key themes were:

- the importance of **health coverage for all**; and
- **progress to date**, with WHO, Rockefeller Foundation and three countries explaining their approaches to universal health coverage.

Note: Article 25.1 of the Universal Declaration of Human Rights states that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.’

Judith Rodin (Rockefeller Foundation) began by stating that the Rockefeller Foundation finances many projects to expand universal coverage.

The WHO’s assistant director-general, **Carissa Etienne**, set out some of the international documentation and help for countries seeking to establish universal coverage. The UN passed a Resolution on ‘Sustainable health financing structures and universal coverage’ in May 2011, which urges member states to strengthen and invest in health-delivery systems (also improving their accountability and transparency), with the aim of ‘affordable universal coverage and access for all citizens’. This builds on the 2010 WHO World Health Report, which outlined steps countries can take to modify their existing health-financing systems with the goal of moving closer to universal coverage for all – since this report, 60 countries have begun working with the WHO towards universal coverage. She also particularly stressed the call in the Resolution to invest in primary healthcare, essential in tackling NCDs.

The final three presentations illustrate the **progress** some countries have made recently in moving closer to universal health coverage:

- The minister of health from Brazil, **Alexandre Padilha**, noted that the right to health is enshrined in the Constitution. There are 190 million people in the country, 145 million of whom depend on the universal healthcare system, the SUS (Sistema Único de Saúde – Unified Health System). Access to insulin is free under the SUS.
- The deputy minister of health in Thailand, **Torphong Chaiyasan**, noted that 30 million people live in poverty in Thailand. In 2001, a ‘30 baht treats all diseases project’ was launched – a public health insurance scheme providing treatments within a defined benefit package to registered members for a co-payment of 30 baht (about US\$0.80) per chargeable episode (or free to those under 12 or over 60, the very poor, and volunteer health workers).
- Germany’s deputy minister of health, **Annette Widmann-Mauz**, said that Germany has a longstanding commitment to universal health coverage, and that its health system is used as a model by other countries.

Patients as catalysts for change

This event was held on 20 September, co-sponsored by Bupa and The George Institute. A new policy paper on patient empowerment, 'Realising the potential of patient empowerment for tackling chronic disease: moving from concept to business as usual' (available here: <http://www.bupa.com/chronicdiseasereport>) was launched at the seminar, presenting how patient empowerment can offer clear, practical and sustainable strategies to achieve effective change at all levels of the health-care system – where the individual is the catalyst for health-system reform.

The key themes were:

- the need for a shift in thinking around **patient empowerment**, embedding it firmly in health reform; and
- money and distress can be saved by **a combination of better management and empowering the patient**.

'Power is a zero sum game – to empower the patient, the doctor has to give up power' – Rushika Fernandopulle (IORA Health)

The three presenters noted below were also joined by a speaker from the International Alliance of Patients' Organizations, with participation from LiveSTRONG and Heartlink.

The first speaker was **Dr Anne Marie Feyer** (George Partners), who stressed that **patients are an untapped resource in tackling health issues**. Patient empowerment, according to the policy paper, 'can be thought of as patients being an active and self-determining part of their health care, rather than a passive recipient of services'. She summarised the main messages of the paper, which include: a lack of clear, operational definitions of 'patient empowerment', a lack of robust design, and (as yet) lack of wide-scale systematic, evaluated implementation of the ideas. There is a need for thought leadership – the case has been made for patient empowerment, but it is under-developed, and it needs to be taken from a nice-to-have to an accepted part of health-system reform around NCDs.

The final two speakers both gave examples of ways in which **better management and patient empowerment** have been beneficial. **Dr David Wennberg** (Health Dialog – Bupa) described an example of effective patient empowerment: an RCT of almost 175,000 people who were given access to a health coach (telephone care management strategy) and who took part in shared decision-making. The average monthly pharmacy and medical costs for this group were 3.6% lower than the control group (who had access to the usual, rather than enhanced, support), with the majority of these savings accounted for by a 10.1% reduction in annual hospital admissions in elective surgery and NCDs, as people chose to use fewer health resources. (More detail on this initiative is available on p. 16 of the policy paper.)

Dr Rushika Fernandopulle (IORA Health) noted that most of his patients spend a maximum of two hours a year with their doctor, which shows the importance of good self-management and patient empowerment. 4% of US health investment is on primary care. He is a primary care doctor, and noted that 20% of his new patients (in the United States) have blood pressure that is out of control. He has worked with his patients to encourage them to quit smoking, with a success rate of around 50%, and he has also seen a 40% fall in emergency hospital admissions among his patient.

g) New technologies

Mobile phones and social media in the response to NCDs

This side-event was held on 16 September, organised by the Healthy Caribbean Coalition, Global Health Council, the Young Professionals Chronic Disease Network, NCD Action Network, PAHO, and the Get the Message campaign, supported by the NCD Alliance, Health Action Partnership International and the National Heart Forum.

The event was to highlight ways in which new media technology – specifically mobile phones and social media – can be used to tackle NCDs through advocacy, education and patient support, and brought together young people with global NCD leaders to share experiences of these technologies.

Key themes were:

- utilising **mobile phone technology** to best effect;
- using **social media, particularly to engage young people**; and
- using social media to **create a movement for social justice**.

It was chaired by Isabella Platon (International Diabetes Federation), and James Hospedales (PAHO/WHO) and Lynda Williams (Healthy Caribbean Coalition) gave opening remarks.

Several speakers highlighted initiatives that use **mobile phones for advocacy and for help in managing NCD issues**. **Chris Hassell** (Healthy Caribbean Coalition) talked about the Get the Message campaign, run in 17 countries to encourage creativity in messaging. He explained that a significant educational component is needed in such a campaign – where all that happens is frequent text-messaging, those taking part are likely to push back against it. Examples of mobile health technologies were also given during the panel discussion – **Yael Harris** (Office of Health IT, Health Resources and Services Administration) described the Text for Baby programme, which has enrolled 200,000 people since its launch in February, all of whom receive evidence-based health-information messaging appropriate to the stage of development. ‘Behaviour change is hard!’, but careful evaluation should reveal what motivates different groups, to allow better tailoring of information in the future.

Jody Ranck (mHealth Alliance) highlighted how mobile technologies can be used for much more than just messaging – for prevention, monitoring, treatment information and peer-to-peer data collection. She proposed much greater future integration of the technology – both with other disease areas such as HIV, but also with social networks and peer-to-peer interventions, which can be facilitated by smartphones.

Sandeep Kishore and **Philip Baker** spoke about the two **new social networks** with which they are involved – respectively, the Young Professionals Chronic Disease Network (YP-CDN) and the NCD Action Network. The YP-CDN is a web-based global coalition of young people that encourages learning from one another – not just young health professionals, but also across disciplines. In particular, it is focusing on global access to essential medicines and NCDs as a human rights issue, building collaboration with student branches of organisations such as Oxfam. It is also now promoting the message of the importance of NCDs in journals that are seen as being ‘youthful’, such as the *Huffington Post*.

Online networking is also intrinsic to the NCD Action Network, which currently has 415 members in 48 countries, and a website with over 2,000 visitors a month. The Network is explicitly driving the idea that NCDs are an issue of **social justice**. While this is controversial, it is a message that resonates with young people. In his concluding comments, **Sir George Alleyne (PAHO/WHO)** drew a parallel with the civil rights movement in the United States, and how it was the churches and black universities – places where people can communicate and interconnect – where that social movement really began.

Sir George also stressed the importance to work across sectors, including his hope that the ‘fundamental role that the private sector has to play’ will be recognised – unless we all work together, we will not succeed. Change is ambitious, but none of us wants to accept the immutability of human behaviour.

Communicating the noncommunicable

This event was held on 19 September, and overlapped with the opening plenary, so we were not able to remain for the whole event. The event was to launch a variety of ‘communication tools and resources that individuals, communities, institutions and countries can use to make NCD healthy choices easier and counter hazard promotion’.

The key themes were:

- how best to **communicate NCDs**; and
- the different ways in which **communication tools can be used to empower individuals to make healthy choices**.

‘[There is] an enormous communication gap around NCDs, and often a lot of miscommunication – and this costs lives’ – Peter Anderson, co-editor of *Journal of Health Communication*

Communication is absolutely central both to tackling and to spreading non-communicable diseases. As **Pekka Puska** (leader of the groundbreaking North Karelia study in Finland) pointed out, while you need close contact to communicate an infectious disease, you do not need physical contact to spread NCDs: instead, it is through communication – advertising etc. – that NCDs are spread, or could be halted. The basic messages are the same worldwide – ‘tobacco kills everywhere’ – but these messages need to be tailor made and appropriate to the new world of communication in which we live. And change can happen – CVD mortality fell by 80% in Finland following the project there: ‘I have no doubt we can change lifestyles.’

Both Dr Puska and **Scott Ratzan** (Johnson & Johnson) noted that **health needs to be rebranded** in a positive way. There has also been significant miscommunication of NCDs over the years – whether it is failing to appreciate what the health messages really mean (5g of salt, for example, is just one small teaspoon – a measurement that **Peter Anderson**, the co-editor of the *Journal of Health Communication* had to do for himself to find out) or failing to appreciate that communication is also about action, and motivating policy-makers to make a difference. A powerful motivator was highlighted by **Eva Jané-Llopis** of the World Economic Forum – thanks to a new study (*The Global Economic Burden of Non-communicable Diseases*), we now know that NCDs will cost \$30 trillion over the next 30 years, enough to move countries from growth to recession. We now have these ‘magic numbers’ that can spur real action.

The event saw the launch of **three new tools to help empower individuals to make healthy choices**:

- The World Health Professionals Alliance ‘Health Improvement Card’:
 - This was presented by **Julian Fisher** (World Dental Federation, on behalf of the WHPA) as a tool to catalyse dialogue between health professionals and patients about the risk factors. It provides a simple layout of the risks, which is easy to read and triggers people to think about their lifestyles. He particularly noted that it is not called a ‘scorecard’ – it is a ‘health improvement’ card.
- *Journal of Health Communication* special edition on ‘Communicating the Noncommunicable’:
 - This supplement (<http://www.tandfonline.com/toc/uhcm20/16/sup2>), presented by Peter Anderson, was planned a year ago. It is in two main sections, ‘Risk factors and impact’ and ‘Communicating and acting on solutions’, and contains 17 articles. He noted the need to use new communication tools – spreading health through social networks, and reframing tools such as BlackBerries to make them health products. When the *Journal of Health Communication* was launched, 16 years ago, half the world had never made a phone call; now, there are 5 billion mobile phones.
- The World Health Communication Associates ‘Making healthier choices easier: reducing the risk of non-communicable diseases (NCDs)’:
 - The tool does not yet appear to be online. It is marketed as a ‘health literacy action guide’, and health literacy was key to many of the tools presented.

h) Looking to the future

NCD Alliance debrief

This was held on 21 September, hosted by the NCD Alliance. It included group work around a number of set questions, but the notes below deal solely with the main discussion.

Key themes were:

- the **successes and challenges** of the UN High-level Meeting; and
- **the future action to be taken by the NCD Alliance.**

Ann Keeling (NCD Alliance) highlighted the **positive outcomes** of the UN HLM – notably the very high levels of engagement by member states. The hours of the plenary had to be extended on both days to accommodate statements by 135 countries – and 35 heads of states were present, 10 more than attended the HIV meeting in 2001. Key paragraphs in the Political Declaration were identified as being: 45 (establish/strengthen national policies and plans on NCDs), 61 and 62 (establish global monitoring system and targets), 64 (options on how to strengthen multi-sector action are to be submitted to the General Assembly in 2012) and 65 (comprehensive review and assessment of progress to be submitted in 2014).

A key lesson learned is that there is a need to shift from a disease- and risk-factor-focus to a focus on the **human face of NCDs**, through the use of stories. There were challenges, particularly around awareness of the meeting – one of the people present noted that students at Columbia University did not know that the UN HLM was taking place.

The NCD Alliance needs to build quickly on the success of the UN HLM, so as not to lose momentum. It will continue to communicate positively, and hopes to establish web-based evaluation. The main point of focus in the next few months should be the frameworks and targets – a draft report is due to go in December to the WHO's Executive Board, so action must be speedy. A letter was to be sent to Margaret Chan within a few days, and NGOs must stay involved in the process.

Robert Beaglehole (formerly at the WHO, now at International Public Health Consultants in New Zealand, but attending as a representative of UnitedHealth) reiterated the message about the need for targets – and told delegates that Ala Alwan is looking for feedback both on the current proposed targets (which one delegate described as having seemed to have 'come from nowhere') and on the monitoring framework.

Appendix 1: The Political Declaration

The Political Declaration was unanimously adopted by all 193 member states of the UN at the opening plenary of the UN HLM on 19 September: <http://www.un.org/Docs/journal/asp/ws.asp?m=A/66/L.1>.

It begins with a preamble acknowledging existing initiatives, and is then split into seven main sections:

- **A challenge of epidemic proportions and its socioeconomic and development impacts** sets out a very wide range of NCD-related concerns, including the scale of the diseases, inequalities, gender issues, socioeconomic status (including the ‘vicious cycle whereby NCDs and their risk factors worsen poverty, while poverty contributes to rising rates of NCDs’), the importance of the early origins of health, linkages with communicable diseases such as HIV (including strengthening health systems), and the impacts of other contemporary issues such as climate change, food security and food prices on NCDs.
- **Responding to the challenge: a whole-of-government and a whole-of-society effort:** This focuses on cooperation, leadership and multi-sector effort, and notes that there is a ‘fundamental conflict of interest between the tobacco industry and public health’. It also notes that ‘prevention must be the cornerstone of the global response to NCDs’ and that evidence-based interventions can be affordable.
- **Reduce risk factors and create health-promoting environments:** This focuses on developing and implementing multi-sector policies and interventions focusing on the four major risk factors, including accelerating the implementation of the Framework Convention on Tobacco Control, the WHO Global Strategy on Diet, Physical Activity and Health, and the WHO Global Strategy to Reduce the Harmful Use of Alcohol. It also calls on the business sector to take action, including promoting healthy foods (including working towards reformulating products, reducing salt and eliminating industrially produced trans fats) and creating healthy workplaces. Breastfeeding should also be supported, as well as increasing access to cancer screening and other medicines to prevent and control NCDs.
- **Strengthen national policies and health systems:** This calls for the establishment and strengthening of national policies and plans on NCDs by 2013, according to national circumstances, including risk factors, surveillance, treatment and care. Also, it notes the need to take gender-based approaches and to recognise the needs of indigenous people, as well as the importance of universal coverage for poor populations. It also encourages networks to develop new medicines and technologies, particularly learning from HIV/AIDS, for full use of TRIPS flexibilities in promoting access to medicines, and calls for training and retention of a skilled health workforce.
- **International cooperation, including collaborative partnerships:** Exchange of best practice in health promotion, regulation, technology, medicines etc. is highlighted, and the need for the UN, development banks and other key organisations to work together. It also encourages non-health actors (including, as appropriate, the private sector) to form collaborative partnerships to reduce risk factors.
- **Research and development:** Promotion of investment in research on prevention and control of NCDs, including incentivising innovation and using information technology.
- **Monitoring and evaluation:** Strengthening surveillance at country level is critical – and it specifically calls on the WHO in collaboration with member states and others, to ‘prepare recommendations for a set of voluntary global targets for the prevention and control of NCDs, before the end of 2012’ and to consider developing national targets and indicators.
- **Follow-up:** The Secretary-General is requested to submit to the General Assembly (by the end of 2012) options for strengthening action through effective partnership, and is also requested to present a report on achievements towards the fulfilment of the Political Declaration, in preparation for a comprehensive review in 2014 of progress made, including impact on achievement of the MDGs.

Note: Not all the ‘asks’ of civil society organisations have been included in the Declaration – it does not, for example, set a target for reducing NCD deaths, which had been called for. But – as is very clear from the section of the Declaration on ‘follow-up’ – the UN HLM is not the end of the process: it is the beginning. Implementing the Political Declaration, and making a real difference on the ground, is the challenge all UN member states now face.

Appendix 2: Some useful links

Websites

Homepage for the UN HLM on the UN website	http://www.un.org/en/ga/ncdmeeting2011/
Homepage for the UN HLM on the WHO website	http://www.who.int/nmh/events/un_ncd_summit2011/en/
Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (adopted at the opening plenary, and available for download on this page in six languages)	http://www.un.org/Docs/journal/asp/ws.asp?m=A/66/L.1
NCD Alliance website	http://www.ncdalliance.org/
C3 Collaborating for Health website (UN HLM page)	http://www.c3health.org/un-summit-2011/

Selected media coverage

'UN targets top killers', <i>Nature</i> 477:260–1, 15 September 2011	www.nature.com/news/2011/110914/full/477260a.html
'Chronic diseases in developing countries: growing pains', <i>The Economist</i> , 22 September 2011	http://www.economist.com/node/21530099
'Battling against lifestyle diseases', <i>Financial Times</i> , 18 September 2011	http://www.ft.com/cms/s/0/59e8ff76-e05c-11e0-ba12-00144feabdc0.html
'NCDs: celebrating success, moving forward', <i>The Lancet</i> , 378(9799): 1283–4 October 2011 (R. Beaglehole et al.)	http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961559-6/fulltext

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