SYNTHESIS

Summary, Conclusion & Recommendations

3 February 2019
09:00-10:30
Conference programme structure

• Pre-conference: 29 – 31 January 2019
  52 side meetings
  6 field trips
• Main conference: 1 – 3 February 2019
  3 keynote addresses
  4 plenary sessions
  15 parallel sessions
  4 abstract sessions
  6 special events
  34 E-poster presentations
  421 entries of World Art Contest

• Total registered participants
  1,090 participants from 77 countries (F 52%, M 48%)
19 Plenary and parallel sessions
121 Moderators/speakers/panelists

Gender
- Female: 54
- Male: 67

WHO Regions
- PAHO: 41
- EUR: 28
- WPR: 22
- SEAR: 17
- AFR: 11
- EMR: 2

Organization
- Private Sector: 3
- Public Sec of Developing country: 9
- Public Sec of Developed country: 9
- Bilat/Multilat/Inter Agency: 12
- UN Agency: 14
- NGO/CSO: 20
- Academic/Research Institute: 48
- N/A: 6
Conference Summary and Synthesis
1. BACKGROUND

1.1 Global commitment on NCDs

Political declaration of the 1st, 2nd, 3rd HLM of the GA on the prevention and control of NCDs (2011, 2014, 2018)

Meet SDG3.4 to, by 2030, reduce by 1/3 premature mortality from NCDs and promote mental health and well-being

SDG 3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate
1.2 NCD situation

- NCDs cause the highest burden of disease across the world, and yet financing of NCD prevention and control is largely inadequate.

- NCDs are rooted in the social, economic, environmental and commercial determinants of health and cannot be stopped through individual action alone.

- Despite availability of scientific evidence and cost-effective interventions, implementation of high-level commitments has been slow in many LMICs.
Painful facts
NCD causes 41 Million deaths of the 57 Million global deaths

NCDs are estimated to account for 71% of the **57 million** global deaths

- 31% Cardiovascular diseases
- 16% Cancers
- 7% Chronic respiratory diseases
- 3% Diabetes
- 15% Other NCDs
- 20% Communicable, maternal, perinatal and nutritional conditions
- 9% Injuries

Source: WHO NCD country profiles 2018
78% of NCD deaths occurred in LMICs
Key fact: Risk factors, metabolic risk factors

- 6.4 litres of consumption
- 11% of global deaths
- 28% of adults and have not decreased in the past 15 years
- Average intake of 9-12 grams
- Attributed to >180,000 global deaths
- Kills more than 7 million
- 7 million premature deaths

22% of adults

650 Million obese adults

Nearly quadrupled since 1980
2. Problem stream and root causes

2.1 NCDs, risk factors and consequences

- Influenced by a series of complex, dynamic and intertwined determinants requiring effective multisectoral actions
- Neglected in particular in high burden of communicable diseases.
- Emerging risk factors: air pollution, climate change contribute significantly to NCD

2.2 Social determinants of NCDs

- Social inequality; poverty, lack of education, unemployment
2.3 Commercial determinants of NCDs

- Unhealthy commodities industry and harmful corporate practices: powerful, deep pocket, unethical marketing – e.g. promoting unhealthy foods to children, misled discourse

- Lobbying by trans-national corporation, digital marketing, and interferences by industry to policy makers
  - Tobacco industry cigarettes account for around 2/3 of the illicit cigarette market, industry resists and interferes with the “Illicit Trade Protocol” Litigation in international and domestic trades

- Perceived COI between regulators, government officials and industries, regulatory capture and industry funded research and foundation such as Foundation for a Smoke-Free World was funded by PMI
## 3. Challenges

### 3.1 Policy and implementation gaps

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<thead>
<tr>
<th>At global levels</th>
<th>At national levels</th>
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<tr>
<td>1. Lack of internationally legally binding instrument in regulating NCDs risk factors, except FCTC</td>
<td>1. Lack of political will and leadership</td>
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<td>2. Low engagement of social and community</td>
<td>2. Weak governance: corruption, COI</td>
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<td>3. Policy inertia: Lack of accountability mechanism</td>
<td>3. Poor progress in closing the “know-do gaps”</td>
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<td>4. Unethical global financing systems</td>
<td>4. Lack of effective, timely M&amp;E to hold partners accountable</td>
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<td>5. Lack of mechanisms, infrastructure, resources to facilitate policy adoption and implementation, especially in LMICs</td>
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<td>6. Limited investment in health</td>
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<td>7. Inadequate multi-sectoral action</td>
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<td>8. Policy inertia: weak regulatory capacities</td>
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<td>9. Lack of policy coherence between public health goals and economic growth</td>
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<td>10. Short tenure of political leaders</td>
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3.2 Evidence gaps

• Lack of political economy analysis in public health arena

• Lack of policy evaluation and assessment
  – in holistic approach
  – on health outcomes (such as taxation, SSB tax)

• Limited evidence on emerging health risks (pollution, climate changes)

• Limited evidence in LMICs
4. Solutions and role of actors

4.1 Actions by global actors

a. Global governance regimes

- International agreements:
  - Learning from FCTC, UN member states can negotiate for FCAC, FCFS
  - It helps foster coherent policies and regulatory measures against industry interferences

- Global NCDs framework
  - Continuously review and implement Global Frameworks which promotes multi-sectoral collaborations and foster impacts
  - Strengthen accountability across all stakeholders: health, non-health, public and private, at country, regional, and global levels
4. Solutions and role of actors (continue)

b. Global financing mechanisms

• Fill the funding gaps for NCDs implementation in particular in LIC
• Align Development Assistance for Health with countries’ NCD prevention and control plans and improve effectiveness and efficiency of ODA pool
• Integrate NCD into existing financing mechanisms and explore new innovative financing sources and models through bilateral & multilateral cooperation (e.g. catalytic trust fund for NCD)
• Regional tobacco tax harmonization can reduce cross border smuggling; shifting profits out of higher-tax jurisdiction and tax evasion
4.2 Actions by national actors

a. Improve governance and leadership

• Strategic leadership, prioritize health in public sector budget and resource allocation for NCD

• Greater policy coherence through whole-of-government and health-in-all-policies approaches

• Strengthen good governance, transparency, accountability, regulatory and enforcement capacities, improve legal capacities
4.2 Actions by national actors

a. Improve governance and leadership (cont.)

• Paradigm shift: beyond the health sector
  – From health systems to systems for health;
  – From survival and treating diseases to enabling people to live healthy lives

• Implement the cost-effective, affordable interventions, good practices, and WHO 16 best-buys

• Strengthen leadership
  – Establish effective multi-stakeholder and multi-sectoral coordination mechanisms at the highest level to ensure the whole of government, whole of society approach
Singapore’s War on Diabetes

Government declares war on diabetes

"We need to tackle the diabetes challenge. Therefore, I am declaring war on diabetes."

Aim
To mobilise a whole-of-nation effort to fight diabetes.

Vision
To create a supportive environment for Singaporeans to lead lives free from diabetes and for Singaporeans with diabetes to manage their diabetic condition well.

Source: Yik Ying Teo

Turning Discovery into Healthier Communities
4.2 Actions by national actors

b. Address financing gaps

- Adequate funding for implementation of NCD action plan, multi-sectoral action
- Mobilizing additional fund: introduce pro-health taxes

Source: Dr. Johanna Birckmayer
4.2 Actions by national actors

b. Address financing gaps (cont.)

- Prioritization: explicit criteria to prioritize budgets for prevention and promotion

- Provider payment: design provider payment to support continuum of care; utilize payment information to inform service provision
  - Shifting from paying individual service contact to support care coordination
4.2 Actions by national actors

c. Improve implementation capacities

• Reforming health delivery systems to respond to demographic and epidemiologic transitions
• Improve health systems response
• Ensure diagnostic and essential medicines for NCD and mental health available at PHC level
• Strengthen FCTC implementation in particular in LMIC
  – Legislation e.g. plain packaging
  – Effective enforcement and implementation
• Implement 16 best buys in line with country context
  – Singapore’s War on Diabetes: National policies on NCD prevention guided by global intelligence
SSB interventions – evidence base

**Mandatory Front-of-pack labels on product packaging**

Mandatory front-of-pack labels for SSBs to inform consumers about the nutritional quality:

- **Nutri-Score in France (2017)**
  ![Nutri-Score](image1)

- **Traffic Light’ Label in UK (1st introduced in 2006)**
  ![Traffic Light Label](image2)

- **Warning label in Chile (2015)**
  ![Warning Label](image3)

“High in sugar”

**Restrictions on advertisements of high sugar SSBs**

Restrictions on advertisements on high sugar SSBs targeted at children:

- Australia (self-regulation)
- Canada (statutory in Quebec, self-regulation in the rest of Canada)
- Chile (statutory)
- Denmark (self-regulation)
- EU (self-regulation)
- Finland (self-regulation)
- Ireland (self-regulation)
- The Netherlands (self-regulation)
- Norway (statutory)
- South Korea (statutory)
- Sweden (statutory)
- Taiwan (statutory)
- UK (statutory)
- US (self-regulation)

**Mandatory health advisories on advertisement**

Health advisories on advertisements for high sugar beverages:

- France (2007)
- San Francisco (2016 - Delayed)
- Peru (2017)

**Taxes/ Excise duties on SSBs**

Taxation on SSBs is the most common measure internationally:

- Finland (1940)
- Norway (1981)
- Hungary (2011)
- France (2012)
- Berkeley & Mexico (2014)
- Chile (2015)
- Philadelphia (2016)
- Portugal & South Africa (2017)
- United Kingdom (2018)

**Ban on high sugar beverages in schools**

Ban on sugary beverages such as carbonated soft drinks in schools:

- United States & Singapore (2016)
- Israel (2017)
- France (2005)
- South Korea (unspecified date)

**Source**: Yik Ying Teo (PS 2.2)
4.2 Actions by national actors
d. A whole of society approach

- Political economy lens
- Using Universal Health Coverage lens
- Example of Singapore and Philippines: Whole-of-Government and Whole-of-Nation strategy
4.2 Actions by national actors

d. A whole of society approach (cont.)

• Collaboration and partnership:
  – Empower and strengthen the capacity of civil society: synergies with other social movement e.g. climate change and environment
  – Public Private Partnerships must engage the right members from the start and manage of COI i.e. MOH, MOF, civil society etc.
d. A whole of society approach (cont.)

- Public awareness and improve health literacy
  - Raise awareness about the public health burden caused by NCDs & the relationship between NCDs, poverty and social and economic development

- Changing environments including physical, economic, digital and social is the most promise for changing behavior in the populations.
How ThaiHealth works

Collaborates with ministries, departments, local governments, armed forces, police forces, private organizations, temples, universities, schools, etc.

Population groups

Works with different settings to strengthen communities

Organizations

Settings

Health risk factors: alcohol, tobacco, road accidents, unsafe sex

Health promotion factors: Physical Activity, Food

Promotes learning and communication of health status, creative activities, volunteering, art and culture, religion, reading, media awareness

Source: Pairoj S.
e. Information system

- Address evidence and information gaps, highlight case NCD health and economic burden
- Support evidenced based social movement and policy advocacy
- De-normalization and correcting misinformation through involvement of health, non-health sectors, public media, civil society
- Investing in implementation research and use of information for policy monitoring
4.3 Actions by Community

- Civil engagement & social mobilization to drive political actions.
- Engaging people living with NCD in the responses
- Building alliances and coalition for NCD at the community level e.g. Healthy city movement
- Sri Lanka: establish community infrastructures for management and control of NCDs
  - Establish Healthy Lifestyle Centres in 2011
  - Launch of well women clinics in 1996
4.4 Actions by Individual

• UK experiences on Change for life—App, empowering consumers

• Application of NUDGE theory in combination with CHOICE architecture to influence individual behaviour in favour of healthy choices
PMAC 2019 – healthy meeting

• Set global and national norm and standard of healthy and active meeting

**Healthier Food and Nutrition**
- Variety of grains
- Fruits and vegetables
- Water as default
- Alcohol-and tobacco free
- Less use of plastic

**Physically active**
- Standing zone during meeting
- Active breaks
- Active zone

**Mental pleasant environment**
- Massage
- Meditation
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