PACIFIC NCD FORUM MEETING REPORT

Convened by

Secretariat of the Pacific Community

and

World Health Organisation
Office of the South Pacific

Tanoa International Hotel, Nadi, Fiji
21-23 June 2010

Report prepared by the Healthy Lifestyle Section

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This report has been prepared by the Healthy Pacific Lifestyle Section, Public Health Division on behalf of the 2-1-22 Pacific NCD Team for governments of Pacific Islands countries and territories and for the participants, consultants and observers at the Pacific NCD Forum held in Nadi, Fiji Islands, on 21-23 June 2010.

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Executive summary

This was the second regional meeting under the Pacific Framework for the Prevention and Control of non-communicable diseases (NCDs) and the 2-1-22 Programme (two organisations and one team serving 22 Pacific Islands countries and territories).

Held on 21-23 June 2010 in Nadi, Fiji Islands, the three-day event was organised by the Secretariat of the Pacific Community (SPC) and the World Health Organization (WHO). It drew 75 participants and observers from more than 20 countries in the region. There was extensive media coverage of the event.

The forum focused on how countries and territories were using funds and resources provided by the 2-1-22 programme, and therefore how they were implementing their plans and monitoring them. Other highlights were keynote addresses on salt and causes of mortality, and on moves for collaboration with the Caribbean Community (CARICOM) Secretariat countries at a global level.

Guided by the theme 'From Evidence to Action', the forum allowed for the identification and discussion on new and emerging issues in the long-term battle against NCDs, how to overcome impediments, and how to work out priorities and consensus moving forward.

This report provides an account of the forum's proceedings and its focus on building capacity in monitoring, evaluation and surveillance of NCD interventions. It records how the gathering provided an opportunity for network building, information sharing and collaboration within PICTs.

Background

WHO estimates that 75 per cent of deaths in the Pacific are caused by NCDs such as diabetes, heart disease and cancer. SPC and WHO have identified the high prevalence of associated risk factors such as obesity, smoking, excessive alcohol consumption, poor nutrition and lack of physical activity.

The 2-1-22 programme has financial support from the governments of Australia and New Zealand and provides grants to countries to help them reduce these risk factors through education, health promotion, environmental and clinical interventions.

The principal objectives of the 2-1-22 programme are to:

- strengthen development of multisectoral national NCD strategies
- support countries to implement these NCD strategies
- develop sustainable funding mechanisms to deliver the strategies
- strengthen national health systems and capacity to address and prevent NCDs
- strengthen regional and country M&E and surveillance systems

Objectives

The objectives for the Forum were to:

- provide the latest updates on evidence-based practice in integrated, non-communicable diseases prevention and control
- discuss and share progress in implementation of the 2-1-22 Pacific NCD Programme at national and regional levels.
- build capacity in monitoring and evaluation of NCD interventions
- provide an opportunity for network building, information sharing and collaboration within PICTs

Outcomes

The meeting appealed for increased United Nations support in the battle against the NCDs epidemic in the Pacific Islands region. It noted the Pacific Islands Health Officers Association (PIHOA) declaration of a regional state of health emergency due to the epidemic of non-communicable diseases in United States-Affiliated Pacific Islands. And it backed a call on the UN to hold a world summit on NCDs, to include them in the Millennium Development Goals (MDGs), and to create a global fund for NCD prevention and control.

The call for more UN assistance on 'up-streaming' (going directly to manufacturers) recognises that efforts to reduce salt, sugar and fat in imported food in the Pacific needs pressure on food industries at the global level.

The Forum also called on governments, the private sector, neighbouring countries and the international community to give due recognition to the prevention and control of these diseases which can cause premature, slow and painful death.

The meeting revealed that increasing efforts at regional and national levels to promote greater consumption of nutritious local fruits and vegetables. These are plentiful but often left to rot in preference to less nutritious canned and packaged food.

Countries were encouraged to push through legislation addressing the risk factors, especially tobacco control, and to follow up with effective regulation. Recognising that many of the causes of NCDs lie outside of the health sector, participants shared their experiences of initiatives to include other sectors in activities addressing these diseases. Countries were also given assistance on the task of monitoring and evaluating the progress of these campaigns, and adjusting them where necessary.

It was acknowledged that reducing the prevalence of NCDs is a long-term project requiring sustained effort and support. Indications on how countries are faring are therefore expected to only start showing up over the next three years in national WHO-administered NCD STEPS surveys conducted at different times in countries within seven-year periods.

NB The forum outcomes statement encapsulating the above appears on page 31 of this report.

Programme

Time	Monday 21st	Tuesday 22nd	Wednesday 23rd
Theme	**Evidence-based practice in NCD prevention and control**	**Monitoring, evaluation and surveillance**	**Progress on implementation of NCD prevention and control initiatives**
6.00 am	Walk for health	Walk for health	Walk for health
8.30	Registration Opening Ceremony Participants Introduction	**Keynote address** Causes of mortality in the Pacific—impact on life expectancy. (RT *et al*)	**Report on progress:** Food Summit (CB) *Healthy Islands* and primary health care (TW) Health and sustainability (RC)
9.00	**Keynote Address** Role of evidence-based practice in NCD prevention and control in the Pacific		
9.30		Introduction to M&E (GK)	
10.00	**NCD overview:** From Global to regional to national (TW) **Brief overview** of 2-1-22 Pacific NCD Programme- (VP)	Introduction and implementation of NCD Surveillance (LD, RT)	Country implementation — marketplace
10.30	**Photos and refreshments**	**Refreshments**	**Refreshments**
11.00	**What works in NCD prevention and control?** Salt Réductions Stratégies - (*Jacqui Webster)* Fruits and Vegetables *(KF)*	**Workshops in parallel session** (groups to swap after lunch) Room 1. Monitoring and Evaluation for Group 1 (the 11 PICTs) (GK, TP, TW) Room 2. Surveillance for Group 2 (the other 11 PICTs) (LD, RT)	Country implementation – marketplace
12.00	**Lunch**	**Lunch**	**Lunch**
1.00 pm	Physical Activity *(SI)* *Tobacco Control (LD/Jennie)* Alcohol interventions (*Nina Rehn-Mendoza)*	**Continuing workshops in parallel sessions** (groups to swap after lunch) Room 1. Monitoring and evaluation for Group 2 (the other 11 PICTs) (GK, TP, TW)	Country Implementation – marketplace
2.00	**Small group discussions**: How could this evidence be implemented in your country?	Room 2. Surveillance for Group 1 (the 11 PICTs) (LD, RT, CB, JM)	Show and tell: secretariat marketplace showing what is available to assist countries (Available tools) • NCD training • Physical Activity • Nutrition • Tobacco control • Communications **Conclusions and Official Closing**
2.30		**Summary** on issues from the workshops (LD, KF and GK)	
3.00	**Tea break**	**Tea break**	**Tea break**
3.30	**Panel discussions** on relevance and applications of the evidence	Pacific Research Priorities (C-POND)	Summary and discussions of marketplace activities (TW) **Conclusions and closing**
5.00	Explanation of marketplace Session ends	Session ends Aerobic Session	
6.00	**Cocktail**	**Free time for delegates**	**Forum and JMC Dinner**

Day 1

Theme: Evidence-based practice in NCD prevention and control

Participants were welcomed by WHO South Pacific Office Technical Officer, Nutrition and Physical Activity, Dr Temo Waqanivalu, and SPC Healthy Pacific Lifestyle Section Head, Dr Viliami Puloka. Dr Puloka led the meeting prayer.

1.1 Opening statements

Dr Chen Ken, WHO Representative in the South Pacific

Dr Chen Ken informed delegates of the outcomes of the 63rd World Health Assembly in May 2010 where delegations from all member states reached consensus on a resolution to confront the harmful use of alcohol. A new resolution on 'marketing of foods and non-alcoholic beverages to children' was also adopted.

He said the forum will facilitate and support implementation of these resolutions which had taken NCDs to another level, bringing the issues to the highest levels of government. Leaders would now need to pay more attention to NCDs and there were moves for NCD control and prevention to be included in the Millennium Development Goals (MDGs). This would provide more support to the work of participants in the Forum, he said, adding was this was a very important development in the battle against NCDs.

Other milestone achievements in the past year were the recent Food Summit in Vanuatu in April and the declaration of state of emergency on NCDs in US affiliated countries of the Pacific in May.

WHO would continue to assist countries in their efforts on NCDs and he congratulated the organisers of the forum. At last year's meeting he had asked whether participants' strategies were reaching the grassroots level. He hoped they would share evidence around these questions at this the second meeting. However it was clear that more initiatives were occuring at the village level and these were reaching communities and individuals.

He called on all parties to step up their work and action on addressing these major killers, and he appreciated all collaborations on this. He reminded the meeting that the Health Ministers felt the 'Healthy Islands' vision was still valuable and NCD prevention and control was a very important part of this. He thanked Australia's development assistance agency AusAID, the New Zealand Aid programme and the United States for their assistance.

Mrs Fekitamoeloa 'Utoikamanu, SPC Deputy Director-General

The Deputy Director-General said that 2010 marks 10 years since the launch of WHO action on NCDs. It gave the meeting an opportunity to focus on the theme 'from evidence to action' and also reflect on global and regional developments and challenges, and the translation of these into progress at the national level.

She welcomed the convening of a high-level UN meeting on the prevention and control of NCDs, placing these diseases on international agendas similar to HIV/AIDS. The Millennium Development Goals (MDGs) review summit in October 2010 was an opportunity for NCDs to be brought into the core of the evaluation system. They needed to be recognised as more than a health challenge, but also as a developmental issue. She said there was sufficient lead time for Pacific Islands countries and territories (PICTs) to prepare submissions on MDGs, and the Pacific region could contribute and to shaping the global agenda on NCDs.

Mrs Fekitamoeloa 'Utoikamanu said Pacific Islands Health Ministers were continuing to support regional efforts on NCDs as was shown at the last meetings in Vanuatu and Madang. SPC was committed to the Pacific Framework and collaboration with WHO.

The 2-1-22 Programme needed to be enhanced with:

- a coordinated response at national, regional and country levels
- development partners continuing to work together
- finding ways to retain and health personnel to ensure delivery of primary health care and sustainable health systems
- seeking commitment of continued long-term financing of NCD activities
- strengthening surveillance and evaluation of programmes
- gaining political will and support on NCDs

The Deputy D-G said the Forum theme of 'from evidence to action' required a dedication to action by NCD coordinators.

'Together we can make a difference in the lives of the people of our respective countries,' she said.

1.2 Keynote: Dr Pepe Talalelei Tuitama

Honourable Dr Pepe Talalelei Tuitama, Associate Minister of Health of Samoa

NCDs were a priority health issue in Samoa, Hon. Dr Tuitama said, and the subject was of great interest to him. It concerned him that he was seeing more and more cases over the years and more younger people presenting with NCDs.

There was a need to address this issue with vigour and decisiveness as many of these cases could be delayed or managed through adopting healthy lifestyles from an early age. This was when they should be given information to assist them in understanding the negative impacts of tobacco and alcohol, he said. Early detection was also important.

PICTs had recognised the serious health threat of NCDs for many years, he said. He reminded participants of the concern and commitment of Pacific Islands Health Ministers expressed in the *Healthy Islands* vision in the Yanuca Island Declaration of 1995. This was for countries as places where:

- children are nurtured in body, mind and spirit
- environments invite learning and leisure

- people work and age with dignity
- ecological balance is a source of pride, and
- the ocean that surrounds us is protected for future generations

This was reinforced at subsequent health ministers' meetings, urging member states to further strengthen national NCD strategies, improve access to preventative and curative care and emphasise primary health care.

The Hon. Associate Minister explained that in Samoa the MOH was working with community groups to promote health and well-being through aerobic dancing to musical physical activity programmes.

In addition to the passing of the *Tobacco Control Act* in 2008, media programmes to inform people of the negative impacts of alcohol was continuing through womens' committees to schools and in the community.

A parliamentary advocacy group were promoting healthy lifestyle programmes. Having members of parliament as mentors for healthy living was a powerful way to address NCDs. The aims of the programmes were to change the mindset of people in Samoa to accept the need to adopt healthy lifestyles.

'This is no easy task. At the end of the day we all need to find innovative ways to reverse the trend of NCDs in our Pacific Islands countries and work with our country leaders, our communities and families if we are to ensure that we live as long as possible and enjoy fully the paradise islands we live in.'

1.3 NCD Overview

1.3.1 From global to regional to national

Dr Temo Waqanivalu, WHO South Pacific Office Technical Officer, Nutrition and Physical Activity

Dr Waqanivalu's presentation showed that globally NCD accounts for 35 million deaths (60% of all global deaths). A high proportion of these deaths in the low (gross national income US$825) and middle income (GNI US$825-US$10066) countries are below the age of 60 years which are preventable. In low income countries, out of the 26.4 million deaths, 10.5 million are from NCDs, and of this 3.7 million were occurring among those under 60 years.

Morbidity and premature mortality from NCD lead to loss of productivity and economic loss and will affect the development of low and middle income countries. In the Western Pacific Region, NCD is the major and leading cause of death, he said. NCDs had overtaken all deaths combined from communicable diseases (CD), maternal and child health (MCH), nutritional conditions (NUT) and injuries. A similar pattern was evident in the Americas and Europe.

Trends were that while death from communicable diseases was decreasing death from NCDs was increasing with 26,500 people expected to die from NCD in the Western Pacific region every day. This resulted in huge direct and indirect costs. He added that reaching the target of 2% reduction every year over the next 10 years can save 10 million lives in the region.

He said it is more effective to intervene at the risk factor level rather than treating NCDs. High proportions of NCD risk factors in low and middle income countries point to the urgent need for interventions.

Over the last two decades there has been a major shift in the way we live. Physical inactivity is contributing to obesity and related health outcomes. This was not limited to the affluent classes and even poor people are becoming obese and prone to NCDs due to unhealthy diets and physical inactivity. Tobacco and alcohol are the other major risk factors with tobacco the single most important preventable risk factor for NCD.

Based on the WHO NCD STEPS reports, Dr Waqanivalu showed how overweight and obesity levels are increasing in almost all countries of the region. Pacific Island countries have high rates of overweight and obesity, he said.

He said that WHO has responded to the global NCD epidemic through appropriate strategies and guidance. Major initiatives were the framework convention on tobacco control and the global strategy on diet and physical activity.

Global and regional action plans were developed to help the Member states in planning integrated NCD prevention programmes. WHO was also supporting networks and partnerships in the fight against NCD.

Responding to the 2007 call of Pacific Health Ministers for multisectoral action to prevent non-communicable diseases, WHO had led efforts to improve food security in the Pacific. It had supported six national food summits and chaired a partnership of six agencies to improve food security across the region.

This led to the landmark Pacific Food Summit in Vanuatu in April which was the first time Trade, Agriculture and Health sectors have met together to work out ways to improve food security in the Pacific.

He said WHO was particularly interested in food security because improvements in food security demand the multisectoral approach WHO and Health Ministers have long been calling for prevent NCDs.

In the Western Pacific Region, WHO had initiated and promoted the Healthy Cities Initiative as an integrated and multisectoral approach to address urban health issues since the late 1980s. Initially oriented to environmental health, more public health components are being integrated in the approach such as tobacco control, food safety, healthy lifestyle promotion and NCD prevention.

Dr Waqanivalu noted the leadership shown by US affiliated countries declaring a regional state of emergency on NCDs. The challenges for other countries was to gain political commitment, leadership and sustained advocacy on NCDs.

1.3.2 2-1-22 Pacific NCD Programme

Dr Viliami Puloka, Head, Healthy Pacific Lifestyle Section, SPC

Dr Puloka provided the meeting with an overview of the 2-1-22 NCD Programme under the Pacific Framework for prevention and control of NCDs endorsed by Pacific Health Ministers at Manila in September 2008.

'The Pacific is our home, NCD is our issue, *Healthy Islands* is our vision, and the 2-1-22 programme is our strategy,' he said.

The overall goal of the programme was to reduce death rates from NCD in the Pacific. But in order to achieve that there had to be a reduction in risk factors and diseases. Its purpose was to assist PICTs to improve the health of their populations by establishing a comprehensive approach to profiling, planning, implementing and monitoring and evaluating sustainable initiatives to combat NCDs and associated risk factors in their populations.

In consultation with PICTs, 2-1-22 built on what is already happening in countries and provided a comprehensive integrated programme of support for them to progress further at respective stages of prevention and control, coordinated and harmonized efforts of regional support agencies, countries and development assistance agencies and AusAID and the New Zealand Aid programme.

Governments of the 22 PICTs were key partners driving and delivering the programme in country and ensuring it meets the needs of their communities. There were three streams of funding under 2-1-22, initially funded under AUD$26 million in grants from Australia and New Zealand, the bulk of which was administered by the Secretariat of the Pacific Community (SPC).

The country grants administered through SPC were lump sums given under some agreement with the recipient country. Small grants through SPC of amounts up to AUD$10,000 could be accessed for small projects. Earmarked funds through WHO are specific for each activity agreed with respective technical staff according to best practice. This is in addition to current WHO country budget allocated for NCD and would be heavily weighted for those not receiving country grants.

Dr Puloka told the meeting the programme managers were trying to help countries so that they could reach their own goals. He said 13 countries had signed letters of understanding (LoUs) and had received a large grant. Thirty small grants had been given out to countries.

At the same stage last year only four large grants had been approved, so there had definitely been a lot of progress. It was time, he said, for countries 'to really keep track' on how they were performing—hence the emphasis on evaluation at the Forum.

1.3.2 What works in NCD prevention and control

Keynote: Getting serious about salt

Jacqui Webster, the George Institute for International Health, Sydney

Ms Webster said that for most countries daily salt consumption is now five to 10 times higher than the 1-2 grams we need. The WHO target of 5 grams per person a day was a pragmatic compromise. She showed how salt increases blood pressure, heart attack and stroke and made

the point that salt reduction can reduce blood pressure. Other damaging effects of salt were cancer of the stomach, stroke, heart failure, idiopathic and cyclical oedema, kidney disease, renal stones, bone demineralisation and asthma.

It was estimated that a 5-6 gram reduction in daily salt intake could prevent about 600,000 stroke and heart attack deaths in the Western Pacific each year. Even reducing children's salt intake has a big impact on blood pressure levels in later life, she said. Blood pressure was the second leading cause of total disease burden (7.6 per cent) after tobacco (7.8 per cent), and the problem wasn't getting any better.

There was a two-pronged approach to the problem—exercising clinical hypertension control, identifying those at highest risk and treating to reduce high levels; and through population-based salt reduction where everyone was considered a risk and efforts were made to try and get a small reduction in salt in everyone. It was plausible tat a 3-5 grams a day reduction in mean population salt consumption could lead to a 10-20 per cent reduction in vascular disease.

The actual costs of national or regional salt reduction programmes were 1-2 per cent of the costs of hypertension management programmes. The conclusion was that there was a strong case for the addition of national salt reduction programmes to existing clinical hypertension programmes delivering substantial health benefits and minimal additional costs.

Ms Webster explained how effective salt reduction campaigns had been in Europe, in some cases cutting salt content in packaged foods by 20-40 per cent. It was estimated that in UK alone, by 2008 26 tons of salt a year had been removed from the diets of the population. For the Pacific, she recommended that clear targets for salt reduction be established as well as specific actions on salt and effective monitoring of progress. 'Salt reduction is a simple and cheap way of addressing NCDs —but will only be effective with a targeted approach.'

Stakeholders (government, food industry, NGOs and church groups) need to be mobilised to support salt reduction strategies, she said. Ideas for actions included distributing low salt recipes through local markets, working with other community projects, cooking TV programmes, establishing standards for imported food engaging with food companies, discouraging the use of salt on dining tables, targeting schools. It wasn't just about food controls, she said, but also employing the food industry as a positive force for change.

Questions

Ms Webster was asked that whereas in Australia the food industry could be controlled, in the Pacific, countries just imported products and had no control over external manufacturers. Acknowledging this as a good point, she said there was a strong case for regional action and standards. New Zealand's experience in this respect was an important example of what can be achieved. She recommended regional agreements with companies.

On the question of salt substitutes, she said it was difficult for people change when they were accustomed to taking salt with their meals. It took about three weeks for the taste buds to adjust to lower levels of salt in food. However, it was shown that you could take 10 percent of salt out without people noticing. She recommended working with the food industry to gradually change the salt content in their products. Chilli, lemon and garlic were salt substitutes.

Asked whether more salt was required in diets in hotter countries, Ms Webster said it was very unlikely that people had too little salt because of heat and sweating. Unknown though, was

whether preserving fish in salt was contributing to salt intake. Some countries were looking at refridgeration as the alternative. The question was also raised on whether there should be a salt watchdog for the Pacific. Meanwhile, there was a need for continuing advocacy and discussion on salt.

1.3.3 Fruits and vegetables

Karen Fukofuka, Nutrition Adviser, Healthy Pacific Lifestyle Section, SPC

Ms Fukofuka provided an overview on nutrition initiatives in PICTs including *Go Local* in FSM, the *5+a day* campaign in Cook Islands, *Kastom garden* in the Solomon Islands, the annual Bob Festival event in RMI, along with obesity prevention campaigns in Fiji and Tonga and World Food Days throughout the region in October each year.

She said the key elements for success in these programmes was to make sure there were multisectoral and private-public partnerships. The projects needed to be evidence based and sustainable by being community owned and drive.

World Food Days provided an excellent opportunity for advocacy. Government policies needed to target settings such as schools, churches and workplaces and should have a holistic, from 'farm-to-fork' approach. The general principles food, fruit and vegetable promotion programmes were to:

- include initiatives which target demand and supply-side issues based on a needs assessment
- be coherent with, and complementary to, national policies and action plans such as food and nutrition, health, agriculture, and any existing environmental policies
- attempt to mobilize existing resources (people, information, initiatives, policies)
- be socially inclusive and participatory, targeting all social classes through specific actions, particularly vulnerable groups

They should also ensure that:

- messages were consistent across policies and programmes
- policies or interventions (eg in schools) promote a healthy diet including increased fruit and vegetable intake
- the process and all interventions are evaluated
- best practices prevail.

In spite of the principles and the many initiatives under way, people were not meeting the challenges which included limited:

- funding support to scale up action
- evaluation capacity
- variety and supply of F&V in most Pacific countries—seasonality, economic environment, pests, poor soil, limited available land

In the Pacific we were very good at doing things, she said, but not so good at recording and evaluating. Also, she asked whether the agricultural sectors in PICTs were producing enough. There was often a low value placed on fruit and vegetables in communities and that these were for tourists. 'It's about time we looked at these things, our fruit and vegetables are very nutritious.'

Ms Fukofuka also briefed the meeting on progress made towards food security at the recent Pacific Food Summit in Vanuatu and drew participants' attention to the outcome documents and its framework for action *Towards a Food Secure Pacific*.

Questions

One participant said he was concern that farmers were using more chemicals on their fruit and vegetables, and Mr Fukofuka replied that most governments have strict guidelines on what pesticides can be used, but she also recommended washing vegetables before cooking.

She was also asked about recommended proportions and intake of calories. She said all fruit and vegetables are rich in nutrients and low in calories and there was a need to replace energy dense fatty foods and rice. Asked what was the message to Pacific Islanders who like to eat a lot, her advice was to just eat less. What about sweet fruit, was there a diabetes connection? Ms Fukofuka replied that to balance this, people should eat more vegetables.

1.3.4 Physical activity

Dr Si Thu Win Tin, NCD Adviser—Physical Activity, Healthy Pacific Lifestyle Section, SPC

Dr Si briefed the meeting on the *Toronto Charter for Physical Activity: A Global Call for Action* launched at the 3rd International Congress for Physical Activity and Health in Toronto, Canada on 8 May 2010.

The *Toronto Charter* is a call to all countries to help make physical activity a priority for all. It provides a framework for action and partnerships across multiple sectors and with communities to build healthier, active, environmentally sustainable communities. It is a result of two years of international drafting and large scale global consultation. It was ratified by delegates with overwhelming support for its call to all countries to seek greater political commitment, resources and community action to support health enhancing physical activity for all. The Charter is an advocacy tool, designed for use with decisions makers and to build partnership towards achieving political commitment and resources towards increasing participation in health-enhancing physical activity.

Dr Si submitted that the charter is consistent with the *Non Communicable Diseases Action Plan* (2008) and the global strategy *Diet, Physical Activity and Health* (2004) and other international health promotion charters. The charter for physical activity outlines guiding principles four actions in *A Framework for action* including:

- implementing a national policy and action plan;
- introducing policies that support physical activity;

- reorienting services and funding to prioritise physical activity, and;
- developing partnerships for action.

Dr Si highlighted that these guiding principles and framework for action are a good tool for PICTs to strengthen physical activity advocacy and interventions in country level by adopting and incorporating these actions into existing national NCD plans. He then led forum participants through a 10-minute physical activity session with a modern music routine.

1.3.5 Tobacco control

Dr Li Dan, NCD Medical Officer, WHO Office of the South Pacific

Dr Li Dan described WHO's Regional Action Plan for the Tobacco Free Initiative in the Western Pacific Region (2010-2014), which aims for half of countries participating in leadership training programmes for tobacco control and all countries having national plans for associated human resource development.

He briefed the meeting on World No Tobacco Day (WNTD) 2010 activities in Fiji and publicity including establishment of a tobacco free village at Nabukaluka in Naitasiri province on the island of Viti Levu.

Dr Li Dan also reported on a similar project with the Fiji Sugar Corporation in the northern division of Fiji, and WNTD activities in CNMI, Palau, Marshall Islands and Federated States of Micronesia (FSM). He recommended to those countries not already running WNTD programmes to get in touch with WHO for technical and financial support.

1.3.5 Alcohol interventions

Jeanie McKenzie, NCD Adviser—Alcohol and Tobacco Control, Healthy Pacific Lifestyle Section, SPC

Ms McKenzie briefed the Forum on the latest information regarding the prevalence of current drinkers in the Pacific, which was highest in Tokelau, American Samoa and Nauru, followed by Solomon Islands, FSM, Kiribati, Fiji and Marshall Islands, and in that order. Despite the many frameworks, plans, strategies and networks, alcohol control was the 'poor cousin' in NCD prevention and control programmes. However, SPC and WHO had reinvigorated these programmes.

Linked to WPRO initiative, SPC was undertaking two large-scale, evidence-based interventions each year, with PNG and Solomon Islands being the targets in 2010. Ms McKenzie listed the most effective ways of regulating access and availability of alcohol through :

- comprehensive legislation restricting advertising
- lowering drink-drive limits
- taxation

- regulatory agencies
- banning discount selling
- enforcing age restrictions
- licensing
- shorter trading hours
- restricting alcopops,
- limiting imports, and
- controls of smuggling

Strategies to reduce the harmful use of alcohol included:

- mass media campaigns
- community action restrictions on sponsorships
- responsible beverage serving
- encouraging low alcohol alternatives
- engagement of government and civil society participation
- training
- interventions
- treatment and rehabilitation

These programmes needed high-level government endorsement, to be comprehensive and cross-sectoral with clearly identified roles for partners and lead agency responsibility. They needed to be sustainable, evidence based, monitored and publicized.

Meanwhile, the major challenges were reconciling differing interests between business and governments on revenues—on trade such as the lowering of tariffs accompanied by lifting of advertising bans post WTO. There were also challenges over implementation failure, lack of enforcement and production of 'home brew'.

1.3.6 Small group and panel discussions

The meeting then broke up in to small group discussions on how the NCD evidence of best practise can be implemented at a national level.

After a break Professor Boyd Swinburn of Deakin University and C-POND briefed the Forum on issues and developments in evidence-based practice in NCD prevention and control. This included the possibilities of the application of research from other countries to the Pacific such as in tobacco, CVD and injury control. He explained the International Obesity Taskforce (IOTF) framework for obesity prevention and the Cochrane Review on Interventions for preventing obesity in children, including how problems are identified and solutions and tools for action found. This included examples of the interplay of evidence and intervention diet and physical activity for children.

Picking up on the earlier group discussion, the panel then fielded questions from the floor under the subject heading 'the relevance and application of the evidence to the implementation of best practice in NCD prevention and control'. On the panel were: the Honourable Dr Pepe Talalelei Tuitama, Associate Minister of Health, Samoa, Dr Janet Clinton, University of Auckland, Professor Richard Taylor, University of New South Wales, Ms Jacqui Webster, George Institute, Professor Boyd Swinburn C-POND, and Dr Colin Bell, WHO.

Keep yourself honest

Dr Bell stressed the importance of evidence and Professor Taylor said it was very important to 'keep yourself honest' as it was very easy to 'fall in love with your own promotion programmes'. The representative of American Samoa asked whether evaluation tools could be developed and session facilitator Dr Waqanivalu (WHO) said this is why academics had been invited to the Forum and were being engaged. They were helping the 2-1-22 programme fill this capacity gap.

Professor Swinburn said C-POND had a collaboration of support services and the single biggest area countries lacked confidence was on evaluation of community-based programmes. They needed to link up with organisations that had this expertise, he said.

Dr Clinton said evaluation would help countries' programmes. In New Zealand there were three universities developing online evaluation tools and there were a lot of things countries could access and be helped on. The universities were keen to engage with countries, she said.

Dr Alafia Samuels, representative of Chronic Disease Prevention and Control (CARICOM [Caribbean Community]), made the point that evaluation had to be set up at the start of a programme so that at the end countries would know what needed to be done.

Professor Taylor said evaluation can be 'very scary', but he encouraged scepticism right from the beginning, so that everyone knew that it would be a test, and they were going to be evaluated. Problems occurred when people had preconceived ideas that it would be a success. Hon. Associate Minister Tuitama said there was a need to alter an approach from time to time, evaluating always the line of management and this was the same with projects of this nature.

Ms Webster said [programme managers] will not get topics off the ground unless they convinced people they were going to work. It was about being clear what we want to do and how we want to make a difference and to keep those questions in mind. Dr Clinton said if projects were constantly adjusting, it was not scary.

The representative of Tokelau told the panel his country had undertaken a screening process and looked at the disease burden in line with the national strategic plan to determine the cost of NCDs over the next five years—and then to work out where to intervene. Could the panel assist in the analysis of Tokelau's data? Dr Clinton replied that they [the University of Auckland] were prepared to look specifically at what Tokelau needed. Certainly New Zealand could help, she said, and they would look for the right person.

Samoa asked whether evaluation would reflect the need for cultural sensitivity and disruption caused by (unforseen) events. Professor Swinburn replied that these things happen and cited the example of how his organisation's evaluation process was interrupted in Tonga. He added that it was best to get help on setting up the evaluation process when you were planning the project, not when you were already doing it. He recommended holding a workshop earlier and setting up the evaluation then.

Capacity questions

Rather than expect countries to provide data to be analysed elsewhere, was it possible, the representative of Kiribati asked, for training and IT assistance to enable countries to analyse their own data? Dr Bell said this pointed to building capacity in countries. Countries could do

simple evaluations without having statistical packages, but there was also a need for capacity to do those evaluations well. There were questions here about where that capacity should sit. 'I hope you keep us accountable too.'

Professor Boyd said there was tension between high capacity countries doing analysis on the one hand and keeping locals upskilled. 'We have struggled in many cases simply because of the capacity issues in countries.' Tonga said there needs to be some kind of regional capacity for this. Kiribati added they really needed predictive factors on this and to find a way to address it from country grants. Dr Waqanivalu responded that for monitoring and evaluation tools countries needed statistical software, but they did not need sophisticated software. Countries had the resources, he said.

The representative of the Cook Islands said that for them people were comfortable with the evaluation process, were participating and some were not aware it was being done. There was no mention, New Caledonia observed, on whether consumers were satisfied with the services provided by practitioners. For example in Wallis and Futuna people were expecting a lot from testing and many came along. Dr Waqanivalu asked whether this research was the role of academics role.

Referring to actions in countries, Professor Taylor said governments were still influenced by powerful corporate political contributions. Ms Webster submitted it was important to document the impact of actual interventions. The representative of Guam said their cancer registry was collecting that information. A lot of their interventions were to do with prevention and this took a long time and the process was influenced by competing priorities. The representative of Samoa said that whatever the intentions were, countries needed political will. The priority was to come back to parliament as they were really dependent them.

Changing the environment

The representative of CNMI raised the question of whether the focus for interventions should be focussed on children and adolescents. Professor Swinburn responded it was a lot easier to change behaviour with under five-year-olds, but 'you have to deal with the adults', and it was important to focus on them. Samoa called for a focus on families because children were impacted on what they saw happening in families. Dr Bell agreed this was a 'really good point' and a reminder that NCDs are a huge problem in the Pacific.

Creating supportive environments and establishing good life long habits could be helped during adolescence, the meeting heard. If the environment was not changed progress would be marginal, Professor Swinburn argued. With obesity the job was much tougher in the Pacific and not enough had been done on the socio-cultural dimension. Ms Webster endorsed the need to address the environment and Professor Taylor added it was shown that epidemics could be reduced using pharmaceuticals, but people continued to use expensive ones when cheaper ones were available. Palau said we were operating on clinical model and we need to look at the environment model and the person as a whole, including the spiritual dimension.

Respects paid

The Forum observed a minute of silence on being informed that Amato Elymore, FSM Cancer Prevention Coordinator, had passed away from heart failure the day before. Known to many participants, his contribution and giving of his best was remembered.

Day 2

Theme: Monitoring, evaluation and surveillance

2.1 Keynote: Causes of Mortality in the Pacific—Impact on Life Expectancy

Professor Richard Taylor, University of New South Wales

Professor Taylor provided the Forum with a broad historical, international analysis of the impact of NCDs on premature adult mortality and life expectancy.

Since the 1970s NCDs were increasingly evident among the lower socio-economic strata (SES) urban populations in developed countries and by late 20 century also in developing countries. Employing a series of charts and graphs, he showed the trends in the epidemic of coronary heart disease mortality. NCDs were not inevitably or irreversibly associated with urbanisation, Westernisation, modernisation, globalisation, development and affluence. Nor were they 'degenerative diseases' and no more 'man-made' than HIV, diarrhoeal disease or under nutrition.

NCDs were a consequence of specific and reversible aspects of diet (animal fat, salt, calories) physical exercise and tobacco smoking. Something could be done about this, he said, citing dramatic reductions in premature mortality from NCD mortality over the past 30-40 years in many countries, including Australia and New Zealand. Most of the decline could be explained on the basis of reductions in population risk factors.

In several Pacific Island states a plateau in life expectancy was observed in the last 30 years, especially in males, and during continued declines in child mortality. This has been referred to as 'stagnation' in mortality decline, usually a consequence of increasing adult mortality, implying significant premature mortality from NCD and injury. This stage in the 'Epidemiological Transition' occurred in the 1960s in Anglo-Saxon and northern European countries, Australia and New Zealand.

The considerable variation in mortality estimates for several Pacific Island countries from different sources is a significant concern for public policy. It was unlikely that many published estimates were derived from models (using infant or childhood mortality) which underestimated adult mortality in Pacific Island populations, over-estimated life expectancy, and 'masked' the importance of cardiovascular disease as a public health issue.

There were also difficulties in cause of death recording, sequencing, coding, tabulation and interpretation. Improvement of mortality data to reduce uncertainty was urgently needed to ensure that policy and program initiatives to address health issues can be appropriately evaluated.

Looking at the challenges to NCD control in populations, Professor Taylor identified individualism where NCDs were seen as due only to (wrong) choices: 'gluttony' and 'laziness'; and medicalisation with the focus on detection and treatment of cases over prevention.

The food industry and their influence on government and international agencies was a factor, as was economic globalisation which restricts countries ability to regulate food imports and trade.

The pharmaceutical industry funding for research which focuses on drug treatment/prevention was another challenge, as was the reluctance of governments to intervene in choices considered to be the province of the individual for diseases that are non-transmissible.

There was a lack of compelling evidence to explain declines in NCD mortality and the effectiveness of prevention due to difficulties of scientific studies in whole populations.

Prevalent economic paradigms at national and international level that prevented price and import manipulation to foster availability of cheap healthy food. Often locally produced was another challenge, as was the lack of recognition of sedentary work as an occupational hazard, and the view that exercise is only recreation.

His recommendations were to:

- focus on the population or mass approach for prevention of NCD in addition to individual screening
- introduce intensive health promotion and multisectoral structural change for impact diet, tobacco smoking and physical exercise
- involve non-government organizations (NGOs), universities, and professional groups
- understand and use what has been successful in other populations, after adaptation for local implementation
- monitor activities and results— NCD risk factors and mortality

2.2 Introduction to Monitoring and Evaluation

Greg Keeble, M&E Officer, Healthy Pacific Lifestyle Section, SPC

Mr Keeble presented the technical components of developing an M&E framework to groups of country representatives. He showed the participants the different components of an M&E framework for performance monitoring and for impact evaluation. He said the log frame elements need to be included in an M&E framework and provided examples of these to the workshop participants.

These elements included defining the programme outputs, outcomes and impacts, specifying performance and impact indicators, determining the means of verification, and identifying risks and assumptions. He stressed that it is critically important to develop the M&E framework prior to implementation of NCD plans.

Mr Keeble indicated that technical assistance and resources were available from SPC for the purposes of developing and implementing M&E frameworks for national NCD plans. Countries asked questions about data sources and about which were best for M&E. The sources are he said were dependent on the type of indicators and reference was made to national data sources,

such as health information systems and national surveys. Results need to be attributable to activities implemented by countries.

Janet Clinton, Programme Evaluator, University of Auckland

Dr Clinton provided a context for programme evaluation within communities and gave a brief overview of the evaluation process and methods. She showed how to design evaluation methods and set up evaluation plans.

In the second session, countries broke into small groups to design an evaluation plan based on a planning be matrix. The countries reported back that they enjoyed the exercise and learned that using the planning matrix was useful to set objectives, determine activities, targets, success indicators, and measures.

Dr Clinton introduced the community tool box which provides tools to collect data for evaluation in communities. She discussed analysis and interpretation of data, and using appropriate techniques for disseminating and presenting results.

She summed up that programme evaluation is very powerful and useful to improve programme implementation. It needed to be systematic and engage all stakeholders and to use the information to tell their story. Questions were asked about how to deal with bias in the evaluation and it was emphasized that it is not ethnical to mess with the data. There was a need to be open and transparent with information.

2.3 Introduction and implementation of NCD surveillance

Dr Li Dan, NCD Medical Officer WHO South Pacific Office

Dr Lin Dan provided the Forum with a summary of the WHO STEPwise approach to surveillance of risk factors for NCDs. Initiated in 2001 and introduced to PICTs from 2005, WHO headquarters conducted “weighting of data” from STEPS and WHO Suva Office was analyzing and producing standardised tables and data books. STEPS thus offered scientific, national, updated, comparable data for Pacific Islands countries, he said.

STEPS reports showed that diabetes rates were highest in American Samoa and Tokelau and lowest in the Solomon Islands. Hypertension was most prevalent in American Samoa and Fiji, and obesity highest in Tokelau, American Samoa and Nauru. Tobacco use was highest in Kiribati, Nauru and Tokelau. Combined risk factors of NCDs were current daily smoking, eating less than five combined servings of fruit and vegetables a day, low levels of physical activity, the overweight rate and raised blood pressure.

Overall, STEPS showed the region had the highest prevalence of overweight, obesity and diabetes in the world. Countries were now basing the NCD strategies based on the STEPS data. Dr Li Dan summarised the environmental, lifestyle and clinical interventions and advocacy on NCDs and how STEPS was being used to advance these. It provided evidence for PICs to identify their priorities, background data for the national and Pacific food summits and information of the prevalence of hypertension linked to the consumption of salt. STEPS also provided data for gender analysis and he showed how this was evident with patterns of smoking.

2.4 Surveillance workshops

Five key areas covered in the Surveillance Workshops were STEPS, mini STEPS[1], mortality data, Cancer registries and Youth survey data (specifically the Global School based Health Survey (GSHS) and Global Youth Tobacco Survey (GYTS)). A panel lead by Dr Li Dan, with Dr Colin Bell, Professor Richard Taylor and Ms Jeanie McKenzie facilitated a wide ranging discussion.

STEPS

Discussion focused on how countries had utilized their STEPS surveys.[2] Countries reported how STEPS had provided key baseline data, assisting them to develop policy, produce media releases and factsheets and use the information for advocacy and lobbying for funds. Many PICTs reported that they had taken the information back to the people, using it I community talks and briefings.

Mortality data

Professor Taylor emphasized the importance of collecting the data by sex and age, rather than just reporting on total mortality. He explained coding of cause of death data, and highlighted issues in many countries ensuring full registration of data and with the classification of cause of death, particularly ensuring that the underlying and contributing cause of death are accurately recorded. This was an area were many countries requested assistance, he said, some emphasising the fragility of their country's health information systems and the difficulties in setting up comprehensive mortality monitoring. The meeting heard that NCD mortality data is available in the WHO CHIPS annual reports. An AusAID-funded project has been assisting PICTs to improve the data of NCD mortality in some PICTs, like Fiji, Tonga, Nauru, Kiribati, Palau.

GSHS, GYTS

The representative of Niue, Ms Grizelda Mokoia, presented an overview of the Global School-based Health Survey (GSHS), which is underway in Fiji and Nauru. Another key survey instrument is the Global Youth Tobacco Survey (GYTS). The target age group is 13-15. Training workshops were being conducted in New Zealand and the Philippines in 2010.

Cancer registries

[1] Mini-STEPS is an evaluation tool to use WHO STEPS approach on the intervention at community level. Some PICTs have done Mini-STEPS.

[2](1) STEPS (A) Original STEPS Surveys (15 PICs), Published STEPS reports (8 PICs) – Fiji, Nauru, American Samoa, Tokelau, FSM, Marshall Islands, Kiribati and Solomon;. Finalized Fact Sheet (1 PIC) – PNG; Finalizing Report by the country (1 PIC) – Samoa; Drafting the Report (1 PIC) – Cook Islands; Data Input (1 PIC) – Tuvalu; Conducting NCD Surveys and No STEPS Reports (3 PICs) – Palau, Tonga and Vanuatu; (B) New or 2nd round STEPS Surveys (5 PICs, 7 STEPS Surveys): French Polynesia, CNMI, Fiji, FSM (Chuuk), FSM (Yap), FSM (Kosrae) and Palau; Data/information from STEPS reports is shared with leaders, government, NGOs, community groups. Media releases, workshops and meetings, health promotion materials, data is used as the main evidence for NCD plans, strategic plans, identifying priorities of intervention, etc.

In this final discussion, the meeting heard that a few countries have operational cancer registries, with others considering one. Some key issues in the discussion related to the difficulty of confirming the diagnosis and following up pathology reports, as well as following up patients who are being treated overseas. WHO reported cancer registration has been conducted in some PICTs, including Fiji, Solomon Islands, Palau, CNMI, American Samoa, Guam, Marshall Islands and FSM, New Caledonia and French Polynesia. There were problems with coding of cancer cases—of overlapping and missing cases through overseas referral for confirmation of diagnoses.

2.6 Pacific research priorities

Wendy Snowdon, C-Pond

Wendy Snowdon asked the Forum to think about potential regional research priorities and to come up with a wish-list of research areas that could be worked on by C_POND researchers. The analysis would not involve working in countries as it would be done only at a regional level, for example secondary analysis of STEPS and waist circumference action points for the Pacific region.

She mentioned that economic impact of NCDs and the cost-effectiveness of interventions was area that is already being worked on. BMI of children was another area for potential research. Risk scores can identify risks of difference NCDs and requires longitudinal data.

Diabetes prevention in Pacific (DPIP) is also a possible priority and potential social cultural issues for research. Policies on assessment of current actions are also an important area for research as are sodium levels in food intake.

Discussions suggested areas such as salt consumption, intergenerational studies were needed and capacity building and research will support the implementation of NCD activities in the region.

Day 3

Theme: Progress on implementation of NCD prevention and control initiatives

3.1 Keynote: CARICOM, Chronic NCDs—a priority for the Caribbean

Dr Alafia Samuels, Caribbean Community (CARICOM) Secretariat Consultant, NCD Prevention and Control www.healthycaribbean.com

Dr Samuels briefed the Forum on the burden and trends of NCDs in Caribbean countries. Her presentation revealed that heart disease and cancers were the leading causes of death with diabetes more prevalent among women. Trends showed increasingly inactive populations.

Obesity in the Caribbean was not as high as in the Pacific, 'but we are up there,' she said. Alcohol problems were higher, although these were not described as such in the Caribbean because the region produced rum. Tobacco and sedentary behaviour were major problems. 'Our kids are sitting, not moving,' she said.

In 2007 Caribbean countries produced the Port of Spain Declaration advocating tobacco control, healthy eating (salt), physical activity and treatment targeting workplaces, schools, faith-based organisations and communities. It involved an NCD secretariat with plans and M&E, NCD commissions, surveillance, and partnerships in the private sector and civil society, and outreach through the media and communications. Priority lines of action were for:

- risk factor reduction and health promotion (tobacco, salt, alcohol, physical activity)
- integrated disease management and patient self-management education
- surveillance, monitoring and evaluation
- public policy, advocacy and communications
- programme management (NCD plans, focal points, funding [tobacco taxes in Jamaica], NCD summits and inter-sectoral NCD commissions, training and capacity building)

Dr Samuels described the multi-sectoral initiatives and emphasised how important it was to engage government ministers on NCDs. 'We've had a little bit of success, but we need to work more with them [the ministers] and also with NGOs.

Following the Port of Spain Declaration, the message was 'Love that Body' linked to the initiative of *Caribbean Wellness Day*. She provided examples of activities in the Bahamas (*Mega Health Extravaganza*) health testing in the First Caribbean International Bank in St Vincent and Grenadines, and the *Biggest Loser* title in Grenada.

In St Kitts there was a *Share Your Fruits* event, in Trinidad and Tobago communities blocked streets for community exercise activities and biking; and in Port of Spain there was the *Wellness Festival*, to promote sustained physical activity and was the face of the *Wellness Revolution*.

In conclusion, Dr Samuels said the Caribbean did have the political will from heads of government, but were small countries and donors were not interested in us. Activities tended to be sporadic and there was only token funding. There were opportunities however to work with the Pacific in collaborations engaging with civil society, the private sector, on health promotion, NCD plans and evaluation.

Responding, SPC's head of the Healthy Pacific Lifestyle section, Dr Viliami Puloka, thanked Dr Samuels for her presentation and noted that the Pacific was not alone regarding NCDs. Dr Puloka said this was a great opportunity for collaboration. The Pacific needed to look at these countries with similar problems.

Professor Richard Taylor of UNSW asked whether sport connections were being made in the Caribbean, whether they were being developed as role models. Dr Samuels said yes this was a very good idea and in the Caribbean HIV used the cricket team in this way. However, the problem was that Jamaicans liked to sit and watch cricket, and there was also a need to 'get them going'.

3.2 Progress reports on implementation of NCD prevention and control initiatives

3.2.1 Health and sustainability

Professor Ruth Colagiuri, Menzies Centre, University of Sydney

Professor Colagiuri submitted that way in which people and societies were living was not sustainable. It was drowning people, she said, and she knew 'who pushed them in'. It was the way we eat, the way we grow, our dependency on cars, the design of towns and cities around cars and the way we use our leisure time.

'It's just not working out and it's time to turn of the tap,' Professor Colagiuri said. We have to level out that steep climb in NCDs, and this was not just about health choices. 'The healthy choices are just not there.' It was about changing environments.

Professor Colagiuri stressed the importance of getting the 'high-level, global policy right to create the right climate to turn off the tap'. She endorsed the idea of international alliances such as the lobbying from the Caribbean countries that NCDs were a development issue.

'I would absolutely encourage you to get behind the Caribbean on this,' she said. WHO in Geneva were quite weak on NCDs, she said. 'They don't have anyone to push for NCDs.' She encouraged countries lobby and have a united front in the UN processes. The UN will appoint a senior UN person to drive the process and Caribbean countries would be involved.

'We have to get it right on what we want when we go to the summit. We therefore have to speak with one voice. We have to get our advocacy right.' Heart disease groups had already

agreed to work together and she urged country representatives at the Forum to lobby their governments to lobby WHO. This needed to be done immediately.

These were the opportunities that the Pacific needed to take. 'Your voices sing beautifully in the Pacific, make your voices roar like lions.' And she repeated that Pacific countries should link up with the Caribbean countries.

3.2.2 Food Summit

Dr Colin Bell, WHO Manila

Dr Bell reported on the Pacific Food Summit at Port Vila in Vanuatu on 21-23 April. A broad cross section of the Pacific community attended the meeting as a response to calls from Health Ministers and the Pacific Islands Forum leaders. He referred the audience to the resulting framework for action *Towards a Food Secure Pacific* and the summit outcomes document which could be viewed at www.foodsecurepacific.org

Food security existed, he said, when all people at all times had physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. The main issue was that although we have access to food, it was not necessarily the right type of food.

Risks for food security in the Pacific were population growth to 10 million in 2010 with larger numbers of urban poor, climate change with fewer crops producing lower yields, and reduced production of most nutritious local foods.

Increasing dependence on imported foods and fuel meant that people were eating more and getting less nutrition; and consuming more foods high in fat, salt and sugar. The region had low food security, he said, and was shown to be vulnerable during the period of increased fuel and food prices in 2008 that came with the global financial crisis (GFC).

The relevance for NCD prevention could be found in five themes at the summit:

- multisectoral response and support
- strengthening food control systems and collaborating with the private sector
- enhanced sustainable production, processing, marketing, trading and use of safe and nutritious local food
- protecting infants and vulnerable populations, and
- consumer empowerment and mobilizing partners

This allowed countries to expand NCD plans into other sectors and fields, integrating in their plans for multisectoral involvement, and modifying products by for example lowering salt and sugar content. This would become evident on product labels and in the fortification of foods.

3.2.3 Healthy Islands

Dr Temo Waqanivalu, WHO Suva

Dr Waqanivalu briefed the Forum on the evolving context, strategies and proposed actions to revitalise 'Healthy Islands' for development in the Pacific. WHO was doing a stocktake of activities over past years, examining the effect of issues such as climate change, food security, disease trends and health systems was having on the vision application of *Healthy Islands* at regional and country levels.

Coming out of the Yanuca Declaration in 1995, *Healthy Islands* is envisioned as a time when the Pacific Islands would be a place where:

- children are nurtured in body and mind
- environments invite learning and leisure
- people work and age with dignity
- ecological balance is a source of pride
- the ocean which sustains us is protected

There was need to bring *Healthy Islands* on to the development agenda he said. WHO was therefore providing technical support for development of a repositioning strategy for 'Healthy Islands' as core strategy for health and development. An example of how it could be developed was evident in Samoa where the national development plan involving family incorporates the principles of Healthy Islands. This needed to be extended to health community workers. How many of them knew about NCD programs, he asked, adding that revitalisation of primary health in communities was 'absolutely vital'.

There was also a need identified for recognition of current efforts hence WHO has developed a recognition programme that PICs could apply for and be recognised during the Ministers of Health Meeting in categories of 'Best Proposal and Best Practice'. Meanwhile, there was consensus among health leaders in the pacific that *Healthy Islands* was still the relevant vision for health and development and a revitalised primary health care was the means to achieve that vision.

Dr Viliami Puloka, Head, Healthy Pacific Lifestyle section, SPC

Commenting on the morning's presentations, co-forum organiser, Dr Viliami Puloka highlighted the opportunity collaboration with CARICOM offered the Pacific an opportunity to 'roar like a lion'.

3.3 Country implementation—Marketplace

Representatives of 21 countries then were given 10 minutes each to showcase their progress in NCD prevention and control under the four phases of profiling, planning, implementation and evaluation. They used posters, photographs, videos, publications and demonstrated their marketing skills to sell their 'products' to other participants. The guiding spirit of the marketplace was to exchange experience and ideas for the benefit of all attending the Forum. The 21 countries were divided into two groups (inside and outside of the conference room).

In sum, the main items traded at the marketplace were:

American Samoa were top of the charts for diabetes, hypertension and overweight people, the marketplace heard. But people working on NCDs had to first convince their chief, the minister of health, before going to villages to sell their product—a one-stop-shop offering free screening, tobacco counselling, checks by a doctor and advice from a nutritionist. The theme of their offering was the heart, which 'makes a big difference'. The approach was to tell people if they planned to live in this village, you have to do exercise, make the family the core of your whole being and live happy and free of smoking. American Samoa particularly liked using the SPC posters with spoons educating about the composition of food because Samoans loved to eat and this was the main reason why they were 'at the top'.

CNMI explained there was need for sensitivity on the many languages in their country, and as a first step brochures were being translated into Carolinian. CNMI showed their physical activity and World no-tobacco day t-shirts for schools and the *Get real* and *Move it* campaigns information. The latter involved a walk on Wednesday when patients and others were encouraged to walk for 30 minutes. Families in CNMI were being encouraged to remain fit for life. One healthy workplace initiative involved a local grocery store whose staff took walks each weekend on the beach path. A recipe book was produced in collaboration with Northern Marianas College. A pre-taped cooking with colours show drew in members of the community to 'take a stand for a healthier CNMI'. People were being encouraged to think about how investment in a healthier lifestyle now would save health costs later.

Cook Islands were guided by the vision of their people living healthier lives and reaching their aspirations. Cook Islands' health care system was provided at minimal costs as they believed cost should not hinder access to care. They offered their annual statistics bulletin for sale which showed incidence trends and the Mini STEPS surveillance conducted through the Ministry of Health. Buyers expressed interest in their free pens and the women's triathlon event.

Fiji told participants 60 per cent of people were under 30 years of age and 60 per cent of the NCD budget was directed at them. The focus on addressing the tsunami of premature mortality from NCDs in Fiji was in primary health care. Health care workers use a human trafficking system in screening people and allocating them a card coloured green, orange or red—and intervening on that basis. Fiji had also rebranded their logo, adopting the *Three-m's*—of mouth (what you eat), muscle (exercise, especially swimming), and medicine prescription. Health professionals would then assist people on all three in a wholistic manner.

FSM offered posters trying to persuade people to eat less and educating about foods high in salt. There was now a combined national NCD strategy with five pillars addressing the key risk factors. Overweight and obesity was a problem and they said this was being tackled through physical activity and diet.

French Polynesia offered smoking control poster artwork and presented three projects. First were two posters on healthy eating and fresh fruit and vegetables, second an initiative on workplaces and third one on school areas and children. They also sold a food handout sheet for readers of French.

Guam marketed pedometers with the expectation that those who wore them should walk at least 10,000 steps a day. Admitting that smoking rates were 'atrocious' in their country, Guam

had decided to change the environment to make smoking socially unacceptable. Laws were passed making restaurants and workplaces smoke-free, and academic institutions tobacco-free.

Kiribati updated buyers on what they were doing to develop a logo promoting drinking water, stopping smoking and eating vegetables. Efforts were being concentrated on three settings, the workplaces, schools and manaebas. STEPS data which MOH had yet to present to other ministries was showing that in schools 48.6 per cent were overweight. In manaebas where people live, 46 per cent had high blood pressure and 75 per cent were overweight.

Nauru marketed their 'Stomp the Fat' and 'Walk for Life' t-shirts. The regular 12-week 'Stomp the Fat' programme for overweight and obese people had mid-term assessments, final assessment and advice on healthy lifestyles, and if participants reached their targets they were eligible to win prizes. The 'Walk for life' around the airport is held on Wednesdays and aerobics on Tuesdays and Thursdays.

Niue promoted their new NCD plan (including M&E) which addressed in 'simple and wholistic' ways the high rates of diabetes, hypertension, gout and now cancer cases. Developing the plan required data and government support and policy by proving to them there was a problem. In Niue there was a focus on national, school and village/community settings, and then on individuals. The smoking cessation programme was a key element, and nicotine gums and patches were being provided. Thirty-two people were on this programme and 14 had relapsed.

New Caledonia offered the kit box tool *J'apprends le bien-etré* for teachers to help them educate school children on healthy living and physical activity. They also presented posters showing the quantities of foods they should eat and simple activities that can be done every day for a healthy lifestyle.

Marshall Islands emphasised the importance of the fact that the Minister of Health and the President were women and they were the main agents for change on NCDs. In the NCD plan there was a taskforce with subcommittees addressing the key risk factors. These committees needed more women. Marshall Islands were engaging in community training on the risk factors including promotion through the media of cooking and healthy eating.

Palau featured new products coming on line including an exercise ball, which interested buyers. For Profiling, Palau had developed diabetes and cancer strategic plans which fitted in with the overall public health strategy. Schools were a focal point for physical activity programmes which had been introduced to the curriculum. Two ministries and the court system had had adopted physical activity programmes. Palau was also starting a 'biggest loser' activity.

PNG marketed healthy food preparation and shopping workshops for women. A lot of selling needed to be done in the future, they said. There were healthy workplace policies as they had found that a lot of working class people are obese and had high blood sugar. Government departments and private sector companies were adopting healthy policies regarding smoking chewing and drinking, and were arranging hours and days for physical activity. PNG had also developed its diabetic management guidelines draft and a new 10-year national NCDs plan to be ready in July 2010.

Samoa presented a nutrition initiative that used a comedian to sell local foods.

Solomon Islands impressed buyers with new tobacco legislation just passed through parliament which enabled the earmarking of tobacco revenue for funding a health foundation. Other items

on sale were live healthy CDs with songs and World Health Day t-shirts. Solomon Islands also briefed the marketplace on a large number of garden and physical activity projects under way in the community.

Tonga offered the way the Health Foundation was working with 20 villages building linkages between healthy lifestyle projects and the community. For example, they were linking gardening and sports groups, physical activity projects, and healthy eating outputs. They also promoted a nutrition package being incorporated into school curricula on a trial basis. One buyer asked if they could try and do something about smoking among the Tongan army rugby team also staying at the same hotel (as the Forum).

Tokelau sold a programme the crew on the MV Tokelau had developed for themselves on the 72 hour return trip from Samoa to the atolls. They had been screened and took on broad the key message of the Tokelau NCD campaign: 'own the choice, own the change and own your life'. They changed their diet, having porridge for breakfast and stir-fry with vegetables for lunch, stopped drinking kava and alcohol, and ran an exercise programme in the hold of the ship for two hours a day. The crew identified discipline and dedication as important, not letting the disease control your life and keeping it within a spiritual dimension.

Tuvalu announced their STEPs survey was being analysed and the national NCD plan was in draft form. They were meanwhile implementing a few activities which they wanted to sell, namely the *Tobacco Act* passed through parliament in 2008. An NGO was forming a coalition with law enforcement officers on this. The second thing on sale which some buyers picked up was a physical activity workplace activity involving volleyball each Friday for MOH staff. Third, it was revealed that five people from each village were attending healthy cooking projects.

Vanuatu was pleased to have their Director-General of Health, Mark Bekonan, at the forum as NCD initiatives needed his support. Another highlight for Vanuatu was the expansion of part of the NCD programme to the north of the country.

Wallis and Futuna Wallis and Futuna described the NCDs risk factors study made possible with the help of SPC and volunteers. The low-cost health profiling project was an excellent purchase for other countries. The team drew buyers' attention to pictures of people from Ovea in the 1960s which showed they were slimmer then—demonstrating how much people had changed since then. Also on sale were three healthy nutrition projects on Wallis and two to follow in a few months time in Futuna. The territory was also preparing a five-year NCD plan. Other items on sale included SPC documents on fruit and vegetables for schools and diabetes information and monitoring books provided under the 2-1-22 programme.

3.4 Show and Tell

In the final session of the Forum, the secretariat (SPC and WHO) displayed and promoted materials and resources available to assist countries. These included WHO's Health Promoting School Policy', physical activity guidelines, and SPC's physical activity workshop manuals and workplans, CARICOM also provided some resource material. SPC also provided factsheets, tools and resources for physical activity advocacy, food promotion, tobacco control, including the '*Diabetes is Everybody's Business'* resource.

SPC communications officer Richard Thomson invited participants to provide feedback on SPC's posters which were being reviewed. He drew the Forum's attention to the new-look *Pacific*

Islands NCDs (PIN) magazine and encouraged countries to submit contributions. He then presented the new SPC HPL website at www.spc.int/hpl where countries could find these materials and keep abreast of news, initiatives and developments on NCDs. He showed them the country profiles and urged them to treat them as their resource.

Outcomes

The outcomes statement of the Forum was:

Under the 2-1-22 Pacific NCD Programme in support of the UNGASS resolution on NCD (A/RES/64/265)

We, the participants from 22 Pacific Island Countries and territories, at the Pacific NCD forum held in Nadi, Fiji from 21–23 June 2010,

being front line workers and friends of the Pacific – a region with greatest burden of NCD,

acutely aware of loss of family and friends who have died prematurely from non-communicable diseases,

seeing people daily who are sick, suffering and dying in our countries and territories,

deeply concerned about the health of our children and determined to make a difference,

urge our leaders to revitalise the vision of *Healthy Islands*[3],

implore our governments, the private sector, our neighbouring countries and the international community to mobilise appropriate resources for the prevention and control of non-communicable diseases in the Pacific, and

call on the Heads of Governments in the Pacific and the United Nations to specifically include non-communicable diseases as one of the Millennium Development Goals.

[3]http://whqlibdoc.who.int/wpro/2001/WPR_ECP_DPM_2001.pdf

Closing statements

Forum co-organiser Dr Viliami Puloka thanked all participants for their contributions. He specially thanked Dr Chen Ken (WHO) and Dr Thierry Jibeau (SPC) for their attendance.

Dr Chen Ken, WHO Representative in the South Pacific

Dr Chen Ken congratulated participants for their hard work: for what they did in the marketplace, for the SPC website, resources, guidelines and posters which were all very useful. He suggested that the closing statement should be strengthened and specific for the Pacific which was number one for NCDs and facing a health crisis.

Second, there were a lot of resolutions, guidelines and materials that needed to be converted into action involving everyone as NCDs were everyone's business. Countries were doing a good job and there was plenty of evidence, but we needed to involve everyone with simple messages that people could understand. For example, what did 10g salt mean?

There was also a need to create an NCD control friendly environment. For example, he had had to move table in a restaurant away from smokers, and these kinds of environment needed to be created.

'We are talking about control of fat, cooking oil, fat and drink. Why is coke cheaper than water? Let us create a political socially friendly environment, he said.

The challenge was to make people change perceptions about tobacco and drink, and grandmothers, mothers, women and children needed to be targeted. Another NCD friendly environment was being created with 'Healthy Schools'. 'But we really needed to do something different to slow down NCDs.'

Dr Chen Ken thought this had been a very useful and successful meeting that would bring benefits to the countries, communities and families. 'I really appreciate your hard work,' he said. He further thanked the academics and other organisations who had attended and the media for their coverage.[4] Finally, he welcomed the prospect of collaboration with CARICOM.

Dr Thierry Jibeau, Manager, Public Health Division, SPC

There was an excellent mix and a sense of family at the Forum, Dr Jibeau said, and he congratulated participants and organisers for the excellent atmosphere. It was also good to renew acquaintances and friendships among people working towards a common cause.

Dr Jibeau said NCDs was the core threat for our society in the future and he welcomed revitalisation of the 'Healthy Islands' approach.

'I would like to implore the leaders to put the NCDs as the major action in the health area. At SPC we are committed to this in all the decisions... and sectors we are covering.

[4] The Forum received extensive coverage in the media, including Radio Australia's 'Pacific Beat' and 'In the Loop' programmes, *The Fiji Times*, fijivillage.com, Radio Fiji, Fiji TV, Radio New Zealand International, and *Matangi Tonga*.

'We are committed to working with our partner WHO in support of these activities. We have to act conclusively to address the burden. Together we have to slow down and reverse the trend in NCDs,' he concluded.

Dr Puloka moved a special vote of thanks to Honourable Dr Pepe Talalelei Tuitama, Associate Minister of Health of Samoa, for his leadership throughout the Forum.

The Forum concluded with a prayer led by Fiji's NCD Coordinator Dr Isimeli Tukana.

Annex 1: Evaluation

At the end of the Forum, 37 participants and observers provided an evaluation on the key objectives of the Forum. Overall 95% of the participants/observers commented that they had a better understanding of the evidence based practice in integrated NCD prevention and control, especially on salt reduction strategies (9), physical activity (4), nutrition (3) and alcohol and tobacco (3). Of those who indicated they needed more information on evidenced-based practices, comments were made that there was a need for information on food consumption patterns, and on the relationship between obesity, cholesterol and physical activity.

Most participants/observers (84%) thought that they benefited from learning about monitoring and evaluation and surveillance during the workshops. Several participants made specific mention of learning about monitoring and evaluation frameworks and programme evaluation methods (7) and surveillance tools (2). In particular, participants learned that monitoring and evaluation needs to be planned at the beginning of the programme and implemented throughout the duration of the programme interventions. Some participants (12) commented that there were not enough practicals during the workshops and no time for sharing of experiences within the small groups. Unfortunately the lack of time available for workshops meant not all planned practical sessions could be held.

The vast majority of participants/observers (86%) rated the marketplace for showcasing country implementation as very good or better. More than half of the participants rated the country marketplace studies as excellent. A number of participants specifically mentioned that they would buy: the Fiji village screening and 3Ms products (5), physical activity guidelines (3), school nutrition guidelines (4), country NCD Plans (5), NCD IEC materials (2), nutrition guidelines (2), and a variety of other country products.

A large proportion (86%) of the participants/observers thought that the progress on the implementation of NCD prevention and control initiatives at national and regional level were adequately discussed. There was a general impression that there had been progress at the regional level, but at the national level countries, while making some progress, were at different stages. Some commented that progress has been made on the production of various risk factor guidelines (1), the regional framework for food security (1), STEPS surveys and mini-STEPS assessments (1), and collaboration with WHO bureaux on NCDs (2). Several participants (7) indicated there was a need for more reporting on progress with country NCD plans.

Most participants/observers (81%) thought there was adequate opportunity for network building, information sharing and collaboration between countries. However many participants (13) mentioned that there should be more discussions on the challenges faced by countries, and some participants (8) thought there should be more time available for interacting and networking, especially on collaboration with other countries. While a number of participants (6) mentioned that the Forum was well organized, several participants thought there were too many presentations (4) and too much focus on academic issues (2). As with all evaluations lessons should be learned and identified problems rectified at the next Forum.

Annex 2: Participants

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