Strategy for prevention and control of non-communicable diseases and injuries in the Republic of Tajikistan for the period of 2013-2023

1. Key Concepts

The nearest (interim) results - products, services, and other developments (e.g., guidelines for the prevention, regulations, tax provisions) that are the direct outcome of the program or organization's activity.

Invested resources - financial and material resources, as well as the skills of staff and volunteers used in the specific program or process.

Evidence-based medicine - a conscious and consistent application in clinical practice of interventions, which usefulness has been strongly proven.

Healthy lifestyle - the way of life, aimed at disease prevention and health promotion.

Infection - this is a biological phenomenon, the essence of which is the intrusion and multiplication of microorganisms in macro organism with subsequent development of their various forms of interaction from the agents' carriage to manifested disease.

Infectious diseases - a group of diseases caused by penetration into the body of pathogenic (disease-causing) microorganisms (bacteria, viruses, fungi, protozoa, etc.) characterized by presence of the incubation period, some reaction of the infected organism on insertion and reproduction of an gent and having a cycling disease course, the result of which is the formation of post-infection immunity.

Clinical guidelines are the systematically developed regulations that help the practitioner and patient in making the right decisions concerning the patient's health, in particular clinical situations.

The end results (outcomes) – a caused by the interference change in the current or future state of health or health-related behavior.

Cross-sectoral (intersectoral) actions - joint efforts of the health sector and other sectors in order to achieve a common goal.

Multifactor (*adjective***)** - a term that is based on the concept that disease or other outcome may have more than one reason.

Capacity building - the accumulation of knowledge and experience in planning, implementation and evaluation of interventions aimed at the prevention and control of NCDs in different settings.

Nasvay - type of smokeless tobacco product, that is traditional namely for Central Asia.

Non-communicable diseases (NCD) - chronic non-communicable diseases of non-infectious (viral, bacterial, fungal or parasitic) nature. As a rule, they can not be communicable, air-, water- or foodborne.

Non-drug therapy - actions to change the patient's lifestyle (lifestyle interventions), which help to reduce the influence of disease risk factors on their further development.

Accidents - injuries due to domestic, traffic or industrial casualties.

Life style – a combination/the aggregate of made by man decisions that affect their health. In addition, the way of life can characterize life in general, based on the interaction of living conditions in the broad sense and traits of individual behavior determined by socio-cultural factors and personal attributes.

Public places - buildings, facilities, territories, natural objects or space of potential location of people who can communicate freely; they include places of work, leisure, recreation and sports, as well as health, educational and preschool institutions, enterprises of culture, catering, trade, transport and their surroundings.

Public Health - it is a science, and specific activities to promote and improve public health, extend life through social mobilization and execution of the organizational activities at various levels, and provide health management as one of the major social systems, where medicine is one of the components along with economics, sociology, political science, industry and agriculture.

Oncological diseases - chronic, long-term current illnesses with the emergence and abnormal growth of typical or atypical cells of a tissue or organ.

Target-organs - those undergoing pathological changes, which are due to the influence of a factor (e.g., hypertension)

Primary health care- its definition was given in the Declaration adopted at the WHO conference in 1978 in Alma-Ata: "PHC is an essential part of health care that is based on practical, scientifically sound and socially acceptable methods and technology that have become universally available both to individuals and families in the field, thanks to their full participation in the work at a cost justified for community and for the country at every stage of development, to ensure their self-determination and independence in these matters. It is an integral part of the national health system, the core of which it is, and at the same time serves as a major component of the overall social and economic development of society. It is the first step in the contact between individuals, family, community and national health authorities, making health care as close as possible to the place of residence and work and constituting the first element of continued health care process".

Implementation plan - a list of activities to be organized in a certain way and implemented in accordance with the timetable for achieving the set goal. The plan specifies who does what and when, and may include data on the cost of each phase of work. Implementation also means transforming program objectives into real actions (e.g., through changing the policy, regulation and institution).

Planning - the process of identifying needs, setting priorities, determining the causes of problems, assessing resources and constraints, and the allocation of resources to achieve goals.

Accountability means that the decision-makers at all levels fulfill their responsibilities and are accountable for their actions.

Politics - a general guide to actions and decision-making, which facilitates the attainment of goals.

Advocacy -the actions taken by health professionals and other opinion leaders in order to influence the decision-making process in the community and governments.

Prevention – it covers approaches and interventions aimed at reducing the probability of occurrence of a disease or disorder of an individual, stopping or slowing the progression of the disease and reducing disability. Primary prevention reduces the chance of the disease or disorder occurrence while secondary prevention interrupts, prevents or minimizes the progression of the disease or disorder at an early stage and tertiary prevention inhibits progression of the disease that has already led to significant damage.

Profile - a set of data, often presented graphically and representing the most significant features of a situation, for example, the frequency of occurrence of a distinctive trait in individuals and in groups.

Leadership - a mechanism that directs the efforts of the collective or individual to perform common tasks. It encourages people to achieve this goal through an effect on their needs.

Diabetes - an endocrine and metabolic disease, which due to a combination of genetic and environmental etiological factors develops absolute or relative insulin deficiency, leading to disruption of carbohydrate, fat, protein metabolism and profound disruption of intracellular metabolism.

Cardiovascular diseases - diseases which are based on cardiac and vascular affection, which development reduces the quality of life of the patient, and can lead to death, including sudden death.

Screening – a strategy for healthcare organization aimed at identifying the disease in clinically asymptomatic individuals in a population, the purpose of which is the early detection of diseases, thus allowing for early treatment, based on relief of the patient's condition and reducing mortality.

NCD prevention strategy - a document containing a general guiding line, guidelines or basic statements necessary for the preparation and implementation of NCD prevention.

Risk factor – it is any human property or trait or any effect on them, increasing the risk of illness or injury.

Network - number and the nature of social relationships and connections between individuals (and institutions), which can provide access to social support of health or mobilize such support.

The evaluation system is a description of how the program should be evaluated.

A coalition – establishing a temporary alliance of factions, parties, individuals and groups with a specific purpose (in the case of a program - for its support and joint development).

Community - a group characterized by common value systems and care for the development and well-being of their group or geographical area.

Social marketing - this is a direction, using a tool to influence the people's notion through technologies and approaches to improve the lives of individuals and society as a whole.

Mass media - the means of conveying information (verbal, audio and visual) on a broadcast channel, covering a large (mass) audience and acting on a constant basis.

The strategy is an action plan designed to achieve long-term goals and taking into account the available resources and the obstacles and opportunities for cooperation between the relevant stakeholders.

Injuries - mechanical, chemical, radiation or thermal ones damaging living organism, leading to the loss or limitation of its functions

Health promotion involves a combination of educational and environmental support activities promoting health and living conditions. Such actions can be taken by individuals, groups, communities, policy makers, employers, teachers and all those who are able to influence the tractors determining health. The aim of health promotion is to allow people to better control the determinants of their own health.

Participants/actors and stakeholders - all those who have a common interest in implementing the project and can agree in principle to support it by providing for this, depending on their capacity, technical, material, financial and human resources.

Epidemiological surveillance – it is gathering information and dynamic risk assessment, assessment of quality of life and morbidity in specific territory, providing a rational in carrying out the necessary preventive measures.

2. Introduction

The Ministry of Health of the Republic of Tajikistan having read the letter from the European Regional Bureau of the World Health Organization (WHO EURO) supplemented with World Health Assembly Resolution (WHA64.11) and a list of information resources on the Program of Integrated Prevention of Non-communicable diseases (NCDs) and injuries (CINDI/WHO program) , has drafted a strategy of prevention and control of non-communicable diseases and injuries in Tajikistan for the period of 2012-2023 years (hereinafter Strategy). The urgency of formulating this strategy, its effective implementation is an urgent task for developing countries, including Tajikistan, as in the long term it will allow to reduce the burden of non-communicable diseases (NCDs) and injuries by curtailing mortality and disability caused by them, and making additional resources available for poverty reduction, and undoubtedly will really makes its contribution to improving the welfare of the people of Tajikistan.

3. The relevance of non-communicable diseases and injuries in the Republic of Tajikistan

1. In Tajikistan, as in most countries of the world, priorities in health are prevention and organization of effective care to patients with cardiovascular and endocrine diseases, cancer and broncho-pulmonary diseases and injuries and poisoning, as the most essential causes of high disability and premature death in the modern urbanized population.

2. The heaviest burden on the society from these diseases due to premature death, as well as a high level of temporary and permanent disability is increasing with its significant controversial impact on the quality of life. All this is creating new economic problems impeding measures to strengthen the well-being of the people, especially on the part of the fight against poverty, slowing the process of improving the welfare of the people.

3. Despite the efforts of health care, the projected disease burden tends to be extremely alarming, and chronic non-communicable diseases remain a leading pathology. In the post-Soviet countries rates of non-communicable disease morbidity and mortality are particularly high and increasing.

4. One of integrative indicators measuring both physical and psychological state of the population is **Human Development Index (HDI)** published annually by the United Nations and its trends over time. Tajikistan in this ranking is slowly but surely moving forward, albeit behind a number of post-Soviet states (United Nations Development Program: Human Development Index 2011). Below is a list of countries at different levels of the index.

Countries with very high Human Development Index (top five, out of a sample of 187 countries)

Rank	**Country**	**HDI**
1	Norway	0.943
2	Australia	0.929
3	Netherlands	0.910
4	U.S.	0,910
5	New Zealand	0.908

Countries with high Human Development Index (7 of 187)

Rank	**Country**	**HDI**
65	Belarus	0.756
66	Russia	0.755

68	Kazakhstan	0.745
76	Ukraine	0.729
88	Iran	0.707

Middle-Human Development Index

Rank	**Country**	**HDI**
101	China	0.687
102	Turkmenistan	0.686
115	Uzbekistan	0.641
126	Kyrgyzstan	0.615
127	Tajikistan	0.607

Countries with low Human Development Index (5 out of 187 countries)

Rank	**Country**	**HDI**
143	Kenya	0.509
145	Pakistan	0.504
146	Bangladesh	0.500
172	Afghanistan	0.398
187	Congo, Dem. Resp.	0.286

5. As can be seen from the list of the United Nations Development Program: Human Development Index-2011, out of 187 countries analyzed, Tajikistan takes the 127th place with index 0.607. Among CIS countries, it is the ultimate bottom position.

Also an important indicator of the population's health is: "Life expectancy at birth (years)". Below is the "List" according to the UN (2005-2011), composed of 194 countries reviewed. Tajikistan is on the list of 131st position, ahead of Kyrgyzstan, Turkmenistan and Afghanistan.

Ranking	**Country**	**Life expectancy at birth (years)**	**Male**	**Female**
1	Japan	82.6	78.0	86.1

2	Hong Kong	82.2	79.4	85.1
3	Switzerland	82.1	80.0	84.2
108	Georgia	71.0	67.1	74.8
108	Iran	71.0	69.4	72.6
112	Russia	70.3	65.5	75.3
124	Ukraine	69.0	62.1	73.8
125	Azerbaijan	67.5	63.8	71.2
127	Uzbekistan	67.2	64.0	70.4
128	Kazakhstan	67.0	61.6	72.4
131	Tajikistan	66.7	64.1	69.4
133	Kyrgyzstan	65.9	62.0	67.7
145	Turkmenistan	63.2	59.0	67.5
188	Afghanistan	43.8	43.9	43.8
194	Swaziland	39.6	39.8	39.4

6. Quality health indicators largely depend on the economic components of the country where the GDP per capita has a crucial role to play. Below is the (optional) list of countries, divided by income, which was published by the World Bank: World Development Indicators, 2011. Gross National Income per Capita 2010.

Place	Economy / income	
High level	Country	Income per capita (In U.S. dollars))
1	Monaco	183,150
2	Liechtenstein	137,070
4	Norway	84,290
7	Switzerland	71,530
17	USA	47,390
Middle	income	per capita

67	Russia	9,900
78	Kazakhstan	7,590
91	Belarus	5,950
103	Iran	4,520
107	China	4,270
114	Turkmenistan	3,790
149	Uzbekistan	1,280
Low	income	per capita
167	Kyrgyzstan	840
168	Tajikistan	800
184	Zimbabwe	460
189	Afghanistan	410
198	Burundi	170

7. As can be seen from the table, Tajikistan by its population income is one of the poorest countries in the region (CIS), but it's population income is two-fold higher than in neighboring Afghanistan ($ 840 vs. $ 410), but by 12.4, 9.2 and 5.3 times lower than in the Russian Federation, Kazakhstan and neighboring China, respectively. Naturally, with such economic indicators it's much more challenging for Tajikistan to carry out preventive measures. However, these preventive interventions are considered to be more crucial for the country as they allow reducing the burden of the most common and significant by their damage diseases and, ultimately, benefiting to the people and the whole country.

8. Features of the demographic situation in the country are conditioned by global political, social and economic changes after the experienced civil war, deteriorated living conditions, accelerated transition to market relations, partial disturbance of sex and age structure of the population, weakened social protection of families with many children, alteration of the national structure of the population and a decrease in the share of its part, which focused on few children. Thus, as at January 01, 2011, the resident population of the country was 7,616,764 people with 50.4% and 49.6% of male and female, proportionally. At the end of 2010, the share of the working population in the country was about 60%.

9. According to the general census of the population of Tajikistan, implemented in 2010, the overall demographic situation is characterized by a high birth rate (29.3 per 1,000 population) and the relatively low death rate (4.2 per 1,000). In this case, there is still reported high child

(20.9 per 1,000 live births) and maternal mortality rates (45.0 per 100 thousand live births) against the background of the relatively low level of urbanization and large-scale external labor migration. In 2010, a natural population increase was 25.1 per 1,000 population that dropped by 28.3% compared to 1991 (32.2 per 1,000 population).

10. As the current statistics show, the total mortality rate in Tajikistan over the past decade has remained relatively high. It is higher than the mortality in the developed countries of Europe and the world. However, it stays at a somewhat lower level than in the CIS as a whole. Thus, according to the latest global statistics published by UNDP in 2010, the standardized death rate from non-communicable diseases (NCDs) in Tajikistan is 884 per 100,000 population that is somewhat lower than that of Russia (904) or Kazakhstan (1145), and much lower than in neighboring Afghanistan (1309). However, the death rate is almost 2 times higher than in Western Europe and the United States (450), 1.4 times higher than in China (627) and 1.3 times higher than in Iran (687).

11. Out of the total mortality in Tajikistan coronary heart disease is a leader, which, according to the UNDP -2010, made 194.4 per 100 thousand men aged 25-64 years. This figure is 2.8 times higher than in the UK, 3.5 times higher than in Germany and 6.8 times higher than in France. However, it is 2 times lower than that for Russia (406.3), more than 1.5 times below that for Kazakhstan (305.5) and slightly lower than that of Tajikistan's immediate neighbors in the CIS - Uzbekistan (203) and Kyrgyzstan (243.1).

12. When considering the structure of the primary disease incidence in Tajikistan, the leading position is occupied by respiratory diseases (11399.6 per 100 thousand population), diseases of the digestive system (3419.2) and diseases of the circulatory system (1094.1). Endocrine diseases and cancer are respectively 1214.7 and 37.8 per 100 thousand population.

13. Among the causes of death among the population cardiovascular diseases are in the first place with the indicator of 206.0 per 100 thousand people (2010), cancer is in second place (33.7) and respiratory diseases are in third place with index of 29.0. Injury and poisoning as the cause of death of the population was 20.0 per 100 thousand population.

14. It is known that many of the indicators of health and quality of life depend on a number of objective and subjective factors, including those that are genetic, geographic, socio-political and economic ones, having an essential impact on health of the population. Tajikistan, prior to gaining independence, was a backward agrarian outskirts of the Soviet Union.

15. After the collapse of the Soviet Union, Tajikistan was in a difficult economic situation relating to unexpected problems or concerns of energy, communication and information isolation. All this quite seriously affected the main health indicators of the people of Tajikistan. Economic situation was further aggravated during the Civil War. In the early postwar period, the Government of Tajikistan could not allocate enough resources to health.

16. However, by 2012, compared with 2001, health expenditure rose from 0.9% to 2.0% of gross domestic product (GDP) and 2.2-fold increased in the last decade.

17. "Evidence based medicine" has been introduced in the medical practice resulted in bringing the national guidelines for the diagnosis and treatment in compliance with international standards, improving the quality of the introduced in clinical practice of medical care guidelines in order to facilitate the work of practitioners. We clearly understand that the spiritual and physical health of the people is a national treasure, and the vital capacity, which conditions further progress of society on its path to economic, social and cultural development.

18. The results of the latest research and their analysis found that cardiovascular diseases in all regions of Tajikistan in the common structure of morbidity and by their prevalence compared to other pathologies are a leader. At the same time, in the structure of total mortality in Tajikistan, cardiovascular diseases since 1986 keep being in the first place. This is due to the high prevalence of major risk factors for cardiovascular diseases.

19. Implementation of the WHO program aims at reducing the burden of non-communicable diseases to society by addressing the major risk factors for NCDs progression. The SINDI's main and ultimate purpose is to improve health by reducing the mortality and morbidity associated with the main, the most common and therefore the most important by there relevance NCD, through integrated, based on close co-operation of the prevention and health promotion program.

20. The main immediate goal is the simultaneous reduction in the prevalence of common risk factors of major NCD, such as smoking, poor diet, excessive alcohol consumption, lack of physical activity and psychosocial stress. To achieve these targets, the CINDI participating countries worked out effective mechanisms of cooperation and gained some experience of integrated cross-sectoral prevention and control of NCDs.

21. SINDI main policy objectives can be formulated as follows: to achieve an integrated approach, development of inter-sectoral collaboration, building bridges between science and practice and international cooperation. Through long-term cooperation between the participating in the program countries, which number now has increased to 24, a huge amount of knowledge and expertise to prevent non-communicable diseases has been accumulated through applying integrated approaches at the community level. This approach has been tested by time and gave very positive results. Thus, the most impressive results have been achieved in one of the provinces of Finland, where for 25 years it became possible to reduce mortality from coronary heart disease by 73%! Tajikistan can and should join this experience through effective cooperation in the prevention of NCDs.

4. The Strategy's goal and objectives

22. The aim of this strategy is the development and implementation of effective actively interactional intersectoral system aimed at enhancing the role of prevention and control of non-communicable diseases (NCDs) and injuries in the Republic of Tajikistan to address the political and social issues, given its importance in strengthening and maintaining the health of

the population, the potential labor force , promoting the fight against poverty, building the national economic potential and improving the quality of life for all.

23. To do this, the available experience of NCD prevention and control in the RT is gathered, the provisions of the European NCD strategy, agreed by European countries - members of the WHO in 2006, are used taken into account the successful case studies in this field around the world. In the study "The global disease burden", initiated by the World Bank in 1992 and held in conjunction with the WHO, an attempt was made to quantify the burden of premature death and disability globally, using such indicators as disability adjusted life years, which is a composite measure of health-related problems, computed with the premature deaths and disability.

24. The top five causes of the burden of disease since 1990 and projections up to 2020 are shown in Table 1. (WHO, 2006)

Table 1. The leading five causes of high burden of disease (in % in 1990, with a forecast for 2020)

		% of the total burden	
		1990	**2020**
1.	Coronary heart disease	9,9	10,2
2.	Cerebrovascular diseases	5,9	6,2
3.	Road traffic accidents	4,4	4,3
4.	Cancer of the trachea, bronchus and lung	2,9	4,5
5.	Congenital abnormalities /anomalies	2,2	1,0

25. Analysis of the situation in Tajikistan showed that cardiovascular diseases remain the main cause of death in the tajik population. In the structure of total mortality of population of Tajikistan since 1986 they have been taking the first place followed by tumors (the second major cause of death), broncho- pulmonary diseases and violent deaths from injury and poisoning (the third and fourth places, respectively). Endocrine diseases are also in the top five leading causes of death among the population of Tajikistan (see Table 2).

Table 2. N**umber of deaths from non-communicable diseases in the Republic of Tajikistan, 2008-2010**

Causes of death	**2008**	**2009**	**2010**
Diabetes, endemic goiter	769	907	1064

Diseases of the circulatory system	15645	15347	15750
Tumors	2343	2509	2518
Broncho-pulmonary diseases	2556	2157	2319
Injuries, poisoning and wounds	1488	1490	1623

24. Studying the dynamics of the number of deaths per 1,000 urban and rural populations in 2000-2010 showed that the urban population is more susceptible to death from these diseases and conditions than in rural areas (see Table 3).

Table 3 Dynamics of the number of deaths per 1000 population

	Persons			**Per 1,000 population**		
	Total population	**Urban population**	**Rural population**	**Total population**	**Urban population**	**Rural population**
2000	29387	9320	20067	4,7	5,7	4,4
2005	31520	9697	21823	4,6	5,4	4,3
2006	31990	9203	22787	4,6	5,0	4,4
2007	33686	9488	24198	4,7	5,1	4,6
2008	31996	9492	22504	4,4	4,9	4,2
2009	32322	9171	23151	4,3	4,7	4,2
2010	33327	9920	23407	4,4	5,0	4,2
M	32032,6±1399,9	9470,1±270,2	22562,4±1326,8	4,5±0,16	5,1±0,33	4,3±0,14
Δ,%	4,4	2,9	5,9	3,9	6,5	3,5

25. Cardiovascular disease is also the major cause of disability in the population. Thus, in 2010, the number of patients who, because of cardiovascular disease was first recognized as disabled exceeded 1,928 people and was by 6.2% higher than that of such cases registered in 2008. The second major cause of disability in Tajikistan are endocrine diseases, due to which increase in people for the first time recognized disabled outpaces all other causes of disability of the population of Tajikistan, showing growth over the past three years at 55.7% (see Table 4) followed by tumor and broncho-pulmonary diseases (the third and fourth positions).

Table 4 Number of persons newly registered disabled

	2008	**2009**	**2010**
Total #	12,322	12,805	12,899
Endocrine diseases and diabetes	564	615	878
Diseases of the circulatory system	1815	1769	1928
Tumors	558	371	562
Broncho-pulmonary diseases	324	382	320

26. Based on the above and to achieve the ultimate set out goal the main project objectives were formulated.

5. The Strategy's main objectives

This strategy is aimed at achieving the following objectives:

- Increase the priority of NCD prevention and control in the National action program to improve the public health;
- Strengthen inter-agency cooperation on health promotion and disease prevention;
- Make proposals for the establishment of an effective infrastructure for the NCDs prevention;
- Offer ways to increase the resources devoted to the NCDs prevention and control in strictly controlled target use and transparency to achieve intermediate (annual) and final outcomes for the whole society;
- Develop proffers for integration of the proposed strategy with the NCD existing and newly elaborated and launched national programs.

6. AREAS OF INTERVENTION

27. In line with the implementation of the tasks the following applicable laws, regulations of the Government and National Programs will be primarily used (through the active integration):

- The Law of the Republic of Tajikistan "On public health protection ";

- The Law of the Republic of Tajikistan "On compulsory treatment of alcohol and drug abuse";

- The Law of the Republic of Tajikistan "On Psychiatric Care";

- The Law of the Republic of Tajikistan "On radiation safety";

- The Law of the Republic of Tajikistan "On the medical and social protection of people with diabetes" (Decree of the Government of the Republic of Tajikistan № 647 dated from 08.05.2009)

- National program for prevention, diagnosis and treatment of diabetes in RT for 2012-2017- (Resolution of the Government of RT, № 130 as of 04.03.2012);

- The Law "On the restriction of the use of tobacco products" (Enactment of Government of Tajikistan as at December 29, 2010, № 649);

- The Law of the Republic of Tajikistan "On iodized salt";

- National Strategy on Public Health of the Republic of Tajikistan for the period of 2010-2020, approved by the Decree of Government of the Republic of Tajikistan on August 2, 2010, № 368;

- Strategic Plan for the restructuring of medical institutions of the Republic of Tajikistan for the period of 2011-2012, approved by Decision of the Government of Tajikistan on March 30, 2010;

- Reproductive Health Strategic Plan of the Republic of Tajikistan until 2014, endorsed by Enactment of Government of the Republic Tajikistan on August 31, 2004, № 348;

- National Action Plan for Maternal Health Protection in the Republic of Tajikistan for the period up to 2014, approved by Decision of Government of Tajikistan on August 1, 2008, № 370;

- National Strategy for Child and Adolescent Health f in the Republic of Tajikistan for the period of 2015, approved by Decision of Government of the Republic of Tajikistan on August 1, 2008, № 370;

- National program of diagnosis, treatment and prevention of coronary heart disease in Tajikistan for the period of 2007 - 2015 years. (Resolution of Government of Tajikistan № 334 as of 30 June 2007).

- National program for prevention, diagnosis and treatment of cancer in the Republic of Tajikistan for 2010-2015 (adopted by Decree of the Government of the Republic of Tajikistan № 587 dated from 31.10.2009).

- National program for prevention of occupational diseases in the Republic of Tajikistan for the period 2010-2015, which is approved by the Government of Tajikistan on March 30, 2010, № 165;

- National program: "Prevention, diagnosis and treatment of injuries and their consequences in Tajikistan for 2010-2015"

- National Program for prevention, diagnosis and treatment of patients with congenital and rheumatic heart disease in the Republic of Tajikistan for 2011-2015 (enacted by Governmental Resolution № 154 as of 01.04.2011)

- National program for prevention, diagnosis and treatment of gastrointestinal diseases in the Republic of Tajikistan for the period of 2012-2016, adopted and approved by Resolution of Government of the Republic of Tajikistan on December 30, 2011, № 639;

- National program for prevention, diagnosis and treatment of diabetes in the Republic of Tajikistan for 2012 - 2017, approved by Governmental Enactment of the Republic of Tajikistan on April 1, 2012, № 130;

- National program to prevent drug abuse and improving drug treatment in the Republic of Tajikistan for 2013 – 2017, adopted and approved by Decision of the Government of Tajikistan dated from April 30, 2012, № 183.

28. Organized by the Association of Cardiologists of Tajikistan screening epidemiological studies among adults carried out in Tajikistan under the CINDI/WHO program in 2005 and subsequent years, have given an opportunity to clarify the prevalence in the Tajik population of individual risk factors for coronary heart disease, which takes away the greatest number of lives in our population.

29. As part of these studies have found a high prevalence of tobacco use, including the use of smokeless tobacco-nasvai by adult men (in some regions it reached to 71, 95 ± 1, 56%). Following the carried out preventive interventions in implementation of the main provisions of the "National Program for diagnosis, treatment and prevention of coronary heart disease in Tajikistan for the period of 2007 - 2015 years" in 5 years, these figures fell to levels of 57,5 ± 2,14, that is 1,3 times.

30. Also the studies revealed high prevalence of hypertension in men (21.2 +0.4%) and women (24.8 ± 0.6%). In the general population hypertension was found in more than 22% of the adult population.

31. Prevalence rates of such risk factors as overweight (16%), obesity (3.5%) and excessive total cholesterol (about 15%) turned out to be lower in the adult population.

32. Given the identified problems in the health status of the Tajik population, the acute problem of cardiovascular diseases and significant prevalence of risk factors, in 2007 the country adopted a "National program of diagnosis, treatment and prevention of coronary heart disease in Tajikistan for the period of 2007 - 2015". Since 2007 implementation of the main objectives of this program has allowed not only to attracting investment in the national cardiac care service, but also to large-scope modernization of a cardiology service of Tajikistan. Thus, the budget of cardiology and cardiac surgery services, thanks to the government expenditure and other types of investments for the past 10 years has increased from 642,368 TJS in 2000 to 4, 439,704 TJS in 2010 or by 12.8 times. Given the investment in health made by international organizations, the budget of cardiology and cardiac surgery service increased in the same period by another 14,245,888 TJS, and total investment in the last decade rose by over 100 times! This has indeed reduced the growth rate of cardiovascular morbidity and mortality, introduced new technologies of diagnosis (coronary angiography, radionuclide scintigraphy of the heart and other organs, MRI, etc.) and treatment (use of stem cell implantation into the

damaged myocardium, coronary artery bypass surgery without stopping heart, stenting of coronary and other arteries).

33. Allocation of extra funding resulted in more efficiently addressing the health care-related challenges. So, the cardiovascular disease mortality rate decreased from 215.2 in 2005 to 206.0 in 2010, i.e. by 4.5%, with simultaneous reducing the growth rate of morbidity in acute forms of coronary heart disease (unstable angina, acute coronary syndrome, myocardial infarction): in the period of 2007-2010, the coronary heart disease incidence rate per 100 thousand population fell from 452.5 to 422.8 (or by 6.6%).

34. Given the persistence of problems of congenital heart defects and not sagging tension associated with rheumatic diseases Tajikistan adopted the "National Program for prevention, diagnosis and treatment of patients with congenital and rheumatic heart disease in the Republic of Tajikistan for 2011-2015" (01.04.2011, № 154), which implementation is currently underway.

35. Taking into account the high prevalence of smoking in Tajikistan, the "Law on the restriction of use of tobacco products" (Resolution of Government of the Republic of Tajikistan as of December 29, 2010, № 649) was enacted that is already yielding positive results. Also, in order to prevent physical inactivity (sedentary lifestyle), as one of the risk factors for coronary heart disease, and health promotion Government of Tajikistan passed Presidential Decree on April 26, 2006 (№ 1740) "On the National Racing Day", annually publicly held in May 20 on the initiative of the Government and the personal involvement of the President of RT. In this framework, massive sports, promoting healthy society, has acquired special status in Tajikistan. In this regard, additional hours devoted to physical education and sport were incorporated in school syllabus and university curriculum. We believe that the personal example of heads of the State, government officials, and respected parliamentarians is an additional and effective incentive for improving the health of each population.

36. This endeavor is also promoted by organized and effectively operating under the Ministry of Health of the Republic of Tajikistan

1. National Healthy Lifestyle Centre, established in 1999 (17.09.1999, № 355/2) with its regional, city and district health promotion centers created in 2000.

2. National Nutrition Centre, established in 2001, which regulates and develops the scientific basis of national nutrition and food quality control.

37. We also attach great importance to metabolic diseases and endocrine diseases, which are also quite common and make its quite big adverse contribution to population disability and mortality patterns. These major diseases in Tajikistan include diabetes mellitus (DM) and iodine deficiency disorders (IDD).

38. Tajikistan has a commitment in terms of diabetes care.

39. Currently, implementation of the "Program to combat diabetes in Tajikistan for 2012 - 2017 years" and the Law "On health and social protection of patients with diabetes mellitus "(Government Resolution № 647 as of 08.05.2009) is underway.

40. These normative documents underpin the importance of a national system for diabetes drug supply and provision of social protection for citizens, patients with diabetes, the issues of early diagnosis of diabetes, prevention of serious complications of diabetes, training of staff and creation of the state register of patients with diabetes.

41. In this regard, study of the heritage of unsurpassed genius of world level, the great son of the Tajik people, Abu Ali Ibn Sina, better known in the scientific world as the great Avicenna (980-1037 years.) is also regarded crucial. He was the first medical scientist, who predicted the most important elements of diabetes of type II-and, in fact, developed the doctrine of pre-diabetes and metabolic syndrome, its diagnosis and the basic principles of its treatment. Herbal medicine for diabetes, according to Avicenna, has not lost its importance to the present. The rich heritage of Avicenna nowadays is widely studied in the "International Institute for the study of heritage of Ibn Sina (Avicenna)" in Dushanbe.

42. Patients with diabetes are provided with insulin and anti-diabetic drugs due to humanitarian assistance and support of the Government of Tajikistan. Annually the country is delivered with around 20-38 thousand bottles of insulin (annual requirement 36-38 thousand bottles) worth 5.7 million U.S. dollars. According to the program, all endocrine centers have established the "School for diabetes", which for a five-year period of operation trained about 10,000 patients.

43. In Tajikistan there is a healthy lifestyle center, created in 2000. This center does coordinate all health-related public education campaigns conducted by regional cardiac, pulmonological oncology, endocrinology and other centers on their own, and in cooperation with the National Healthy Lifestyle Center on a permanent basis. It provides educational seminars for doctors and the public on the prevention of risk factors for most problematic diseases such as hypertension, coronary heart disease, diabetes and cancer in various media. Since 2006 Tajikistan regularly holds the "World Day against diabetes" with the support of government agencies, pharmaceutical companies, international organizations and NGOs.

44. Another major problem in health care in Tajikistan is malignant neoplasms. It is known that every year all over the world more than 9 million cancer cases are registered and 5 million people die from cancer. In developed countries it is the second leading cause of death. Epidemiological studies in recent years show similar trends and in developing countries. The main factors contributing to such spread of cancer are an increasing proportion of the older age groups in all populations, increased incidence of some cancers, particularly lung cancer from smoking tobacco.

45. According to the WHO, it is likely that in the next 25 years there will be 300 million new cancer cases and 200 million deaths from cancer, and nearly 2/3 of them will be in developing

countries. Therefore, the problems of cancer are on the list of priority health problems of our country.

46. In Tajikistan, as in all developing countries, cancer tends to increase. According to the National Center for Health Statistics and Information, about 3,000 new cases are annually registered in the country and in 2010 the incidence rate of this group of diseases reached 37.8 per 100 thousand population. Naturally, they are a serious problem, both for the state and for society as a whole.

47. In the period of 2005-2010, the primary incidence rate in Tajikistan rose from 28.7 to 37.8 per 100 thousand population with the reported higher incidence rate in women compared to men (43.1 vs. 34.6 per 100 thousand population in 2010). In the last decade, malignant breast cancer and cervical cancer occupy the first place in the structure of the malignant tumor incidence of female population. Each year over 300 new cases of breast cancer and 250 cases of cervical cancer are reported.

48. Of particular concern today is rejuvenation of the contingent that gets sick and negative trend of increasing rare and more aggressive forms of cancer. Newly diagnosed cancer patients make up the vast majority of people in rural areas (65.4%).

49. As part of the "National Program on the diagnosis and treatment of cancer in the Republic of Tajikistan for 2010 - 2015 years" (adopted on October 31, 2009, № 587), the structure of cancer services has undergone fundamental changes aimed at organizing and modernization of regional cancer centers. Thus, in the two major cities in Khatlon, Kulyab and Kurgan-Tube, well-equipped regional cancer centers have been commissioned with mammography equipment first installed for detection and early diagnosis of breast cancer in Kulob Cancer Center. Training of personnel and equipment for these centers have enabled these institutions to improve access and quality of provision of specialized cancer care to the people of the region

50. The level and quality of provision of specialist-cancer care is directly related to material investments, the state of the material - technical base of institutions and training. Over the past 10 years, the state budget allocations were thirty-fold increased for development of cancer services in the country. Thus, the funds received by the Cancer Research Center totaled 62,700 TJS in 2000 vs. 2,196,978 TJS in 2010.

51. In the period of 2005-2010, the installed equipment for external beam radiation therapy (TERAGAM production of Czech Republic), the planning system and simulator for radiation treatment (manufactured in the USA), beam equipment for intracavitary radiotherapy (braheo-therapeutic device made in Germany) enabled receiving proper radical radiotherapy in the country without having to travel abroad.

52. Another major problem in Tajikistan is respiratory diseases. By primary incidence rates, they take the first place. Over the last 10 years, registration of respiratory diseases in primary uptake has almost two-fold increased (from 5,200 to 11,672 per 100,000 population).

53. Analysis of the primary incidence rates of respiratory diseases for the period of 2000-2010, shows its doubled growth from 5262.0 to 11399.6 per 100 thousand population.

54. Comparative analysis of the number of reported cases of asthma has indicated its steady increase: from 138 and 140 cases in men and women in 2000 to 3,375 and 3,391 cases in men and women in 2009, respectively. There is no statistically significant difference by gender observed. The same trends are reported for bronchiectasis and chronic obstructive pulmonary disease.

55. In terms of chronic bronchitis incidence rates, they also tend to increase by registered cases. In addition, the gender differentiation is noted: in men this diagnosis was detected significantly more often than in women (17 488 male cases against 16,106 female cases in 2009). At the same time it should be noted that the mortality rate of this group of diseases has two-fold declined from 58.2 (2000) to 29.0 (2010).

56. Hospital mortality rates from respiratory diseases in recent years seem to be relatively stable in numbers with no significant variability both by year and region and range from 0.1 to 0.3 per 100 patients of relevant age.

57. In Tajikistan, the injury has traditionally been one of the major causes in the structure of overall morbidity, mortality and disability, and, until recently, tended to a steady progression due to socio-economic changes, relatively weak material and technical conditions of trauma care service, increased risk of injuries in employment of the general population in the works with the primary use of manual labor in the countryside with a high degree of risk, the leading role of vehicles in movement of people in mountainous terrain and transportation of national economic goods, along with climatic and geographical characteristics of Tajikistan, and the relatively poor road infrastructure, worsening living conditions and other factors. In Tajikistan up to 138,200 different kinds of injuries are annually registered nationwide. In the total incidence structure injuries are in fourth place, they go the fourth in the causes of death, the second in temporary disability and the third in primary disability. Growth and qualitative change of the injury is currently of particular concern. Today, in Tajikistan is marked the increase in the proportion of multiple and associated injuries, open fractures and complications of injuries, as well as the increased proportion of household (from 18.4 to 31.8%), street (from 17.1 to 29.6%), road transport (from 19.6 to 22.9%) and fire (from 0.1 to 2.6%) injuries. Meanwhile there is a decrease in job-related (occupational) accidents from 35.0 to 4.6% but increased traumatism of children. Injury analysis showed that in its structure males prevail (70.2%), especially of working age. In general, in recent years, the share of injuries in the morbidity pattern was 5.6%. Of the above number of injured people, 65.0% and 12.3-43.8% of cases constitute temporary and persistent disability, respectively.

58. The steady progression of the traumatism rate, the lack of clear mechanisms for inter-sectoral collaboration on this issue, the exceptional complexity of the rehabilitation of the victims with a relatively weak material and technical support, as well as adoption of the "Concept of Healthcare Reform of the Republic of Tajikistan" directed on ensuring equal access

to health services that meet the needs and requirements of the poor by strengthening primary health care necessitated taking urgent national scale actions.

59. Given the above, in 2010 the Government of RT enacted National program "Injury prevention, diagnosis and treatment of injuries and their consequences in the Republic of Tajikistan for 2010 - 2015". The main objectives of this program are to prevent and reduce the proportion of deaths and disability from injuries by reducing or minimizing the impact of risk factors for injuries, educate doctors – traumatologists with modern technologies and principles of treatment of injuries and provide trauma and orthopedic departments with modern equipment for treatment of the musculoskeletal system injuries, promoting medical knowledge on injury prevention and public awareness on first aid in case of injuries and integrating the program into the NCDs prevention and control strategy.

7. Prospective actions of relevant ministries and agencies

60. In order to achieve the objectives of this Strategy, the ministries and departments take the following appropriate steps.

61. Ministry of Agriculture: provision of eco-friendly meat and dairy products, grain legumes, vegetables and fruits produced domestically.

62. Research Nutrition Institute of the Ministry of Energy and Industry of the Republic of Tajikistan and the Ministry of Health: develop and provide informational materials on the diet of children and adults in the Republic of Tajikistan.

63. The Ministry of Internal Affairs: monitoring the implementation of the law on restricted use of tobacco and tobacco products, ensuring traffic safety and control the degree of meeting by vehicles the environment-friendly requirements or standards.

64. The Ministry of Health within the state budget allocations shall ensure earmarked funding for prevention programs for the control of NCDs and injuries.

65. The Ministry of Trade and Economic Development: providing network expansion and increase the availability of dietary nutrition; planning elaboration of investment projects aimed at the NCDs prevention.

66. Ministry of Education: adaptation and implementation of educational programs on healthy lifestyles and combat NCD risk factors in educational and training programs of preschool institutions, schools, universities and technical colleges.

67. Ministry of Labor and Social Security jointly with the Tajik Institute of disability expertise and medical rehabilitation of the Ministry of Labor and Social Security: develop and provide measures for sustainable reduction of NCDs-resulted disability and effective rehabilitation of handicapped.

68. The Ministry of Transport and Communications: reduce road traffic injuries by improving road safety and transport communications (timely road maintenance and repair, their lighting, allocation of sectors for bicyclist trafficking (tracks), etc.), provide appropriate assistance to the infrastructure of emergency medical care in case of accidents, ensuring the comfort and safety of movement of disabled people.

69. Statistics agency under the Office of the President of the Republic of Tajikistan and the National Center for Health Statistics: ensuring availability of reliable statistical information on the dynamics of morbidity, mortality and disability in the population of cities and regions of Tajikistan, integration in statistical reporting the most significant factors of NCDs; opening sites for the dissemination of basic statistical information except for the legally established restrictions;

70. Todzhikstandart Agency jointly with the State epidemiological surveillance service and customs authorities of the Government of the Republic of Tajikistan: ensuring quality control of the domestic market and import of food products for carcinogenicity, non-market of genetically modified and counterfeit, substandard products.

71. State Financial Control and Anti-corruption Agency: exercising control of targeted funding allocated for prevention of NCDs and injuries.

72. The Committee for Environment Protection under the Government of the Republic of Tajikistan: ensure environmental security and control of technical facilities and vehicles, industrial, agricultural enterprises and private businesses/entrepreneurs.

73. Youth and Sports Committee together with the Committee on Women's Affairs: inculcating the public, especially the young, healthy living habits, arrangements of permanent recreational sports activities.

74. Committee for Television and Radio Broadcasting, in conjunction with other media (newspapers, magazines, Internet): coverage and promotion of healthy lifestyles to combat risk factors for non-communicable diseases, through the creation of programs and public service announcements.

75. Committee for Religious Affairs of the Government of the Republic of Tajikistan: increased participation of religious organizations in promoting the implementation of healthy lifestyles, and disseminate public hygiene practices necessary for NCD and injury prevention (cessation of smoking, alcoholism, physical inactivity, obesity and unhealthy food, exclusion of violence against women and children).

76. Communications Agency under the Government of Tajikistan: ensure continuous and quality communication over the Internet reaching population with current and accessible information on healthy lifestyles, NCDs and reducing injuries.

77. Tadzhikpotrebsoyuz together with the local authorities of cities and districts: organizing network of invalid food or clinical nutrition services.

8. Indicators - the Strategy's final goal

Table 5

№	Control indicator	Year of achievement
1.	Reduction in the prevalence of individual risk factors for coronary heart disease (CHD) ✓ Reduce smoking and use of tobacco products (nasvay) by 5% by 10% by 20% ✓ Inactivity factor by 15% ✓ Factor of overweight and obesity by 10%	2013 2017 2023 2017 2023
2.	Reducing the prevalence rate of hypertension in Tajikistan by 3-5%	2017-2023 continuously
3.	2% reduction of hospital mortality from acute myocardial infarction	2015-2023
4.	Reduced the rate of disability in CHD by 5-7%	2020 continuously
5.	The decline in mortality rate from broncho-pulmonary diseases by 0,5-1%	2017 continuously
6.	Improving the detection of COPD by 4-5%	2020 continuously
7.	Improving primary detection of the initial stages (I-II degrees) of cancer by 8%.	2015-2023 continuously
8.	Improvement of coefficients of one- and five -year survival of patients with malignant tumors.	2023 continuously
9.	Reducing economic costs of treating patients in the early stages of the disease	2020 continuously
10.	Decline in temporary and permanent disability of persons injured by 5%	2020 continuously
11.	Reduce temporary and permanent disability of persons injured by 7%	2020

		continuously
12.	Reduced mortality in traumatic injuries by 0,5-1,0%	2020 continuously

9. Plan of development and implementation of the Program on integrated prevention of non-communicable diseases and injuries in the regions of the Republic of Tajikistan

78. The Program for Integrated Prevention of Non-communicable Diseases and Injuries in the RT (province, city and district) (hereinafter the Program) will be developed and approved by local authority with appointed responsible persons for the program implementation plan along with nominated regional leaders and program audits.

79. The aim of the project with the defined proposed outcomes for the improvement of specific health indicators, leading to disability and mortality in the working age. For example: reducing the number of amputations of the lower limbs in result of occlusive disease, or a decrease in the number of diabetes complications (leg amputation, blindness, nephropathy), or reduction in mortality from myocardial infarction in the working-age population, reducing the frequency and severity of myocardial infarction and stroke in working age, or the decreased in incidence of cancer of the mouth, respiratory tract, lungs, or curtailed household consumer and transport accidents, etc.

80. Brief characteristic of health indicators in urban and rural areas that are expected to get improved through implementation of preventive interventions.

81. The territory and the populations covered by the integrated preventive interventions. Should specify a city, urban / rural health center, doctor's sites, factory (ginnery, chemical plant, Talco\ smelting plant, etc.), university, school, etc., along with the population profile, reached by the carried out preventive measures (number, age, gender, occupational status, etc.).

82. Risk factors for non-communicable diseases, which incidence rates are expected to have an integrated impact. The WHO recommends all or some of the following risk factors:

- Arterial hypertension;
- Smoking tobacco;
- Overweight;
- Diabetes or pre-diabetes;
- Lack of physical activity;
- Mental stress;
- Use of alcohol and drugs.

83. Based on the specific conditions of the region, where the integrated prevention program is implemented, it may include occupational factors, environmental factors, national and regional food habits, family history, etc.

84. It should be sought to completely eliminate correctable factors, as they are less time-consuming to measure in the prophylactic examinations, clinical examinations.

85. Methods of prevention interventions should be given special attention, as the CINDY program basically is a program of preventive effect on the population rather than the study of incidence, what, unfortunately, most of the programs are completed. Preventive activities relate to both health measures, such as in the medical examination and preventive examinations of the population and measures of sanitary nature; educational measures – educating the covered by the project population on healthy lifestyle. The protocol reflects the activities directed at reducing both those risk factors, which are determined by the project objectives and which are supposed to evaluate the process of preventive interventions and the workplace rehabilitation measures, streamlining nutrition/food diet and interventions to mitigate the risk factors through health institutions that require changes in technology of medical examination of the population. In particular, people, who have risk factors or disease, the occurrence of which is associated with these risk factors should be sure to get the necessary preventive advice through group preventive exposure, individual recommendations made orally or in writing (memo, lifestyle recipe, etc.) through a variety of plays/games, rides, fairs, flyers, newspapers and etc.

86. Numerous methodological literature in available on methods of carrying out prevention interventions. Secondary prevention, aimed at reducing the risk of complications, sustainable health defects and disabilities, is implemented through individual patient rehabilitation program controlled during clinical examination.

87. *Human resources or staff that support up examinations (routine inspections) and realize preventive interventions*. Specific experts must be identified and they should be trained on the protocol and its implementation. Each full-time and part-time senior specialist health authorities must find the resources and cooperate with the local authorities in organizing a screening of the population on risk factors for the most common and problematic diseases.

88. The number of persons and timeframe of a survey to establish the basic characteristics of health indicators related to the purpose of preventive interventions. Control examinations and tests are carried out in samples of the population covered by the project (at least 200 people in the 10-year age group, separately for men and women). If covered, for example, population aged 20-70, size of samples have to be at least 1,000 men and 1,000 women.

89. *Control of preventive interventions process.* It is done by controlling the level of specific measurable risk factors in individual samples of the population covered by the demonstration project every 1.5-2 years. It is advisable to combine this work with the routine baseline medical examination of the population, reached by the project.

90. *Control of preventive interventions effect.* It's indicated in which years and how the quality of the attained goal will be assessed, that is, percentage of decreased disability and mortality in the working age population from stroke, heart attack, lung cancer, and other localizations that are associated with selected risk factors. Effect control or monitoring is carried out by the so-called endpoints, rather than volume of the work done.

91. Integrating medical labor force that is not traditionally engaged in preventive care in order to reduce non-communicable diseases (health (medical, sanitary) service, drug treatment services, nursing clinics, health centers, etc.). The protocol defines the specific tasks of the Services.

92. Integrating non-health sectors, that is, raising the issue of lifestyle modification in reducing risk factors for non-communicable diseases and involving labor force and professionals working in organizations of other ministries, departments and public organizations.

93. It is well known that health services are able to affect only 10% of the capacity of the healthy population, and 90% of your health is determined by lifestyle, working conditions, environment, diet, hereditary factors. Similarly, as clean air and clean water, the quality and variety of food are essential for human health. The health is influenced not only by the health sector but also agriculture, trade, food and meat and dairy industry and other sectors related to food availability. Providing access to a variety of healthy and safe food is one of the best ways to improve health. Accordingly, WHO Europe developed proposals for health professionals that contain the famous "Twelve steps/stages of healthy eating", again having a recommendation nature in view of the fact that every nationality, ethnic group, every region has its own, specific traditions and food culture.

94. The Program for prevention of NCDs and injuries suggests that the protocol will identify the tasks followed by implemented preventive measures, based on the immediate needs of each Service. For example, the executive committee of the Council, on whose territory the project is realized, through making its decision shall recruit subordinate services: health, education, media, sports, trade and public catering, social welfare, culture, job safety and environment protection, police and traffic police. Managers of enterprises and institutions should be tasked with labor protection, for the development of technologies of minimal hazardous for health, sanitation of workers, creating a healthy psychological climate in the team, the introduction of incentives for those who stay healthy, with no sick leave, etc. Education authorities must, for example, through the school curriculum, work with parents, students and their families to provide education of children for a healthy lifestyle (no smoking, raise their cultural level, take exercise, eat right, etc.). Institutions of agriculture, trade and public catering/food service should take steps to grow, deliver to the trading network, advertising of food capable of maintaining the health of the population, based on the population's real and especially low-income, as these groups of people are the most numerous and give a major negative morbidity, disability and mortality in the working age population.

95. Each service has, as part of its functions, assignments that directly or indirectly affect human health. The program requires availability at each service of its plans to achieve the goal.

The result of integration of efforts of non-medical sectors is estimated through the random surveys carried out by health care institutions.

96. Preventive effects on the population should not be intrusive and excessive or very expensive if the effect is dubious. It's also necessary to eliminate the appearance of "kompaneyshina/companionable spirit" and "populism" that is very typical for us. One should choose measures based on specific conditions, traditions and habits of the population, its educational and cultural level, etc. Religious denominations can make important contribution on these questions of formation of moral health.

97. Experience in the United States, Britain, Canada, France and Finland shows that the cheapest and most effective way is the active involvement of the media, where medical practice and science basically play a methodological role.

98. This project provides for the active involvement of civil society organizations, especially those working with the broad masses of the population and being publicly respected, for example, professional associations and movements, and national healing. Today through traditional healers the population is quickly heard both rational recreation ideas, and many unproven approaches, where success is questionable. It is advisable to establish cooperation with healers and help in testing rational approaches through demonstration projects, which are now beyond the capacity of social organizations and managed only by public health agencies. Such an approach would give way to rational concepts and articulate informed opinion about questionable or ineffective methods, in which the public is almost impossible to sort out. "Commercialization" of traditional medicine and healing should be excluded.

99. As part of the Research Institute of Preventive Medicine of the Ministry of Health it is planning to set up a separate coordination structure.

100. *Funding for projects*. It is assumed that funding will be allocated by local governments, which carry out the project(s). However, the successful experience of some countries shows the need to involve and extra budgetary sources. In Canada, for example, for 5 years of the program more than 350 projects were deployed. In this case, one dollar is invested by Government and 10 dollars are drawn from various other funds, companies, public organizations, private donations, funds of enterprises, etc. Specific target financial support for the projects undertaken by Ministry of Health should be both from the national/republican and local budgets.

101. *Project implementation units/bodies*. The project Coordination Council is assigned, involving representatives of different services, and headed by the project manager. It is advisable, where possible, a specialist in the field of prevention of NCDs will be the head of the project or in addition to the project main manager (director), and the project supervisor will be appointed, which is very important in the early project stages.

Since the project requires the implementation of a significant amount of non-standard work, financial incentives are needed to professionals involved in the organization of the project, the

development of documents, control surveys, group forms of preventive actions, preparing memos, information for professionals and the public.

Projects at the level of cities, districts, regions should be led by one of the Vice Chairman of the Council/Board.

10. Conclusion

102. In Tajikistan, as in any developing country, there is a problem of non-communicable diseases, the severity of which naturally increases. In this case, the economic and human losses remain high and tend to grow with the population's urbanization and aging along with current negative environmental impacts. The economic and financial crisis in modern society has exacerbated the situation.

103. Meanwhile, the progress of modern medicine, effective health care reform is not possible without adequate funding. All this provides the enduring need to mobilize additional resources and ensure their more effective utilization in line with the highest priorities with parallel development of multiple-prevention interventions, differentially aimed at every individual and the collective, as well as to the entire population as a whole, taking into account the socio-cultural, ethnic and climatic and geographical features of living with limited resources. In tajik society, more broad and effective involvement of public health is needed as public health is the science and art of disease preventing, prolonging active longevity and ensuring health through the organized efforts of all the structures and all the members of society.

104. In accordance with these provisions, the Republic of Tajikistan, as a full member of the community of nations, as a representative of the ancient culture of mankind, responsibly recognizing the challenges of urbanization and environmental disasters, recognizing all the growing of life and humanity losses from NCDs and injuries, adheres to the WHO recommendations in terms of development and implementation of the Strategy for NCDs and injuries prevention and control in the Republic of Tajikistan for the period of 2013-2023 years.