Report of the Global Survey on the Progress in National Chronic Diseases Prevention and Control

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Table of Contents

Foreword

The World Health Assembly (WHA) endorsed the Global Strategy for Prevention and Control of Noncommunicable Diseases (NCDs) in May 2000. In 2001 and as a follow-up to the Global Strategy, WHO conducted a survey to assess its Member States' capacity to respond to NCDs, and to learn how best to assist them. Since then, WHO has prompted actions targeted at NCDs, which culminated in a series of vital WHO documents. The World Health Report 2002, *Reducing Risk, Promoting Healthy Life*, raised awareness of risk factors. In 2003 and 2004, the WHA endorsed, respectively, the Framework Convention on Tobacco Control (FCTC) and the WHO Global Strategy on Diet, Physical Activity and Health (DPAS). In October 2005, the WHO Global Report on "Preventing chronic diseases: a vital investment" was launched. This report makes the case for urgent action to halt and turn back the growing threat of chronic diseases. WHO has at all times been actively supporting partnerships and networking among Member States committed to NCD prevention and control.

While the achievements made at country and global levels since 2000-2001 are encouraging, the NCD burden is predicted to grow unless more decisive action is taken. In this context, the Department of Chronic Diseases and Health Promotion at WHO Headquarters initiated a new wave of surveys whose instruments included quantitative and qualitative components. Thanks to the cooperation of the regional offices, all WHO regions were surveyed in 2005-2006 with the exception of the Western Pacific Region (WPR), where the Regional Office had conducted a similar survey in 2004. A quantitative questionnaire was mailed or emailed to Member States and responses were checked by WHO regional offices. Later, in all WHO regions except the European Region (EUR), key informant interviews were carried out aimed at collecting relevant qualitative information from a total of 26 countries across low income, lower-middle income and upper-middle income classes.

The purpose of this report is to present the findings and conclusions of this survey, with special regard to the progress being made in national chronic diseases prevention and control by comparison with the previous one, and to examine the implications for future action.

I would like to take this opportunity to express my appreciation to the survey respondents from Member States, and to our colleagues at WHO representative offices, regional offices and Headquarters who kindly gave their time and assistance to this survey. The survey also benefited from the valuable contribution of the WHO Collaborating Centre on Chronic Diseases Policy at the Public Health Agency of Canada.

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Abbreviations

AFR	African Region
AMR	American Region
CHP	Chronic diseases and health promotion
CVDs	Cardiovascular diseases
DPAS	Global strategy on diet, physical activity and health
EMR	Eastern Mediterranean Region
EUR	European Region
FCTC	Framework Convention on Tobacco Control
MOH	Ministry of Health
NCDs	Noncommunicable diseases
NCDPC	Noncommunicable diseases prevention and control
NGO	Non-governmental organization
PHC	Primary health care
SEAR	South-East Asia Region
WHO	World Health Organization
WHR	World Health Report
WPR	Western Pacific Region

Executive Summary

While achievements made at country and global levels since 2000-2001 are encouraging, the NCD burden is predicted to grow unless much more decisive action is taken. It is in this context that the Department of Chronic Diseases and Health Promotion at WHO Headquarters has conducted a new survey with the following objectives: to assess the capacity of national chronic disease prevention and control in development, implementation of national policy, and action plan and programmes; to promote sharing of information, experiences and best practices; to identify constraints and needs of technical assistance; and to assist national strategy and policy formulation, development, implementation and evaluation. This report contains the results of these inquiries.

The survey had quantitative and qualitative components: a self-administered questionnaire and key informant interviews. Five WHO regions were surveyed in 2005-2006; in the Western Pacific Region (WPR), a questionnaire similar to that administered in the other regions, was already completed in 2004 and was reinforced by interviews in 2006. The global questionnaire had an overall response rate of 69%, and was completed by 133 countries. A sub-set of 118 countries responded to both the first and later surveys, permitting an assessment of progress. Progress is also reported for a group of 97 countries; these do not include WPR because some questions were not in the WPR survey. In total, 26 key informants were interviewed from all regions except the European Region (EUR).

In the group of 97 countries that excludes WPR, progress since 2000-2001 is evident for a number of indicators: more countries have NCD units or departments in their ministries of health, more have budgets specific to NCD policies, and more have action plans for tobacco control, diabetes, heart disease and cancer. Across all Regions, national policies and programmes are most common for tobacco control, followed by nutrition/diet, cancer and diabetes. Policies for other risk factors and diseases are in place in between 20% and 35% of countries, depending on the region. But despite the progress in policy development, key informants cautioned that simply having a policy may suggest that the issue has high priority when, in reality, implementation is often constrained by lack of financial resources.

As regards the FCTC and DPAS, 65% of respondents, excluding WPR, are contracting parties to the FCTC and 31% report a corresponding comprehensive action plan. In the same group of countries, only 29 reported implementing DPAS while 19 replied that they planned to do so.

Among all respondents, 85% have now introduced tobacco control legislation, an increase of 23% since 2000-2001. About 50% have no legislation for alcohol control. The proportion of countries with food and nutrition legislation has increased since 2000-2001, but it is unclear whether this concerns NCD prevention and control, as opposed to food safety.

Compared to 2000-2001, more countries now include NCD information in their annual health reporting systems but still only a small proportion (26%) include

risk factor data in these systems. More countries take account of hypertension, diabetes and cancer in their surveillance systems but, again, risk factors are less often included. However, between 2000-2005, all responding countries carried out studies or surveys on risk factors, most often for tobacco use (82%), and between 60% and 70% for overweight and obesity, hypertension, diabetes, diet, physical activity and alcohol use. The frequency of these studies is not known. Training for surveillance remains a barrier according to key informants, and the challenge remains as to how to convert the available data into strategic information that can influence policies and mobilize resources for prevention.

On average, half of the 133 countries responding reported national targets for NCD prevention and control. About 60% of them said that ministries of health were involved in setting these targets, while some 40% of countries reported the additional involvement of WHO, disease-specific associations, medical/health professionals and academic institutions. Private citizens, community organizations, specific population groups and consumer organizations played a role in less than one-quarter of countries.

Across regions except WPR, almost half of the countries reported demonstration programmes that apply an integrated approach to NCD prevention and control, while 37% have such programmes specific to certain risk factors. In about 35% of countries, the projects target children aged under 15 and adults aged 25-64 years. Most common are projects in schools.

Countries have made progress since 2000-2001 in making available and using national protocols for dealing with hypertension, diabetes and cancer. Protocols are less common for risk factors than for individual diseases, and they now exist most often for diet (in 38% of countries) and smoking cessation (in 33%).

With regard to the sources of financing for NCD prevention and control, about 32% of countries on average identified international financial aid. The proportion in EUR was lowest (16%). Very few countries reported taxation on tobacco, alcohol and unhealthy food as sources of funding. As for taxes on alcohol, the countries in EUR have the highest proportions (18%); while the countries in AMR have the highest proportions of taxation on cigarettes (26%).

Progress is apparent in the countries that responded to both surveys. However, there are a number of key areas for action that are similar to those reported in 2000-2001 and which re-emerge as priorities for WHO technical support to Member States. These areas include advocacy, continuing assistance to countries to strengthen surveillance systems, capacity building for the development, implementation and evaluation of policies, action plans and programmes, and the creation of more channels, platforms and other occasions for sharing information with best practice at different levels. In addition, regular global reviews should be encouraged in order to help WHO to measure the progress as well as to identify the Member States' needs for technical support.

Introduction

The Global Strategy and Resolution WHA 53.14 requested WHO to provide technical support and appropriate guidance to Member States in assessing their needs, developing effective programmes and adapting their health systems to respond to the NCD epidemic. Following the adoption of the Resolution WHO conducted its first Global Survey on *Assessment of National Capacity for Noncommunicable Disease Prevention and Control: The Report of a Global Survey* (2001). The Survey was aimed at: assessing existing country capacity in health policy, programmes and infrastructure to prevent, control and treat NCD; identifying constraints and needs among Member States; setting priorities for WHO technical support to Member States; and assisting them in planning, implementing and evaluating their responses.

Since 2000, WHO has invoked various other instruments to prompt action on NCD prevention and control. The 2002 World Health Report *Reducing Risk, Promoting Healthy Life* focused on risk factors; in 2003, the World Health Assembly (WHA) endorsed the Framework Convention on Tobacco Control (FCTC); and in 2004 WHO released the Global Strategy on Diet, Physical activity and Health (DPAS). WHO has also supported partnerships and networking among Member States by convening four global forums on NCD prevention and control since 2001, encouraging the development of policy observatories, and supporting new and existing networks of national and demonstration level programmes aimed at preventing and controlling NCDs.

Despite global successes since 2000 such as the FCTC and individual country achievements, the risk factors and the NCD threat have been neglected in many parts of the world, and the NCD burden is growing. Out of a projected total of 58 million deaths from all causes in 2005, WHO estimates that 35 million were due to NCDs. By 2015, unless there is significant decisive action, the estimate will increase to 41 million deaths. Low and middle income countries, where 80% of deaths are occurring, suffer the largest burden. Human and economic development on a global scale are threatened, as affected individuals lose quality of life, workforces are reduced by premature deaths, and economic losses are experienced from household to national levels.

In 2005-2006, in order to assess progress in NCD prevention and control capacity since 2000, and to re-examine the nature of WHO technical assistance that is most needed, the Department of Chronic Diseases and Health Promotion at WHO Headquarters conducted a new survey, also with quantitative and qualitative components. With the cooperation of the regional offices, all WHO regions were surveyed in 2005-2006 with the exception of WPR, where the regional office had conducted a similar survey in 2004.

The new survey had six core topics repeated from the 2000-2001 survey. They covered: national focal points, units/departments and institutes; national acts, laws, legislation, decrees; national policies, strategies, action plans and programmes; national health reporting systems, surveys and surveillance;

protocols, guidelines and standards; and financial resources. Three topics were new: demonstration programmes; national targets; and DPAS and FCTC. The sections common to both surveys deal for the most part with NCD prevention and control. Treatment capacity was not assessed in the new survey to the extent that it was in 2000-2001.

This report presents the quantitative and qualitative findings from the new survey. The progress made in the period between the two surveys is estimated for topics covered in both surveys, and the development of new capacities is reported.

1. Methods

1.1 Data Collection and Data Entry

All regional offices were involved in coordinating data collection. They mailed or emailed the quantitative questionnaires to Member States and were the first to check the survey responses. (See Annex 1 for the quantitative questionnaire.) The WHO HQ survey team double checked the responses. These were then organized into a database using Epi-Info 6.04d and Excel 2003. The responses to the survey conducted in 2004 in WPR were combined with those from the other regions, which were collected in 2005-2006, to give a global perspective.

For the qualitative component, with the exception of EMR and EUR, WHO HQ interviewers interacted with key informants using a semi-structured questionnaire, similar to that used in 2000-2001, and prepared notes. (See Annex 3 for the qualitative questionnaire.) The regional advisors for NCD recommended key informants to the WHO HQ research team on the basis of the informants' knowledge of NCD situations in their respective countries, their English language capacity and their technical background. Interviews were not conducted in EUR. Information was collected for 26 countries, from low income, lower middle income and higher middle income groupings. Most often, there was one key informant per country, interviewed during April, May, June or July of 2006. For the most part, interviews occurred over the telephone.

The data and information collected were not validated by independent sources. Depending on the number of key informants interviewed in a region, it may be possible to generalize their information to the region. But overall, the interview information cannot be generalized across regions.

1.2 Data Imputation and Cleaning

Missing data from the quantitative survey were inferred after additional consultation with focal points at the WHO regional offices and with Member States. In order for the final database to be sufficiently complete and accurate for analysis, the WHO HQ team thoroughly cleaned all the variables in the dataset in addition to the built-in check procedure of the data entry program.

1.3 Data Analysis

Descriptive analysis is generally used for this first stage data analysis. STATA 9 software was used for writing all the statistical programs for analysis.

2. Quantitative Results

2.1 Response Rate

In total, 133 countries from across WHO regions completed the quantitative questionnaire. Table 1.1 shows the numbers of respondents and non-respondents. The overall response rate was 69% (133 respondents out of a total of 192 Member States). The regional response rates varied from 55% in SEAR to 78% in WPR.

Table 1.1 Response rates to the global survey, by WHO Region

Region	Respondent States	Non-Respondent States	Total	Response Rate (%)
AFR	26	20	46	57
AMR	27	8	35	77
EMR	15	6	21	71
EUR	38	14	52	73
SEAR	6	5	11	55
WPR[a]	21	6	27	78
Total	133	59	192	69

[a] WPR data were collected in 2004.

Table 1.2 showed that a sub-set of 118 countries responded to both the first and latest surveys, permitting an assessment of progress. Progress is also reported for a group of 97 countries that excludes WPR, because some questions were not in the WPR survey. In total, 26 key informants were interviewed from all regions except EUR.

Table 1.2 Countries responding to the first survey in 2000-2001 and the second survey in 2005-2006, and countries responding to both surveys

Region	Countries responding to		Countries responding to both surveys
	The first survey in 2000-2001	The second survey in 2005-2006	
AFR	39	26	24
AMR	33	27	24
EMR	17	15	13
EUR	41	38	30
SEAR	10	6	6
WPR	27	21	21
Total	167	133	118

2.2 Focal Point, Unit / Department and Institute

National focal point, unit/department and institute for chronic diseases prevention and control

Table 2-1 and Table 2-2 report, by WHO region, on the availability of a national focal point, national unit (or department) in the Ministry of Health (MOH), and a national institute for chronic disease prevention and control. A national focal point refers to the person responsible for prevention and control of chronic diseases in MOH, in a national public health institute or in a chronic disease prevention and control institute; MOH unit or department refers to an

administrative agency in MOH for disease prevention and control or for prevention and control of chronic diseases; a national institute refers to a national public health institute or a specialized institute for chronic disease prevention and control.

FINDINGS

Table 2-1 showed that, among the 112 respondent countries (omitting WPR), although 86% had focal points for chronic diseases prevention and control, only about half of the states (49%) reported having national institutes for chronic disease prevention and control. Most responding states (79%) reported having a unit (or department) in the Ministry of Health for NCD and, as shown in Table 2-2 for all the five regions, in 2005~2006 this percentage was at least 24% higher than that in 2000~2001.

Table 2-1 Percentage of countries establishing national focal point, a MOH unit (or department), and an institute for chronic diseases prevention and control, by WHO Region, 2005~2006

Region	Focal point	MOH Unit/Department	National institute
AFR	89	81	39
AMR	78	82	41
EMR	87	87	40
EUR	87	74	66
SEAR	100	67	50
WPR	NA	NA	NA
Total	86	79	49

NA, no data available

Table 2-2 Percentage of countries establishing an MOH unit (or department) for chronic disease prevention and control

Region	2000~2001	2005~2006
AFR	63	83
AMR	63	83
EMR	62	92
EUR	60	83
SEAR	33	67
WPR	NA	NA
Total	60	84

NA, no data available.

2.3 Act, Law, Legislation and Ministerial Decree

National act, law, legislation and ministerial decree for chronic diseases prevention and control

Table 3-1 and Table 3-2 report, by WHO region, on the existence of a national act, law, legislation and ministerial decree for NCD prevention and control. This refers to nationally approved legal documents targeting prevention and control of chronic diseases and risk factors; or to prevention and control of chronic diseases or related risk factors as part of the relevant legislation.

FINDINGS

Table 3-1 showed that out of the 133 respondent countries, 85%, 83%, 52% and 23% reported having legislative instruments dealing respectively with tobacco control, food and nutrition, alcohol control and physical activity legislation related to chronic disease prevention and control. In addition, the results in Table 3-2 showed that the last five years saw 23% and 16% increases in the proportion of countries having legislation for tobacco control and for food and nutrition. By contrast, the percentages of countries having legislation for alcohol control and physical activity were on average much lower, with only around 25% of respondent states having legislation for physical activity (Table 3-1).

Table 3-1 Percentage of countries having national act, law, legislation, ministerial decree for chronic diseases prevention and control, by WHO Region, 2005~2006

Risk factors	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Tobacco control	85	69	74	93	97	100	86
Food and nutrition	83	73	82	80	92	100	76
Alcohol control	52	35	59	60	74	33	24
Physical activity	23	12	19	27	34	50	14

[a] WPR data were collected in 2004.

Table 3-2 Percentage of countries having legislation for tobacco control, and food and nutrition in 2000~2001 and 2005~2006, by WHO Region

Region	Tobacco control		Food and nutrition	
	2000~2001	2005~2006	2000~2001	2005~2006
AFR	25	67	50	75
AMR	58	71	67	83
EMR	69	92	69	85
EUR	80	100	80	100
SEAR	67	100	83	100
WPR[a]	71	86	76	76
Total	61	84	70	86

[a] WPR data were collected in 2004.

2.4 Policy, Strategy, Action Plan, Programme

Table 4-1 and Table 4-2 report on the existence, by WHO region, of a national policy, strategy and integrated programme for NCD prevention and control. A national strategy means a long-term plan of action designed to achieve the goal of prevention and control of chronic diseases. A national policy for chronic disease prevention and control refers to a written document endorsed, in collaboration with related sectors, by the country's Ministry of Health, which includes a set of statements and decisions defining goals, priorities and main directions for attaining these goals. The policy document may also include a strategy containing main lines of action that are adopted to give effect to the policy.

A national integrated programme refers to the country's core public health principles incorporated into a country action plan for chronic diseases prevention and control through a concerted approach addressing the multidisciplinary range of issues within a prevention and health promotion

framework across the broad range of chronic diseases. A national integrated programme generally targets all major common risk factors common to main chronic diseases, and integrates primary, secondary and tertiary prevention, health promotion and disease prevention. It may include programmes across sectors and disciplines and, rather than relying on a disjointed set of small-scale projects, it will seek to harmonize and integrate actions within existing public health systems by incorporating contemporary evidence-based concepts.

FINDINGS

Table 4-1 showed that the percentages of countries having a national health policy and a strategy relevant to chronic disease prevention and control were respectively 63% and 54% (except for WPR), while 64% of countries reported having a national integrated programme in all regions. As shown in Table 4-2, for the comparable 97 countries between 2000~2001 and 2005~2006, there was a 28% increase in the percentage of countries having a national policy relevant to chronic diseases prevention and control. The Table also showed that, when compared with AMR, EMR and EUR, for AFR there was a persisting low rate of issuance of national policy relevant to chronic diseases prevention and control, while SEAR significantly improved on its shortfall over the past five years.

Table 4-1 Percentage of countries having national policy, strategy, and integrated programme relevant to chronic diseases prevention and control, by WHO Region, 2005~2006

	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
National policy	63	39	70	67	74	50	NA
National strategy	54	31	63	53	63	50	NA
National integrated programmes	64	39	63	67	74	50	76

NA, no data available.
[a] WPR data were collected in 2004.

Table 4-2 Percentage of countries having national policy relevant to chronic diseases prevention and control in 2000~2001 and 2005~2006, by WHO Region

Region	2000~2001	2005~2006
AFR	17	46
AMR	42	75
EMR	69	77
EUR	57	83
SEAR	17	67
WPR	NA	NA
Total	42	70

NA, no data available.

Table 5, Table 6-1, Table 6-2 and Table 7 report on the existence of a national action plan and a programme for NCD prevention and control by WHO region. A national action plan is a scheme, prepared according to policy and strategic directions and with defined activities, to generate a set of products/targets in order to achieve the desired goals. The action plan should identify who does what (type of activities and people responsible for implementation), when (time frame), how and for how much (resource). It should ideally have an inherent

mechanism for monitoring and evaluation.

A national programme refers to a set of comprehensive goals and objectives within the framework of national chronic disease prevention and control, which translate into programme goals and objectives that are consistent with the chosen intervention strategies; the programme also develops from these a blueprint of how the intervention activities will operate and how to evaluate the results.

FINDINGS

Among the respondent countries, generally, the proportions of countries having specific risk factor related national health policy (action plan, programme) for tobacco control and nutrition/diet were in general higher than those of countries having a specific national policy directly targeting chronic disease. But this is not the case for risk factors like physical activity and alcohol control (Table 5, Table 6-1, Table 7).

Table 6-2 showed that, although the current percentages of countries having a specific national action plan for tobacco control, diabetes, heart diseases and cancer were consistently much higher than those reported in the 2000~2001 survey, the corresponding percentages for AFR in both surveys were much lower than for the other four regions. And when compared with the other regions, AFR achieved much less progress in these action plans except for tobacco control and cancer. For instance, in AFR the percentage having a specific national heart disease action plan remained the same over the last five years, while AMR, EMR, EUR and SEAR increased by 17%, 15%, 13% and 17%, respectively.

Table 5 Percentage of countries having a specific national policy for chronic diseases prevention and control, by WHO Region, 2005~2006

Risk factors & Diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Tobacco control	56	39	48	73	74	67	38
Nutritional/diet	50	46	56	33	63	67	33
Physical activity	29	12	26	33	50	33	10
Alcohol control	28	12	26	13	50	33	19
Hypertension	30	23	37	47	40	NA	10
Diabetes	41	27	44	60	53	NA	29
Heart diseases	34	8	33	47	53	NA	NA
Stroke	24	8	22	13	45	NA	NA
Cancer	41	23	41	60	61	17	24
Chronic respiratory disease	20	4	22	33	34	NA	5
Other chronic disease	24	15	26	20	26	50	NA

[a] WPR data were collected in 2004; NA, no data available.

Table 6-1 Percentage of countries having a specific national action plan for chronic diseases prevention and control, by WHO Region, 2005~2006

Risk factors & Diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Tobacco control	66	39	63	80	76	100	NA
Nutritional/diet	48	35	52	33	61	50	NA
Physical activity	32	12	37	27	42	50	NA
Alcohol control	30	19	22	13	47	33	NA

Hypertension	35	19	48	47	32	33	NA
Diabetes	54	27	63	60	61	67	NA
Heart diseases	46	12	48	53	61	50	NA
Stroke	20	4	26	13	26	33	NA
Cancer	60	35	59	67	68	100	NA
Chronic respiratory disease	18	4	15	33	24	17	NA
Other chronic disease	24	27	26	27	21	17	NA

NA, no data available.

Table 6-2 Percentage of countries having a specific national action plan for tobacco control, diabetes, heart diseases, and cancer in 2000~2001 and 2005~2006, by WHO Region

Region	Tobacco control		Diabetes		Heart disease		Cancer	
	2000~2001	2005~2006	2000~2001	2005~2006	2000~2001	2005~2006	2000~2001	2005~2006
AFR	17	38	17	25	13	13	21	33
AMR	29	63	46	63	29	46	50	58
EMR	54	85	46	69	54	69	54	77
EUR	37	77	53	67	57	70	60	77
SEAR	67	100	50	67	33	50	83	100
WPR	NA	NA	NA	NA	NA	NA	NA	NA
Total	34	66	41	56	37	49	49	63

NA, no data available.

Table 7 Percentage of countries having specific national programmes for chronic diseases prevention and control, by WHO Region, 2005~2006

Risk factors & Diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Tobacco control	54	31	41	67	66	100	57
Nutritional/diet	50	42	56	47	53	33	57
Physical activity	32	8	22	20	45	33	57
Alcohol control	32	12	30	7	45	33	52
Hypertension	42	23	52	40	42	33	57
Diabetes	48	23	59	60	53	17	57
Heart diseases	38	15	33	53	53	33	NA
Stroke	25	12	26	13	37	33	NA
Cancer	47	19	48	60	61	33	48
Chronic respiratory disease	21	8	26	27	26	0	NA
Other chronic disease	21	19	19	7	26	33	NA

[a] WPR data were collected in 2004; NA, no data available.

2.5 National Target

Table 8-1 and Table 8-2 report on the availability of national targets for NCD prevention and control. A national target refers to the setting of quantitative output, impact, outcomes or health indicators for chronic diseases prevention and control (or for risk factors such as tobacco use, unhealthy diet and physical inactivity, and health determinants such as environment, lifestyles, socio-economic levels etc).

FINDINGS

Half of the 133 respondent countries reported having national targets for chronic disease prevention and control, but the percentages varied widely from

region to region.

As shown in Table 8-2, among the respondent states, the proportion of countries having sectors/organizations involved in national target-setting ranged widely from the reported 19% for the involvement of "other ministries" to the highest percentage of 62% for the Ministry of Health. The percentage of countries reporting the Ministry of Finance's involvement in national target-setting varied from 5% in WPR to 32% and 33% in EUR and EMR.

Table 8-1 Percentage of countries having national targets for chronic disease prevention and control, by WHO Region, 2005~2006

Region	National targets
AFR	23
AMR	48
EMR	60
EUR	71
SEAR	33
WPR[a]	52
Total	51

[a] WPR data were collected in 2004.

Table 8-2 Organizations involved in setting a national target for chronic diseases prevention and control (percentages), by WHO Region, 2005~2006

Organizations	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Ministry of Health	62	42	56	80	79	50	52
Ministry of Education	31	23	26	47	50	33	0
Ministry of Finance	21	15	19	33	32	17	5
Other Ministries	19	15	11	20	29	33	10
Subnational government	20	4	15	13	34	33	NA
World Health Organization	42	39	41	67	50	50	14
National NGO	37	27	26	40	50	33	NA
Citizen or community representatives	24	19	22	13	34	17	NA
Associations for specific population groups	21	19	19	20	32	33	5
Consumer Organizations	16	15	7	7	32	17	5
Medical/Health Professional Associations	39	19	48	20	58	50	29
Disease-specific Associations	41	27	44	47	58	33	24
International Nongovernmental Organizations	17	15	7	20	26	17	10
Other Bilateral/ Multilateral Organizations	13	8	15	13	18	33	0
Academic institutions	39	19	41	27	58	33	NA
Others	12	8	15	7	16	0	NA

[a] WPR data were collected in 2004; NA, no data available.

2.6 Implementation of FCTC and DPAS

Table 9 reports on the status of FCTC and DPAS implementation. FCTC refers to the national action plan or work plan for implementing the Framework Convention on Tobacco Control (FCTC), adopted by WHA 56 in May 2003. DPAS refers to the Global Strategy on Diet, Physical Activity and Health (DPAS), endorsed by WHA 57 in May 2004.

FINDINGS

Among the 112 respondent countries in AFR, AMR, EMR, EUR and SEAR, 65% became contracting parties to the WHO's FCTC, and 31% already have implemented an action plan for FCTC. As regards DPAS, 26% of 112 countries had implemented DPAS, 17% had plans to do so, and 27% had established a mechanism for discussion /interaction between national authorities and private sector interests related to DPAS. Currently no country has implemented DPAS in the EMR's 15 respondent countries, but three reported having plans to do so. Table 9 also showed that, out of 112 respondent countries, slightly over one quarter had established a mechanism for discussion/interaction between national authorities and the private sector.

Table 9 Percentage of countries implementing FCTC and DPAS, by WHO Region, 2005~2006

	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Contracting party to the WHO FCTC	65	65	52	80	66	83	NA
Implementation action plan of FCTC	31	27	30	47	24	67	NA
Implementation of DPAS	26	8	26	0	45	50	NA
Plans for the implementation of DPAS	17	15	19	20	13	33	NA
Mechanism for discussion / interaction between national authorities and private sector interests related to the DPAS	27	8	30	27	34	50	NA

NA, no data available.

2.7 National health Reporting System, Survey and Surveillance

Table 10-1, Table 10-2, Table 11, Table 12-1 and Table 12-2 report on the availability of a national health reporting system, survey and surveillance in respect of NCD and related risk factors. A health reporting system includes annual health reports of the MOH which contain data on national capacity, human resources, demographic aspects, health expenditure and health indicators. Morbidity information may include incidence or prevalence data from disease registries, hospital admissions or discharge data. A national survey (with either fixed or unfixed time intervals) will examine the main chronic diseases, or the major risk factors common to chronic diseases. National surveillance refers to information on risk factors, chronic diseases and their determinants, used to permit which is a continuous analysis, interpretation and feed-back of systematically collected data using a survey or regular registration.

FINDINGS

Table 10-1 showed that the proportion of countries having an established health information system covering chronic diseases and major risk factors ranged

from 60% in EMR to 84% in EUR and 100% in SEAR. And out of 112 countries from AFR, AMR, EMR, EUR and SEAR, around 93% had included chronic diseases in the annual health report system. Regarding the data included in the annual health report system, 26% reported having full coverage across risk factors, cause-specific mortality and morbidity. This Table also showed that approximately 68% among 133 respondent countries had a routine or regular surveillance system for chronic diseases in all regions. And although WPR enjoyed the highest rate (86%) for establishing a routine chronic disease surveillance system, fewer than half of countries in AFR did so.

Table 10-2 showed the progress made in including chronic diseases in the annual health reporting system and in establishing a routine surveillance system for chronic disease. For the best comparable 97 countries of the two surveys conducted in 2000~2001 and in 2005~2006 (except WPR), in general a 14% increase was found for the inclusion of chronic diseases in the annual health reporting system. As regards data included in the surveillance system, among 118 countries there was a 12% increase (from 60% in 2000~2001 to 72% in 2005~2006) in countries reported to have included risk factors, cause-specific mortality and morbidity.

Table 10-1 Health information system covering chronic diseases and major risk factors, by WHO Region, 2005~2006

Channels of collecting information on risk factors and chronic diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Health information system covering chronic diseases and major risk factors	77	73	74	60	84	100	NA
Inclusion of chronic diseases in the annual health report system	93	100	96	73	92	100	NA
Data included in the annual health report system							
- Cause-specific mortality	12	8	22	27	3	0	NA
- Risk factors/Cause-specific mortality/morbidity	26	8	22	13	45	33	NA
- Cause-specific mortality/morbidity	35	46	44	13	32	17	NA
Routine or regular surveillance system	68	46	67	53	76	83	86

[a] WPR data were collected in 2004; NA, no data available.

Table 10-2 Percentage of countries having included chronic diseases in annual health reporting system and surveillance system in 2000~2001 and 2005~2006, by WHO Region

Region	Inclusion of chronic diseases in the annual health reporting system		Routine surveillance system for chronic disease	
	2000~2001	2005~2006	2000~2001	2005~2006
AFR	96	100	29	50
AMR	75	96	54	67
EMR	46	77	54	62
EUR	93	97	77	87
SEAR	67	100	67	83

WPR[a]	NA	NA	81	86
Total	81	95	60	72

Table 11 showed that during the period 2000-2005, among 112 respondent countries from AFR, AMR, EMR, EUR and SEAR, the proportion of countries having conducted national/provincial surveys or studies on such risk factors as tobacco use, unhealthy diet, physical inactivity and alcohol consumption stood at 82%, 63%, 62% and 61% respectively. The percentage of countries reported as having national/provincial studies/surveys covering risk factors and diseases varied widely from 29% for chronic respiratory diseases to 82% for tobacco control.

Table 11 Percentage of countries having national/provincial studies/surveys during 2000-2005, by WHO Region

Risk factors & diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Tobacco use	82	73	82	80	87	100	NA
Unhealthy diet	63	35	67	47	84	83	NA
Physical activity	62	31	63	53	82	83	NA
Alcohol consumption	61	35	70	20	84	83	NA
Hypertension	66	50	67	67	74	83	NA
Diabetes	66	42	74	73	71	83	NA
Overweight and obesity	68	42	74	60	82	83	NA
Raised blood glucose	51	35	59	60	50	67	NA
Raised blood pressure	57	35	63	60	63	83	NA
Dyslipidaemia	42	23	48	60	42	50	NA
Heart diseases	39	12	52	33	53	33	NA
Stroke	33	8	44	20	47	33	NA
Cancer	46	19	48	47	63	50	NA
Chronic respiratory diseases	29	12	26	27	45	17	NA

NA, no data available.

Table 12-1 indicated the coverage of the chronic disease surveillance system. Out of 133 respondent countries, less than two-fifths covered the major risk factors such as tobacco use, unhealthy diet, physical activity and alcohol consumption. The results showed that the proportion of countries covering diabetes, hypertension, heart diseases and cancer in their chronic disease surveillance system was higher than those which included risk factors such as tobacco control, unhealthy diet, physical inactivity and alcohol consumption. Table 12-2 indicated that the last five years saw 24%, 20% and 15% increases respectively in the proportion of countries reported as covering hypertension, diabetes and cancer in their chronic disease surveillance system.

Table 12-1 The coverage of the chronic disease surveillance system, by WHO Region, 2005~2006

Risk factors & Diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Tobacco use	41	27	22	40	50	83	52
Unhealthy diet	36	19	22	40	47	67	43
Physical activity	35	15	26	47	40	67	43
Alcohol consumption	34	23	22	7	50	83	38
Diabetes (Elevated blood glucose)	59	50	59	47	61	50	81
Hypertension (Elevated blood pressure)	58	50	59	53	50	100	71
Overweight and obesity (Body Mass Index)	38	23	33	40	42	67	48

Dyslipidaemia (Cholesterol)	26	8	26	33	29	33	33
Heart diseases	43	35	41	20	58	50	NA
Stroke	35	31	33	13	45	50	NA
Cancer	64	50	59	40	76	67	76
Chronic respiratory diseases	33	27	33	20	45	17	NA

[a] WPR data were collected in 2004; NA, no data available.

Table 12-2 The coverage of the chronic disease surveillance system in 2000~2001 and 2005~2006, by WHO Region

Region	Hypertension		Diabetes		Cancer	
	2000~2001	2005~2006	2000~2001	2005~2006	2000~2001	2005~2006
AFR	25	54	25	54	29	54
AMR	42	58	42	58	42	58
EMR	46	62	46	54	46	54
EUR	27	53	47	67	70	87
SEAR	50	100	33	50	50	67
WPR[a]	52	71	62	81	71	76
Total	37	61	43	63	53	68

[a] WPR data were collected in 2004.

2.8 National Community-based Demonstration Programmes

Table 13, Table 14 and Table 15 report on the existence of national community-based demonstration programmes and their target population and settings. A national community-based demonstration programme is one which addresses issues relevant to chronic disease prevention and major risk factors; applies existing knowledge to put into practice effective prevention at community level; examines different methods of disease prevention and health promotion; evaluates their feasibility; and validates their effect to show how they can be a source of public and professional inspiration. Large or national programmes based on the experience of the demonstration areas can then be launched.

FINDINGS

Table 13 showed that among 112 countries, 47% had established a demonstration programme for integrated chronic disease prevention and control, and 38% had a demonstration programme for tackling specific risk factors.

Table 14 and Table 15 dealt with the population groups and settings targeted by the countries' demonstration programme for prevention and control of chronic diseases. Out of 112 countries, 35% had a demonstration project for under 15s, and the corresponding percentages were 26% for 15-24 years, 35% for 25-64 adults, 26% for elderly (aged 65 and over), and 31% for women. As expected, among the 112 respondent countries, those whose demonstration project targeted schools (47%) had the highest proportion among all the listed settings.

Table 13 Percentage of countries having a national demonstration programme for chronic diseases and/or health promotion, by WHO Region, 2005~2006

Integrated and/or Specific risk factors	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Integrated NCD prevention and	47	19	44	47	66	67	NA

control							
Tackling specific risk factors	38	19	41	27	53	33	NA

NA, no data available.

Table 14 Percentage of countries having a demonstration project for population groups, by WHO Region, 2005~2006

Population groups	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Children under 15	35	23	33	20	55	0	NA
15-24 years	26	19	26	13	37	17	NA
Adults, 25-64 years	35	23	30	27	50	33	NA
Elderly, 65 years and over	26	19	30	27	29	17	NA
Women	31	27	30	20	42	17	NA
Others	6	4	4	7	11	0	NA

NA, no data available.

Table 15 Percentage of countries having a demonstration project for settings, by WHO Region, 2005~2006

Settings	Total	AFR	AMR	EMR	EUR	SEAR	WPR
Workplace	35	12	37	20	55	33	NA
School	47	27	44	33	68	50	NA
Hospital and clinic	37	27	33	27	50	33	NA
Community	39	23	37	27	58	33	NA
Family	24	15	22	20	34	17	NA
Others	12	8	11	0	21	0	NA

NA, no data available.

2.9 Protocols /Guidelines /Standards

National protocols/guidelines/standards for chronic diseases and conditions

Table 16-1 and Table 16-2 report on the availability of national protocols/guidelines/ standards for chronic diseases and conditions. These refer to prevention, treatment or management services that deal with an already existing chronic disease or with risk factors, and aim to treat and control the condition, prevent complications, and improve outcomes and quality of life of patients.

FINDINGS

Table 16-1 showed that among the 118 countries for which the data were available, nearly half or over had the national protocols/guidelines/standards for chronic diseases such as hypertension, diabetes, heart diseases and cancer, while 30% or less had the corresponding materials for weight control and physical activity. Table 16-2 showed that the last five years saw 17%, 17% and 13% increases in the proportion of countries reported as having national protocols/guidelines/standards for hypertension, diabetes and cancer, respectively.

Table 16-1 Percentage of countries having national protocols/guidelines/standards for chronic diseases and conditions, by WHO Region, 2005~2006

Risk factors and Diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Hypertension	74	54	78	80	79	67	81
Diabetes	78	58	82	93	82	83	81

Heart diseases	49	23	44	47	74	33	48
Stroke/cardiovascular accident	38	15	37	13	61	33	48
Cancer	69	50	78	60	82	67	67
Chronic respiratory diseases	35	15	30	33	55	17	NA
Smoking cessation	33	12	30	27	53	33	NA
Weight control	26	4	22	20	47	17	NA
Diet	38	15	52	27	47	33	NA
Physical activity	30	19	26	20	45	17	NA
Other chronic diseases/NCD	21	12	30	13	26	0	NA

[a] WPR data were collected in 2004; NA, no data available.

Table 16-2 Percentage of countries having national protocols/guidelines/standards for chronic diseases and conditions in 2000~2001 and 2005~2006, by WHO Region

Region	Hypertension		Diabetes		Cancer	
	2000~2001	2005~2006	2000~2001	2005~2006	2000~2001	2005~2006
AFR	50	54	46	58	38	46
AMR	58	79	63	79	75	79
EMR	62	85	54	92	54	69
EUR	70	87	80	87	73	90
SEAR	33	67	33	83	33	67
WPR[a]	62	81	67	81	48	67
Total	59	76	62	79	58	71

[a] WPR data were collected in 2004.

2.10 Financial Resources

Table 17, Table 18 and Table 19 report on the availability of financial resources for national chronic prevention and control. Financial resources refer to governmental budget allocation as well as to other sources of financial support for prevention and control in any of the chronic diseases components.

FINDINGS

Among the 112 respondent countries, Table 17 showed that overall 68% had specific allocated resources or a dedicated budget for implementing a national policy or strategy for chronic diseases prevention and control. The corresponding percentages for AFR, AMR, EMR, EUR and SEAR were 58%, 63%, 77%, 73% and 83%, respectively.

For the comparable 97 countries of the two surveys conducted in 2000~2001 and 2005~2006, Table 17 further showed that there was a 29% increase in the proportion of countries having specific budget for a national policy or strategy in chronic disease prevention and control.

For the specific chronic disease components listed in Table 18, the proportions of countries having dedicated budgets were 54% for cancer, 53% for diabetes, 50% for tobacco use, 49% for nutrition/diet, but only 32% for physical activity, for alcohol consumption and for obesity control.

Table 19 reported on the sources of financial support for chronic disease prevention and control. Around two-fifths among the 112 respondent countries (except WPR) reported the existence of unspecific resources of financial budget for chronic diseases prevention and control. But the financial situation

varied across the six concerned regions. For instance, in AMR and EUR, unspecific resources of financial budget are dominant as compared to those relatively preferable and more stable methods of raising fund such as taxation. When compared with EUR, international financial aid played a more important role in the other five regions.

Table 17 Percentage of countries having a specific budget for the implementation of national policy or strategy for chronic disease prevention and control in 2000~2001 and 2005~2006, by WHO Region

Region	2000~2001	2005~2006
AFR	33	58
AMR	29	63
EMR	31	77
EUR	50	73
SEAR	67	83
WPR	NA	NA
Total	39	68

NA, no data available.

Table 18 Percentage of countries having specific/dedicated budgets for the following chronic diseases components, by WHO Region, 2005~2006

Risk factors and diseases	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Tobacco use	50	31	41	53	55	50	71
Nutrition/diet	49	50	48	27	55	33	57
Physical activity	32	15	37	13	37	17	57
Alcohol consumption	32	23	30	7	45	0	48
Obesity	32	12	37	13	37	17	57
Hypertension	45	31	48	47	42	17	71
Diabetes	53	35	52	60	55	33	71
Heart diseases	41	23	44	40	53	33	NA
Stroke	30	23	41	13	32	33	NA
Cancer	54	31	52	53	68	50	62
Chronic respiratory diseases	26	15	33	33	26	17	NA

[a] WPR data were collected in 2004; NA, no data available.

Table 19 Percentage of countries having the following financial sources for chronic diseases prevention and control, by WHO Region, 2005~2006

Financial resources	Total	AFR	AMR	EMR	EUR	SEAR	WPR[a]
Increase tax on cigarette	17	4	26	7	21	17	24
Increase tax on alcohol	11	4	15	0	18	17	10
Increase tax on unhealthy imported food	1	4	0	0	0	0	0
International financial aids	32	31	33	27	16	33	62
Fund raising activities	17	15	11	13	24	0	19
Donations from health interested private groups	18	15	22	13	21	0	19
Unspecific resources of financial budget	39	31	52	33	45	0	NA
Others	24	19	22	20	26	50	NA

[a] WPR data were collected in 2004; NA, no data available.

3. Summary

3.1 Summary of Progress

Progress is apparent in the group of 118 countries that responded to both surveys. The proportion with a national act, law, legislation or ministerial decree for tobacco control increased from 61% to 84%, varying from 67% in the African Region to 100% in the European and South-East Asian regions. The proportion with a national act, law, legislation or ministerial decree for food and nutrition related to chronic diseases prevention and control increased from 70% to 86%. The existence of budgets specific to NCD increased from 39% of countries to 68%. In a group of 97 countries that excludes WPR, the proportion with a national policy for chronic diseases prevention and control rose from 42% to 70% between the two surveys, varying from 46% in the Africa Region to 83% in the European Region. The proportion with an NCD unit or department in the Ministry of Health increased from 60% to 84%. In 2005, 64% of all 133 countries reported having a national integrated programme for prevention and control of chronic diseases.

3.2 Summaries by Risk Factor and Disease Groups

Below, findings are organized by risk factor and disease groups, summarizing data derived from across the tables in the previous section.

3.2.1 TOBACCO

Among all 133 respondents, 85% reported having a tobacco control act, law, legislation or ministerial decree. Since 2000-2001, for the 118 countries that responded to both surveys, there has been a 23% increase in the existence of these instruments and almost double the number of countries with tobacco control action plans, now standing at 65%. Again excluding WPR, 65% of respondents are contracting parties to the FCTC, and 31% report a corresponding comprehensive action plan. The extent to which there is overlap in the two sections of the survey asking about tobacco action plans is not known, nor is the nature of the legislation reported, nor the stage reached by any action plan.

Between 2000 and 2005, 82% of respondents (WPR excluded) said that populations were surveyed for tobacco use while 41% (WPR inclusive) reported routine surveillance. The surveys could have been at national or sub-national levels. Smoking cessation guidelines are said to be available in one-third of countries.

Dedicated budgets for tobacco control were reported in 50% of countries and 17% on average said that cigarette tax is contributing to financing NCD prevention and control initiatives. For the latter, the proportions were highest in AMR (26%), WPR (24%) and EUR (21%).

3.2.2 DIET AND PHYSICAL ACTIVITY

Twenty-nine countries, excluding those in WPR, reported implementation of DPAS while another 19 said they had plans to implement the Strategy. 86% of respondents to both surveys reported the existence of legislation related to food and nutrition, up from 70% in 2000-2001. However, at that time, legislation was most often concerned with food safety and sanitation, so whether any new legislation is targeting NCD prevention and control issues is unknown. Around 50% of countries indicated the existence of nutrition/diet policies, action plans and/or programmes, with 49% of countries reporting a dedicated budget.

23% of all respondents indicated that there is national legislation concerning physical activity, the nature of which was not stated. Between one-quarter and one-third of respondents reported national policies, action plans and programmes for physical activity, with 32% having dedicated budgets.

About 60% of countries reported that national or sub-national surveys were conducted between 2000 and 2005 to determine dietary and physical activity habits. Routine surveillance of diet, physical activity and overweight/obesity was reported by just over one-third of countries. National protocols, guidelines or standards were said to be available in 38% of countries for healthy diet, in 30% for physical activity, and in 26% for weight control. From among all reporting countries, only one in AFR uses taxes on unhealthy imported foods as a source of financing for NCD prevention and control.

3.2.3 ALCOHOL

On average 52% of responding countries reported the existence of legislation targeting alcohol control. In about 30% of countries, there are national policies, action plans and programmes for alcohol control, with a similar proportion having dedicated budgets. In 61% of countries, people at national or sub-national levels had been surveyed on their alcohol consumption between 2000 and 2005 while in 34% of countries, alcohol consumption is part of routine surveillance. On average, 11% of respondents said that taxes on alcohol are a source of revenue for NCD prevention and control.

3.2.4 HYPERTENSION

Approximately 30% to 40% of countries reported national policies, action plans and/or programmes dealing with hypertension. Protocols, standards or guidelines for treatment exist in 76% of 118 countries, up from 59% in 2000-2001. Almost 45% of countries have dedicated budgets. Populations at national or sub-national levels have been surveyed for hypertension between 2000-2005 in two-thirds of reporting countries, excluding WPR. Among 118 countries across all regions, routine surveillance of hypertension increased from 37% to 61% since 2000-2001.

3.2.5 DIABETES

The proportion of countries with national action plans for diabetes rose from 41% in 2000-2001 to 56% in 2005-2006. The existence of protocols, standards and guidelines for treatment and control was reported by 79% of countries, up from the 62% found in the first WHO survey. In the most recent survey, about 53% of countries reported budgets dedicated to diabetes. Surveillance for diabetes also rose, occurring now in 63% of countries compared to 43% in 2000-2001.

3.2.6 DYSLIPIDAEMIA

Across regions, 42% of countries (excluding WPR) reported national or sub-national surveys of dyslipidaemia, and almost 26% (including WPR) reported routine surveillance.

3.2.7 CANCER

In the latest survey, 41% of countries reported national policies on cancer and 47% have national cancer programmes. Since 2000-2001, in five regions (excluding WPR), the proportion of countries with national cancer action plans rose by 14%, reaching 63% in 2005-2006. 54% of all reporting countries now have budgets dedicated to cancer. 46% of countries reported having surveys for cancer between 2000 and 2005, and 64% reported routine surveillance (including WPR). Among the 118 countries that responded to both WHO surveys, the proportion that reported the availability of cancer treatment protocols, standards or guidelines rose from 58% to 71%.

3.2.8 HEART DISEASE AND STROKE

Among countries that responded to both WHO surveys, excluding WPR, the proportion with national action plans for heart disease rose from 37% to 49% and about 40% now have dedicated budgets. Plans for stroke were not surveyed in 2000-2001. But in the most recent survey, again excluding WPR, between 20% and 25% of countries reported a national policy, action plan and/or programme for stroke and 30% have dedicated budgets. (The discrepancy is not explained.)

About one-third of countries reported having national policies and/or programmes for heart disease in 2005-2006. Around 40% of countries reported national surveys or surveillance of heart disease; for stroke, it was about one-third of countries. Almost 50% of all reporting countries now have protocols, standards or guidelines for treating heart disease and around 40% have them for stroke.

3.2.9 CHRONIC RESPIRATORY DISEASE

Around 20% of responding countries reported the existence of national policies, action plans and/or programmes for chronic respiratory disease; 35% said there are protocols, standards or guidelines for treatment and 26% reported dedicated budgets. Surveying for chronic respiratory disease between 2000 and 2005 was reported by 29% of countries while one-third are said to have routine surveillance for these conditions.

4. Qualitative Results

Key informants in 26 countries participated in interviews. They were located in low, lower-middle and upper-middle income countries, in all regions except EUR, as shown in Table 20.

Table 20 Key Informant Countries in 2005~2006 Survey

Region	Countries
AFR	Namibia, Uganda, Nigeria
AMR	Brazil, Chile, Trinidad and Tobago, Mexico
EMR	Bahrain, Egypt, Jordan, Lebanon, Oman, Syrian Arab Republic, Sudan
SEAR	India, Thailand
WPR	Cambodia, Fiji, Micronesia, Mongolia, Philippines, Samoa, Solomon, Tonga, Vanuatu, Viet Nam

There were slight variations in the topics explored in each region to accommodate the specific information needs of the NCD regional advisors. All the interviews delivered information about the following core topics:

1) The priority assigned to NCD prevention and control.
2) The major barriers and constraints to the development and implementation of policies and programmes for NCD prevention and control.
3) The nature and extent of surveillance of major chronic diseases and risk factor exposure.
4) The priority areas for WHO technical support.

4.1 Ranking of NCD Prevention and Control as a Priority for Action

Table 21 shows that 15 key informants ranked NCD prevention and control as a high priority in their countries while 11 considered it a medium priority. Where it was a high priority, key informants spoke of strong governmental commitment. Recent evidence of the NCD burden such as rising injury rates, the high prevalence of diabetes mellitus and cardiovascular diseases, and recent public media reports was identified as having contributed to governments placing high priority on NCD policy development.

Table 21 Ranking of chronic non-communicable disease prevention and control as a priority for action

Rank	Key informants
High	15
Medium	11
Low	0

Where a medium rank was assigned, key informants explained that a government may assign a high priority to the NCD issue in terms of intent, but the priority in reality – in terms of response to NCD – is medium. Health system funds are largely consumed by necessary treatment and care services. In some cases, the double burden of disease is constraining an effective

approach to prevent and control NCD. Such policies may be in place but key informants expressed concerns about implementation, and said that policies are not comprehensive of all the issues they are to address, and lack the instruments to be effective. Some WHO-assisted biennial health plans do not identify NCD as a priority. Health promotion in general is a high priority and preventing NCD falls under that initiative. For some countries, advocates for NCD prevention feel that they have to "compete" with the communicable diseases issue which has a high priority, particularly among rural and peasant populations. High risk of NCD disease is seen to reside within middle-class and wealthy populations, who are better able to access (and are expected to access) health care systems once they are affected.

Mentioned also are situations where a country may have a number of separate conditions or risk factor strategies in place and ongoing. For example to prevent cancer and diabetes, and to deal with risk factors such as tobacco. But overall, NCD is not given a high priority, despite data on high mortality and morbidity rates. The public and governments are alarmed by NCD rates but mortality data are proving to be insufficient to mobilize government spending decisions. There remains a big gap between the awareness of the NCD problem and the government decision to respond.

Key informants also noted that there is uncertainty as to how best to take action. NCD prevention and control is a complex issue, and health care infrastructures are not being developed to respond with prevention, in some cases being of relatively small scale to begin with. Planning and finance ministries in government argue a need to hold back the allocation or reallocation of scarce funds on the basis of a lack of evidence on what policies are working in which situations. Some opponents even argue that preventing NCD is an individual's responsibility and not a population-level issue.

The continuing influence of the tobacco industry on government decisions was also mentioned. Policies and action plans that are in place do not comprehensively control tobacco; thus, pricing policy keeps cigarettes still affordable to low-income earners among whom high smoking rates prevail.

4.2 Barriers and Constraints

Key informants ranked a list of barriers and constraints, shown in Table 22. The lack of financial resources or their total lack was the number one barrier to NCD prevention policy implementation in twelve (12) instances, and human resources were the top barrier in seven (7). Information systems and public health policy were the next most often cited barriers, followed by health care infrastructure, and finally knowledge/skills/tools. Essential drugs and equipment were not among the top barriers or constraints to NCD action.

Table 22 Key Informant Ranking of Barriers and Constraints

Barriers and Constraints	Total that Assigned First Priority
financial resources	12
human resources	7
information systems	5

public health policy	5
health care infrastructure	1
knowledge/skills/tools	1
essential drugs and equipment	0

In the interviews, key informants linked the lack of financial resources to implement NCD prevention and control interventions to a number of circumstances. Many were mentioned in section 4.1 above in the explanations of why NCD prevention is not given high priority by governments. To these were added the lack of awareness by the general public of NCD rates in terms of mortality and morbidity, and the lack of knowledge that the risk factors underlying major NCD are modifiable. There is little "room" in the public's attention for NCD prevention given the high profile in the media of such communicable disease concerns as HIV and bird flu, and of access to health care services. Key informants recognize that the potential advocacy of the public is missing, a factor that contributes to the relatively low levels of funding that governments are willing to allocate to NCD prevention.

Human resources as a constraint to NCD intervention were related to health care infrastructure. Key informants said that there is limited or non-existent capacity within some primary care services for health professionals to absorb new activities to deal with risk factors and generally with NCD prevention, both in terms of their time and the availability of health system funds to compensate them for their interventions.

Knowledge/skills/tools as a barrier was related also to the capacity and competencies of two bodies of people – the front-line of health professionals, with reference to their training to provide interventions in their respective settings that prevent and control NCD; and the health policy-makers. For the latter group, key informants characterized the knowledge barrier as related to the design of new policies or strategies that serve to coordinate existing disease- and risk factor-specific initiatives, and at the same time to join up the actions of health and non-health government departments. The difficulty of shifting the government's perspective from a vertical orientation of strategies to horizontal collaboration was acknowledged.

Key informants characterized health information systems as being typically limited to being institution-based, with hospitals and other treatment centres being the source of NCD mortality data and sometimes morbidity data. Key informants also indicated a knowledge gap on the part of public health professionals as to how to use data most effectively to persuade more government action to prevent and control NCD.

Also raised was the issue of how to translate the intentions of national policy into action at the local levels, where the responsibilities and infrastructures for policy implementation, such as they are, are often located. In some cases, local structures with health and social services mandates that are currently providing services have not been certain how to proceed. They understand that taking an integrated approach calls, for example, for increasing and diversifying local coalitions and partners and engaging new sectors, but how to start and who is to play what role is not clear.

4.3 Surveillance of Chronic Disease Prevention and Control and Risk Factors

Eleven key informants mentioned an active survey of conditions and risk factors in their countries, including hypertension, diabetes and mental disorders, and diet, weight, alcohol use, tobacco use and physical activity. Most NCD and risk factor surveys have been conducted since 2002, some at national levels, others in regions. Seven key informants mentioned that the WHO STEPwise approach to chronic disease risk factor surveillance, or a modified approach, is being applied or that preparations are underway, for example the training of interviewers. The lowest income countries in the sample reported no NCD or risk factor surveys. In one case, a shortfall of US $65,000 was said to be holding back application of the STEPwise approach.

4.4 Priority Areas of WHO Technical Support for Chronic Disease Prevention and Control

Key informants assigned first priority for WHO assistance most often to the area of policy, action plan and programme development. WHO help with disease surveillance and training were the next highest priorities.

Table 23 Key Informant Ranking of Areas for WHO Technical Support

Areas for WHO Technical Support	Total that assigned First Priority
Policy, action plans and programme development	6
Assistance with disease surveillance	5
Training for human resource development	5
Establishing demonstration programmes	4
International collaboration and networking	3
Assistance with risk factor surveillance	3

Key informants pointed to different entry points as regards where to begin with WHO technical support. What can be considered a bottom-up approach was mentioned, starting with assistance with demonstration projects or pilots, for these to become the basis for survey design and implementation and to learn more about population-based interventions, then followed by assistance with policy development to scale up to comprehensive national programmes.

A top-down approach was also suggested, asking for stronger international collaboration with WHO, using its high profile to support national efforts to advocate NCD prevention and have it placed on the political agenda, to increase the potential for resources to be mobilized and to make it genuinely a top priority.

Key informants indicated that knowing the policies and interventions that are considered good practice in other countries and situations would give an insight into how to proceed with initiatives in their own countries. They suggested that WHO compile good practices and create the platforms where they can be exchanged. Furthermore, some countries want assistance with tailoring the international guidelines and good practices that are available into policies and programmes that are relevant and feasible in their contexts and applicable at their local levels, where several programmes may already exist. They know that the next steps involve building coalitions and new partnerships at national

and local levels, and want assistance in how to build trust and design the integrating mechanisms needed to move forward with the various players.

Also mentioned was assistance with the reorientation and training of health promotion and disease prevention professionals to deal with NCDs, since their traditional emphasis has been on communicable diseases.

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5 Discussion and Conclusion

The fact that there are some common topics in WHO's first and latest surveys of country capacities for NCD prevention and control has made it possible to estimate the progress made in the period between the two surveys. Equally important is an assessment of country responses in the context of the directions that WHO has encouraged since the first survey. Prominent among them for NCD prevention and control, compared to the context in 2000-2001, is the increased emphasis by WHO on upstream action that targets the main risk factors common to several NCDs, and clarifies the nature of integrated approaches to deal with them. FCTC exemplifies an integrated approach, being a comprehensive regulatory strategy that implicates health and non-health sectors as well as public and private sectors to respond to a population health threat. The Global Strategy on Diet, Physical Activity and Health is another broad-ranging approach, challenging countries to use various instruments across sectors to address two risk factors simultaneously.

Reporting first on progress made since 2000-2001, there is an increase in the proportion of countries reporting policies, action plans and programmes that intend to prevent and control the major risk factors and NCD. However, even with more initiatives apparent, and even with a high priority assigned to NCD prevention, several key informants believe that, in their countries, decisive implementation remains a challenge. Their number one barrier to NCD prevention policy implementation is the lack of financial resources. There continues to be a knowledge gap within governments and in the general public about the extent of the NCD burden and the fact that risk factors are modifiable at a population level. It is clear that a key area for WHO technical assistance, as was reported in 2000-2001, is still advocacy. WHO can better use its high profile to persuade the general public, governments and, where relevant, donor agencies to mobilize sufficient resources for NCD prevention interventions to achieve the preventive dose.

Health budgets around the world are being strained to cover necessary treatment and care of existing NCD cases and, in some countries, of the double burden of communicable diseases. The public understandably defends health care. Given that several risk factors to NCD are modifiable and are the products of global industries, WHO intervention with industry at the global level reduces the pressure on Member States to mobilize, on their own, the national public awareness and the extent of public demand needed to effectively control or eliminate NCD risk factors at the population level. Furthermore, WHO can create more instruments similar to FCTC to deal with diet, physical activity and other major risk factors, so as to support and leverage country efforts in implementing DPAS and other strategies that are emerging.

A top priority for technical assistance from WHO continues to be policy, action plan and programme development. An interpretation of what might appear as a contradiction – the request for assistance with NCD prevention-related policy

while countries have actually made progress in this regard – is that the nature of the assistance with policies and plans has to do with their implementation and how to better design policies to make them more effective. WHO can help with policy development by training policy makers while advocating policy formulation processes that define key aspects of implementation necessary for a policy to "have legs" from the outset. For example, specifying within an NCD prevention policy declaration the sources and amounts of resources to be available, along with identifying the general structures and mechanisms through which interventions are to be delivered, would greatly improve the chances that the results intended by policies, plans and programmes will indeed be realized. Where several initiatives are in place, key informants also indicated a need for assistance in determining how to coordinate or join up efforts in order to bring about a degree of integration specific to their political, social and economic realities.

An area for WHO assistance that emerged was that WHO should create more channels, platforms and other occasions for dialogue among Member States to encourage them to be outward looking, to exchange their experiences with NCD prevention and control policies, plans, programmes and protocols in an environment with peers, to review what is being done and to consider options on how to move forward. WHO can also compile and disseminate examples of what is being done. Given the diversity of country situations and contexts for NCD prevention, and the huge range in country capacities to respond, WHO can encourage research to deliver case studies that profile leadership in applying good practices relevant to countries by income group. The demonstration programmes identified in the current survey are potential case studies, as are FCTC and DPAS action plans.

The number of countries reporting risk factor surveys and surveillance has increased since 2000-2001 but the frequency is not known. Collecting reliable data on the major risk factors on a regular basis needs emphasis and support to produce the trends that can inform policy and action plan development and evaluation and, above all, can support advocacy. Key informants indicate that WHO technical assistance continues to be needed for training and evaluation of surveillance and survey systems for NCD risk factors, disease prevalence and cause-specific mortality. WHO can also encourage, assist with and profile research on the relationship between risk factor exposure and NCD prevalence and socioeconomic determinants, thus broadening the adoption of the equity agenda.

Even with more countries reporting the existence of protocols for dealing with risk factors and disease management since 2000-2001, key informants continue to ask for assistance in assessing their feasibility and appropriateness for their local contexts and capacities, and then in training primary care professionals to use them.

Technical assistance and training are also needed with regard to preparing information that will be strategic in capturing the attention of policy makers. WHO can assist public health professionals to frame the NCD burden in, for example, economic and sustainable human development terms, using the research and methods that have been developed since 2000-2001. WHO can

also give more support to training and dissemination of health impact assessment methods among public health professionals, enabling them to point out the potential population health effects of policies being proposed by non-health sectors and making them better advocates for healthy public policies.

With regard to the sources of financing for NCD prevention and control, about 32% of countries on average identified international financial aid. The proportion in EUR was lowest (16%). Very few countries reported taxation on tobacco, alcohol and unhealthy food as sources of funding. As for taxes on alcohol, the countries in EUR have the highest proportions (18%); while the countries in AMR have the highest proportions of taxation on cigarettes (26%).

While progress is apparent in the countries that responded to both surveys, a number of key areas still call for action, and these are similar to those that were reported in 2000-2001. These key areas also re-emerge as priorities for WHO technical support to Member States. They can be summarized as:

- Advocacy, with a continuing need for WHO to persuade the general public, governments and donor agencies to mobilize sufficient resources for NCD prevention;
- Member States still require assistance in strengthening their surveillance systems;
- Strengthening capacity in developing, implementing and evaluating national policies, action plans and programmes for chronic disease prevention and control;
- Creating more channels, platforms and other occasions for dialogue at global and regional level and among Member States.

Finally, regular global reviews should be encouraged, not only to help WHO to measure the progress made but also to identify the Member States' needs for technical support.

References

1. WHA51.18. A Global Strategy for the Prevention and Control of Noncommunicable Diseases. Resolution of the 51st World Health Assembly. Geneva, World Health Organization, 20 May 1998.
2. WHA53.17. Prevention and Control of Noncommunicable Diseases. Report of the Director General. 53rd World Health Assembly. Geneva, World Health Organization, 20 May 1998.
3. The World Health Report 2002: Reducing risks, promoting healthy life. Geneva, World Health Organization, October 2002.
4. WHO Framework Convention on Tobacco Control. Geneva, World Health Organization, May 2003.
5. WHA51.17. Global Strategy on Diet, Physical Activity and Health. Geneva. May 22, 2004. Resolution of the 57th World Health Assembly. Geneva, World Health Organization, 20 May 1998.
6. Preventing chronic diseases: a vital investment. Geneva, World Health Organization, October 2005.
7. Alwan A, Maclean D, Mandil A. Assessment of national capacity for noncommunicable disease prevention and control: the report of a global survey. Geneva, World Health Organization, 2001.
8. Microsoft Corporation. Microsoft Excel 2003. Redmond, Washington: Microsoft Corporation, 2003.
9. Centers for Disease Control and Prevention. Epi Info: version 6.04d. Atlanta, Georgia: Centers for Disease Control and Prevention, 2001.
10. Stata Corporation. Stata statistical software: release 9.0. College Station, Texas: Stata Corporation, 2005.

Annex 1 - Global Survey Questionnaire

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National Chronic Diseases Prevention and Control Questionnaire

Thank you for agreeing to complete this questionnaire. We really appreciate your efforts. The objectives of the WHO global survey are to assess the capacity of national chronic disease prevention and control in development, and implementation of national policy, and action plan and programmes, to promote sharing of information, experiences and best practices, to identify constraints and needs and to assist national strategy and policy formulation, development, implementation and evaluation of programmes.
The last WHO global survey to assess national capacity for chronic diseases /NCD prevention and control was carried out in 2001. Those results are available from: http://whqlibdoc.who.int/hq/2001/WHO_MNC_01.2.pdf. The results from the analysis of this 2005 survey will be made available through the WHO website with links to relevant policy documents for each country, where these exist. To enhance quality of data collection, some countries may be contacted for further information on receipt of questionnaire.

COUNTRY NAME: _____
This is a current profile of the chronic disease prevention and control in this country/territory. We understand that it will be used in a global analytic report.

NAME OF PRINCIPAL PERSON FILLING IN THE QUESTIONNAIRE:

Surname: _____ First Name: _____

DESIGNATION /TITLE: _____

CONTACT DETAILS: *Please provide contact details in case further information or clarification is needed.*

Address: _____

Tel: _____ Fax: _____ Email: _____

SIGNATURE: _____ DATE OF COMPLETION: ** **24-Apr-13** (dd/mm/yyyy)

Note:

1. This questionnaire is accompanied by two documents to assist you in completing the questionnaire: the *Preamble* which explains the background to this survey, and the *Objectives, Terms and Definitions*.
2. If you have any difficulty or need to discuss this in any way, please contact WHO Regional Office for**********; Dr *******, WHO/***** at ***@****** for ***** Region;
3. We prefer that you complete the questionnaire in an electronic version. Further copies of the form are available at from your Regional counterpart, the WHO Headquarters focal point (shaor@who.int) or the WHO website (http://www.who.int).
4. Some of the questions require that you provide supplementary material (e.g. documents, reports and published papers). We would prefer to receive an electronic copy of each (WORD, PDF etc) and the website where the document is located. If electronic version is unavailable, please send two hard (paper) copies of each. If the original document is in another language, we would be grateful to receive a short abstract in English.
5. We recommend that you discuss this questionnaire with the relevant people or focal points

at the national level prior to completion to ensure as full a response as possible.

A. National Focal Point, Unit/department, and Institute

A1 Is/are there a focal point(s) for overall prevention and control of chronic diseases in the Ministry of Health and /or in your Organization?

Yes ☐ No ☐

If yes, please give contact details of lead person as follows:

Surname:_____ First Name: _____

Designation /Title: _____ Unit /Department: _____

Address: _____

Tel: _____ Fax: _____ Email: _____

A2 Is there a unit (or department) for prevention and control of chronic diseases in the Ministry of Health?

Yes ☐ No ☐

If Yes, what is the total Number of staff: ☐☐

A3 Are there national institutes for public health or chronic disease prevention and control – or equivalent (Other)?

Yes ☐ No ☐ Other ☐

If Yes, please provide us with the name and website of the institute, where this exists:

B	**National Act, Law, Legislation, Ministerial Decree for Chronic Diseases Prevention and Control**			
	These are nationally approved act, law, legislation or ministerial decree for prevention and control of chronic diseases.			
B1	Does your country have an **act, law, legislation, ministerial decree**s developed on the following areas	**Tick box, if yes**	**Type**	**Year, Title and website (or PDF file), if exists**
	a. Tobacco control **	☐		
		☐		
		☐		
	b. Food and nutrition	☐		
	• Specific food product e.g. fat consumption, salt control	☐		
	• Settings: school, workplace	☐		
	c. Alcohol control **	☐		
	d. Physical activity	☐		
	e. Any other regulatory instruments of relevance to Chronic disease prevention and	☐		

	control? (please indicate)			

Any other comments you wish to add regarding section B?:

C	**Policy, Strategy, Action Plan, Programme** These are nationally approved policies, strategies, action plans, programmes for the prevention and control of chronic diseases.		
C1	Does your country have **a national health policy relevant to chronic diseases prevention and control?** Yes ☐ No ☐ If yes, please give: Effective Year:_____ Title (original and English): _____ website (or PDF file), if exists:_____ *Please provide hard (paper) copy, if electronic version does not exist.*		
C2	Does your country have **a national health strategy** relevant to prevention and control of chronic diseases? Yes ☐ No ☐ If yes, please give: Effective Year: _____ Title (original and English):: _____ website (or PDF file), if exists:_____ *Please provide hard (paper) copy, if electronic version does not exist.*		
C3	Does your country have **national integrated programmes for chronic diseases prevention and control** which cover all or some of the major risk factors (tobacco use, nutrition, physical inactivity, alcohol consumption), or main chronic diseases (heart diseases, stroke, cancer, chronic respiratory diseases, hypertension, diabetes)? If yes, please give details: Effective Year:_____ Title (original and English): _____ website (or PDF file), if exists: _____ *Please provide hard (paper) copy, if electronic version does not exist.*		
C4	Does your country have **individual national policies** developed on the following areas	If yes, please tick	**Year, Title (original and English) and website (or PDF file), if exists**
	a. Tobacco Control	☐	
	b. Nutrition/diet	☐	
	c. Physical Activity	☐	
	d. Alcohol Control	☐	
	e. Hypertension	☐	
	f. Diabetes	☐	
	g. Heart Diseases	☐	
	h. Stroke	☐	
	i. Cancer	☐	
	j. Chronic respiratory disease	☐	
	k. Other chronic disease /NCD of importance in your country	☐	

C5	Does your country have **individual national action plans** developed on the following areas	If yes, please tick	**Year, Title (original and English) and website (or PDF file), if exists**
	a. Tobacco Control	☐	
	b. Nutrition/diet	☐	
	c. Physical Activity	☐	
	d. Alcohol Control	☐	
	e. Hypertension	☐	
	f. Diabetes	☐	
	g. Heart Diseases	☐	
	h. Stroke	☐	
	i. Cancer	☐	
	j. Chronic respiratory disease	☐	
	k. Other chronic disease /NCD of importance in your country	☐	
C6	Does your country have **individual national programmes** developed on the following areas	If yes, please tick	**Year, Title (original and English) and website (or PDF file), if exists**
	a. Tobacco Control	☐	
	b. Nutrition/diet	☐	
	c. Physical Activity	☐	
	d. Alcohol Control	☐	
	e. Hypertension	☐	
	f. Diabetes	☐	
	g. Heart Diseases	☐	
	h. Stroke	☐	
	i. Cancer	☐	
	j. Chronic respiratory disease	☐	
	k. Other chronic disease /NCD of importance in your country	☐	

C7. Are there any relevant policies / plans **in preparation**? Yes☐ No☐

If yes, please give details _____

Any other comments you wish to add regarding section C? _____

D	**National Target** Setting of quantitative output, impact, outcomes or health indicators for chronic diseases prevention and control

D1	Has your country set quantitative targets for chronic diseases prevention and control? **If Yes, please provide us with a copy of the document *or Web site and electronic file (in word, PDF)*.**	Yes ☐	No ☐

Please complete the table below on the areas of chronic disease or major risk factors where National targets for prevention and control have been set.

Area/aspect of chronic diseases (or risk factors, health determinants)	National targets

D2 **Which organizations were involved in setting population targets for chronic disease prevention and control? *(Please tick)***

Ministry of Health	☐	Associations for specific population groups e.g. Men's, Women's or Youth Organizations	☐
Ministry of Education	☐	Consumer Organizations	☐
Ministry of Finance	☐	Medical /Health professional Associations	☐
Other Ministries (Specify)	☐	Disease-specific Associations e.g. Cancer Society, Diabetes Associations	☐
Subnational Government	☐	International Nongovernmental Organizations	☐
World Health Organization	☐	Other Bilateral/multilateral Organizations	☐
National nongovernmental Organizations	☐	Academic institutions	☐
Citizen or community representatives	☐	Others (please specify)	☐

Any other comments you wish to add regarding section D?

_____

E. Implementation of the Framework Convention on Tobacco Control (FCTC) and the Global Strategy on Diet, Physical activity and Health(DPAS)

E1. Has your country become a contracting Party to the WHO FCTC?

Yes☐ No☐

If Yes, does your country have an action plan for the implementation of the FCT, in addition to any Tobacco Control action plan already mentioned in section C?

Yes☐ No☐

If Yes, please provide us with a copy of the document or Web site and electronic file (in word, PDF).

E2. Are there aspects of FCTC implementation you need assistance with from WHO?

E3. Does your country implement the DPAS? Yes☐ No☐

If Not, Does your country have plans for the implementation of the DPAS? Yes☐

No☐

If **Yes**, please provide us with links to the website where the plans is the and the electronic copy (word, PDF, etc), or provide us with a hard copy.

E4. Does your country have a mechanism in place for discussion/interaction between national authorities and private sector interests related to the DPAS?

Yes☐ No☐

If yes, what is the mechanism?

E5. Are there aspects of DPAS implementation you need assistance with from WHO?

F	**National health reporting system, survey and surveillance**			
	National health reporting system refers to annual or regular health report system of MOH; Survey refers to regular, fixed or unfixed time interval national health survey; Surveillance refers to the ongoing monitoring and reporting/analysis of chronic disease/risk factors, morbidity and mortality due to chronic disease in a population.			
F1	a. Does your country have a health information system in which chronic disease and major risk factors are part of system? Yes ☐ No ☐ If yes, **b. Are chronic diseases included in the annual health report system?** **Yes** ☐ **No** ☐ **If yes,** **c. Please specify the data included:** **1) Risk factors** ☐ **2) Cause-specific mortality** ☐ **3) Morbidity** ☐ d. How are the results made available e.g. website? _____ e. How has the information been used for decision-making or policy-making? _____			
F2	**During the past 5 years (2000-2005), were national/provincial studies/surveys carried out on:** ***(Please tick)***			
	Tobacco use	☐	Raised blood glucose	☐
	Unhealthy diet	☐	Raised blood pressure	☐
	Physical inactivity	☐	Dyslipidaemia	☐

	Alcohol consumption	☐	Heart diseases	☐
	Hypertension	☐	Stroke	☐
	Diabetes	☐	Cancer	☐
	Overweight and obesity	☐	Chronic respiratory diseases	☐
F3	**Does your country have a routine or regular surveillance system for chronic diseases/risk factors? Yes ☐ No ☐** ***If** Yes**, please state:*** • ***the** year initiated* **date last completed:** • ***the periodicity*** **age groups covered:** ***and provide us with a Web site and electronic file (in word, PDF)of the most recent report***			
F4	**Which of the following chronic diseases/risk factors does your country's chronic disease surveillance system cover? *(Please tick)***			
	Tobacco use	☐	Overweight and obesity (Body Mass Index)	☐
	Unhealthy diet e.g. low fruit and vegetable intake	☐	Dyslipidaemia (cholesterol)	☐
	Physical inactivity	☐	Heart diseases	☐
	Alcohol consumption	☐	Stroke	☐
	Diabetes (Elevated blood glucose)	☐	Cancer	☐
	Hypertension (Elevated blood pressure)	☐	Chronic respiratory diseases	☐

F5. Has the WHO Stepwise approach to surveillance for risk factors been implemented in your country? Yes☐ No☐

Any other comments you wish to add regarding section F?

G	**National community-based demonstration programme for chronic disease prevention and/or health promotion** Refers to national demonstration community-based chronic disease prevention and control and/or health promotion programmes targeting major risk factors, group of population or settings.
G1	**Does your country have health promotion and chronic disease prevention and control demonstration site(s) for** integrated chronic disease prevention and control**?** **Yes**☐ **No**☐ If yes, what? Please provide a website and electronic evaluation report, if these exist?

G2	Does your country have health promotion and chronic disease prevention and control demonstration site(s) for tackling **individual risk factors**? Yes☐ No☐ If yes, what? Please provide a website and electronic evaluation report, if these exist?		
G3	Does your country have health promotion and chronic disease prevention and control demonstration project(s) for **individual population groups**? *(Please tick all that apply).* Please provide a website and electronic evaluation report, if these exist?	Yes	**No**
	Children 15 years and Under	☐	☐
	Young People and Adolescents, 15 –24 years	☐	☐
	Adults, 25 – 64 years	☐	☐
	Elderly, 65 years and over	☐	☐
	Women	☐	☐
	Others (please indicate)	☐	☐
G4	Does your country have health promotion and chronic disease prevention and control demonstration project(s) for **individual settings**? *(Please tick all that apply).* *Please provide a website and electronic evaluation report, if these exist?*	*Yes*	***No***
	Workplace	☐	☐
	School	☐	☐
	Hospital and clinics	☐	☐
	Community	☐	☐
	Family	☐	☐
	Others(please indicate)	☐	☐

Any other comments you wish to add regarding section G?

H	**National Protocols/Guidelines/Standards for Chronic Diseases and Conditions** Refers to the prevention, treatment or management services that deal with an already existing noncommunicable disease or risk factor aiming to prevent, treat and control the condition, prevent complications, improve outcomes and quality of life of the patients.		
H1	Does your country have **national protocols/guidelines/standards** developed and implemented for the **prevention, treatment or management** of the following chronic diseases or risk factors? *If yes, please provide a website and electronic document, if these exist?*	**Tick box, if yes**	Type
	a. Hypertension	☐	
	b. Diabetes Mellitus	☐	

	c.	Heart diseases	☐	
	d.	Stroke/CVA (Cardiovascular Accident)	☐	
	e.	Cancer	☐	
	f.	Chronic Respiratory Diseases	☐	
	g.	Smoking Cessation	☐	
	h.	Weight Control	☐	
	i.	Dietary	☐	
	j.	Physical activity	☐	
	k.	Other chronic diseases /NCD of importance in your country	☐	

Any other comments you wish to add regarding section H?

I	**Financial Resources** Specific budgetary and other financial resources allocated for chronic disease prevention and control.				
I1	Has your country allocated specific resources or a dedicated budget for implementation of a national policy or strategy for the prevention and control of chronic diseases?		Yes ☐		**No** ☐
I2	Does your country allocate specific/dedicated budgets for prevention and control in any of the following chronic diseases components?		Yes		**No**
	a.	Tobacco use	☐		☐
	b.	Nutrition/diet	☐		☐
	c.	Physical activity	☐		☐
	d.	Alcohol consumption	☐		☐
	e.	Obesity	☐		☐
	f.	Hypertension	☐		☐
	g.	Diabetes Mellitus	☐		☐
	h.	Heart diseases	☐		☐
	i.	Stroke	☐		☐
	j.	Cancer	☐		☐
	k.	Chronic respiratory diseases	☐		☐
I3	What is the source of financial support for chronic diseases prevention and control? *(Please tick).* Government appropriation from:				
	Increase tax on Cigarette		☐	Fund Raising Activities	☐

	Increase tax on Alcohol	☐	Donations from Health Interested Private Groups	☐
	Increase Tax on unhealthy imported food	☐	Unspecific resources of financial budget	☐
	International Financial Aids	☐	Others (please indicate)	☐

Any other comments you wish to add regarding section I?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Annex 2 - Explanation of Terms

Objectives, Terms and Definitions

Objectives

This survey aims at assessing the current national capacity in health policy, strategy, action plan and programmes for prevention and control of chronic diseases, in order to:

1. Assess progress of national chronic diseases prevention and control;
2. Share information, experiences and best practices;
3. Identify constraints and needs;
4. Assist in the formulation, implementation and evaluation of policy, strategy and action plan in countries.

Terms

In order to assure standardization in responding to the questionnaire, it is essential that the respondent reviews the following terms and definitions before attempting to complete the questionnaire:

Chronic Diseases (Noncommunicable Diseases)

In this questionnaire, the terms "chronic diseases" and "noncommunicable diseases" are considered synonymous. This questionnaire primarily focuses on four prominent chronic diseases, which are given a high priority by the WHO Global Strategy for Noncommunicable Diseases Prevention and Control. These four diseases are, cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases. Cardiovascular disease include heart disease and stroke (cerebrovascular accidents); cancer includes malignant tumors of organs such as brain, lung, prostate, breast but also leukaemias and lymphomas; diabetes refers to diabetes mellitus; and chronic respiratory diseases includes chronic obstructive pulmonary disease (COPD) and asthma.

Chronic Disease Prevention and Control (CDPC)

For the purpose of this questionnaire, CDPC includes all activities related to surveillance, prevention and management of the four chronic diseases mentioned above.

Risk Factors

Refers to the major risk factors common to the four chronic diseases namely: tobacco use, unhealthy diet, physical inactivity, alcohol consumption, elevated blood pressure and blood glucose, overweight and obesity, and dyslipidaemia.

Copies of documents

Copies of strategies, policies, action plans and guidelines can be in local

languages but please provide an abstract in English, if another language is used. Please provide links to the website(s) where the documents are located and attach electronic files (Word, PDF, etc), or provide hard copies. Effective year refers to year that policy, legislation or thing in question takes effect.

Respondent group

If information for different sections of the questionnaire is managed by a different person or different ministries in countries, it is advised to convene the people responsible in order to prepare the response.

Definitions

1. National Focal Point, Unit/Department, Institute:

i. ***National focal point***: refers to the person responsible for prevention and control of chronic diseases in MsOH, in a national public health institute or chronic disease prevention and control institute;

ii. ***Unit or department:*** refers to a unit or department in MsOH for disease prevention and control or prevention and control of chronic diseases;

iii. ***Institute***: refers to a national public health institute or chronic disease prevention and control institute.

2. National Act, Law, Legislation, Ministerial Decree:

i. Refers to nationally approved acts, laws, legislation, ministerial decrees targeting prevention and control of chronic diseases and risk factors; or prevention and control of chronic diseases or related risk factors as part of legislations concerned.

ii. ***Tobacco legislation*****:** This deals with legal provisions for tobacco control including information on health hazards from different tobacco products, passive smoking, protection of children, and different laws for tobacco prevention, cessation, taxation, and distribution of tax revenues.

iii. ***Food and nutrition legislation*****:** Deals with legal provisions for food and nutrition, including manufacturing, labelling, quality assurance standards, food protection regulation, etc. In this questionnaire, the food and/or nutrition legislation is related to chronic diseases prevention and control, or chronic diseases prevention and control is part of its concerns.

3. National Policy, Strategy, Action Plan/Programme:

i. ***Strategy*****:** Refers to the national strategy that includes a long term plan of action designed to achieve the goal of prevention and control of chronic diseases.

ii. ***Policy*****:** In the context of the Chronic Disease Prevention and Control, policy means consensus among relevant partners on issues to be addressed and on approaches or strategies to be used in doing so. Therefore, a national policy for chronic disease prevention and control refers to a written document endorsed, in collaboration with related sectors, by the country's Ministry of Health (MOH), which includes a set

of statements and decisions defining goals, priorities and main directions for attaining these goals. The policy document may also include a strategy containing main lines of action that are adopted to give effect to the policy.

iii. ***National integrated action plan (NIAP)***: Refers to the countries core public health principles incorporated into country action plan for chronic diseases prevention and control through a concerted approach to addressing the multidisciplinary range of issues within a prevention and health promotion framework across the broad range of chronic diseases. NIAP targets all major common risk factors common to main chronic diseases, and integrate primary, secondary and tertiary prevention, health promotion and diseases prevention, and programmes across sectors and disciplines through, rather than rely on, a disjointed set of small scale projects through a set of actions, harmonizing actions, integrating actions with existing public health systems by incorporating contemporary evidence-based concepts into this approach.

iv. ***National action plan*:** This is a scheme, prepared according to policy and strategic directions, and defining activities, to generate products/targets set to achieve the desired goals. The plan should identify who does what (type of activities and people responsible for implementation), when (time frame), how and for how much (resource). It should ideally have an inherent mechanism for monitoring and evaluation.

v. ***National programmes*:** Refers to the understanding of the national overall goal and objectives within the framework of national chronic disease prevention and control, translate these into programme goals and objectives that are consistent with the intervention strategies and from these develop a blueprint of how the intervention activities will operate and evaluate the results.

vi. ***Capacity:*** The ability to perform appropriate tasks effectively, efficiently and sustainably (at national level)

4. National Target:

Refers to setting of quantitative output, impact, outcomes or health indicators for chronic diseases prevention and control (or risk factors such as tobacco use, unhealthy diet and physical inactivity, and health determinants such as environment, lifestyles, socio-economics etc).

5. National health reporting system, survey and surveillance:

i ***Annual health reporting system*:** This includes the annual health reports of the MOH, containing data on national capacity, human resources, demographic data, health expenditure, health indicators. Morbidity information many include incidence or prevalence data from disease registries, hospital admission or discharge data.

ii ***National survey*:** Refers to national fixed or unfixed time interval survey on the main chronic diseases, or major risk factors common to chronic diseases.

iii ***Surveillance*:** Refers to information on risk factors, chronic diseases and their determinants, which is a continuous analysis, interpretation and feed-back of systematically-collected data using survey or regular

registration.

6. National community-based demonstration programmes for chronic disease prevention and/or health promotion:

Refers to national community-based demonstration programmes that address issues relevant to chronic disease prevention and major risk factors; apply existing knowledge to practice effective prevention at community level; examine different methods of disease prevention and health promotion; evaluate their feasibility; and validate their effect and how they can be a source of public and professional inspiration. Large or national programmes based on experience of the demonstration areas can be launched.

7. Implementation of FCTC and DPAS:

Refers to the national action plan or work plan for implementation of the Framework Convention on Tobacco Control (FCTC) adopted by WHA 56 in May 2003, and the Global Strategy for Diet, Physical Activity and Health (DPAS) endorsed by WHA 57 in May 2004.

8. National Protocols/Guidelines/Standards for Chronic Diseases and Conditions:

Refers to prevention, treatment or management services that deal with an already existing chronic disease or risk factors aiming to treat and control the condition, prevent complications, improve outcomes and quality of life of patients.

9. Financial Resources:

Refers to specific chronic disease prevention or risk factors intervention and budget allocation for prevention and control in any of the chronic diseases components and the source of financial support for chronic diseases prevention and control.

Annex 3 - Key informant questions

Interview Questions Regarding Chronic Diseases Prevention and Control for Key Informants

Date:
Member State:
Key Informant:

1. How would you rank NCD prevention and control as a priority for action given the present health status of your country's population and the capacity of your health system?

   low median high

   Interviewer comments:

2. What do you think are the major constraints or barriers (top 3) to the development and implementation of policies and programmes for chronic diseases prevention and control in your country? (rank in order all that apply).
   a) Public health policy
   b) Fiscal resources
   c) Human resources
   d) Information systems
   e) Health care infrastructure
   f) Essential drugs and equipment
   g) Knowledge/skills/tools
   h) Other

   Interviewer comments:

3. In the survey conducted in 2005 by WHO entitled " The Global Survey on Progress of National Chronic Disease Prevention and Control ", your country indicated that it had an official policy or plans in the area of chronic diseases prevention and control. In a few words could you describe the nature and extent of the policy or plans or programmes?

   1) Policies

   2) Action plans

4. In the survey mentioned above, your country indicated that it had national programmes/projects in the area of chronic diseases prevention and control. In a few words could you describe the nature and extent of these programmes/projects?

Interviewer comments:

5. In the survey mentioned above, your country indicated that there was legislation in place regarding tobacco control and food and nutrition. In a few words could you describe the nature and extent of this legislation?

Tobacco:

Food and Nutrition:

Interviewer comments:

6. In the survey mentioned above, your country indicated that there was a surveillance system (or register) for chronic diseases. In a few words could you indicate the nature and extent of this system?

Chronic diseases	**Population-based**	**Institution-based**
Hypertension		
Diabetes		
Heart diseases		
Stroke		
Cancer		
Chronic respiratory diseases		

Interviewer comments:

7. In the survey mentioned above, your country indicated that there was a surveillance system that included surveillance for some of the chronic diseases risk factors namely _____. In a few words please indicate the nature and extent of these systems?

Risk factors	**Population-based**	**Institution-based**
Tobacco use		
Unhealthy diet		
Physical inactivity		
Alcohol consumption		
Overweight and obesity		
Raised blood glucose		
Raised blood pressure		
Dyslipidaemia		

Interviewer comments:

8. In the survey mentioned above, your country indicated that there were chronic disease prevention and control programmes integrated with the

primary health care system. In a few words could you describe the nature of these programmes and explain what the term "integrated" means in this context?

Interviewer comments:

9. Implementation of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS):

   1) In the survey mentioned above, your country defined the mechanism in place for discussion/interaction between national authorities and private sector interests related to the DPAS. In a few words could you please indicate the nature and extent of this mechanism?

   2) Are there aspects of DPAS implementation for which you need assistance from WHO?

10. What do you think should be the major priority areas for WHO technical support for chronic diseases prevention and control for your country? (Rank in order all that apply).
    a) Training for human resource development
    b) Establishing demonstration programmes
    c) Policy, action plans and programmes development for chronic diseases prevention and control
    d) Assistance with chronic diseases surveillance
    e) Assistance with risk factor surveillance
    f) International collaboration and networking
    g) Other

Interviewer comments:

Annex 4 List of WHO Member States responding to the Global Survey

AFRICAN REGION	Angola
	Benin
	Cameroon
	Cape Verde
	Congo
	Côte d'Ivoire
	Democratic Republic of the Congo
	Eritrea
	Ethiopia
	Gabon
	Ghana
	Kenya
	Madagascar
	Malawi
	Mali
	Mauritania
	Mauritius
	Namibia
	Niger
	Sao Tome and Principe
	Seychelles
	Swaziland
	Uganda
	United Republic of Tanzania
	Zambia
	Zimbabwe
REGION OF THE AMERICAS	Antigua and Barbuda
	Argentina
	Bahamas
	Barbados
	Belize
	Bolivia
	Brazil
	Chile
	Colombia
	Costa Rica
	Cuba
	Dominican Republic
	Ecuador
	El Salvador
	Guatemala
	Guyana
	Haiti
	Jamaica
	Mexico
	Nicaragua
	Panama
	Paraguay
	Peru
	Suriname
	Trinidad and Tobago
	Uruguay

	Venezuela (Bolivarian Republic of)
EASTERN MEDITERRANEAN REGION	Afghanistan Bahrain Egypt Iran (Islamic Republic of) Jordan Lebanon Libyan Arab Jamahiriya Morocco Oman Pakistan Saudi Arabia Sudan Syrian Arab Republic Tunisia Yemen
EUROPEAN REGION	Albania Andorra Armenia Belarus Belgium Bulgaria Croatia Cyprus Czech Republic Denmark Estonia Finland Georgia Greece Hungary Ireland Israel Italy Kazakhstan Latvia Lithuania Netherlands Poland Portugal Republic of Moldova Romania Russian Federation Serbia and Montenegro Slovakia Slovenia Spain Sweden Switzerland Tajikistan The former Yugoslav Republic of Macedonia Turkey United Kingdom of Great Britain and Northern Ireland Uzbekistan

SOUTH EAST REGION	Bangladesh India Indonesia Myanmar Nepal Sri Lanka
WESTERN PACIFIC REGION	Australia Brunei Darussalam China (People's Republic of) Cook Islands Fiji Japan Lao People's Democratic Republic Malaysia Micronesia (Federated States of) Mongolia Niue Palau (Republic of) Philippines Republic of Korea Samoa Singapore Solomon Islands Tonga Tuvalu Vanuatu Viet Nam