

2013

ASSESSING NATIONAL CAPACITY FOR THE
PREVENTION AND CONTROL OF
NONCOMMUNICABLE DISEASES

GLOBAL SURVEY



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FOREWORD

There has never been a more opportune moment to strengthen national capacity to prevent and treat noncommunicable diseases (NCDs). In May 2013, the World Health Assembly endorsed the second *Global Action Plan for the Prevention and Control of Noncommunicable Diseases, 2013–2020*. This plan is articulated around six objectives related to NCDs and their risk factors and includes nine concrete realizable targets. Its overarching goal is that by collectively implementing the recommended actions, Member States, WHO and partners should strive to achieve a 25% reduction in premature mortality from NCDs by 2025.

As part of efforts to attain this, WHO conducts periodic monitoring of national progress in efforts to control NCDs, to help countries identify gaps in NCD prevention and control efforts, and to assist future planning.

In 2013, WHO conducted the fourth Global Country Capacity Survey (CCS) to review progress to date, identify possible gaps, highlight lessons learned, and recommend opportunities for improvement or replicability.

This report offers an overview of the situation in relation to national capacity to address NCDs and the progress made since the last review conducted in 2010. It also proposes some additional areas, not included in previous monitoring activities but related to NCDs and their risk factors, where greater focus could also help achieve progress towards the 2025 target. The report reveals that while progress has been made at country level, there is still a way to go to create the infrastructure, policies, and capacity within health systems to respond to NCDs and their contributing risk factors if we are to defy predictions and successfully halt their advance.

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EXECUTIVE SUMMARY

Noncommunicable diseases (NCDs) continue to claim too many lives too soon. It is estimated that NCDs are responsible for over 60% of global deaths, including a high percentage of deaths among people aged less than 70 years. This represents a major public health challenge for all countries, but especially for lower-middle- and low-income countries. NCDs pose a threat to economic and social development. Without concerted country-level efforts, they are predicted to increase over the next decade. Yet, NCDs are preventable and, through carefully targeted interventions, it is possible to treat or manage them among those already affected. Key to this is capacity: physical, human and at the policy level.

To assess the capacity of countries to respond to NCDs, WHO carries out periodic global country capacity surveys. The first of these was conducted in 2000. A second, intended to assess progress, was conducted in 2005 and a third was carried out in 2010. The fourth, and most recent, survey was conducted in early 2013. It was timed to coincide with the preparation by WHO of the second Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (hereafter referred to as the second Global NCD Action Plan), adopted by the World Health Assembly in May 2013 (resolution WHA66.10). The survey asked countries to provide detailed information about their capacity to address NCDs. By conducting the survey at the start of the second Global NCD Action Plan, the intention was to assess country progress since the 2010 survey in order to determine their current strengths and weaknesses in terms of NCD infrastructure, policy response, surveillance and health systems response at the beginning of the period. The overarching objective was to identify gaps in prevention and control efforts and to assist with future planning. The comparisons will also help to determine a baseline to assess progress against the Action Plan indicators agreed for the second Global NCD Action Plan. Further surveys are planned for 2015 and 2020.

The 2013 NCD Country Capacity Survey (CCS) was conducted by way of an electronic questionnaire sent to NCD focal points or designated persons within the ministry of health or a national institute or agency in all 194 WHO Member States. The survey tool included questions on (1) public health infrastructure, partnerships and multisectoral collaboration for NCDs, (2) the existence of NCD-relevant policies, strategies and action plans, (3) capacity for surveillance to address NCDs and their risk factors at national level and (4) capacity for NCD prevention, early detection, treatment and care within the health system. The survey took place between January and May 2013. Completed questionnaires received by WHO were validated against databases held by the WHO Secretariat.

In all, 92% of countries (178) responded to the survey. To assess progress, the results were compared with those of the 2010 survey. The response rate to the 2013 survey was marginally lower than that of the 2010 survey when 96% of countries (185) responded. A total of 172 countries responded to both survey rounds providing a small enough difference to permit an effective comparison and allow an accurate picture of progress to emerge. Only minimal changes were introduced to the 2013 survey instrument to ensure that such comparisons could be made. Earlier comparisons with the 2000 and 2005 surveys are limited as the survey questions changed considerably and the response rate was substantially lower in the earlier rounds.

The analysis of results revealed that in 2013 some 94% of countries had a unit, branch, division or department with responsibility for NCDs within their ministry of health. Eighty per cent (80%) of countries had at least one full-time staff member working on NCDs. Eighty-nine per cent (89%) of countries reported that funding was available for NCD health care and treatment; the same number reported having available funding

for primary prevention and health promotion. Major sources of funding included government revenues (90%), international donors (64%), health insurance (54%) and earmarked taxes on alcohol and tobacco (32%).

Seventy-eight per cent (78%) of countries reported having an integrated policy, strategy or action plan to address NCDs and/or their risk factors. However, far fewer (50%) reported that the policy, strategy or action plan was operational.

Only 25% of countries reported having an office, department or administrative division within the ministry of health dedicated to NCD surveillance. However, 78% of countries reported having a civil registration system capable of reporting NCD mortality. Although 80% of countries reported having a cancer registry, only 35% of countries reported that this was nationally representative and population-based. Overall, the prevalence of countries having conducted risk factor surveys was high (>75%), although the prevalence of countries having conducted population-based risk factor surveys was considerably lower (two thirds or less for the various risk factors, with the exception of tobacco use at 75%).

Ninety-four per cent (94%) of countries provided primary prevention and health promotion within the primary health-care system, while 88% offered risk factor detection and 85% offered risk factor and disease management. Fewer countries offered support for self-help and self-care (75%) and support for home-based care (67%); only 44% offered rehabilitation services within their primary health-care systems.

While the majority of countries reported having evidence-based guidelines, protocols or standards available for the management of diabetes (84%), cardiovascular diseases (76%) and cancer (73%), only one third or fewer countries reported having fully implemented guidelines for each of these conditions.

The majority of countries reported having essential medicines for the management of diabetes, hypertension, chronic respiratory diseases and cardiovascular disease generally available in the public health sector. However, nicotine replacement

therapy was only generally available in 40% of countries.

While most high-income countries reported having capacity (tests and procedures as well as trained staff generally available) for detecting a range of cancers including cervical cancer, breast cancer, and colon cancer, as well as raised total cholesterol, only two thirds or fewer of low-income countries reported having such procedures available.

Similarly, while the majority of high-income countries had chemotherapy and radiotherapy generally available, fewer than one quarter of low-income countries had these available. A similar pattern emerged for the treatment of end-stage kidney disease (generally available in nearly all high-income countries but in only 24% of low-income countries). The pattern was also similar for coronary bypass procedures or the insertion of stents, where fewer than 10% of low-income countries reported having these available compared with over 90% of high-income countries.

Where possible, the report includes comparisons with the results of the 2010 NCD CCS survey, to illustrate progress. Where comparisons are explicitly made, these are among the 172 countries that participated in both surveys.

The 2013 NCD CCS revealed that challenges in addressing NCDs at the national level included: gaps in infrastructure; disparities between the existence of policies and operational plans to address NCDs and their implementation; weak population-based surveillance and inadequate funding for surveillance; gaps in health systems related to NCD service provisions; and weaker capacity among low- and lower-middle-income countries, with low-income countries having very weak capacity. Opportunities revealed by the survey included widespread recognition of the importance of addressing NCDs; existence of policies, plans and strategies to address NCDs; availability of funding and diversified funding sources; improvements in country capacity across the board; increased surveillance; and new and diverse platforms for communicating as part of efforts to influence and encourage sound health behaviours.

CLEAR PRIORITIES FOR ACTION WERE IDENTIFIED, AND INCLUDED THE FOLLOWING:

1

Existing NCD infrastructure needs to be used more effectively.

2

Existing policies need to be funded, implemented, and improved.

3

Greater investment is needed in population-based surveillance to build on existing surveillance systems.

4

Further development is needed of evidence-based national guidelines, protocols or standards for managing NCDs.

5

New and innovative funding solutions need to be sought.

6

Greater focus is needed on strengthening capacity in low- and lower-middle-income countries.

INTRODUCTION

Noncommunicable diseases (NCDs) – cardiovascular diseases, diabetes, cancers and chronic respiratory diseases – continue to claim too many lives too soon and to compromise human and economic development (1, 2). It is estimated that NCDs are responsible for sixty-three per cent (63%) of all deaths worldwide (i.e. 36 million of the 57 million global deaths). Nearly eighty per cent (80%) of NCD deaths (28 million) occur in low- and middle-income countries (3). Nine million deaths among people aged less than 70 years are attributed to NCDs.

Yet, NCDs are preventable, and with adequate care it is possible to manage treatment of NCDs to mitigate their impacts among those already affected. Research has shown that effective interventions aimed at tackling major NCD risk factors – tobacco use, unhealthy diets, lack of physical activity, and harmful use of alcohol – are key to prevention.

WHO conducts periodic global Country Capacity Surveys (CCS) to assess individual country capacity for NCD prevention. A first survey was conducted in 2000. This was followed by a second survey in 2005, with a third carried out in 2010; the latest survey was conducted in 2013. Future surveys are planned for 2015 and 2020. These surveys are intended to help countries assess their strengths and weaknesses related to NCD infrastructure, policy response, surveillance, and health systems response to address NCDs at national level.

The results of the 2010 NCD Country Capacity Survey (CCS) were provided as background information to inform the United Nations (UN) High-Level Meeting on Noncommunicable Disease Prevention and Control that took place in New York in September 2011. The outcome of this UN High-Level Meeting was the adoption by the United Nations General Assembly of a Political Declaration in which Member States were called upon to take action by setting national targets, developing national plans and implementing proven interventions to prevent,

control and monitor NCDs. At the same time, WHO was tasked with drafting a *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (4) (hereafter referred to as the second *Global NCD Action Plan*). This second *Global NCD Action Plan*, endorsed by the World Health Assembly in May 2013, is articulated around six objectives and based on 25 outcome indicators that are related to nine concrete targets to be achieved by 2025. Furthermore, the WHO Secretariat, in consultation with Member States and other relevant stakeholders, developed a set of nine action plan indicators to inform reporting on progress of the implementation of the second *Global NCD Action Plan*. The intended goal is that by collectively implementing the actions included in the second *Global NCD Action Plan*, Member States, WHO and partners should strive to achieve a 25% reduction in premature mortality from NCDs by 2025. (Details are shown in Box 2 and Box 3)

To coincide with the start of the period for the second *Global NCD Action Plan*, it was decided that a fourth Global Country Capacity Survey (CCS) should be undertaken between January and May 2013 to provide a baseline. This survey sought to assess individual country capacity for responding to NCDs – cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes – in order to guide Member States, WHO Regional Offices, WHO Headquarters and other stakeholders in planning future actions and technical assistance required to address NCDs.

This report seeks to summarize the results of the NCD CCS of 2013 and, where possible, compare these with the results of the NCD CCS of 2010 to assess progress, and identify limitations and challenges for national capacity for the prevention and control of NCDs. The findings will also be used as a baseline to inform progress against the indicators for the second *Global NCD Action Plan*.

METHODS

Overview

An electronic questionnaire was sent to the NCD focal points or designated colleagues within the ministry of health (MOH) or a national institute or agency in all WHO Member States (194 countries). The survey took place from January to May 2013.

In order to ensure completeness of information, the instructions requested that a team of respondents, led by a focal point or survey coordinator and including topic-specific experts, complete the survey to ensure detailed assessment. For most questions, the survey tool included a "Don't know" option among the responses. The instructions further requested that where a respondent ticked several "Don't knows", another respondent, with greater awareness of the information, be asked to complete the section.

Upon receipt of the completed questionnaires, the secretariat carried out additional validation on a number of survey item responses. The existence of a cancer registry, for example, was validated against the

IARC GLOBOCAN database, which holds information on recognized cancer registries. Responses related to the collation of mortality data were checked against information on vital registration systems held within WHO in the Department of Health Statistics and Informatics. Information on recent NCD risk factor surveys was checked against the WHO Global InfoBase and the internal survey tracking systems for WHO-supported risk factor surveys. These included WHO STEPS (adult risk factor surveillance), the Global School-based Student Health Survey (GSHS), and the Global Youth Tobacco Survey (GYTS) held in WHO's Prevention of Noncommunicable Diseases Department. Responses were also checked for consistency against those provided in the 2010 survey.

Where discrepancies were noted between the country response and these other sources, a clarification request was returned to the country for their consideration and an updating of their response. In most cases, an amended version of the survey instrument was returned.

Questionnaire

Questions for the 2013 survey were developed through a series of technical meetings with international experts and consultation of WHO at all levels. The questions were developed in a manner intended to obtain objective information, rather than opinions, about adequacy of capacity and were reviewed in relation to the development of the objectives of the second Global NCD Action Plan. Questions that yielded valuable data and information in the 2010 survey were retained, while question wording remained unchanged to enable comparison.

The 2013 questionnaire was divided into four modules, each set up as a separate worksheet within a single electronic Microsoft Excel questionnaire tool. (The full questionnaire is included as Annex 3.) The four modules comprised: infrastructure; policies and programmes;

information and surveillance; and health systems capacity. The 2010 survey included an additional fifth module: partnerships and collaboration, which, in the 2013 survey tool, was merged into Module I: Public health infrastructure, partnerships and multisectoral collaboration for NCDs.

The survey included a set of detailed instructions on how to complete the questionnaire and a glossary defining the terms used in the survey instrument (Box 1 and Annex 4).

Specific components of the questions were as follows:

- **Module I:** The infrastructure component included questions relating to the presence of a unit or division in the ministry of health dedicated

to NCDs, staffing and funding, and whether other institutes, agencies, or other government departments conducted NCD prevention and control functions. In a departure from the 2010 survey tool, this module included questions on the availability of funding for early detection and screening of NCDs, capacity-building and rehabilitation services. The module also included a section on the existence of fiscal interventions (e.g. taxation on alcohol or tobacco) as incentives to influence health behaviours and/or to raise funds for health-related activities. Focusing on partnerships and collaboration, and in line with the second Global NCD Action Plan, the survey tool also asked about the existence of a formal and/or operational multisectoral mechanism to coordinate NCD policies. Finally, questions on settings for NCD collaborations and partnerships were included and, in particular, whether these covered schools and workplaces.

- **Module II:** The policy component included questions relating to the presence of policies, strategies, or action plans (Box 1). As in 2010, the questions differentiated between integrated policies/strategies/action plans that addressed several risk factors or diseases, and policies/strategies/action plans that addressed a specific disease or risk factor.

In a further departure from the 2010 survey tool, the 2013 questionnaire asked more detailed questions on the existence of policies for reducing the impact on children of marketing of foods and non-alcoholic beverages with a high trans-fat sugar or salt content, as well as the existence of policies aimed at limiting fatty acids and trans-fats in industrially-produced foods. This module additionally included questions on policies aimed at encouraging breastfeeding and the International Code of Marketing of Breast-milk

Substitutes (ICM). Ministries of health were asked to name the policies (and provide a web URL if possible) and indicate if the plans were currently in operation.

- **Module III:** The surveillance component asked questions relating to the mortality, morbidity and risk factor reporting systems of each country and whether NCD mortality, morbidity and risk factor data were included in their national health reporting systems (Box 1). Additionally, under "Risk Factor Surveillance", for the first time the 2013 survey tool included questions specifically related to salt/sodium intake.
- **Module IV:** The health-care systems component asked countries to assess their health systems' capacity related to NCD prevention, early detection, and treatment and care within the primary health-care sector. Specific questions focused on availability of guidelines or protocols to treat major NCDs, and the tests, procedures and equipment related to NCDs within the health-care system. For the first time since the survey process began in 2000, the 2013 questionnaire asked about the existence of rehabilitation services for NCDs in primary health care.

In addition to the standardized questionnaire, the survey tool used in the African Region also included region-specific questions.

Although the 2013 survey included additions, the questions in both 2010 and 2013 survey tools were similar enough to allow an effective comparison.

The questionnaire was translated into Spanish, French and Russian to facilitate completion in all countries. Where possible, completed questionnaires were submitted to the relevant ministry of health senior officials for approval before submission to WHO.

Analysis

Data were automatically extracted from the country questionnaires using Microsoft Excel and compiled into regional and global databases. Data cleaning was performed to ensure consistency with responses within a question and its sub-questions. All statistical analyses, including analysis by WHO region and World Bank

income groups (2013 groupings, see Annex 2), were carried out using STATA 11 software (Stata Corporation, 2009). All data cleaning, extraction and analysis were performed at WHO Headquarters.

For all analyses, the denominator used was the total

number of responding countries, either overall or within the subgroup of interest. To avoid fluctuating denominators, percentages reported were based on the positive responses from countries to the survey items. Non-positive responses (i.e. "No", "Don't

know", and items left unanswered) were treated equally. Trends in national capacity for NCDs were derived from comparing the results of the 2013 survey with those from the capacity survey conducted in 2010 by WHO.

BOX 1:

Key definitions used in the 2013 global Country Capacity Survey for NCDs

Capacity:

The ability to perform appropriate tasks effectively, efficiently and sustainably.

Fiscal interventions:

Measures taken by the government, such as taxes and subsidies.

International Code of Marketing of Breast-milk Substitutes:

An international health policy framework for breastfeeding promotion adopted by the World Health Assembly in 1981. The policy recommends restrictions on the marketing of breast-milk substitutes, such as infant formula, to ensure that mothers are not discouraged from breastfeeding and that substitutes, if needed, are used safely.

Multisectoral collaboration:

A recognized relationship between parts of, or different sectors of, society (such as ministries [e.g. health, education], agencies, non-government agencies, private for-profit sector and community representation) which has been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

Multisectoral collaboration:

A recognized relationship between parts of, or different sectors of, society (such as ministries [e.g. health, education], agencies, non-government agencies, private for-profit sector and community representation) which has been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

National focal point, unit or department:

the person, unit or department responsible for prevention and control of NCDs in a ministry of health or national institute.

National health reporting system:

The process by which a ministry of health produces annual health reports that summarize data on, for example, national health human resources, population demographics, health expenditures, health indicators such as mortality and morbidity. This includes the process of collecting data from various health information sources such as disease registries, hospital admission or discharge data.

National integrated action plan:

A concerted approach to addressing a multiplicity of issues within a NCD prevention and health promotion framework, targeting the major risk factors common to the main NCDs, including the integration of primary, secondary and tertiary prevention, health promotion and disease prevention programmes across sectors and disciplines.

National policy, strategy, action plan or programme:**Policy:**

A specific official decision or set of decisions designed to carry out a course of action endorsed by a political body, including a set of goals, priorities and main directions for attaining these goals.

Strategy: a long-term plan designed to achieve a particular goal. Action plan: A scheme of course of action, which may correspond to a policy or strategy, with defined activities indicating who does what (type of activities and people responsible for implementation), when (time frame), how, and with what resources, to accomplish an objective. Programme: A planned set of activities or procedures directed at a specific purpose.

Operational:

A policy, strategy or plan of action which is being used and implemented in the country, and has resources and funding available for its implementation.

Partnership for health:

An agreement between two or more partners to work cooperatively towards a set of shared health outcomes.

Rehabilitation:

A set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments. Rehabilitation services: Include rehabilitation medicine, therapy and assistive technology.

Sample registration system:

A method and procedure for estimating vital statistics in national and regional populations by intensively registering and verifying vital events in population samples; one that provides a reliable picture of the national pattern of vital events at a cost that is feasible and reasonable.

Self-regulation:

In this context refers to when a group or private sector entity governs or polices itself without outside assistance or influence.

The results were examined in relation to the objectives and key recommendations made to Member States in the second *Global NCD Action Plan* (Box 2). Emphasis was placed on identifying positive aspects of capacity and where progress had been made, as well as on

identifying challenges. Going forward, the findings will be used to inform progress towards the nine targets (Box 3) to be achieved by 2025 to reduce by 25% premature deaths from NCDs.

BOX 2:

Key objectives of the second WHO *Global NCD Action Plan 2013–2020*

Objective 1.

To raise the priority accorded to the prevention and control of noncommunicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.

Objective 3.

To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments.

Objective 5.

To promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases.

Objective 2.

To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of noncommunicable diseases.

Objective 4.

To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage.

Objective 6.

To monitor noncommunicable diseases and their determinants, and evaluate progress at national, regional and global levels.

BOX 3:

Nine global voluntary targets to be achieved to reduce by 25% premature deaths



RESULTS

RESPONSE RATE

In total, 178 Member States (92%) responded to the survey (a list of participating countries by region can be found in Annex 1). This was slightly lower than the completion rate for the 2010 survey questionnaire, where 185 Member States (96%) responded. In total, 172 countries responded to both the 2010 and 2013 NCD CCS questionnaires.

In 2013, the Eastern Mediterranean Region and the Western Pacific Region both had a response rate of 100%; the European Region had a response rate of 96% and the Region of the Americas 91%. The African Region had a lower response rate at 79%;

this represented a decrease from 2010 when the rate was 100%. Across income categories, low-income countries had the lowest rate of response in 2013. The generally high rate of response across all regions, however, meant that there was good representation of all countries. (The response rates by WHO region are shown in Table 1.)

The high rate of response to both questionnaires was sufficient to offer a global picture of progress in efforts to prevent, contain and manage NCDs. Where explicit comparisons are provided (Table 1), these are based on the 172 respondents of both surveys.

TABLE 1:

Comparison of response rate by WHO region 2010–2013*

Region	Total number of countries (2013)**	Number of responding countries	Response rate (2010)	Number of responding countries (2013)	Response rate (2013)	Increase/decrease**
AFR	47	46	100%	37	79%	⬇️
AMR	35	29	83%	32	91%	⬆️
EMR	21	21	100%	21	100%	⚖️
EUR	53	51	96%	51	96%	⚖️
SEAR	11	11	100%	10	91%	⬇️
WPR	27	27	100%	27	100%	⚖️
Total	194	185	96%	178	92%	

*In total 172 countries responded to both the 2010 and 2013 questionnaires.

**Between 2010 and 2013 South Sudan joined the community of nations bringing the number of WHO Member States to 194.

MODULE I. ASPECTS OF NCD INFRASTRUCTURE

Countries were asked about the existence of a unit, branch or department in their ministry of health with responsibility for NCDs. Additionally, they were

asked about staff capacity and availability of funding and funding mechanisms.

Unit, branch or department responsible for NCDs

Ninety-four per cent (94%) of countries reported the existence of a unit, branch or department with responsibility for NCDs in their ministry of health (Table 2).

Meanwhile, income grouping was shown not to be an obstacle to the presence of such a unit: 97% of low-income countries and 98% of lower-middle-income countries responded in the affirmative.

One hundred per cent (100%) of countries in the South-East Asia Region reported having such a unit.

94%

Ninety-four per cent of countries reported the existence of a unit, branch or department with responsibility for NCDs in their ministry of health, including 98% of lower-middle-income countries and 97% of low-income countries.

TABLE 2:

Percentage of countries with units, branches or departments within the ministry of health (or equivalent) with responsibility for NCDs in 2013

	Percentage of countries	
WHO region	AFR	97
	AMR	94
	EMR	90
	EUR	92
	SEAR	100
	WPR	96
	World Bank income category	Low-income
Lower-middle-income		98
Upper-middle-income		90
High-income		95
All	94	

Comparison with the 2010 survey

When considering figures for the 172 countries that responded to both the 2010 and 2013 surveys, some progress has been made: 89% of countries reported having a unit, branch or department in the ministry of health with responsibility for NCDs in 2010, compared

with 95% in 2013. Similarly, when reviewed by income group, 82% of low-income countries reported having such a unit or branch in 2010, compared with 96% in 2013. This was the largest increase for any income group.

Full-time staff members working on NCDs

Eighty per cent of countries (80%) reported having at least one full-time staff member working on NCDs, indicating that 14% of countries had a unit for NCDs in their ministry of health, but no full-time staff member dedicated to NCDs. Ninety-two per cent (92%) of respondents from the African Region reported having a full-time staff member

working on NCDs. Interestingly, a higher percentage of respondents from low-income countries (86%) and lower-middle-income countries (84%) indicated the presence of at least one full-time staff member working on NCDs than from upper-middle-income countries (75%) and high-income countries (80%).

Funding mechanisms



FUNDING FOR NCD HEALTH CARE AND TREATMENT, PRIMARY PREVENTION AND PROMOTION

Eighty-nine per cent (89%) of countries reported available funding for NCD health care and treatment and for NCD primary prevention and health promotion.

A higher percentage of countries in the Region of the Americas, the European Region, the South-East Asia Region and the Western Pacific Region reported having funding for various NCD activities or functions (Figure 1a); while the figures were highest for these in upper-middle-income and high-income countries (Figure 1b).



FUNDING FOR NCD HEALTH CARE AND TREATMENT, PRIMARY PREVENTION AND PROMOTION

The prevalence of funding for surveillance, monitoring and evaluation was comparably lower overall (74%) and was particularly low in the African Region (49%) and Eastern Mediterranean Region (48%). Funding for surveillance, monitoring and evaluation was also considerably less prevalent in the low- and lower-middle-income countries (60%) as compared to the upper-middle- and high-income countries (84%).

Comparison with the 2010 survey

When comparing figures for the 172 countries that responded to both the 2010 and 2013 surveys, progress has been made, with 81% of countries in 2010 reporting available funding for NCD prevention and health promotion compared with 88% in 2013.

iii

FUNDING FOR EARLY DETECTION AND SCREENING OF NCDs

The 2013 survey tool additionally included questions on available funding for early detection and screening of NCDs, with 84% of countries reporting they had such funding available. While prevalence was greatest in the Region of the Americas (94%), the European Region (94%), the South-East Asia Region (90%) and the Western-Pacific Region (93%), nearly two thirds of countries in the African Region (59%) and three quarters of countries in the Eastern Mediterranean Region (76%) reported having available funding. Meanwhile, 59% of low- and 74% of lower-middle-income countries reporting available funding for early detection and screening compared with 94% of upper-middle- and 96% of high-income countries.

iv

FUNDING FOR CAPACITY-BUILDING FOR NCD FUNCTIONS

Across all countries, only 74% reported available funding for capacity-building. Eighty per cent (80%) of countries in the European Region and the South-East Asia Region reported such available funding, a percentage that rose slightly for the Western Pacific Region to 81%. Meanwhile, the prevalence of funding for capacity-building was not markedly different across the African Region (68%), the Region of the Americas (69%) and the Eastern Mediterranean Region (67%).

v

FUNDING FOR REHABILITATION SERVICES

The availability of funding for rehabilitation services was moderately low across all regions with only 64% of countries surveyed reporting having such funding. At the higher end, 80% of countries in the European Region reported available funding for these services, while, at the lower end, only 43% of countries in the African Region reported funding for this purpose. When considered across income groupings, only 38% of low-income countries and 49% of lower-middle-income countries had available funding. The percentages rose to 73% for upper-middle-income countries and 82% for high-income countries.

vi

ABSENCE OF FUNDING

In the 2013 survey, 6% of countries (i.e. 10 countries) reported having no funding stream for NCD activities. The African Region and the Eastern Mediterranean Region were the most disadvantaged, each with 14% of countries receiving no funding. There was a significant drop in availability of funding for NCD activities in low-income countries (18% with no funding) compared with lower-middle-income (7%) or upper-middle- and high-income countries (2%).

Comparison with the 2010 survey

If the figures are considered for the 172 countries that responded to both the 2010 and the 2013 survey, there are signs of progress. In 2010, 19 countries (11%) reported no funding stream for NCD activities. The African Region showed similar improvement, with 32% of countries reporting receiving no funding for

NCDs in 2010 versus only 14% in 2013. Progress was also made in low-income countries with 36% of countries in this income grouping receiving no funding for NCD prevention and control in 2010 compared with 18% in 2013.

FIGURE 1:

Percentage of countries with funding for NCD activities, by function, 2013

a) By WHO region



b) By World Bank income group



Funding sources

The survey asked countries to describe their sources of funding for NCD activities. In decreasing order of prevalence, the following were among the main sources of funding for NCDs in 2013:

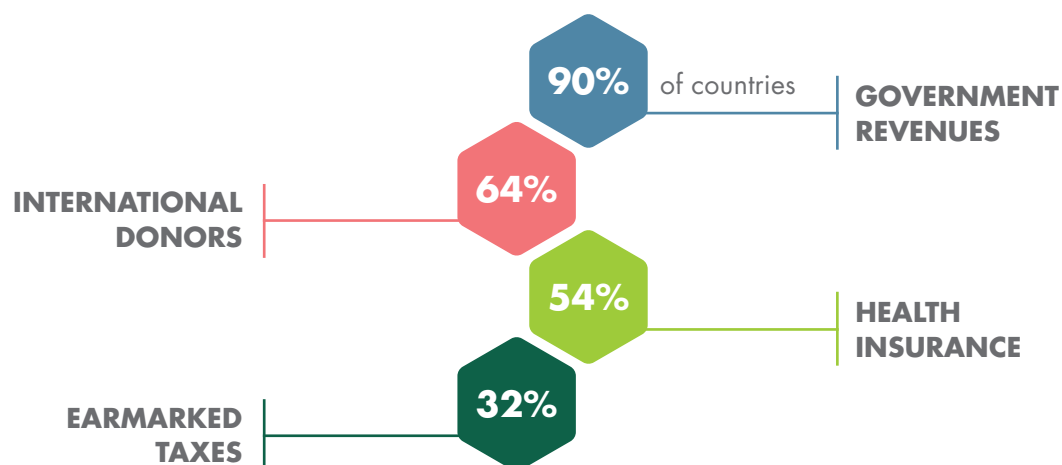


TABLE 3:

Major funding sources for NCDs in 2013

FUNDING SOURCES FOR NCDs
(Percentage of countries with funding source)

		General government revenues	Health insurance	International donors	Earmarked taxes on alcohol, tobacco, etc.	Other
WHO region	AFR	76	30	73	16	19
	AMR	100	78	69	41	16
	EMR	86	43	62	33	14
	EUR	96	73	49	35	25
	SEAR	90	50	90	50	10
	WPR	93	37	67	30	15
World Bank income group	Low-income	66	28	76	10	14
	Lower-middle-income	91	44	88	40	28
	Upper-middle-income	96	61	73	41	14
	High-income	98	71	31	29	18
ALL		90	54	64	32	19

As illustrated in Table 3, low-income countries reported receiving less funding from all sources: 66% of low-income countries received government revenues compared to more than 90% of countries in other income groups. Although the percentage of low-income countries receiving funds from health insurance had progressed to 28% in 2013, this still remained markedly lower than that of countries in other income groups.

Thirty-two per cent of countries (32%) reported using earmarked taxes to fund NCDs. The percentage of African countries using earmarked taxes on alcohol and tobacco remained low at 16%. Similarly, only 10% of low-income countries received earmarked taxes compared with 29% in high-income countries and 40% in lower-middle- and upper-middle-income countries. In 2013, a smaller percentage of low-income countries (76%) reported receiving donor funds relative to lower-middle income countries (88%).

Comparison with 2010 survey

A comparison of the 172 countries that responded to questions in both surveys revealed improvements in funding sources since 2010, with figures showing the following: government revenues, 85% of countries in 2010, versus 91% in 2013; international donors, 55% in 2010, versus 63% in 2013; health insurance, 41% in 2010, versus 53% in 2013; and earmarked taxes, 21% in 2010, versus 33% in 2013. The overall order of prevalence of funding sources remained the same. There were some variations in the order of prevalence of sources within the different regions.

The percentage of low-income countries receiving funds from international donors increased from 57%

in 2010 to 75% in 2013. Similarly, there was an increase in the percentage of countries that reported using earmarked taxes to fund NCDs: 20% in 2010 versus 33% in 2013. Although, the percentage of countries using earmarked funds remained particularly low in the African Region (16%), compared with 30% and more in other regions, the percentage of countries using earmarked funds increased across all other regions. The increase was marginal in high-income countries: 26% in 2010 versus 30% in 2013, but more pronounced in lower-middle- and upper-middle-income countries, where 41% of countries use earmarked funds compared with 23% in 2010.

Fiscal interventions

The 2013 survey tool included questions on fiscal policies and interventions in place to tackle NCD risk factors (Figure 2). These included items such as **taxes on alcohol and tobacco; taxation of high sugar**

content food and non-alcoholic beverages; taxation on high-fat foods; price subsidies for healthy foods; and tax incentives to promote physical activity.



TAXATION ON TOBACCO AND ALCOHOL

Eighty-five per cent of countries (85%) reported having taxes on tobacco. These included 70% of countries in the African Region, 81% of countries in the Eastern Mediterranean Region and the Western Pacific Region, and 90%, or higher, of countries in the Region of the Americas, the European Region and the South-East Asia Region.

Similarly, 76% of countries reported taxation on alcohol. Here, differences in prevalence among the different geographical regions were more marked – the likely outcome of different cultural and religious belief systems. Forty-eight per cent (48%) of countries in the Eastern Mediterranean Region, for example, reported taxation on alcohol whereas 63% of countries in the Western Pacific Region, 65% of countries in the African Region and 78% of countries in the Region of the Americas reported levying such taxes. Thereafter figures

rose to 90% of countries in the South-East Asia Region with a high of 98% of countries in the European Region. When taken across income groupings, figures on alcohol taxation ranged from 59% of low-income countries and 72% of lower-middle-income countries to 76% of upper-middle-income countries, and 87% of high-income countries.

ii

TAXATION ON FOODSTUFFS AND NON-ALCOHOLIC BEVERAGES

Far fewer countries reported other fiscal interventions and policies. Only 11% of countries reported **taxation on high sugar content food** and **non-alcoholic beverages** and only 3% reported **taxation on high-fat foods**. When examined across the different geographical regions or when compared across the different income groupings, no significant discrepancies or differences emerged with all percentages remaining low.

ONLY **11%**

of countries reported taxation on high sugar content food and non-alcoholic beverages, and only 3% reported taxation on high-fat foods.

iii

SUBSIDIES FOR HEALTHY FOODS

Only 7% of countries reported **price subsidies for healthy foods**. The region with the largest percentage of countries reporting price subsidies for healthy foods was the Region of the Americas, although here the figure was only 19%. This was followed by the Western Pacific Region where 11% of countries reported such price subsidies. Meanwhile, no countries in the Eastern Mediterranean Region or the South-East Asia Region reported the existence of such subsidies. When considered in terms of income groupings, no countries in the low-income category reported the existence of price subsidies for healthy foods, while only 9% of lower-middle- and high-income countries reported such subsidies. This is a key area where there is scope for progress.

iv

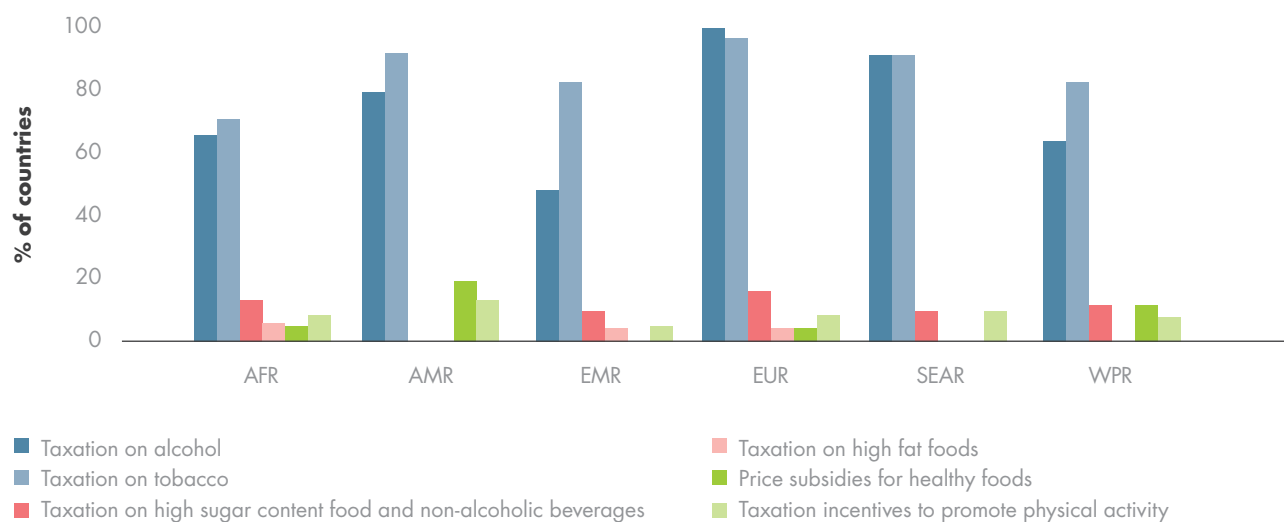
INCENTIVES TO PROMOTE PHYSICAL ACTIVITY

Only 8% of countries reported tax incentives **to promote physical activity**. Such incentives might include tax exemptions or rebates on sports equipment or fitness programmes and gym memberships. Alternatively, they may include higher taxation on items that encourage sedentary lifestyles, such as home entertainment equipment.

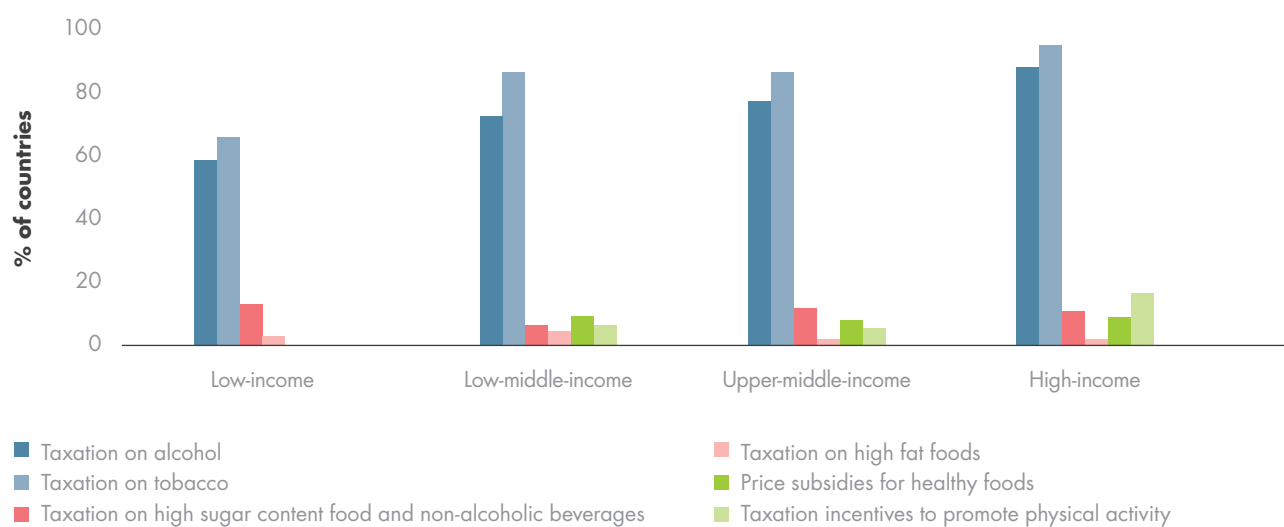
The region with the highest percentage of tax incentives was the Region of the Americas where 13% of countries reported such incentives. This was followed by the South-East Asia Region (10%), the African Region and the European Region (both 8%), the Western Pacific Region (7%), and the Eastern Mediterranean Region (5%). When examined in terms of income grouping categories, the highest percentage of countries with tax incentives to promote physical activity was the high-income category where 16% of countries had such incentives. No low-income countries (0%) had such incentives.

FIGURE 2:
Fiscal interventions to address NCD risk factors, 2013

a) By WHO region



b) By World Bank income group





MOTIVATION FOR FISCAL INTERVENTIONS

In answer to questions on motivations for fiscal interventions, 39% of countries responded that such policies and interventions were intended to raise general revenues, with 34% of countries responding that they were intended to influence health behaviour. **Only 6% of countries responded that these interventions were intended to raise funds for health, with 5 of the 11 countries in the lower-middle-income grouping.**

ONLY 6% of countries – mainly lower-middle-income – reported using fiscal interventions to raise funds for health programmes.

Collaborative arrangements

Countries were asked about collaborative arrangements for implementing key activities related to NCDs. Such arrangements include cross-ministerial collaboration, collaboration with UN bodies, or agreements and partnerships with nongovernmental organizations (NGOs) and civil society organizations and the private sector.



INSTITUTIONAL COLLABORATION

Eighty-four per cent (84%) of countries reported having some form of partnership or collaboration for implementing key activities related to NCDs with most countries (74%) reporting collaborations at the national government level in the form of a cross-departmental or ministerial committee. Fewer countries had interdisciplinary committees (66%) or joint task forces (52%). Collaborations with other, non-health government ministries were also common (79% of countries). Meanwhile, 66% of countries reported collaboration with UN agencies, while 76% of countries reported collaboration with academia. Nongovernmental organizations, community-based organizations and civil society together formed a stakeholder in the partnerships or collaborations in the majority of countries (80%). Private sector entities were the least common stakeholder (57%), although they were more common as stakeholders in upper-middle-income and high-income countries (68%) than in lower-middle-income (44%) and low-income countries (34%).



NCD CONDITIONS AT THE CENTRE OF COLLABORATIVE ARRANGEMENTS

In order of magnitude, collaborations most often addressed diabetes (81% of countries), tobacco use (79%), cancer (78%), unhealthy diet (75%), physical inactivity (75%), harmful use of alcohol (72%), overweight and obesity (71%) and hypertension (71%). Chronic respiratory diseases (58%) and abnormal blood lipids (48%) were the least common areas for collaborations. With a few minor variations, these figures were similar to those obtained from the 2010 survey.

Across all countries, schools provided the most common setting for partnerships and collaborations (76% of countries), followed by workplaces (66%), and cities (63%). The same pattern was observed across income groupings, with the prevalence being highest in the high-income group and decreasing in each successive income group.



EXISTENCE AND OPERATIONALIZATION OF COORDINATION MECHANISMS

In line with the development of the second Global NCD Action Plan, the 2013 survey tool also included questions on the existence and operationalization of a formal multisectoral mechanism to coordinate NCD policies (Figure 3). Overall, 61% of countries reported the existence of such a formal mechanism; the South-East Asia Region had the highest percentage of countries (80%), and the African Region the lowest (51%). The range did not vary greatly across income-category groupings.

In response to questions on whether the mechanism was operational, only 33% of countries reported the existence of an operational mechanism. Again, the region with the highest percentage of countries reporting this was the South-East Asia Region (40%); the African Region (24%) had the lowest. When viewed across income-group categories, the high-income grouping had the highest percentage of countries with an operational mechanism (44%), while the lowest percentage (23%) was in the lower-middle income category.

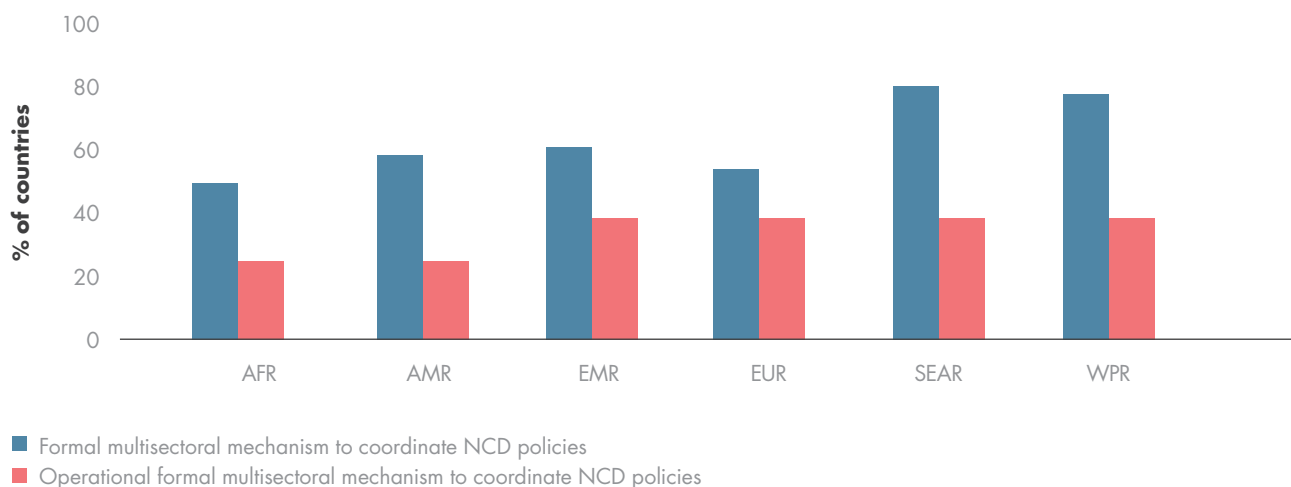
61%

Sixty-one per cent of countries reported the existence of a formal multisectoral mechanism to coordinate NCD policies, however only 33% of countries reported that the mechanism was operational.

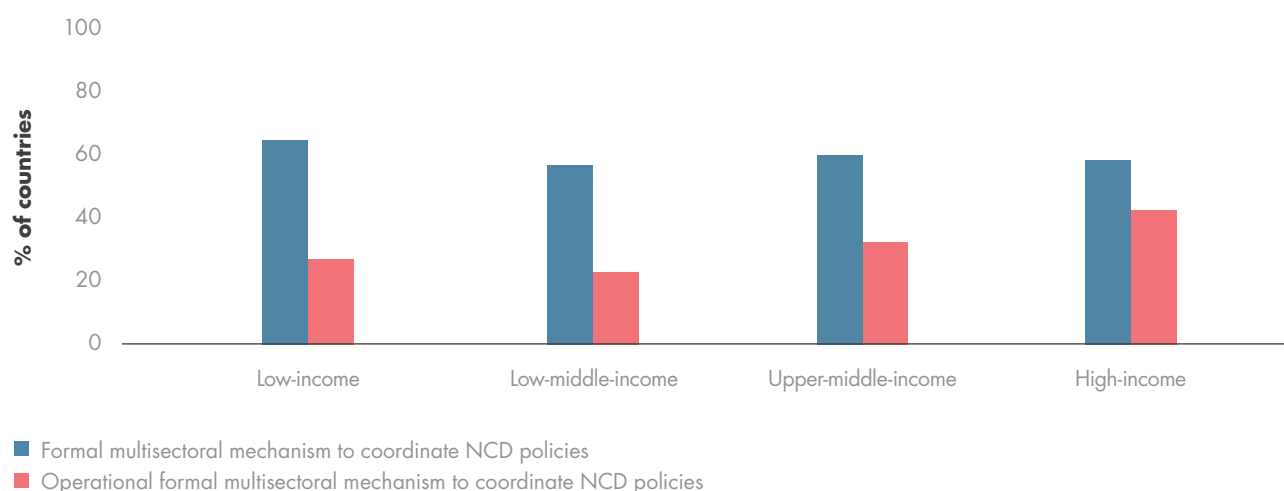
FIGURE 3:

Percentage of countries with formal multisectoral mechanism to coordinate NCD policies versus countries with an operational mechanism, 2013

a) By WHO region



b) By World Bank income grouping



MODULE II. POLICIES, PLANS AND STRATEGIES

The 2013 questionnaire sought to uncover whether countries had policies to address major NCDs and their risk factors and whether or not these policies existed only on paper or were operational. In addition, the survey

looked to identify whether countries had in place policies to encourage breastfeeding among women of child-bearing age as well as implementation of the International Code of Marketing of Breast-milk Substitutes (ICM).

Policies addressing the major NCDs and/or their risk factors

In consultation with Member States and other relevant partners, the WHO Secretariat developed a set of nine action plan indicators to inform reporting on progress of the implementation of the second *Global NCD Action Plan*. The 2013 CCS tool included questions intended to assess countries' current preparedness in relation to these indicators and the progress required. One of the action plan indicators assessed by the current survey was: "Number of countries with at least one operational multisectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors in conformity with the global and regional NCD action plans 2013–2020". While 78% of countries reported they had developed an integrated policy, plan or strategy that addressed at least one NCD and/or their risk factors, only 50% of countries had an operational integrated policy, plan or strategy. Furthermore, only 76 countries (43%) specifically met the aforementioned action plan indicator.

The overall percentage of countries with a policy, plan or strategy for each NCD or risk factor is shown in Table 4. For every NCD and risk factor – except for chronic respiratory disease – three quarters or more of all countries had a policy, plan or strategy. For chronic respiratory disease, only 58% reported having such a policy. However, when taking into consideration whether or not the reported policies, plans or strategies were operational, the prevalence dropped considerably. While two thirds of countries had an operational policy, plan or strategy for tobacco use and cancer, only 50–60% of countries reported an operational policy, plan or strategy for the other risk factors or conditions, except for chronic respiratory diseases, for which operational policies, plans or strategies were even less prevalent (38%). It is important to note that the figures shown in Table 4 inform for four additional action plan indicators.¹

TABLE 4:

Percentage of countries with a policy, plan or strategy addressing the major NCDs and/or their risk factors, 2013

	% of countries with a policy, strategy or action plan	% of countries with an operational policy, strategy or action plan
Tobacco use	92	69
Cancer	85	65
Diabetes	84	59
Unhealthy diet	84	60
Cardiovascular disease	82	55
Physical inactivity	80	56
Overweight and obesity	76	55
Harmful use of alcohol	76	52
Chronic respiratory disease	58	38

The picture by WHO region and income group was more complex (Figure 4). The percentage of countries reporting having policies, plans or strategies for NCDs and/or their risk factors was generally lowest in the African Region, with the exception of harmful use of alcohol, which was even lower in the Eastern Mediterranean Region (73% of countries in the African Region, relative to 33% of countries

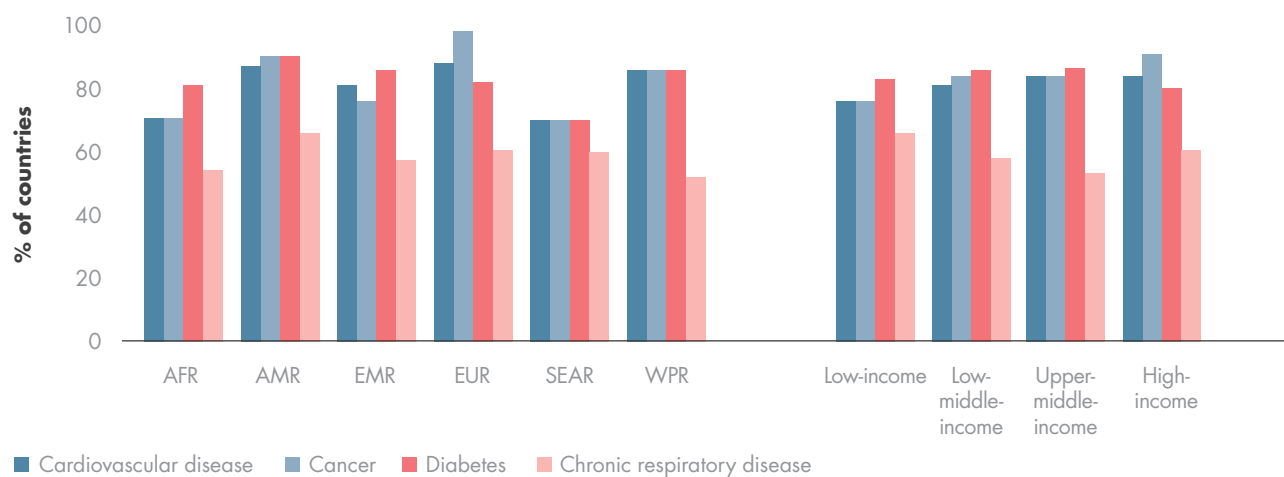
in the Eastern Mediterranean Region). In contrast, the Region of the Americas, the Western Pacific Region and the European Region generally had the highest percentage of countries with policies, plans or strategies. Not surprisingly, there was a general increase in prevalence in policies, plans or strategies with increasing income category, with the exception of chronic respiratory diseases (Figure 4).

These indicators are: i) "Number of countries with an operational policy, strategy or action plan, to reduce the harmful use of alcohol, as appropriate within the national context"; ii) "Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity"; iii) "Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets"; and iv) "Number of countries with an operational policy, strategy of action plan in line with the WHO Framework Convention on Tobacco Control, to reduce the burden of tobacco use".

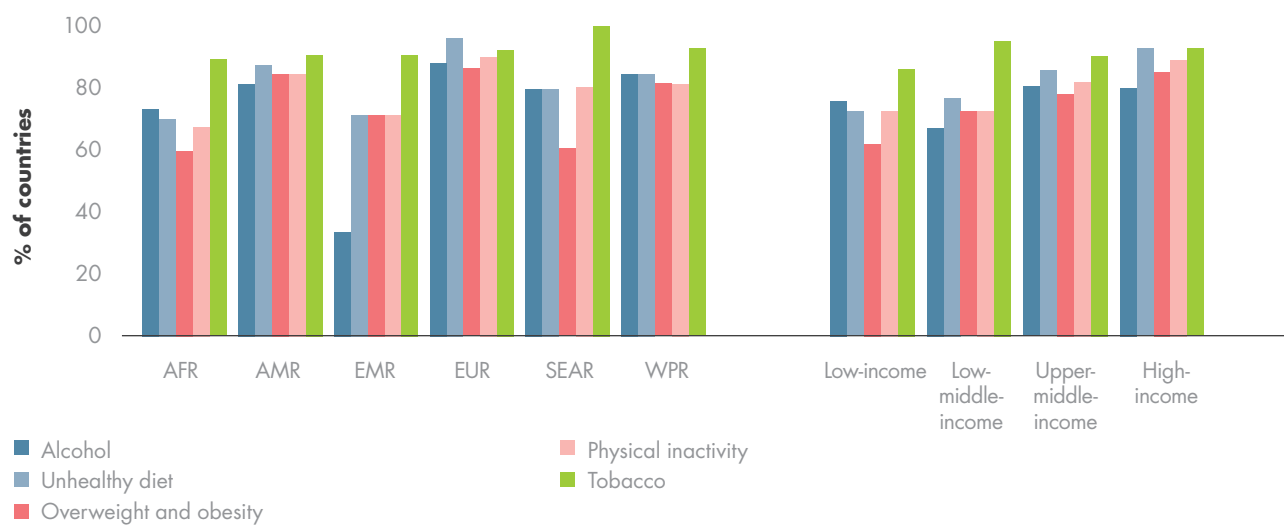
FIGURE 4:

Countries with plans, policies or strategies for the leading diseases and risk factors, by WHO region and World Bank income group, 2013

a) Plans, policies or strategies for leading NCDs



b) Plans, policies or strategies for leading NCD risk factors



Comparison with the 2010 survey

There appear to have been improvements overall in the prevalence of countries reporting policies, plans or strategies for NCD conditions and risk factors when comparing the CCS results of 2010 and 2013. Furthermore, the gap between the percentages of low-income countries and high-income countries reporting policies, plans and strategies has narrowed. Not only did more countries have integrated policies (65% in 2010 versus 78% in 2013), a larger percentage of these were operational (32% overall in 2010 versus 50% in 2013). So, while only half of integrated policies were operational in 2010, the figure had risen to two thirds in 2013.

Whereas in 2010, 72% of high-income countries reported having policies, plans or strategies for cardiovascular disease, relative to 46% of low-income countries, in 2013, the gap narrowed with 85% of high-income countries reporting policies, plans or strategies, relative to 75% of low-income countries. Similarly, for unhealthy diet, in 2013, 92% of high-income countries reported having plans, relative to 71% of low-income countries. This represents a narrowing of the gap from 2010 with 91% of high-income countries reporting plans for unhealthy diet, relative to 43% of low-income countries.

Interestingly, there also appear to have been shifts in the patterns of variation in the number of policies, plans or strategies by income group and region and by disease. In 2010, save for chronic respiratory disease, there was a consistent decline in the percentage of countries with policies, plans or strategies as income group declined. This remained broadly true in 2013, with the exception of diabetes, where lower-middle- and upper-middle-income countries had the highest prevalence (87%) compared with low-income (82%) and high-income countries (81%). Across all NCDs and risk factors, gaps between low-income and high-income countries narrowed which generally is due to a marked improvement in prevalence of NCD policies, strategies and action plans in the low-income countries.

In 2013, 5% of countries reported having no policies, strategies or action plans to address NCDs and their risk factors. This represents a minor improvement over 2010 when 8% of countries reported having no policies. While 11% of countries in the African Region reported having no policies in 2013 (a decrease from 2010 when the percentage was 24%), this region continued to have the highest percentage of countries reporting no policies. This was followed by the Eastern Mediterranean Region where the percentage, at 10%, remained unchanged since 2010. More low-income countries reported no policies than high-income countries.

In 2010, the percentage of countries having no policies on paper matched the figure for countries with no operational policies. In 2013, however, the percentage of countries indicating having no operational policies, strategies or action plans to address NCDs and their risk factors was considerably higher than the figure for countries indicating no policies on paper. This shows that while more countries had policies, a greater number of countries in 2013 had non-operational policies. While 5% of countries indicated having no policies on paper, 21% of countries indicated that they had no operational policies. When compared with 2010, 8% of countries indicated having no operational policies versus 21% in 2013. A similar pattern was observed across WHO regions and World Bank Income groupings. This could be interpreted as a regression in policy development and implementation in relation to 2010; however, the likely explanation is that in several countries policies had expired and new policies, while existing on paper, had yet to be implemented at the time of the survey. Rather than being a step backwards, it is likely that the 2013 survey coincided with a gap between implementation of policies. Nonetheless, close monitoring of the evolution of this particular metric will be valuable in subsequent surveys.

Policies to reduce impact of marketing on children

The 2013 survey tool requested information about the existence of policies for reducing the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fats, free sugars or salt. In addition, the survey tool sought to assess whether such policies were voluntary/self-regulating or enforced through legislation and, where such policies existed, the platforms (schools, broadcast media, print media, web-based social media, sporting events) targeted by these policies.

Only 37% of countries reported having policies for reducing the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fats, free sugars or salt. The region reporting the highest number of countries with such policies was the European Region with 57% of countries. Twenty per cent (20%) of countries reported that the policies were voluntary/self-regulating, while 15% of countries reported that such policies were enforced through legislation. Thirty-three per cent (33%) of countries reported targeting such policies at schools; 23% reported targeting broadcast media, while 20% of countries reported targeting print media (newspapers, billboards). Only 11% of countries reported targeting

web-based social media. The African Region had the lowest percentage of countries with policies intended to reduce the impacts of marketing on children (the only exception to this was in the use of web-based social media, where 3% of countries in the African Region indicated using this platform compared with no countries (0%) in the South-East Asian Region).

Across income groupings, the percentage of countries with policies – whether self-regulating or enforced through legislation – was highest in high-income countries and declined through the different levels of income-group to be lowest in low-income countries.

The low prevalence of countries using web-based social media as part of efforts to reduce the impacts on children of food and beverage marketing is a source of opportunity. Given the continued uptake of mobile communications devices in all parts of the world and the growing popularity of social media, this medium represents an important platform through which governments and health specialists can reach out to populations with information intended to influence health behaviour and reduce the impacts of marketing on children and young people.

Continued global uptake of mobile communications and growing popularity of social media present a potential platform through which to influence health behaviour and reduce impacts of marketing among children and young people.

Policies to limit saturated fatty acids and trans-fats in food supply

The 2013 survey additionally asked about the existence of national **policies to limit saturated fatty acids** and **virtually eliminate industrially-produced trans-fats in the food supply** (Figure 5). Only 23% of countries reported having a national policy to limit saturated fatty acids; 11% of countries reported having a voluntary/self-regulating policy, while 12% of countries reported having policies enforced through legislation. The European Region had the highest percentage of countries with existing policies to limit saturated fatty acids and trans-fats from the food supply; but with only 41% of countries, this was fewer than half of countries in the region. Similarly, countries in the European Region

had the highest percentage of countries reporting the existence of voluntary/self-regulating policies (24%) and policies enforced through legislation (18%). Meanwhile, the African Region reported the lowest percentage of countries with existing policies (3%), all of which were enforced through legislation. When viewed in terms of income groupings, low-income countries had the lowest percentage of countries having policies to limit saturated fats and trans-fats from the food supply. These percentages increased with income to be highest among high-income countries. However, even among high-income countries, fewer than half (49%) reported having such policies (Figure 5).

Fewer than one quarter of countries reported policies to limit saturated fatty acids and virtually eliminate industrially-produced trans-fats in the food supply.

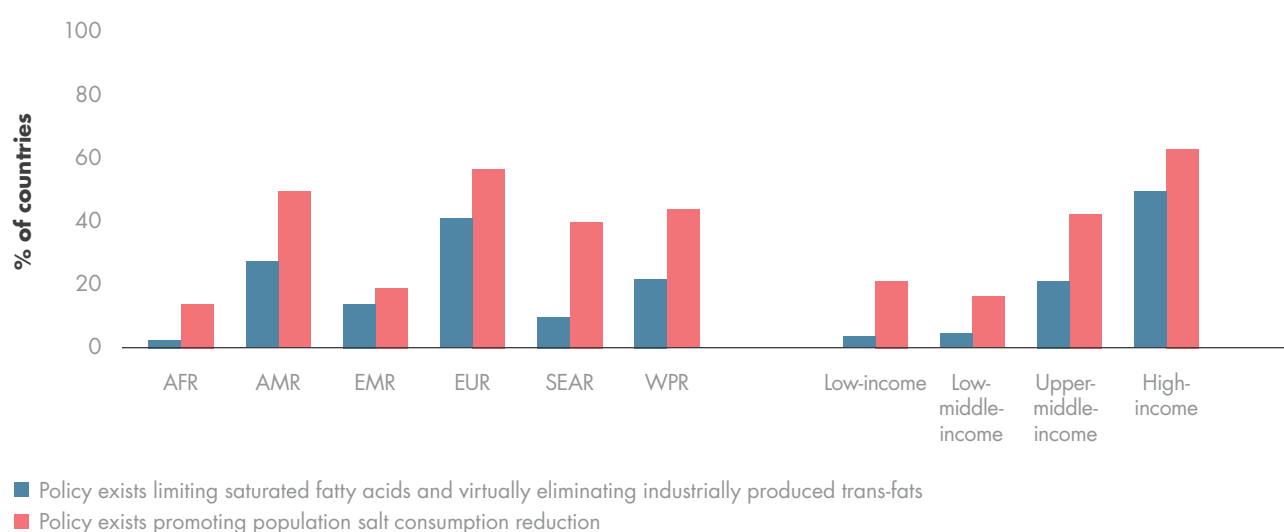
Policies to promote reduced salt consumption

Thirty-nine per cent (39%) of countries reported having a **national policy aimed at promoting reduced salt consumption**; 30% reported having self-regulating/voluntary policies, while only 8% of countries reported having policies enforced through legislation. Twenty-six per cent of countries (26%) reported promoting reduced salt consumption through product reformulation by industry, while 36% of countries promoted reduced salt consumption through consumer awareness campaigns. The regions with the highest percentages of countries reporting the existence of a national policy to promote reduced salt consumption were the European Region (57%) and the Region of the Americas (50%). Forty-three

per cent of countries (43%) in the European Region reported that the policy was self-regulating/voluntary, relative to 41% of countries in the Region of the Americas. The region with the highest percentage of countries enforcing the policy through legislation was the South-East Asia Region with 20% of countries. Interestingly, when viewed across income groupings, a marginally higher proportion of low-income countries (21%) reported having a policy to promote reduced salt consumption than lower-middle-income countries (16%); high-income countries had the highest percentage of countries with national policies to promote reduced salt intake, although even this remained relatively modest at 64% (Figure 5).

FIGURE 5:

Countries with policies limiting fatty acids and trans-fats and promoting reduced salt/sodium intake by WHO region and World Bank income grouping, 2013



Policies to encourage breastfeeding/ICM Breast-milk Substitutes

The 2013 questionnaire included questions on whether countries had policies in place to promote breastfeeding and the International Code of Marketing of Breast-milk Substitutes.



POLICIES TO ENCOURAGE BREASTFEEDING

Eighty-nine per cent of countries (89%) in the 2013 survey reported having a policy to promote breastfeeding. Across all WHO regions the percentages of countries having a breastfeeding policy was high, ranging from 81% of countries in the African Region and the Eastern Mediterranean Region, to 96% in the Western Pacific Region. Similarly, when viewed across income groupings, the prevalence of countries reporting a breastfeeding policy was also high, ranging from 79% of low-income countries to 90% and higher in the other income groupings.



POLICIES FOR IMPLEMENTING THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Sixty-three per cent of countries (63%) reported having a policy for implementing the International Code of Marketing of Breast-Milk Substitutes. Across all WHO regions, more than half of countries reported having such a policy, a figure that was highest in the Region of the Americas (75%). Across income-category groupings, the percentage of countries with a policy to implement ICM ranged from 55–60% of low- and lower-middle- and upper-middle-income countries to 76% of high-income countries.

MODULE III. SURVEILLANCE

The 2013 survey asked detailed questions on country capacity for the surveillance of NCDs and their related risk factors. Countries were asked to indicate whether they had a civil/vital registration system for reporting

mortality or whether they had a sample registration system in place. Countries were also asked to indicate the presence of cancer registries, including population-based cancer registries.

National health information system capacity for surveillance



COUNTRIES WITH A CIVIL/VITAL REGISTRATION SYSTEM

Eighty-one per cent of countries (81%) reported having a system in place for reporting cause-specific mortality in their national health reporting systems. Across WHO regions, there were significant variations, with 100% of countries in the European Region having such a system, 97% in the Region of the Americas and 96% of countries in the Western Pacific Region. Thereafter the percentages declined to 80% of countries in the South-East Asia Region having a system for reporting cause-specific mortality, 67% of countries in the Eastern Mediterranean Region and only 38% of countries in the African Region. When viewed across income groups, high-income and upper-middle-income countries reported near total coverage of countries with a system for generating cause-specific mortality at 98% and 92%, respectively. The percentages declined quite steeply among lower-middle-income countries to 70% and thereafter to only 45% in low-income countries.

There were important variations in the percentages of countries with systems in place for reporting cause-specific mortality, ranging from 100% of countries in the European Region to 67% of countries in the Eastern Mediterranean Region to only 38% of countries in the African Region. Meanwhile, 98% of countries in the high-income grouping reported the existence of such reporting versus 45% of low-income countries.

Seventy-eight per cent (78%) of countries reported having a civil/vital registration system for reporting on mortality. The percentage distribution across WHO regions mirrored fairly closely the regional distribution of cause-specific mortality described. One hundred per cent (100%) of countries in the European Region reported having a civil/vital registration system, followed by 97% of countries in the Region of the Americas and 89% of countries in the Western Pacific Region.

Seventy-four per cent (74%) of countries indicated that cause of death in their civil/vital registration system was certified by a medical practitioner; 72% of countries indicated that the registration system included deaths occurring outside medical facilities while 77% indicated that hospital-based deaths were included. In each case, regional percentage distribution across WHO regions mirrored those observed with the presence of a vital/civil registration system.



COUNTRIES WITH SAMPLE REGISTRATION SYSTEMS

Twenty-eight per cent (28%) of countries reported having a sample registration system for recording mortality. Across WHO regions, the highest percentage of countries reporting having such a system were in the Western Pacific Region with 41% and the South-East Asia Region with 40%. Only 23% of countries reported that death was certified by a medical practitioner in their sample registration systems. Across WHO regions, the region with the highest percentage of countries reporting that death was certified by a medical practitioner was the Western Pacific Region with 41% countries. Interestingly, no countries in the South-East Asia Region reported that death was certified by a medical practitioner. Only 25% of countries reported that data from their sample registration systems included deaths occurring outside medical facilities, while 27% of countries reported that data included deaths occurring within medical facilities.

Cancer registries

Countries were asked about the existence of cancer registries and their coverage (whether national or subnational, population-based or hospital-based).

While 80% of countries reported having a cancer registry, only 35% reported having a national population-based cancer registry. The prevalence of a

cancer registry was fairly high across all WHO regions (ranging from 60% in the South-East Asia Region to 94% in the European Region). Similarly, when viewed against income grouping, the prevalence of a cancer registry was also quite high, ranging from almost two thirds of countries (59%) in the low-income group to 93% of countries in the high-income group.

The percentages for a national population-based cancer registry show a somewhat different picture. The region with the highest percentage of countries having a population-based cancer registry was the European Region with 63% of countries; this dropped to 37% of countries in the Western Pacific Region, 31% in the Region of the Americas, 29% in the European Region and 11% in the African Region. No countries in the South-East Asia Region reported having a national

population-based cancer registry, despite 60% of countries in the region having a cancer registry.

When viewed across income groupings, 75% of countries that reported having a national population-based cancer registry were in the high-income grouping, while only 3% of countries in the low-income grouping reported having a national population-based cancer registry.

Comparison with the 2010 survey

The difference between 2010 and 2013 in the existence of cancer registries for the 172 countries was slight: 81% had a cancer registry in 2013 versus 80% in 2010, while 36% had a national, population-based cancer registry in 2013 versus 39% in 2010.

This apparent decrease most likely stems from previous misreporting, as a more thorough validation process was followed in 2013 which revealed that many countries were found to have misreported previously. The comparison is shown in Table 5.

TABLE 5:

Percentage of countries with cancer registries, by WHO region and World Bank income group, 2013 versus 2010*

		Cancer registry exists, 2013	Cancer registry exists, 2010	Population-based cancer registry, 2013	Population-based cancer registry, 2010
WHO region	AFR	68	62	11	19
	AMR	79	82	36	32
	EMR	76	76	29	48
	EUR	94	92	65	59
	SEAR	60	80	0	20
	WPR	89	81	37	37
World Bank income group	Low-income	57	57	4	11
	Lower-middle-income	72	70	2	16
	Upper-middle-income	85	88	40	35
	High-income	96	92	77	75
ALL	81	80	36	39	

* Among the 172 countries that participated in both surveys.

Risk factor surveillance

The second Global NCD Action Plan identified a set of nine global voluntary NCD targets for 2025, including six targets relating to NCD risk factors. These include reducing by 10% harmful use of alcohol; reducing physical inactivity by 10%; reducing salt/sodium intake by 30%; reducing tobacco use by 30%; reducing raised blood pressure by 25%; and ensuring a 0% increase in rates of diabetes and obesity (Box 3). In order to achieve and monitor progress towards these targets, surveillance is required.

The majority of countries (91%) had NCD surveillance work covered by the ministry of health in some way. One quarter of countries (25%) reported having an office, department or administrative division within the ministry of health dedicated exclusively to NCD surveillance, while an additional 31% of countries reported that NCD surveillance was tasked to an office/department within the ministry of health not exclusively dedicated to NCD surveillance. Thirty-five per cent (35%) said NCD surveillance was a responsibility shared across several offices/departments within the

ministry of health. Five per cent (5%) of countries reported that surveillance activities were coordinated by an external agency (e.g. NGO or statistical organization), although these countries were only in the European Region (16% of countries) and the Western Pacific Region (4% of countries). Finally, only 4% of countries globally indicated that no one in the country had responsibility for NCD surveillance. The majority of these countries (5 of the 7 countries) were in the Eastern Mediterranean Region (representing 24% of countries in the region), while the other two countries were in the African Region and the European Region.

The majority of countries (74–96%) reported having conducted risk factor surveys on various NCD risk factors, with the exception of salt/sodium intake (40% of countries). When restricting inquiry to nationally representative and recent¹ risk factor surveys, the prevalence decreased, far more so for those risk factors requiring blood measurements and salt/sodium intake than for behavioural risk factors (Figure 6).

Comparison with the 2010 survey

For all risk factors, there was a small increase in the percentage of countries that had completed surveys since 2010 (Figure 7). This increase was reflected both across WHO regions and income groupings. The greatest increase was seen in harmful use of alcohol (73% of countries in 2010 versus 89% in 2013), physical inactivity (73% in 2010 versus 88% in 2013) and raised total cholesterol (60% in 2010 versus 75% in 2013). While tobacco-use surveys were already prevalent in 2010 with 91% of countries reporting conducting such surveys, considerable progress

has been made for this risk factor. In 2013, 96% of countries reported conducting such surveys, with a mere 7 countries responding that they had not conducted a tobacco-use survey. While the overall prevalences of recent, nationally-representative surveys were lower, the progress since 2010 has been even greater for some risk factors. The greatest increases in these are shown with: harmful use of alcohol (45% in 2010 versus 66% in 2013), low fruit and vegetable consumption (43% versus 63%), overweight and obesity (47% versus 66%), and physical inactivity (47% versus 65%).

¹ For the purposes of this analysis, in the 2013 data a recent risk factor survey is a one that was conducted in 2009 or later; for the 2010 data it is a survey conducted in 2006 or later.

FIGURE 6:

Percentage of countries that have conducted risk factor surveys, 2013

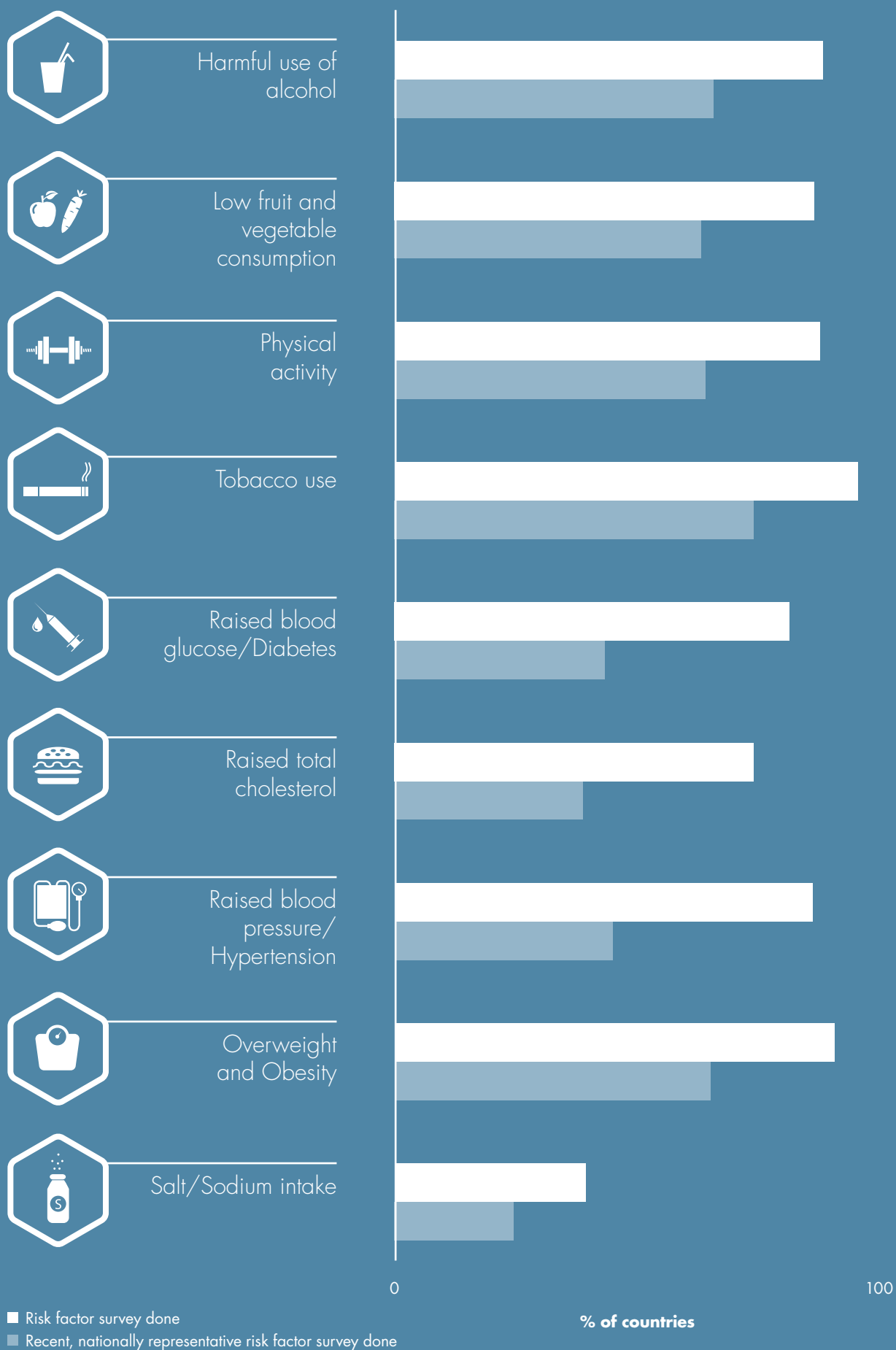
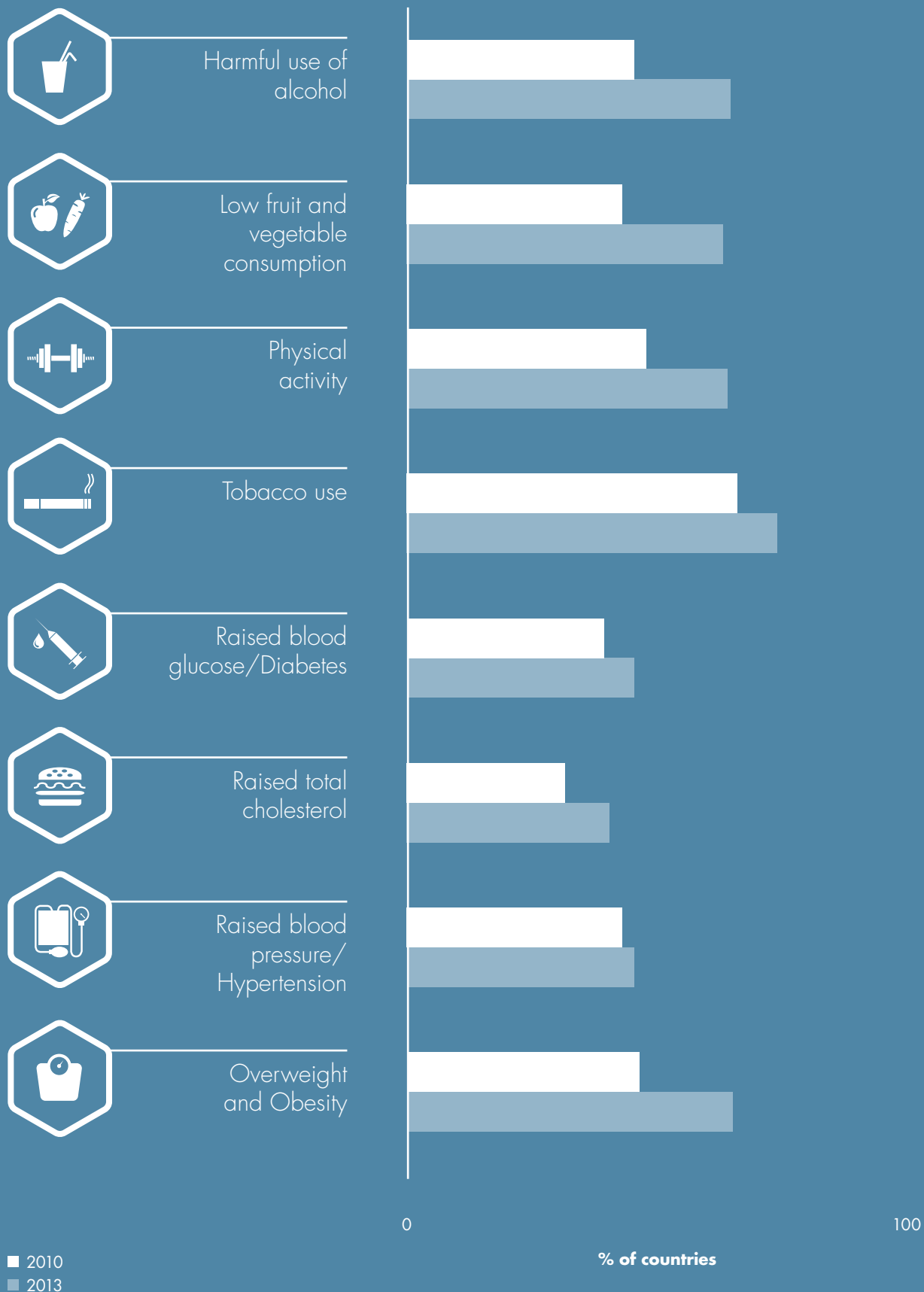


FIGURE 7:

Percentage of countries* that have conducted recent, nationally-representative risk factor surveys, 2010 versus 2013



* Of 172 countries that participated in both surveys.

MODULE IV. HEALTH SYSTEMS CAPACITY

The final section of the 2013 questionnaire asked countries to indicate which NCD functions (risk-factor detection, management), tests (screening)

and treatments (e.g. blood-pressure lowering drugs) were generally available in primary health-care settings.

NCD-related components in the primary health-care system

In 2013, 94% of countries reported providing primary prevention and health promotion in the primary health-care system and 85% reported offering risk factor and disease management. Meanwhile, 75% of countries offered support for self-help and self-care, while 67% of countries offered support for home-based care. The 2013 survey also included a question on the availability of rehabilitation services. Fewer than half of countries (44%) reported having such services available in primary health care.

Across WHO regions, the prevalence of primary prevention and health promotion being provided in the primary health-care system ranged from 89% of countries (African Region) to 100% (Region of the Americas). The African Region lagged behind in risk factor detection in primary care (68%) and risk factor disease management in primary care (54%). The Eastern Mediterranean Region lagged behind in the provision of home-based care in the primary health-care system with only 38% of countries indicating its provision. Meanwhile, when

asked about provision of NCD-related components in the primary, secondary or tertiary health-care system, over 90% of countries across all WHO regions and income groups indicated availability.

Eighty-eight per cent (88%) of countries indicated support for self-help and self-care, while 73% indicated support for home-based care. In the case of integrated support for home-based care over the primary, secondary and tertiary health-care systems, the percentages continued to be low in the Eastern Mediterranean Region (43%); meanwhile about half of countries in low-income and lower-middle-income groupings indicated availability of support for home-based care across the health-care system (Figure 8).

Overall, low-income countries were less likely to have NCD components provided in their primary health-care with 86% of low-income countries reporting the provision of prevention and health promotion in primary care versus 96% of high-income countries.

Comparison with 2010 survey

The percentage of countries that reported providing primary prevention and health promotion in 2013 (94%) represents an increase from 2010 when the figure was 85%. Similarly, an increase was observed in the proportion of countries providing risk factor detection (88% in 2013 versus 77% in 2010) and risk factor and disease management (85% in 2013 versus 82% in 2010). These figures are in line with Objective 4 of the second Global NCD Action Plan which calls on Member States: "To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage". There was also progress in the proportion of countries offering support for self-help and self-care (75% in 2013 versus 59% in 2010) and support for home-based care in primary health systems (67% in 2013 versus 51% in 2010).

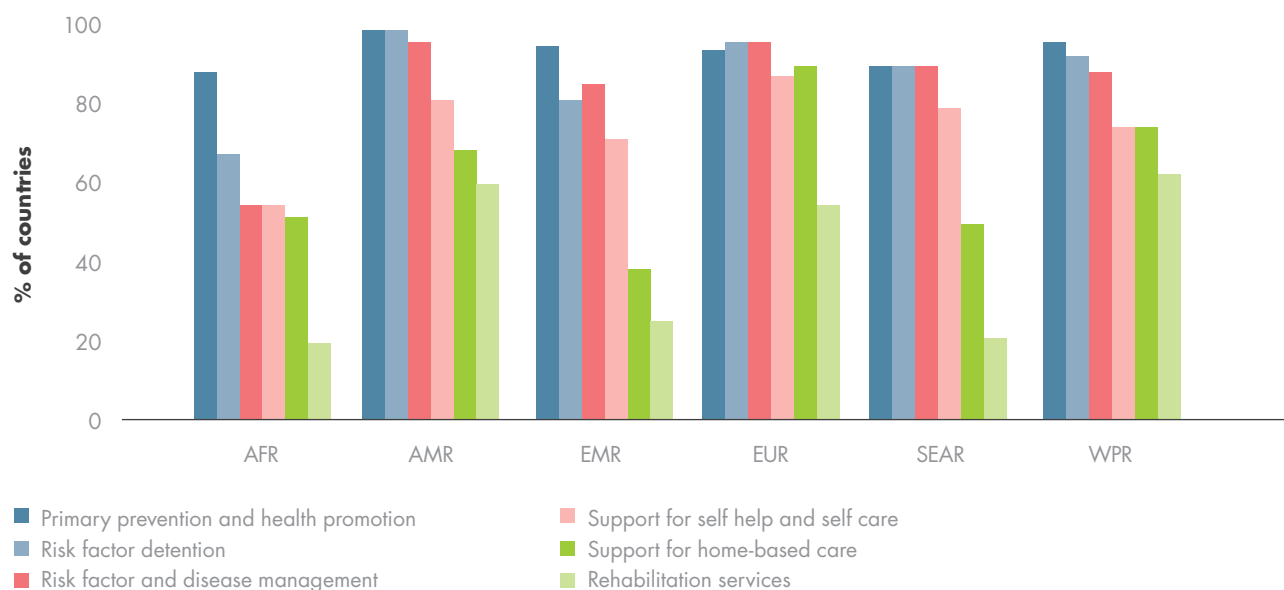
Across WHO regions, the prevalence of primary prevention and health promotion also increased from 2010, although the African Region still lagged behind in risk factor detection and risk factor disease management in primary care.

Overall, low-income countries remained less likely to have these components provided in their primary health-care systems (Figure 8), although the prevalence of prevention and health promotion in primary health care, of risk factor detection and of risk factor and disease management showed a rise in low-income countries. Meanwhile, the prevalence of support for self-help and self-care rose to half (50%) in low-income countries from 39% in 2010. Similarly, 39% of low-income countries provided support for home-based care, a rise from 2010 when less than one quarter (21%) offered the same service. While high-income countries remained more likely to provide these two components, the gaps with low-income countries had narrowed.

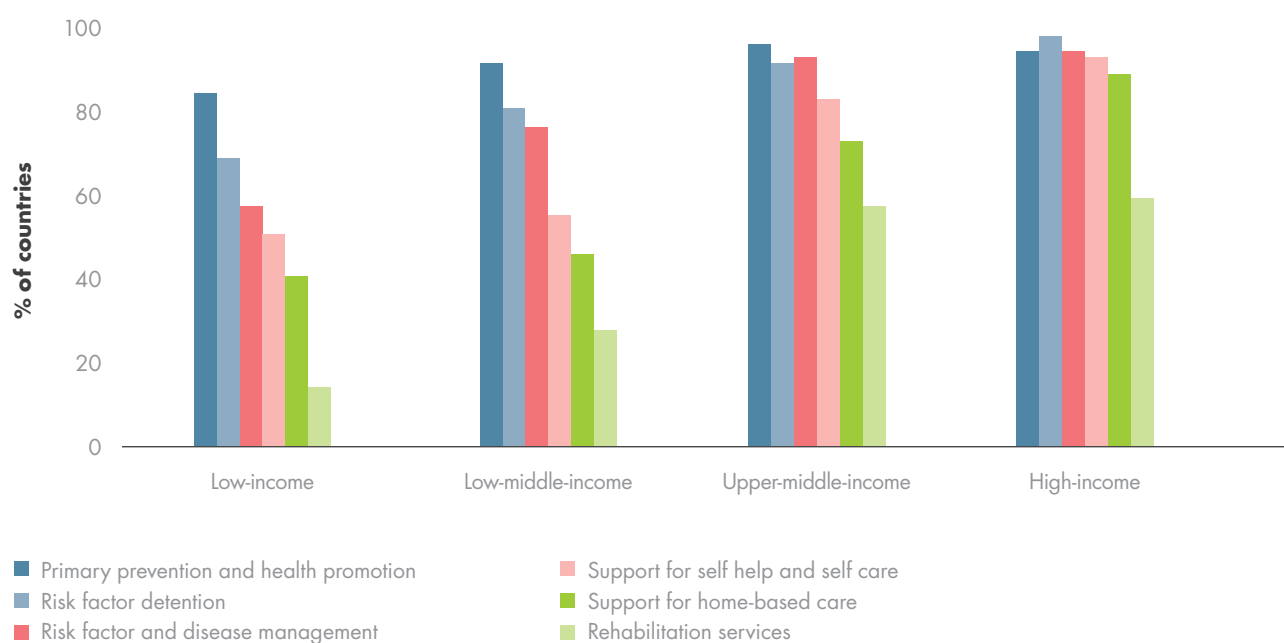
FIGURE 8:

Percentage of countries with select components integrated into their primary health-care system, 2013

a) By WHO region



b) By World Bank income group



Guidelines for the management of NCD conditions

While the majority of countries reported having evidence-based guidelines, protocols or standards available for the management of cardiovascular diseases (76%), diabetes (84%) and cancer (73%), only about one third of countries reported having fully implemented guidelines (Figure 9). For other NCDs and risk factors, the picture was even less encouraging. Only two thirds (67%) of countries reported having guidelines for chronic

respiratory diseases and only about one fifth (22%) reported that they were fully implemented. Meanwhile, only two thirds of countries (61%) reported having available guidelines covering tobacco dependence, with only 19% of countries reporting that they were fully implemented. Overall, full implementation of guidelines was lowest in low-income countries and increased in line with income status.

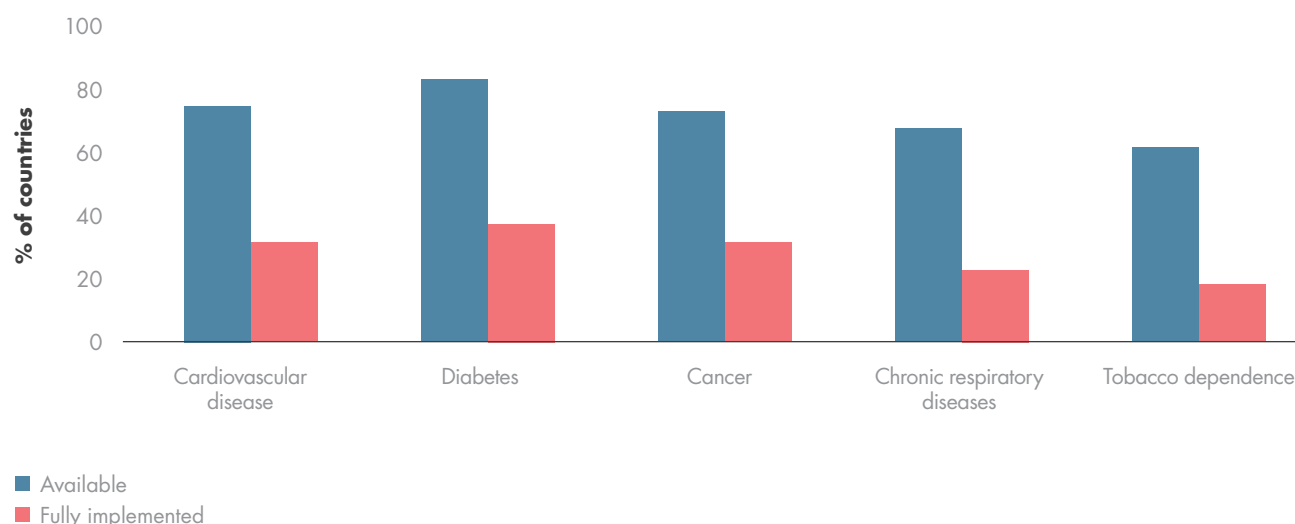
Comparison with 2010 survey

Only questions on guidelines for diabetes and tobacco dependence were included in both rounds of the survey. Both were more widely available in 2013 (diabetes: 78% in 2010 versus 83% in 2013; tobacco

dependence: 48% versus 62%) and fully-implemented guidelines were also slightly more common (diabetes: 32% versus 37%; tobacco dependence 15% versus 19%).

FIGURE 9:

Availability and implementation of management guidelines for NCDs and risk factors, 2013



Availability of tests and procedures for early detection, diagnosis and monitoring of NCDs

The questionnaire asked countries to indicate general availability of a wide range of tests and procedures to aid the detection, diagnosis and monitoring of NCDs.

In general, prevalence of tests and procedures was high across most countries with, for example, 94% of countries indicating that they had at least one type of test for diabetes available. Eighty-four per cent (84%) of countries indicated that they were able to screen for breast cancer by palpation or mammogram and seventy-four per cent (74%) of countries indicated that they were able to screen for cervical cancer using cervical cytology or acetic acid visualization. However, only 52% of countries indicated that peak flow spirometry (for the detection of asthma) was available.

Countries were also asked about the availability of staff with the capacity to test for conditions at the primary health-care level. Overall, the percentages closely matched those for the availability of tests, indicating a correlation between availability of tests and procedures with presence of staff having the necessary training and capacity. So, for example, 94% of countries indicated that they were able to screen for diabetes, with 92% of countries having staff generally available to test for diabetes. Similarly, 75% indicated that they had procedures for cervical cancer screening, with 72%

of countries indicating that they had staff generally available for this.

Interestingly, the South-East Asia Region appeared to lag behind other regions with only 40% of countries reporting availability of cervical cancer screening compared with 51% of countries in the African Region, 57% of countries in the Eastern Mediterranean Region and 100% of countries in the Region of the Americas (Figure 10).

Although the tests and procedures and staff were generally available in most countries, the prevalence of these in low-income countries was lowest than in the other income groups. So, while 75% of countries reported having tests for cervical cancer screening, only 28% of low-income countries reported having these available, with only 24% of low-income countries reporting having generally available staff. Similarly, while 80% of countries reported having the tests and procedures to detect high cholesterol, only 34% of low-income countries reported having these available, compared with 77% of lower-middle-income countries and 100% of high-income countries. Likewise, while 96% of high-income countries reported having tests for colon cancer screening, the figure for low-income countries was only 17% (Figure 10).

Comparison with 2010 survey

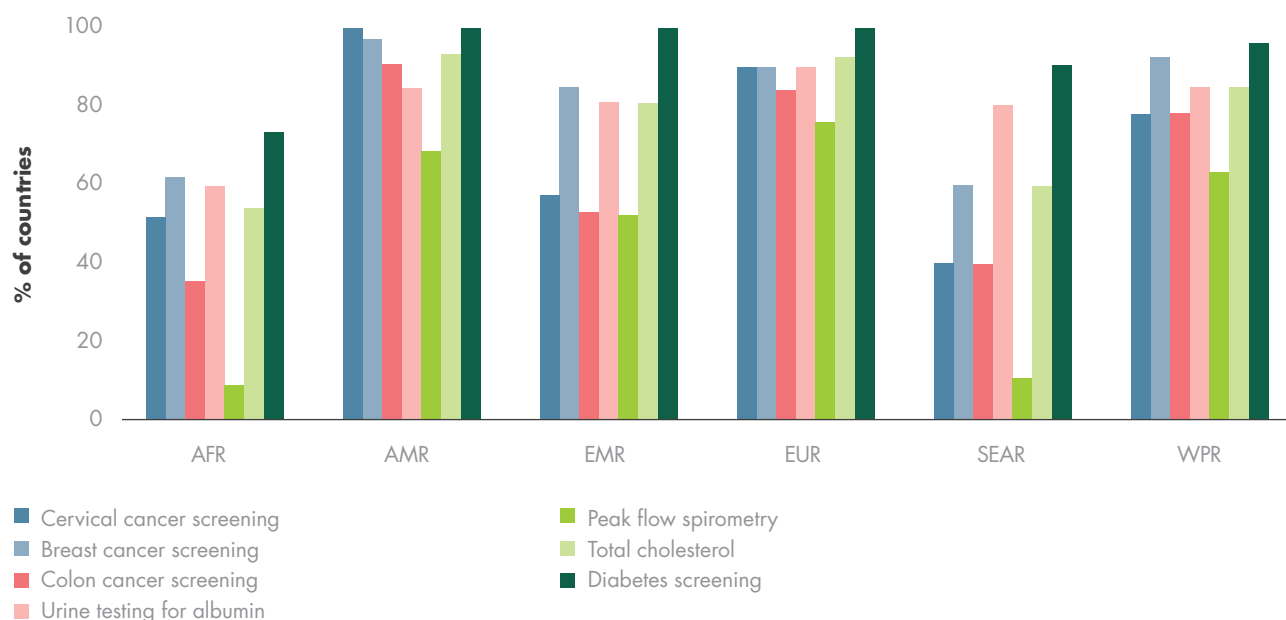
Improvements were observed in the prevalence of tests and procedures available in most countries since the 2010 survey. For instance, the 94% of countries in 2013 that indicated having at least one type of test for diabetes available represented an overall increase from 90% in 2010. Likewise, the 84% of countries in 2013 that indicated being able to test for breast cancer by palpation or mammogram represented an overall increase from 81% in 2010. Meanwhile, the 74% of countries that indicated in 2013 that they were able to screen for cervical cancer using cervical cytology

or acetic acid visualization represented an overall increase from 65% in 2010. Although the proportion of countries indicating that peak flow spirometry (for the detection of asthma) was available remained low, for those countries answering both rounds of the survey, there was nonetheless an increase in prevalence (from 41% in 2010 to 51% in 2013). Finally, among the 172 countries that responded to both surveys, there was a small improvement in the percentage indicating the availability of tests for the detection and diagnosis of colon cancer (65% in 2010 versus 67% in 2013).

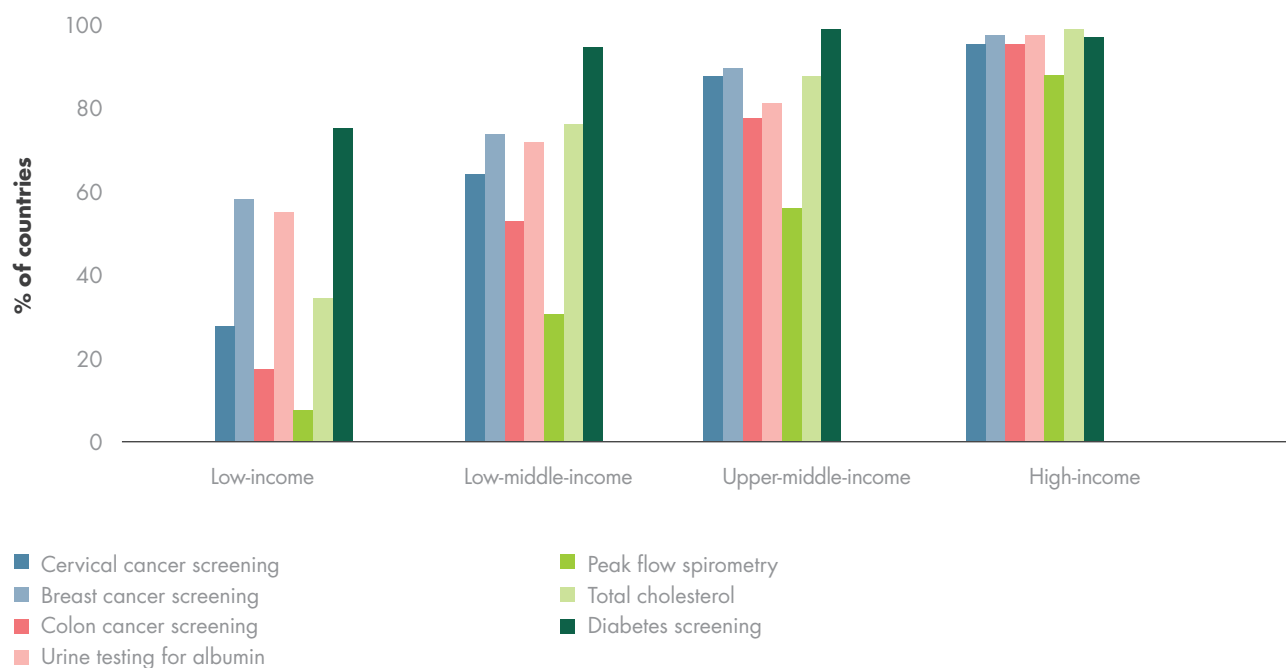
FIGURE 10:

Availability of tests and procedures for early detection, diagnosis and monitoring of NCDs, 2013

a) By WHO region



b) By World Bank income group



Availability of medicines in the public health sector

The 2013 survey gathered information on the availability of basic medicines required for the treatment of NCDs (Table 6).

Essential medicines for the management of diabetes, hypertension and cardiovascular disease were generally available in more than 75% of countries. Oral morphine was reported as being available in 57% of cases.

While most of the drugs and treatments surveyed were available in three quarters or more of countries (with the exception of oral morphine and nicotine replacement therapy), their prevalence tended to be markedly lower in low-income countries. In regional terms, the African Region remained behind other regions.

Comparison with the 2010 survey

There were some improvements in the availability of essential medicines for the management of NCDs since the 2010 survey. When considering the 172 countries that participated in both surveys, the availability of oral morphine had increased from 48% in 2010 to 56% in 2013. The increase in the availability of oral morphine was observed across all regions with the exception of the South-East Asia Region where a

decrease was observed. Meanwhile, the availability of nicotine replacement therapy had decreased slightly from 2010 when the figure was 45%. Availability of this appears to have increased in the African Region and South-East Asia Region, while it decreased in all other regions. A decrease was similarly observed across all income groups, except in the low-income group where a slight increase was observed.

Health insurance coverage for NCD treatments

In terms of insurance coverage for NCD treatments, the majority of countries reported that NCD-related treatments were covered by health insurance, regardless of whether the insurance was social or private. The lowest prevalence was in health insurance coverage for oral morphine (67% of countries) and nicotine replacement therapy (23% of countries). While the prevalence of health insurance coverage had increased across all WHO regions and income groupings, there still remained considerable variability by country income group and WHO region. Overall, the Region of the Americas had the

highest prevalence of insurance coverage (~90%), followed by the European Region, while the African Region continued to have the lowest. Similarly, high-income countries were twice as likely to have NCD services and treatments covered by health insurance than low-income countries. For example, while insulin treatment for diabetes was funded by health insurance in over 96% of high-income countries, it was only covered by health insurance in 48% of low-income countries. Similarly, while statins were covered by health insurance in 95% of high-income countries, the figure for low-income countries was 31%.

TABLE 6:

Percentage of countries with medicines generally available in the public health sector, by WHO region and World Bank income group, 2013

		Insulin	Aspirin (100 mg)	Metformin	Thiazide Diuretics	ACE Inhibitors	CC Blockers
WHO region	AFR	76	78	68	84	78	65
	AMR	97	94	97	100	97	94
	EMR	86	95	86	95	90	81
	EUR	96	96	98	98	98	96
	SEAR	90	80	90	70	80	80
	WPR	85	85	93	93	85	85
World Bank income group	Low-income	59	76	62	76	66	48
	Lower-middle-income	88	81	88	91	88	81
	Upper-middle-income	98	96	96	98	98	96
	High-income	96	96	96	98	96	96
ALL	89	89	89	89	93	90	

		Statins	Oral morphine	Nicotine patches or gums	Steroid inhaler	Broncho- dilators
WHO region	AFR	35	41	5	46	78
	AMR	88	59	19	84	100
	EMR	76	52	38	81	90
	EUR	98	78	86	90	98
	SEAR	80	0	10	60	100
	WPR	85	59	41	74	93
World Bank income group	Low-income	34	38	17	34	79
	Lower-middle-income	65	30	12	58	91
	Upper-middle-income	92	57	37	86	96
	High-income	96	87	78	98	98
ALL	78	57	40	75	93	

Procedures for treating NCDs

Countries were asked about the availability of a selection of procedures for treating NCDs (Figure 11). The majority of countries in the high-income category (96–98%) and in the European Region (86–92%) and Eastern Mediterranean Region (76%) reported they had radiotherapy and chemotherapy generally available. However, only about one third (35%) of countries in the African Region reported having chemotherapy, with only 24% of countries reporting radiotherapy as generally available. Less than one quarter (21%) of low-income countries reported available chemotherapy, a figure which dropped to 17% for radiotherapy.

Similar patterns were seen for procedures for the basic management of end-stage renal disease, with around 95% of high-income countries and 65% of upper-middle income countries having renal replacement treatment available versus only 24% of low-income countries.

Meanwhile, retinal photocoagulation services to prevent blindness were available in half of countries (50%). They were available in 85% of high-income countries and in only 10% of low-income countries. This represents one area where the discrepancy between income groups for any of the treatments addressed by the survey was at its highest (85% for high-income countries versus 10% for low-income countries).

The only area where such discrepancies were higher was in the availability of coronary bypass operations and stenting – a new area in the 2013 questionnaire – where only 48% of countries reported having this treatment available. Regionally, the highest availability was in the European Region where 82% reported having such procedures available, while it was lowest in the African Region where only 5% of countries reported having such treatment available. When viewed in terms of income, 91% countries in the high-income category reported availability of coronary bypass and stenting versus only 7% of low-income countries.

Comparison with the 2010 survey

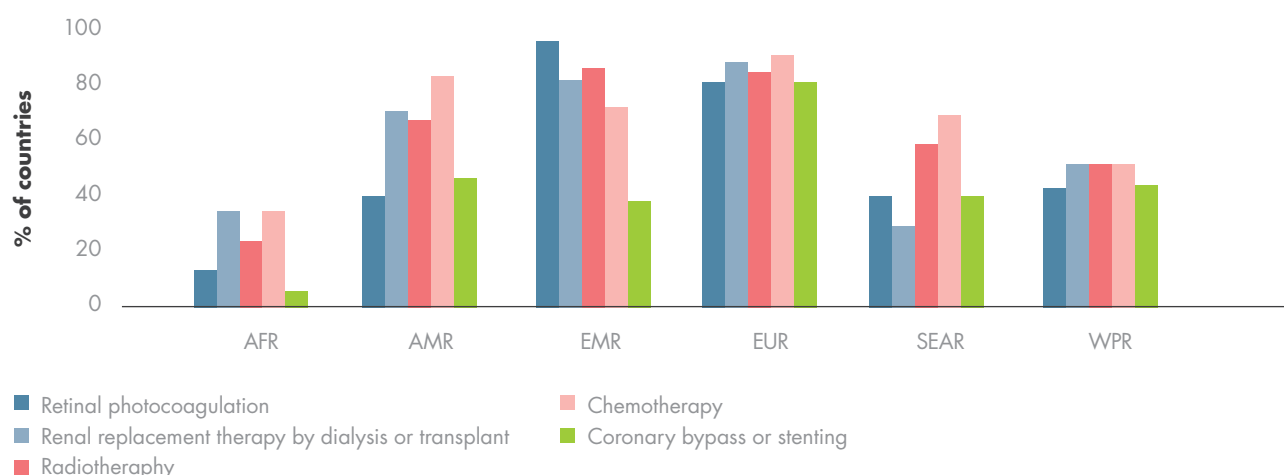
The availability of radiotherapy and chemotherapy had increased slightly since 2010 in high-income countries, in the European Region and in the Eastern

Mediterranean. However, in low-income countries (21%) there was a marked decrease since 2010.

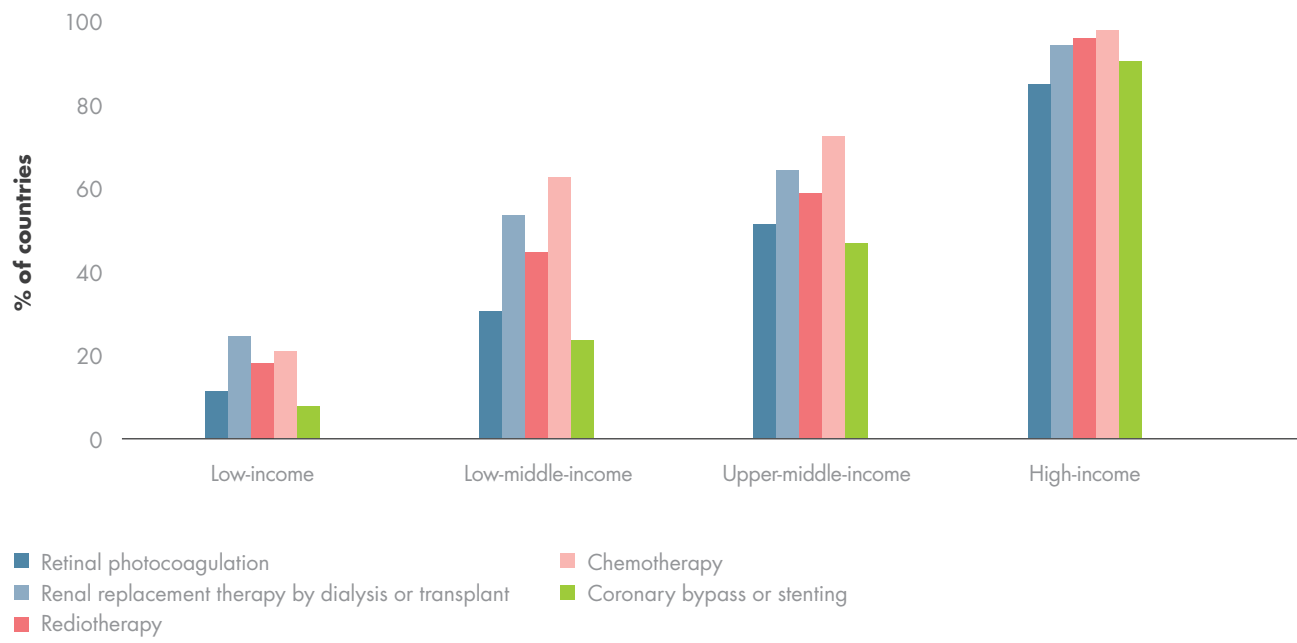
FIGURE 11:

Availability of procedures for the treatment of NCDs, 2013

a) By WHO region



b) By World Bank income group, 2013



DISCUSSION: OPPORTUNITIES AND LIMITATIONS

OPPORTUNITIES TO BUILD CAPACITY TO ADDRESS NCDs

The 2013 NCD CCS highlighted several opportunities on which to build to improve country capacity to contain and reverse NCDs and their impacts on populations and development. These include the following:

1

Across the board, there were improvements in national capacity to address NCDs and their risk factors

This was indicated by the increased prevalence of policies, plans and strategies and their related funding, as well as increased capacity for surveillance, detection and treatment of NCDs and their risk factors. This suggests that the momentum has been created for concerted action to tackle NCDs; this momentum should be encouraged and built upon.

2

Governments have acknowledged that NCDs present a major challenge and deserve particular attention from ministries of health and other bodies, including in low- and lower-middle-income countries

This was born out by the high percentage of countries indicating the presence of a unit, branch, department or division within their ministry of health dedicated to NCDs. This is in line with the second Global NCD Action Plan agreed in May 2013. Equally, the high percentage of countries that now have at least one full member of staff working on NCDs is further testament to this. This acknowledgement, coupled with the adoption of the second Global NCD Action Plan, which is articulated around six objectives and based on nine concrete realizable targets, offers a starting point on which to build further momentum. Countries can measure their progress in efforts to address and contain NCDs through the nine action plan indicators. Although there were gaps in country readiness in relation to the nine action plan indicators, for most of the indicators the baseline was around the 50–60% threshold, indicating that considerable progress has already been achieved. This is an encouraging sign and one that also deserves to be built on.

3

Most countries had some funding available for NCDs

The existence of funding streams implies that there is potential to increase funding and diversify funding sources. There is potential to increase funding from earmarked taxes on tobacco and alcohol. Furthermore, the current extremely low prevalence of fiscal interventions – such as taxation on high sugar-content food and non-alcoholic beverages – implies that there is an opportunity to levy greater taxes, which could add to the volume of funding earmarked for NCDs. Such fiscal interventions could also provide incentives to encourage more healthy behaviour.

4

The widespread presence of existing policies, plans and strategies provides a framework to guide the development and implementation of interventions – while the comparatively low presence of operationalized policies suggests there is scope to build on existing plans and increase implementation

The widespread presence of policies, plans and strategies suggests that governments have recognized their importance in efforts to tackle NCDs and their risk factors. At the same time, the increased prevalence of operational policies, plans and strategies, while still weak, demonstrated that there is important potential to augment operationalization. Greater effort could be invested in translating policies on paper into action on the ground.

5

Surveillance is increasing

Progress made in risk factor surveillance since the 2010 survey – globally as well as across regions and income groups – similarly demonstrates that significant progress is possible in a relatively short time frame. Equally, the high prevalence of nationally representative risk factor surveillance also demonstrates that significant progress is possible in a short time frame.

6

Social media represents an opportunity to reduce the impact on children of marketing of foods and non-alcoholic beverages with high fat and sugar content

Few countries currently have policies in place aimed at reducing the impact on children of marketing of foods and non-alcoholic beverages high in sugar and fat content. This represents an area ripe for growth. The continued uptake of mobile communication platforms, especially in the African Region and the South-East Asia Region and the growing use of social media offers a significant opportunity as a conduit for such efforts. Social media-based platforms offer a simple means of reaching out to youth to influence health behaviours. Very few countries use social media as a platform through which to focus such efforts, making it another potential growth area.

LIMITATIONS IN NATIONAL CAPACITY TO ADDRESS NCDs

The 2013 NCD CCS also highlighted some limitations in national capacity to address NCDs. These included:

1

Gaps in infrastructure

The proportion of countries reporting the existence of a unit, branch or division within the ministry of health responsible for NCDs and their risk factors was very high (94%). Although there have been some improvements in levels of staffing and funding of such units, these continued to lag behind. This was especially the case in low-income countries and to a slightly lesser extent in lower-middle-income countries, and among countries in the African Region. Most funding for NCDs came from general government revenues and to a lesser extent from health insurance or international donors. Only about one third of funding came from earmarked taxes on items such as alcohol or tobacco; meanwhile, a very small proportion was raised through other fiscal interventions. Similarly, while many countries reported mechanisms for partnerships and collaborations for implementing activities related to NCDs, for the most part these remained ministry of health- or NGO-based while participation of other UN agencies or the private sector remained low. Again, prevalence of collaboration with the private sector or other international institutions remained lower among low-income and lower-middle-income countries than in countries in higher-income groupings.

2

Disparity between existence of policies and plans to address NCDs and their implementation

Most countries had a policy, plan and/or strategy to address NCDs. Equally, the prevalence of such plans had improved since the 2010 survey across both WHO regions and income groupings. However, a significant number of these were not yet operational.

A set of nine action plan indicators was developed to inform reporting on progress of the implementation of the second Global NCD Action Plan. For the most part, these involve operationalization of policies, strategies and plans to tackle NCD risk factors, such as harmful use of alcohol or lack of physical activity. The 2013 survey revealed that overall country readiness in line with these indicators is around the two thirds mark (~60%) and significant ground remains to be covered. Missing data relating to some targets presents challenges for monitoring progress.

Very few countries reported having policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fats, sugars or salt; what is more, this declined markedly in line with income grouping. Similarly, while most countries reported policies to promote breastfeeding, implementation remains low. It is important to bridge this gap as available evidence indicates that breastfeeding has positive impacts on both infant and maternal health.

3

Weak population-based surveillance and inadequate funding for surveillance

While most countries reported some form of surveillance for NCD morbidity, mortality and risk factors, few countries actually had a department or division dedicated exclusively to this function. Surveillance was also less well funded than NCD treatment, prevention and detection. Funding for surveillance declined with income group. Most countries lagged behind when it came to producing population-based data. Although the prevalence of countries producing population-based data increased across the board since 2010, it still remained low in relation to general risk factor surveys, especially for risk factors such as raised blood pressure, raised cholesterol, raised blood sugar and salt intake. The prevalence remained lowest among low-income countries. Discrepancies were especially pronounced in the case of cancer registries with 80% of countries reporting a cancer registry, but only 35% of countries reporting a national population-based cancer registry.

4

Gaps in health systems

While the availability of government-approved evidence-based guidelines, protocols and standards for the management of NCDs and their risk factors had improved since 2010, full implementation remained very low (~one third or less). Equally, while there were some improvements in availability of basic equipment necessary for the diagnosis and management of NCDs, availability still remained inadequate in many countries, especially in low-income countries. For several cancers, outcomes can be positively influenced if discovered and treated early. However, the percentage of countries with available procedures for the management and treatment of cancers remained low. For example, many countries did not have procedures for colon cancer screening available at the primary health-care level; the percentage was especially low in low-income countries. The availability of coronary bypass procedures or stents was also especially low, with fewer than 50% of countries globally (and no more than 7% of low-income countries) reporting their availability. The availability of the basic equipment necessary for the diagnosis and management of NCDs appeared to be inadequate in many countries with many countries not having cervical cancer cytology available in primary health care. Without basic tests and procedures being available, early diagnosis and management of conditions such as cancer, where outcomes can be positively influenced if the condition is discovered early in its development, are severely hampered. For some conditions such as cervical cancer, screening can prevent the disease in its entirety. Finally, while a large number of countries reporting had essential drugs for the treatment of NCDs, the inclusion of many of the essential drugs for NCD management was variable and sometimes inadequate in many countries.

Low and lower-middle income countries had weaker capacity, and low-income countries had very weak capacity

The 2013 NCD CCS revealed that there had been improvements overall in country capacity to address NCDs and their risk factors. Similarly, the gaps between high-income and low- and lower-middle-income countries had reduced since the previous survey. However, the general pattern of inequalities remained broadly similar. Capacity to address NCDs and their risk factors remained higher in high-income countries than in low- and lower-middle-income countries. Low-income countries still displayed the lowest capacity. Across regions, capacity tended to be lowest in the African Region. So, for example, although a very high percentage (97%) of countries in the African Region indicated the presence of a branch/unit/department or division within the ministry of health responsible for NCDs, this figure was not matched by figures for overall funding which remained low, not least in comparison to other regions. Capacity for risk factor surveillance reduced according to income group status and remained similarly low among African countries, as did availability of treatments and procedures and available medicines.

STRENGTHS AND LIMITATIONS OF THE SURVEY

The 2013 NCD CCS was the fourth global survey intended to assess national capacity for NCD surveillance and treatment. As such, it is now possible to identify clear strengths and possible limitations of the survey process.

Survey strengths

The development of the 2013 questionnaire was a consultative and collaborative process that took place through technical meetings involving international experts. This contributed towards making the questionnaire robust and highly relevant. Furthermore, the 2013 survey tool was based on the 2010 questionnaire; it included many of the same questions as well as additional items. This made it possible to compare closely results with the previous survey and to assess progress in the intervening period. The data analysis process was both thorough and straightforward.

The high response rate across regions and income groups, and the representativeness of WHO Member States in the survey results, gives clear indication that countries found value in the survey process. Although the information was provided by NCD focal points in the various countries and reflects their understanding of the current status of survey items at the time the survey instrument was completed, NCD focal points could –

and indeed were asked to – consult with colleagues to obtain the correct information and close any gaps. The survey responses were subject to a robust validation process and the measurement tool used to assess responses included automatic error checks. (For example, if a respondent ticked “No” to any question, any additional information relating to that particular question would then be unnecessary; if any additional detail was given, this would indicate that the “No” response was erroneous.) This helped to ensure the validity and accuracy of the responses.

The availability of the questionnaire and instructions given in four of the WHO official languages (English, French, Spanish and Russian), made it accessible to the majority of countries.

Going forward, the success of the 2013 NCD CCS offers very real scope for assessing country capacity to manage and treat NCDs in line with the second Global NCD Action Plan.

Survey limitations

Despite the robust validation process and measurement tool used to assess responses, in a few instances independently validating all survey answers proved challenging.

Similarly, despite the survey being developed through a comprehensive and consultative process, global questions could not always accommodate every country situation. It might not, therefore, always have been possible for countries to give the most complete picture of their situation. This was particularly true for countries with a federated or highly decentralized form of government. However, the questionnaire could be adapted to regional needs – as in the case of the African Region where some additional questions, intended to determine the specific situation, were included.

While the survey offered a good overview of NCD prevention and control at a national level, it was not

intended to provide a comprehensive understanding of specific arrangements or needs. For example, the survey gave information on whether there was funding for NCDs, but not on whether the ministry of health perceived the funding as adequate for basic functions, and what their funding needs were. Similarly, on staffing, the focal points identified the number of full- and part-time staff, but made no judgment as to whether staffing was sufficient (and countries clearly reported on the amount of staff they had using different criteria).¹ Additionally, information was provided on the existence of the agencies and institutes with NCD functions, but not on whether they coordinated well with the ministry of health.

Finally, there may occasionally have been some language issues, especially in relation to the use of certain technical terms that are not universally similar in their interpretation. However, all efforts were made to keep these to a minimum.

¹ In the South-East Asia Region, an additional question was asked in the survey about the adequacy of the staffing capacity.

CONCLUSION: PRIORITIES FOR ACTION

Overall, the 2013 NCD CCS revealed that there has been progress since 2010 in country capacity to address NCDs and their risk factors. This is an encouraging indication that progress is possible over a relatively short time frame. Capacity for monitoring, preventing and treating NCDs has also increased, particularly among low- and lower-middle-income

countries, while gaps between their capacity and that of upper-middle and high-income-countries have narrowed. These are encouraging signs. The results of the 2013 survey, however, highlight that there is still effort needed to overcome limitations in national capacity to address NCDs and bridge the gaps between and among regions and income groupings.

The results of the 2013 NCD CCS reveal several clear priorities for action



Greater and more effective use needs to be made of existing NCD infrastructure

In most countries, capacity exists to tackle NCDs, be it within government agencies or institutes, or in agencies and institutes external to the government. At present, some of this capacity is under-utilized. Greater work is needed to examine these national units and their staffing and funding needs.



Existing policies need to be implemented, funded and improved

In most countries, there is an awareness of the importance of working to address NCDs and their risk factors, as reflected in the existence of policies, plans and strategies. Greater effort is needed to effect their implementation. Lessons could be learned from those areas where significant achievements have been made in implementing policies (e.g. in the areas of tobacco use and cancer) to assess whether they could be applied to other risk factors and NCDs. More research is required to assess why there are important gaps between the existence of policies on paper and their operationalization.

3

Greater investment is needed in population-based surveillance to build on existing surveillance systems

The prevalence of population-based risk factor surveillance has been increasing but is still not high or universal. Greater efforts and information are needed, for example, in the area of chronic respiratory diseases, and in relation to the targets on salt intake and prevention of cardiovascular diseases.

4

The development of evidence-based national guidelines, protocols or standards for managing NCDs remains a challenge that needs to be addressed

This represents an important gap and must be filled if basic standards are to be met by the health-care system.

5

Innovative funding solutions need to be developed

Examples could include increasing earmarked taxes in low-income countries for NCD prevention and control or introducing fiscal incentives such as taxes on high-fat content foods.

6

Focus on low- and lower-middle-income countries

The weakest capacity is found in these countries even though the burden of NCDs and/or their risk factors is high and/or growing rapidly. With progress now being made in the high-income countries in addressing NCDs, the emphasis on building capacity should be on low- and lower-middle-income countries.

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ANNEXES

ANNEX 1.

WHO MEMBER STATES AND SURVEY RESPONDENTS

AFRO

Algeria
Angola*
Benin
Botswana
Burkina Faso
Burundi
Cabo Verde*
Cameroon
Central African Republic
Chad*
Comoros
Congo
Côte d'Ivoire
Democratic Republic of the Congo*
Equatorial Guinea
Eritrea
Ethiopia*
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius*
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone*
South Africa*
South Sudan*
Swaziland
Togo
Uganda
United Republic of Tanzania*
Zambia
Zimbabwe

AMRO

Antigua and Barbuda†
Argentina
Bahamas†
Barbados
Belize
Bolivia (Plurinational State of)
Brazil
Canada
Chile
Colombia†
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
Grenada†
Guatemala
Guyana*
Haiti*
Honduras
Jamaica
Mexico
Nicaragua
Panama
Paraguay
Peru
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines*
Suriname
Trinidad and Tobago
United States of America
Uruguay
Venezuela (Bolivarian Republic of)

EMRO

Afghanistan
Bahrain
Djibouti
Egypt
Iran (Islamic Republic of)
Iraq
Jordan
Kuwait
Lebanon
Libya
Morocco
Oman
Pakistan
Qatar
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
Yemen

* signifies a non-respondent. All other countries responded to the survey.

† signifies that the country responded to the 2013 survey but not the 2010 survey. These countries were thus excluded from the 2013 versus 2010 comparisons.

EURO	SEARO	WPRO
Albania Andorra Armenia Austria Azerbaijan Belarus* Belgium Bosnia and Herzegovina* Bulgaria Croatia Cyprus Czech Republic Denmark Estonia Finland France Georgia Germany Greece Hungary Iceland Ireland Israel Italy Kazakhstan Kyrgyzstan† Latvia Lithuania Luxembourg Malta Monaco Montenegro Netherlands Norway Poland Portugal Republic of Moldova Romania Russian Federation San Marino Serbia Slovakia Slovenia Spain Sweden Switzerland Tajikistan The former Yugoslav Republic of Macedonia Turkey Turkmenistan† Ukraine United Kingdom Uzbekistan	Bangladesh Bhutan Democratic People's Republic of Korea India Indonesia Maldives Myanmar Nepal Sri Lanka Thailand Timor-Leste*	Australia Brunei Darussalam Cambodia China Cook Islands Fiji Japan Kiribati Lao People's Democratic Republic Malaysia Marshall Islands Micronesia (Federated States of) Mongolia Nauru New Zealand Niue Palau Papua New Guinea Philippines Republic of Korea Samoa Singapore Solomon Islands Tonga Tuvalu Vanuatu Viet Nam

ANNEX 2.

LIST OF COUNTRIES BY WORLD BANK INCOME GROUPS

HIGH INCOME

Andorra
Antigua and Barbuda
Australia
Austria
Bahamas
Bahrain
Barbados
Belgium
Brunei Darussalam
Canada
Chile
Croatia
Cyprus
Czech Republic
Denmark
Equatorial Guinea
Estonia
Finland
France
Germany
Greece
Iceland
Ireland
Israel
Italy
Japan
Kuwait
Latvia
Lithuania
Luxembourg
Malta
Monaco
Netherlands
New Zealand
Norway
Oman
Poland
Portugal
Qatar
Republic of Korea
Russian Federation
Saint Kitts and Nevis
San Marino
Saudi Arabia
Singapore
Slovakia
Slovenia
Spain
Sweden
Switzerland
Trinidad and Tobago
United Arab Emirates
United Kingdom
United States of America
Uruguay

UPPER-MIDDLE INCOME

Albania
Algeria
Angola
Argentina
Azerbaijan
Belarus
Belize
Bosnia and Herzegovina
Botswana
Brazil
Bulgaria
China
Colombia
Cook Islands
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
Fiji
Gabon
Grenada
Hungary
Iran (Islamic Republic of)
Iraq
Jamaica
Jordan
Kazakhstan
Lebanon
Libya
Malaysia
Maldives
Marshall Islands
Mauritius
Mexico
Montenegro
Namibia
Nauru
Niue
Palau
Panama
Peru
Romania
Saint Lucia
Saint Vincent and the Grenadines
Serbia
Seychelles
South Africa
Suriname
Thailand
The former Yugoslav Republic of Macedonia
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Venezuela (Bolivarian Republic of)

**LOWER-
MIDDLE
INCOME**

Armenia
Bhutan
Bolivia (Plurinational State of)
Cabo Verde
Cameroon
Congo
Côte d'Ivoire
Djibouti
Egypt
El Salvador
Georgia
Ghana
Guatemala
Guyana
Honduras
India
Indonesia
Kiribati
Lao People's Democratic Republic
Lesotho
Mauritania
Micronesia (Federated States of)
Mongolia
Morocco
Nicaragua
Nigeria
Pakistan
Papua New Guinea
Paraguay
Philippines
Republic of Moldova
Samoa
Sao Tome and Principe
Senegal
Solomon Islands
Sri Lanka
Sudan
Swaziland
Syrian Arab Republic
Timor-Leste
Ukraine
Uzbekistan
Vanuatu
Viet Nam
Yemen
Zambia

**LOW
INCOME**

Afghanistan
Bangladesh
Benin
Burkina Faso
Burundi
Cambodia
Central African Republic
Chad
Comoros
Democratic People's Republic of Korea
Democratic Republic of the Congo
Eritrea
Ethiopia
Gambia
Guinea
Guinea-Bissau
Haiti
Kenya
Kyrgyzstan
Liberia
Madagascar
Malawi
Mali
Mozambique
Myanmar
Nepal
Niger
Rwanda
Sierra Leone
Somalia
South Sudan
Tajikistan
Togo
Uganda
United Republic of Tanzania
Zimbabwe

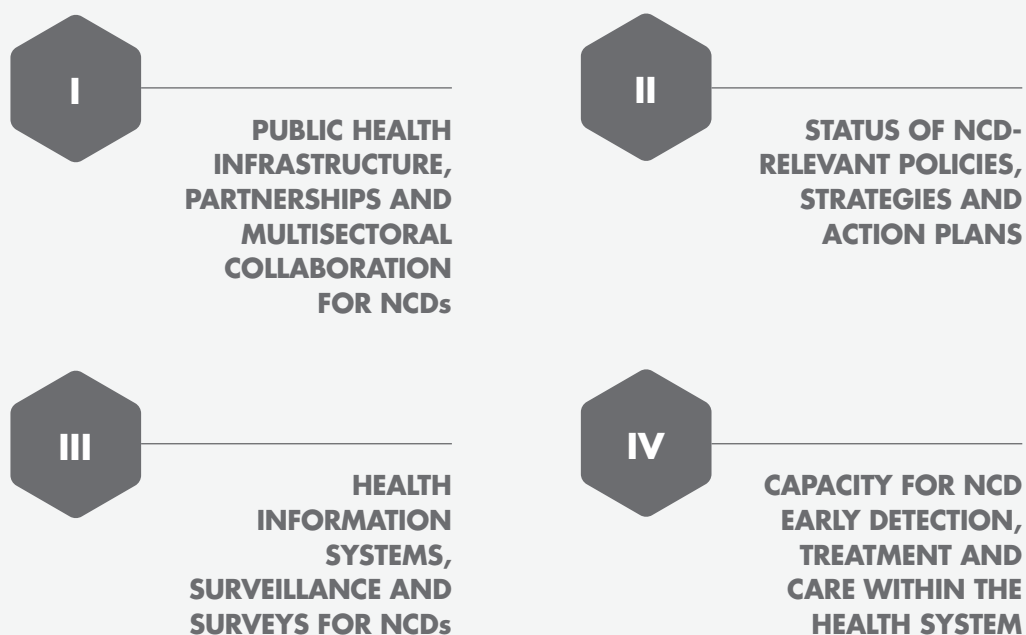
ANNEX 3.

QUESTIONNAIRE

2013

Country Profile of Capacity and Response to Noncommunicable Diseases (NCDs)

MODULES:



Purpose

- The purpose of this survey is to gauge your country capacity for responding to noncommunicable diseases. The four main types of noncommunicable diseases are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. It will guide Member States, WHO Regional Offices and WHO HQ in planning future actions and technical assistance required to address NCDs.
- This is also the basis for ongoing assessment of changes in country capacity and response.
- Use of standardized questions allows comparisons of country capacities and responses. We have divided this survey into four modules, assessing four key aspects of NCD prevention and control.

Process

- The survey is intended to assess national level capacity and response to NCDs. If responsibility for health is decentralized to sub-national levels, it can also be applied at sub-national levels.
- A focal point or survey coordinator will need to be identified to coordinate and ensure survey completion. However, in order to provide a complete response, a group of respondents with expertise in the topics covered in the modules will be needed. Please use the following table to indicate the names and titles of all of those who have completed the survey and which sections they have completed.
- Please note that while there is space to indicate "Don't Know" for most questions, there should be very few of these. If someone is filling in numerous "Don't Knows", another person who is more aware of this information should be found to complete this section.

Information on those who completed the survey**Who is the focal point for completion of this survey?**

Name: _____

Position: _____

Contact Information: _____

Sections completed: _____

Name and contact information of others completing survey	Sections completed

PUBLIC HEALTH INFRASTRUCTURE, PARTNERSHIPS AND MULTISECTORAL COLLABORATION FOR NCDs



Is there a unit/branch/department in the ministry of health or equivalent with responsibility for NCDs?

Yes No Don't know **IF NO: Go to Question 2.**

Does this responsibility include:

- | | | | |
|------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| i) Planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| ii) Coordination of implementation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| iii) Monitoring and evaluation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

Which areas are covered:

- | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| i) Primary prevention and health promotion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| ii) Early detection/screening | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| iii) Health care and treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| iv) Surveillance, monitoring and evaluation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| v) Capacity building | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| vi) Rehabilitation services | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

Is there at least one full-time person/staff member working on NCDs?

Yes No Don't know



2

Are NCDs, or their key risk factors, addressed by any other government ministry or department (e.g. ministry of sport, ministry of education)?

Yes No Don't know

3

Is there funding for the following NCD activities/ functions?

- i) Primary prevention and health promotion Yes No Don't know
- ii) Early detection/screening Yes No Don't know
- iii) Health care and treatment Yes No Don't know
- iv) Surveillance, monitoring and evaluation Yes No Don't know
- v) Capacity building Yes No Don't know
- vi) Rehabilitation services Yes No Don't know

If at least one Yes to above questions:

3a

What are the major sources of funding for NCDs? More than one can apply, rank order them where: 1 = Largest source; 2 = Next largest; 3 = Others

- General government revenues
- Health insurance
- International donors
- Earmarked taxes on alcohol, tobacco, etc.
- Other (specify) _____
- Don't know

4

Is your country implementing any of the following fiscal interventions?

- taxation on alcohol Yes No Don't know
- taxation on tobacco Yes No Don't know
- taxation on high sugar content food and non-alcoholic beverages Yes No Don't know
- taxation on high fat foods Yes No Don't know
- price subsidies for healthy foods Yes No Don't know
- taxation incentives to promote physical activity Yes No Don't know

**If Yes to at least one of the above:
4a) What is the principal motivation for fiscal interventions?**

- Raising general revenues
- Raising funds for health
- Influencing health behaviours
- Don't know

Is there a formal multisectoral mechanism established to coordinate NCD policies?

- Yes No Don't know

Indicate its stage:

- Operational
- Under development
- Not in effect
- Don't know

**Does your country have any partnerships/
collaborations for implementing key activities related
to NCDs?**

- Yes No Don't know **IF NO, skip to module II.**

**What are the main mechanisms for any partnership/
collaboration?**

(Check all that apply)

- Cross-departmental/ministerial committee
- Interdisciplinary committee
 - Joint task force
 - Other (specify) _____
 - Don't know



6b

Which of the following are key stakeholders?

(Check all that apply)

- Other government ministries (non-health, e.g. ministry of sport, ministry of education)
- United Nations Agencies
- Other international institutions
- Academia (including research centres)
- Nongovernmental organizations/community-based organizations/civil society
- Private sector
- Other (specify)
- Don't know

6c

What content areas or settings are covered by any partnerships/collaborations?

Comprehensive NCDs Yes No Don't know

Content areas

- Harmful use of alcohol Yes No Don't know
- Unhealthy diet Yes No Don't know
- Physical inactivity Yes No Don't know
- Tobacco Yes No Don't know
- Cancer Yes No Don't know
- Cardiovascular diseases Yes No Don't know
- Chronic respiratory diseases Yes No Don't know
- Diabetes Yes No Don't know
- Hypertension Yes No Don't know
- Overweight/obesity Yes No Don't know
- Abnormal blood lipids Yes No Don't know

Settings

- Schools Yes No Don't know
- Worksites Yes No Don't know
- Cities Yes No Don't know

STATUS OF NCD-RELEVANT POLICIES, STRATEGIES, AND ACTION PLANS



Are NCDs included in your national health plan and/or your national development agenda?



- Yes, in national health plan
- Yes, in national development plan
- Yes, in both national health plan and national development plan
- No
- Don't know

INTEGRATED POLICIES, STRATEGIES, AND ACTION PLANS



Does your country have a national NCD policy, strategy or action plan which integrates several NCDs and their risk factors?



Please note that disease- and risk factor-specific policies, strategies, and action plans will be reported in other questions later in this module.

- Yes No Don't know **IF NO: Skip to Question 3.**

If yes:

- | | | | |
|--------------------------|------------------------------|-----------------------------|-------------------------------------|
| Is it a policy/strategy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Is it an action plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Is it multisectoral? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Is it multistakeholder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

Please provide the following information about the policy, strategy or action plan:

2a

Write the title: _____

2b

Is there a web site? Yes No Don't know

If yes, please give the web address: _____

2c

Does it address one or more of the following major risk factors?

- | | | | |
|------------------------|------------------------------|-----------------------------|-------------------------------------|
| Harmful use of alcohol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Unhealthy diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Physical inactivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Tobacco | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

2d

Does it combine early detection, treatment and care for:

- | | | | |
|------------------------------|------------------------------|-----------------------------|-------------------------------------|
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Cardiovascular diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Chronic respiratory diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Overweight/obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

2e

Indicate its stage:

- Operational
- Under development
- Not in effect
- Don't know

If Operational:

2e-i) What was the first year of implementation? _____

POLICIES, STRATEGIES, ACTION PLANS FOR MAJOR DISEASES



Is there a policy, strategy, or action plan for cardiovascular diseases in your country?

Yes No Don't know **IF NO: Skip to Question 4.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

Indicate its stage:

Operational

Under development

Not in effect

Don't know

If Operational:

3c-i) What was the first year of implementation? _____

Is there a policy, strategy, or action plan for cancer in your country?

Yes No Don't know **IF NO: Skip to Question 5.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

3

3a

3b

3c

4

4a

4b

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

4c

Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

4c-i) What was the first year of implementation? _____

5

Is there a policy, strategy, or action plan for diabetes in your country?

Yes No Don't know **IF NO: Skip to Question 6.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

5a

Write the title _____

5b

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

5c

Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

5c-i) What was the first year of implementation? _____

Is there a policy, strategy, or action plan for chronic respiratory diseases in your country?

6

Yes No Don't know **IF NO: Skip to Question 7.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

6a

Is there a web site?

6b

Yes No Don't know

If yes, please give the web address: _____

6c

Indicate its stage:

Operational

Under development

Not in effect

Don't know

If Operational:

6c-i) What was the first year of implementation? _____

Is there a policy, strategy, or action plan for another noncommunicable disease of importance in your country?

7

Yes No Don't know **IF NO: Skip to Question 8.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Please provide the following information about the policy/strategy/action plan. If there is more than one, please provide the information for the most recent one.

Please specify which NCD: _____

7a

Write the title _____

7b

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

7c

Indicate its stage:

Operational

Under development

Not in effect

Don't know

If Operational:

7c-i) What was the first year of implementation? _____

POLICIES, ACTION PLANS, STRATEGIES FOR NCD RISK FACTORS



Is there a policy, strategy, or action plan for reducing the harmful use of alcohol in your country?

Yes No Don't know **IF NO: Skip to Question 7.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

8

8a

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

8b

Indicate its stage:

Operational

Under development

Not in effect

Don't know

8c

If Operational:

8c-i) What was the first year of implementation? _____

Indicate the settings for any interventions under the policy/strategy/action plan.

(Mark all that apply or select "Don't know" at the bottom of the list if not known)

Health-care facility

Community

School

Workplace

Household

Other (specify) _____

Don't know

8d

9

Is there a policy, strategy, or action plan for reducing overweight/obesity in your country?

Yes No Don't know **IF NO: Skip to Question 10.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

9a

Write the title _____

9b

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

9c

Indicate its stage:

Operational

Under development

Not in effect

Don't know

If Operational:

9c-i) What was the first year of implementation? _____

9d

Indicate the settings for any interventions under the policy/strategy/ action plan.

(Mark all that apply or select "Don't know" at the bottom of the list if not known)

Health-care facility

Community

School

Workplace

Household

Other (specify) _____

Don't know

Is there a policy, strategy, or action plan for reducing physical inactivity in your country?

10

Yes No Don't know **IF NO: Skip to Question 11.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

10a

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

10b

Indicate its stage:

Operational

Under development

Not in effect

Don't know

10c

If Operational:

10c-i) What was the first year of implementation? _____

Indicate the settings for any interventions under the policy/strategy/action plan.

10d

(Mark all that apply or select "Don't know" at the bottom of the list if not known)

Health-care facility

Community

School

Workplace

Household

Other (specify) _____

Don't know

11

Is there a policy, strategy, or action plan to decrease tobacco use in your country?

Yes No Don't know **IF NO: Skip to Question 12.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

11a

Write the title _____

11b

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

11c

Indicate its stage:

Operational

Under development

Not in effect

Don't know

If Operational:

11c-i) What was the first year of implementation? _____

11d

Indicate the settings for any interventions under the policy/strategy/action plan.

(Mark all that apply or select "Don't know" at the bottom of the list if not known)

Health-care facility

Community

School

Workplace

Household

Other (specify) _____

Don't know

Is there a policy, strategy, or action plan for reducing unhealthy diet related to NCD (salt, fat, sugar intake; low fruit and vegetable intake) in your country?

12

Yes No Don't know **IF NO: Skip to Question 13.**

If yes:

Is it a policy/strategy? Yes No Don't know

Is it an action plan? Yes No Don't know

Write the title _____

12a

Is there a web site?

Yes No Don't know

If yes, please give the web address: _____

12b

Indicate its stage:

Operational

Under development

Not in effect

Don't know

12c

If Operational:

12c-i) What was the first year of implementation? _____

Indicate the settings for any interventions under the policy/strategy/action plan.

12d

(Mark all that apply or select "Don't know" at the bottom of the list if not known)

Health-care facility

Community

School

Workplace

Household

Other (specify) _____

Don't know

13

Is your country implementing any policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt?

Yes No Don't know **IF NO: Skip to Question 14.**

13a

If yes, are the policies:

voluntary/self-regulating
enforced through legislation

13b

Are these targeted to:

Schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Broadcast media (TV/radio)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Print media (e.g. billboards, magazines)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Web-based social media	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sporting events	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

14

Is your country implementing any policies to promote breastfeeding?

Yes No Don't know

14a

If yes, are the policies:

Voluntary/self-regulating
 Enforced through legislation
 Don't know

15

Is your country implementing the International Code of Marketing of Breast-Milk Substitutes?

Yes No Don't know

15a

If yes, are the policies:

Voluntary/self-regulating
 Enforced through legislation
 Don't know

Is your country implementing any national policies that limit saturated fatty acids and virtually eliminate industrially produced trans-fats (i.e. partially hydrogenated vegetable oils) in the food supply?

Yes No Don't know

If yes, are the policies:

Voluntary/self-regulating
 Enforced through legislation
 Don't know

Is your country implementing any policies that promote population salt consumption reduction?

Yes No Don't know

If yes, are the policies:

Voluntary/self-regulating
 Enforced through legislation
 Don't know

Are these targeted at:

Product reformulation by industry Yes No Don't know
Consumer awareness campaigns Yes No Don't know

Is NCD prevention and control included in any other broader national policy, strategy or action plan that addresses a specific target population (e.g. adolescents, women, indigenous people) or specific setting (e.g. schools, cities)?

Yes No Don't know

What is the title? _____

16

16a

17

17a

17b

18

18a

HEALTH INFORMATION SYSTEMS, SURVEILLANCE AND SURVEYS FOR NCDs



In your country, who has responsibility for surveillance of NCDs and their risk factors?

- An office/department/administrative division within the Ministry of Health (MOH) exclusively dedicated to NCD surveillance
- An office/department/ administrative division within the MOH not exclusively dedicated to NCD surveillance
- Responsibility is shared across several offices/departments/administrative divisions within the MOH
- Coordination is by an external agency, such as an NGO or statistical organization
- No one has this responsibility
- Don't know

DATA INCLUDED IN THE NATIONAL HEALTH INFORMATION SYSTEM

(National health information system refers to the annual or regular reporting system of the National Statistical Office or Ministry of Health)

Does your country have a system for generating mortality by cause of death on a routine basis?

- Yes No Don't know

IF YES:

Is there a civil/vital registration system?

- Yes No Don't know



IF YES:

Certification by a medical practitioner

Verbal autopsy

Other (specify) _____

Don't know

2a
i

Do the data include:

Deaths occurring outside of medical facilities Yes No Don't know

Deaths that occur in medical facilities Yes No Don't know

2a
ii

Can the data collected be disaggregated by:

Age Yes No Don't know

Gender Yes No Don't know

Other sociodemographic factor Yes No Don't know

2a
iii

What is the latest year for which data is available? _____

2a
iv

At the national level, who is responsible for the final data?

Ministry of Health

Ministry of Family/Social Welfare or equivalent

Ministry of Interior/Home Affairs/Home Office

Central Statistics Office

Other (specify) _____

Don't know

2a
v

Is there a sample registration system?

Yes No Don't know

2b

IF YES:

How is cause of death determined?

Certification by a medical practitioner

Verbal autopsy

Other (specify) _____

Don't know

2b
i

2b

ii

Do the data include:

- Deaths occurring outside of medical facilities Yes No Don't know
- Deaths that occur in medical facilities Yes No Don't know

2b

iii

Can the data collected be disaggregated by:

- Age Yes No Don't know
- Gender Yes No Don't know
- Other sociodemographic factor Yes No Don't know

2b

iv

What is the latest year for which data is available? _____

3

Does your country have a cancer registry?

- Yes No Don't know

IF YES:

3a

Is it national or subnational?

- National
- Subnational
- Don't know

3b

Are the data collected population-based, hospital-based, or other?

- population-based
- hospital-based
- Other
- Don't know

3c

What is the latest year for which data is available? _____

RISK FACTOR SURVEILLANCE



	4a) Harmful alcohol use	4b) Low fruit and vegetable consumption	4c) Physical inactivity	4d) Tobacco use
<p>4) Have surveys of risk factors (may be a single risk factor or multiple) been conducted in your country for any of the following:</p> <p>(Please fill in all columns: start in the first row, going left to right, and then continue left to right across the second row.)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF NO: Skip to next column.</p> <p>IF YES: i) Was there a survey on adolescents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: i-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>i-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. GSHS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>i-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>i-4) When was the last survey conducted? (give year) _____</p> <p>i-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>i-6) When is the next survey planned? (give year) _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF NO: Skip to next column.</p> <p>IF YES: i) Was there a survey on adolescents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: i-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>i-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. GSHS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>i-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>i-4) When was the last survey conducted? (give year) _____</p> <p>i-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>i-6) When is the next survey planned? (give year) _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF NO: Skip to next column.</p> <p>IF YES: i) Was there a survey on adolescents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: i-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>i-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. GSHS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>i-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>i-4) When was the last survey conducted? (give year) _____</p> <p>i-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>i-6) When is the next survey planned? (give year) _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF NO: Skip to next column.</p> <p>IF YES: i) Was there a survey on adolescents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: i-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>i-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. GSHS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>i-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>i-4) When was the last survey conducted? (give year) _____</p> <p>i-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>i-6) When is the next survey planned? (give year) _____</p>

	4a) Harmful alcohol use	4b) Low fruit and vegetable consumption	4c) Physical inactivity	4d) Tobacco use
<p>4) Have surveys of risk factors (may be a single risk factor or multiple) been conducted in your country for any of the following:</p> <p>(Please fill in all columns: start in the first row, going left to right, and then continue left to right across the second row.)</p>	<p>ii) Was there a survey on adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: ii-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>ii-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>ii-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>ii-4) When was the last survey conducted? (give year) _____</p> <p>ii-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>ii-6) When is the next survey planned? (give year) _____</p>	<p>ii) Was there a survey on adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: ii-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>ii-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>ii-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>ii-4) When was the last survey conducted? (give year) _____</p> <p>ii-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>ii-6) When is the next survey planned? (give year) _____</p>	<p>ii) Was there a survey on adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: ii-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>ii-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>ii-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>ii-4) When was the last survey conducted? (give year) _____</p> <p>ii-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>ii-6) When is the next survey planned? (give year) _____</p>	<p>ii) Was there a survey on adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>IF YES: ii-1) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational</p> <p>ii-2) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey</p> <p>ii-3) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> International donors <input type="checkbox"/> Other (specify) _____</p> <p>ii-4) When was the last survey conducted? (give year) _____</p> <p>ii-5) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>ii-6) When is the next survey planned? (give year) _____</p>

	4e) Raised blood glucose/ diabetes	4f) Raised total cholesterol	4g) Raised blood pressure/ Hypertension	4h) Overweight and obesity	4i) Salt / Sodium intake
<p>4) Have surveys of risk factors (may be a single risk factor or multiple) been conducted in your country for any of the following:</p> <p>(Please fill in all columns: start in the first row, going left to right, and then continue left to right across the second row.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF NO: Skip to next column. IF YES: i) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational iii) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey iv) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) v) When was the last survey conducted? (give year) ____ vi) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK vii) When is the next survey planned? (give year) ____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF NO: Skip to next column. IF YES: i) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational iii) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey iv) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) v) When was the last survey conducted? (give year) ____ vi) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK vii) When is the next survey planned? (give year) ____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF NO: Skip to next column. IF YES: i) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational iii) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey iv) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) v) When was the last survey conducted? (give year) ____ vi) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK vii) When is the next survey planned? (give year) ____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF NO: Skip to next column. IF YES: i) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational iii) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey iv) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) v) When was the last survey conducted? (give year) ____ vi) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK vii) When is the next survey planned? (give year) ____ ii) Was there a survey on adults? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF YES: ii-1) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii-2) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational ii-3) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey ii-4) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) ii-5) When was the last survey conducted? (give year) ____ ii-6) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK ii-7) When is the next survey planned? (give year) ____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK IF NO: Skip to next column. IF YES: i) Was it: <input type="checkbox"/> Measured <input type="checkbox"/> Self-reported ii) Was it: <input type="checkbox"/> National <input type="checkbox"/> Subnational iii) Was it: <input type="checkbox"/> Part of a multi-RF survey (e.g. STEPS) <input type="checkbox"/> a standalone, single-issue survey iv) What was the primary source of funding? <input type="checkbox"/> Government funds <input type="checkbox"/> Int'l donors <input type="checkbox"/> Other (specify) v) When was the last survey conducted? (give year) ____ vi) Are the results published? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK vii) When is the next survey planned? (give year) ____

HEALTH SYSTEM CAPACITY FOR NCD PREVENTION, EARLY DETECTION, TREATMENT AND CARE WITHIN THE HEALTH SYSTEM



Which of the following components related to NCDs are provided in the health-care system?

	Provided in the Primary Health-Care System	Provided in the Secondary Health-Care System	Provided in the Tertiary Health-Care System
1a) Primary prevention and Health promotion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
1b) Risk factor detection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
1c) Risk factor and disease management	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
1d) Support for self-help and self-care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
1e) Support for home-based care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
1f) Rehabilitation services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know



The table below concerns recognized/government-approved, evidence-based national guidelines for the management of NCDs. Please fill in each column.

	Cardiovascular Disease	Diabetes	Cancer	CRD	Tobacco Dependence
2a) Are they available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
2b) Are they being implemented?	<input type="checkbox"/> Yes, fully <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes, fully <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes, fully <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes, fully <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes, fully <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/> Don't Know

3

Indicate the availability of the following basic technologies for early detection, diagnosis/monitoring of NCDs at the primary health-care level, where: Generally available = 1; Generally not available = 2, Don't know = 3.

* Generally available: in 50% or more health-care facilities
 Generally not available: in less than 50% health-care facilities

	Availability in the public sector (1, 2, or 3)	Availability in the private sector (1, 2, or 3)	Are trained staff available? (1, 2, or 3)
Overweight and obesity 3a) Measuring of weight 3b) Measuring of height	_____ _____	_____ _____	_____ _____
Cancer 3c) Cervical cytology 3d) Acetic acid visualization 3e) Faecal occult blood test or faecal immunological test 3f) Bowel cancer screening by exam or colonoscopy 3g) Breast cancer screening by palpation 3h) Mammogram	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
Diabetes mellitus 3i) Blood glucose measurement 3j) Oral glucose tolerance test 3k) HbA1c test 3l) Foot vibration perception by tuning fork or foot vascular status by doppler	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Cardiovascular disease 3m) Blood pressure measurement 3n) Total cholesterol measurement 3o) Urine strips for albumin assay	_____ _____ _____	_____ _____ _____	_____ _____ _____
Asthma and COPD 3p) Peakflow measurement spirometry	_____ _____	_____ _____	_____ _____

4

Describe the availability of the medicines below in the Public Health Sector, where: Generally available = 1; Generally not available = 2, Don't know = 3.

* Generally available: in 50% or more pharmacies
Generally not available: in less than 50% of pharmacies

Generic drug name	Avail-ability*	Covered by health insurance or publically funded	Appears in the National List of Essential Medicines (NA option = not applicable, for those few MS who do not have an essential list of medicines)
4a) Insulin		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4b) Aspirin (100 mg)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4c) Metformin		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4d) Thiazide Diuretics		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4e) ACE Inhibitors		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4f) CC Blockers		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4g) Statins		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4h) Oral morphine		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4i) Steroid inhaler		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4j) Bronchodilator		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA
4k) Nicotine replacement therapy		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> NA

5

Indicate the availability of the following procedures for treating NCDs in the public health system, where: 1=Generally available; 2=Generally not available; 3=Don't know.

Procedure name	Availability
5a) Retinal photocoagulation	
5b) Renal replacement therapy by dialysis or transplantation	
5c) Radiotherapy	
5d) Chemotherapy	
5e) Coronary bypass or stenting	

6

Indicate the availability of community/home care for people with advanced/end stages of NCDs (e.g. advanced cancer pain management and palliative care, stroke sequelae, and disability care).

- Is it: Generally available
 Generally not available
 Don't know

ANNEX 4.

GLOSSARY OF TERMS USED IN THE SURVEY

Academia: Refers to educational institutions, especially those for higher education.

Broadcast media: Media which is broadcast to the public through radio and television.

Cancer: A generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumours and neoplasms. One defining feature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade adjoining parts of the body and spread to other organs.

Cancer registry: A systematic collection of data about cancer and tumour diseases.

Capacity: The ability to perform appropriate tasks effectively, efficiently and sustainably.

Capacity building: The development of knowledge, skills, commitment, structures, systems and leadership to enable effective action.

Chronic respiratory diseases: Diseases of the airways and other structures of the lung. Some of the most common are: asthma, chronic obstructive pulmonary disease, occupational lung diseases and pulmonary hypertension.

Civil registration: The system by which a government records the vital events of its citizens and residents, such as births, deaths and marital status, and cause of death.

Collaboration: A recognized relationship between different groups.

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values and norms and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Consumer awareness campaigns: An organized effort to give consumers more information about the need to reduce their salt consumption.

Determinants of health: The range of personal, social, economic and environmental factors which determine the health status of individuals or populations

Diabetes: A disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces.

Early detection/screening: Measures performed across an apparently healthy population in order to identify individuals who have risk factor or early stages of disease, but do not yet have symptoms.

Earmarked taxes: Taxes which are collected and used for a specific purpose.

Fiscal interventions: Measures taken by the government such as taxes and subsidies.

Free sugars: Monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups and fruit juices.

General government revenue: The money received from taxation, and other sources, such as privatization of government assets, to help finance expenditures.

Health: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. A resource for everyday life which permits people to lead an individually, socially and economically productive life. A positive concept emphasizing social and personal resources as well as physical capabilities.

Health behaviour: Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end.

Health care and treatment: The diagnosis and treatment of diseases.

Health-care facility: Facilities which provide health services. They may include mobile clinics, pharmacies, laboratories, specialty clinics, and private and faith-based establishments.

Health promotion: The process of enabling people to increase control over, and to improve their health.

Indigenous people: Ethnic groups that have historical ties to groups that existed in a territory prior to colonization or formation of a nation state, and which normally preserve a degree of cultural and political separation from the mainstream culture and political system of the nation state within the border of which the indigenous group is located.

Interdisciplinary: Involving two or more professions, disciplines or departments.

International Code of Marketing of Breast-milk Substitutes: An international health policy framework for breastfeeding promotion adopted by the World Health Assembly in 1981. The Code recommends restrictions on the marketing of breast-milk substitutes, such as infant formula to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed.

International donors: Organizations which extend across national boundaries and which give funds for projects of a development nature.

Intervention: Any measure whose purpose is to improve health or alter the course of disease.

Legislation: A law or laws which have been enacted by the governing bodies in a country.

Marketing: Any form of commercial communication or message that is designed to, or has the effect of, increasing the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.

Multisectoral: Involving agencies and organizations from the different sectors of society including government, NGOs, private-for profit, and civil society.

Multisectoral collaboration: A recognized relationship between part, or parts, of different sectors of society (such as ministries [e.g. health, education], agencies, non-government agencies, private for-profit sector and community representation) which has been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

Multistakeholder: Involving stakeholders from different agencies or organizations who may or may not be all within the same sector (e.g. health).

National focal point, unit/department:

- i. **National focal point:** the person responsible for prevention and control of NCDs in a ministry of health or national institute.
- ii. **Unit or department:** a unit or department with responsibility for NCD disease prevention and control in a ministry of health or national institute.

National health reporting system, survey and surveillance:

- i. **National health reporting system:** The process by which a ministry of health produces annual health reports that summarize data on e.g. national health human resources, population demographics, health expenditures, health indicators such as mortality and morbidity. Includes the process of collecting data from various health information sources, e.g. disease registries, hospital admission or discharge data.
- ii. **National survey:** A fixed or unfixed time interval survey on the main NCDs, or major risk factors common to NCDs.
- iii. **Surveillance:** The systematic collection of data (through survey or registration) on risk factors, NCDs and their determinants for continuous analysis, interpretation and feedback.

National integrated action plan: A concerted approach to addressing a multiplicity of issues within a NCD prevention and health promotion framework, targeting the major risk factors common to the main NCDs, including the integration of primary, secondary and tertiary prevention, health promotion and diseases prevention programmes across sectors and disciplines.

National policy, strategy, action plan/programme:

- i. **Policy:** A specific official decision or set of decisions designed to carry out a course of action endorsed by a political body, including a set of goals, priorities and main directions for attaining these goals. The policy document may include a strategy to give effect to the policy.
- ii. **Strategy:** a long-term plan designed to achieve a particular goal.
- iii. **Action plan:** A scheme of course of action, which may correspond to a policy or strategy, with defined activities indicating who does what (type of activities and people responsible for implementation), when (time frame), how, and with what resources to accomplish an objective.
- iv. **Programmes:** A planned set of activities or procedures directed at a specific purpose.

National protocols/guidelines/standards for NCDs and conditions:

A recommended evidence-based course of action to prevent an NCD or condition or to treat or manage an NCD or condition aiming to prevent complications, improve outcomes and quality of life of patients.

NGO: Nongovernmental organization.

Noncommunicable diseases (NCDs): The four main types of noncommunicable diseases are cardiovascular diseases (such as heart attack and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

Noncommunicable diseases prevention and control: All activities related to surveillance, prevention and management of the chronic noncommunicable diseases.

Not in effect: Any policy, strategy or plan of action which has been previously developed but for various reasons is not being implemented, or is no longer under development, .

Operational: A policy, strategy or plan of action which is being used and implemented in the country, and has resources and funding available for its implementation.

Partnership for health: An agreement between two or more partners to work cooperatively towards a set of shared health outcomes.

Price subsidies: Economic benefit provided by the government (such as a tax allowance or duty rebate) to keep the price of healthy foods low.

Primary prevention: Measures directed towards preventing the initial occurrence of a disease or disorder.

Print media: Communicating with the public through printed materials such as magazines, newspapers and billboards.

Product reformulation by industry: The process of changing the composition of processed foods to be healthier and reduce the salt content.

Rehabilitation: A set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments.

Rehabilitation services: Include rehabilitation medicine, therapy and assistive technology.

Risk factors associated with noncommunicable diseases: Most common are tobacco use, harmful use of alcohol, unhealthy diet and low levels of physical activity.

Sample registration system: A method and procedure for estimating vital statistics in national and regional populations by intensively registering and verifying vital events in population samples. For example, in India more than 4000 rural and 2000 urban sample units, with a total of more than 6 million people (i.e. less than 1% of the total national population), are included in a sample registration system that provides a reasonably reliable picture of the national pattern of vital events at a cost that is feasible and reasonable.

Saturated fats: Fats found in animal products, including meat and whole milk dairy products, as well as certain plant oils like palm, palm kernel and coconut oils.

Self-regulation: In this context refers to when group or private sector entity governs or polices itself without outside assistance or influence.

Target: A specific aim to be achieved which should be time bound, and define a “desired”, “promised”, “minimum” or “aspirational” level of achievement.

Taskforce: A temporary group formed for the purpose of accomplishing a specific objective or activity.

Taxation incentives: Involve removing the tax (or a portion of the tax) in order to promote increased use of goods or services to encourage physical activity.

Trans fatty acids (trans fats): A form of fatty acids. While trans fats do occur in tiny amounts in some foods, almost all the trans fats come from an industrial process that partially hydrogenates (i.e. adds hydrogen to) unsaturated fatty acids. Trans fats are therefore a form of processed vegetable oils.

Under development: Something which is still being developed or finalized and is not yet being implemented in the country.

Verbal autopsy: A method used to obtain cause of death by interviewing lay respondents on the signs and symptoms experienced by the deceased before death. It is used where vital registration systems are weak or the proportion of a population under medical care is low and there was no medical certification of the death.

Web-based social media: Uses web-based technologies to communicate between organizations, communities, and individuals. Common examples include Facebook and Twitter.



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