Progress on the Prevention and Control of Noncommunicable Diseases in the Western Pacific Region

Country Capacity Survey 2017

World Health Organization
Western Pacific Region

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FOREWORD

Noncommunicable diseases or NCDs kill 40 million people each year globally. Three out of 10 of those who die from these diseases – mainly cardiovascular diseases, cancer, diabetes and chronic respiratory diseases – come from the Western Pacific Region.

Rising rates of NCDs and risk factors pose an ever-growing threat to public health, and a challenge to economic and social development in the Region. People in low- and middle-income countries are especially vulnerable to these largely preventable diseases.

Leaders globally are committed to fight NCDs. The 2030 Agenda for Sustainable Development calls for a reduction by one third of premature mortality from NCDs by 2030. This target builds on the momentum from the 2011 high-level political meeting of United Nations devoted to NCDs — which is one of the few occasions in history when the General Assembly has convened exclusively to address a public health issue.

Progress on the Prevention and Control of Noncommunicable Diseases in the Western Pacific Region: Country Capacity Survey 2017 updates assessments of Member State efforts to fight NCDs. These findings form a key part of the global WHO report to the United Nations, in preparation for the third High-level Meeting on the Prevention and Control of Non-communicable Diseases in September.

The meeting will include a review of progress on NCD prevention and control efforts within countries and globally. The General Assembly will also look at ways to ensure that individual countries can meet ambitious NCD targets.

While we all take great pride in the Region's progress against NCDs, we realize that much more work remains to be done. We hope this publication will help countries and areas in the Western Pacific Region to assess their accomplishments, and strengthen commitments for bolder action.

As always, WHO will continue to provide strong support to Member States to reach our shared goal of reducing premature deaths from NCDs.

Thank you.

Shin Young-soo, MD, Ph.D.
WHO Regional Director for the Western Pacific

ABBREVIATIONS

CCS	Country Capacity Survey
CRD	chronic respiratory disease
CVD	cardiovascular disease
GINA	Global database on the Implementation of Nutrition Action
HICs	high-income countries and areas
HPV	human papillomavirus
ICD	International Classification of Diseases
LMICs	low- and middle-income countries and areas
NCD	noncommunicable disease
PEN	Package of Essential NCD Interventions
PICs	Pacific island countries and areas
STEPS	STEPwise approach to surveillance
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

Noncommunicable diseases (NCDs) – especially cardiovascular diseases (CVDs), cancer, diabetes and chronic respiratory diseases (CRDs) – are the leading cause of death and are responsible for 71% of deaths worldwide and 86% in the WHO Western Pacific Region. These NCDs share modifiable behavioural risk factors such as tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol, which lead to four metabolic/physiologic changes – raised blood pressure, overweight and obesity, raised blood glucose, and raised cholesterol.

Global and regional commitments were made to respond to the growing NCD epidemic, including the *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases* in September 2011 and development of the WHO *Global Action Plan for the Prevention and Control of NCDs 2013–2020,* the *Western Pacific Regional Action Plan for the Prevention and Control of NCDs 2014–2020* and the WHO Global Monitoring Framework for NCDs, which contains the nine voluntary global NCD targets and 25 indicators to be achieved by 2025.

To monitor the progress and achievements of countries in expanding national capacities to respond to the NCD epidemic, WHO periodically conducts the NCD Country Capacity Survey (CCS). The latest round of the NCD CCS took place in 2017. The first time countries and areas of the Western Pacific Region participated in the survey was in the second round in 2005; the Region has participated in all the succeeding rounds in 2010, 2013, 2015 and 2017.

Progress on the Prevention and Control of NCDs in the Western Pacific Region: Country Capacity Survey 2017 presents a snapshot of the progress on NCD prevention and control in the Region in terms of infrastructure, policies, health information systems and health systems capacity as collected in the NCD CCS 2017. Countries were grouped in the analysis based on the World Bank classification of income status – high-income countries (HICs) and low- and middle-income countries (LMICs) – while Pacific island countries and areas (PICs), including Papua New Guinea, were grouped as one subregion.

The latest round of the NCD CCS in 2017 shows that some progress has been made since 2015 in the capacity of countries in overall NCD prevention and control. In terms of infrastructure, the number of dedicated staff for NCDs has increased during this time period, as well as instances of shifts from other sources to government budget allocation for NCD programmes and activities. In addition to the most prevalent fiscal interventions, which are taxation on tobacco and alcohol, other interventions have slowly been emerging in the Region, such as taxation on sugar-sweetened beverages and price subsidies for healthy foods.

A considerable number of countries in the Region have also been able to develop national multisectoral NCD policies, strategies and action plans that integrate the main NCDs and their risk factors. Some countries and areas have also reported positive change in developing specific policies since 2015, with most policies made addressing the NCD risk factors, especially the harmful use of alcohol. The number of countries reporting that they have a policy or plan on NCD-related research has also more than doubled from five countries in 2015 to 13 countries and areas in 2017.

The majority of the countries and areas in the Region reported having a system for reporting mortality data by cause and for recording patient information that include NCD status. Disease registration has also shown some progress, with a couple of countries able to initiate work on the establishment of a cancer registry; however, these are ad hoc and neither population- nor hospital-based. Diabetes registries have been reported to exist in at least half of the countries and areas in the Region. Recent NCD risk factor surveys that collect information on the NCD risk factors for both adults and adolescents are being collected in half of the countries and areas in the Region. The least-reported NCD risk factor included in these surveys is related to the measurement of salt/sodium intake, which is similar to the findings from the NCD CCS 2015.

Evidence-based national guidelines/protocols/standards for the management of diabetes and CVDs are the most commonly available guideline in the Region; however, utilization in at least 50% of the health-care facilities is only the case for 60% of the existing guidelines. Eighty per cent of existing guidelines on the management of diabetes, CVDs and cancer have referral criteria, while only 68% of the existing guidelines for CRDs include referral criteria. Basic technologies to measure blood pressure, height, weight and blood glucose are generally available in the majority of countries and areas in the Region, while tests to measure diabetes complications, asthma and chronic obstructive pulmonary disease (COPD) are the least available.

National screening programmes for cancers of the cervix and breast are most prevalent in the Region, with pap smear and mammography, respectively, being the most widely used initial screening methods. However, only one fourth of the countries and areas in the Region indicated that more than half of the target population is covered by the screening programme for breast cancer. Forty per cent of the countries and areas in the Region reported that more than half of the target population is covered by screening programmes for cancers of the cervix and colon. A vaccination programme for human papillomavirus (HPV) was reported to be present in 22 countries and areas in the Region; however, only 10 countries reported that at least 50% of the target population is covered. Pathology services for cancer diagnosis are reported to be the most common cancer diagnosis and treatment service available in the public sector, followed by cancer surgery.

A wide variation of countries and areas in the Region (34–91%) reported having essential medicines generally available for management of the main NCDs in the public health sector. Aspirin (100 mg) and thiazide diuretics are the most readily available medicines while nicotine replacement therapy and oral morphine are the least available.

Palliative care was reported to be generally available in 23 countries and areas in the Region, majority of which are HICs, with most providing community- or home-based care.

Cardiovascular risk stratification at primary care facilities is available in 26 of the 35 countries and areas in the Western Pacific Region, but only 13 reported coverage of more than half of the target population.

Provision of care for acute stroke is slightly more prevalent than rehabilitation of stroke patients in the public sector facilities in the Region. Most PICs (75%) reported having a register of patients who have rheumatic fever and rheumatic heart disease, compared to one fourth of the HICs and none of the LMICs.

All the HICs in the Region reported availability of retinal photocoagulation, renal replacement therapy by dialysis, renal replacement by transplantation, coronary bypass, stenting and thrombolytic therapy, while these are available in at least a third of the LMICs. In the Pacific, there is variation in availability (10–55% of the PICs), with thrombolytic therapy and retinal photocoagulation as the most available of these treatment procedures.

The progress monitoring indicators that were most achieved in the Region – either fully or partially – are: having a recent STEPwise approach to surveillance (STEPS) or a comprehensive health examination survey (fully achieved by 15 countries and areas); having evidence-based national guidelines/protocols/standards for the management of the major NCDs (fully achieved by 12 countries and areas); and having a set of time-bound national targets based on WHO guidance (fully achieved by 14 countries and areas). The progress monitoring indicators that are least achieved in the Region are: bans and restrictions on exposure to alcohol advertising; measures to reduce unhealthy diets; and a functioning system for generating reliable cause-specific mortality data on a routine basis. In terms of progress, more countries and areas have improved their 2015 assessment in 2017, especially in the two indicators for health systems to address NCDs.

CHAPTER 1

INTRODUCTION

Noncommunicable diseases (NCDs), mainly cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, are the leading cause of death and are responsible for 71% of deaths worldwide and 86% in the WHO Western Pacific Region *(1)*. These NCDs share behavioural risk factors that are modifiable, such as tobacco use, unhealthy diet, lack of physical activity and the harmful use of alcohol, which in turn lead to four metabolic/physiologic changes – raised blood pressure, overweight and obesity, raised blood glucose and raised cholesterol.

In response to the NCD epidemic, global and regional commitments were made which include the United Nations (UN) *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases* in September 2011 *(2)*, the WHO *Global Action Plan for the Prevention and Control of NCDs 2013–2020 (3)* and the *Western Pacific Regional Action Plan for the Prevention and Control of NCDs 2014–2020 (4)*. The WHO Global Monitoring Framework for NCDs was also developed and endorsed to monitor the progress in the prevention and control of NCDs. The framework includes the nine voluntary global NCD targets and 25 indicators to be achieved by 2025. In 2014, the High-level Meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of NCDs was held to evaluate the progress made on NCD prevention and control, which resulted in the Outcome Document *(5)* and establishment of the four time-bound commitments.

To monitor the progress and achievements of countries in expanding national capacities to respond to the NCD epidemic, WHO has conducted the NCD Country Capacity Survey (CCS) since 2001– and its latest round was in 2017. Countries and areas in the Western Pacific Region have participated in the NCD CCS since the second round in 2005 and the succeeding rounds in 2010, 2013, 2015 and 2017. As was the case in the previous rounds, the survey collects information related to NCD governance and infrastructure, policy response, surveillance, and health systems response at the national level, with some modifications to the questions to make them consistent with the global NCD indicators. The results of the 2015 and 2017 surveys will be included in the report on progress at the Third High-level Meeting of the United Nations General Assembly on the prevention and control of NCDs in 2018.

Progress on the Prevention and Control of Noncommunicable Diseases in the Western Pacific Region: Country Capacity Survey 2017 presents the data gathered from the NCD CCS 2017 and provides a comparison between the previous rounds. Results of the survey will be used to better guide countries and areas in the Western Pacific Region in further strengthening national capacities to respond to the NCD epidemic.

CHAPTER 2

STATUS OF RESPONSE TO PREVENT AND CONTROL NCDs IN THE WESTERN PACIFIC REGION IN 2017

The 2017 NCD CCS is a global survey conducted by WHO to assess the strengths and weaknesses related to NCD governance and infrastructure, policy response, surveillance and health systems response. Data collection and validation were carried out in the Western Pacific Region from February to September 2017.

The 2017 NCD CCS questionnaire (Annex 1) was developed by WHO through a consultative process with relevant technical departments in WHO headquarters and all WHO regional offices. The web-based questionnaire is composed of four modules, as listed below, and includes a set of detailed instructions and a glossary to guide countries in completing the survey:

- Public health infrastructure, partnerships and multisectoral collaboration for NCDs and their risk factors;
- Status of NCD-relevant policies, strategies and action plans;
- Health information systems, surveillance and surveys for NCDs and their risk factors; and
- Capacity for NCD early detection, treatment and care within the health system.

Official communication was sent to all countries and areas in the Region, except the Pitcairn Islands, to nominate a focal point from each who can serve as representatives from their respective ministries of health responsible for the NCD unit or a related unit handling NCDs. Once the nominations were received, unique access codes were sent to the focal points to log in to the survey. The focal points were also encouraged to work collaboratively with colleagues and relevant offices to obtain the most updated and accurate responses. For validation and verification responses, supporting documents were requested to be submitted and uploaded to the online portal for some questions as indicated. Responses were considered as "No" or not achieved if the required supporting document or documents were not submitted.

Upon completion of the survey and as part of the validation process, the designated staff from the WHO regional offices and WHO headquarters reviewed the submissions of countries and areas for completeness, discrepancies with existing data sources and missing supporting documents. The existing data sources included GLOBOCAN from the International Agency

for Research on Cancer (IARC), WHO mortality database and the list of WHO-supported NCD risk factor surveys from WHO headquarters. Submissions were also compared to the 2015 NCD CCS responses to determine whether the differences in responses indicated progress or corrections of a previous responses. A clarification request with a list of queries and comments was sent to the NCD focal points for them to address or clarify, as needed. However, due to some limitations, not all countries were able to address the queries raised and/or submit the required supporting documents.

In the Western Pacific Region, 35 of the 36 countries and areas completed the 2017 NCD CCS, giving a response rate of 97%. The response rate in 2017 was higher than the 89% response rate in 2015. Moreover, of the 35 countries and areas that responded to the survey, 27 countries and areas completed the validation process during the allotted period.

The information submitted by countries and areas was extracted from the web-based platform to an Excel-readable file. Data cleaning was performed to ensure consistency between answers in the questions and sub-questions. Data analysis was conducted per module using Microsoft Excel.

Countries and areas that participated in the 2017 NCD CCS were grouped in the analysis based on income status – high-income countries (HICs) and low- and middle-income countries (LMICs) *(6)* – while Pacific island countries and areas (PICs), including Papua New Guinea, were grouped as one subregion **(Table 1)**. The first part of the report presents the results of the 2017 NCD CCS based on the 35 countries and areas (8 HICs, 7 LMICs and 20 PICs) that responded to the survey, and this number was also used as the denominator in the descriptive analysis to avoid fluctuating denominators between the survey questions and sub-questions.

Table 1. Countries and areas in the Western Pacific Region that participated in the NCD CCS 2017, by World Bank income level and subregion

High-income countries and areas (N=8)	Low- and middle-income countries (N=7)	Pacific island countries and areas v(N=20)	
Australia	Cambodia	American Samoa	Niue
Brunei Darussalam	China	Cook Islands	Northern Mariana Islands (Commonwealth of the)
Hong Kong SAR (China)	Lao People's Democratic Republic	Fiji	Palau
Japan	Malaysia	French Polynesia	Papua New Guinea
Macao SAR (China)	Mongolia	Guam	Samoa
New Zealand	Philippines	Kiribati	Solomon Islands
Republic of Korea	Viet Nam	Marshall Islands	Tokelau
Singapore		Micronesia (Federated States of)	Tonga
		Nauru	Tuvalu
		New Caledonia	Vanuatu

A. Public health infrastructure, partnership and multisectoral collaboration for NCDs and their risk factors

Unit, branch or department responsible for NCDs

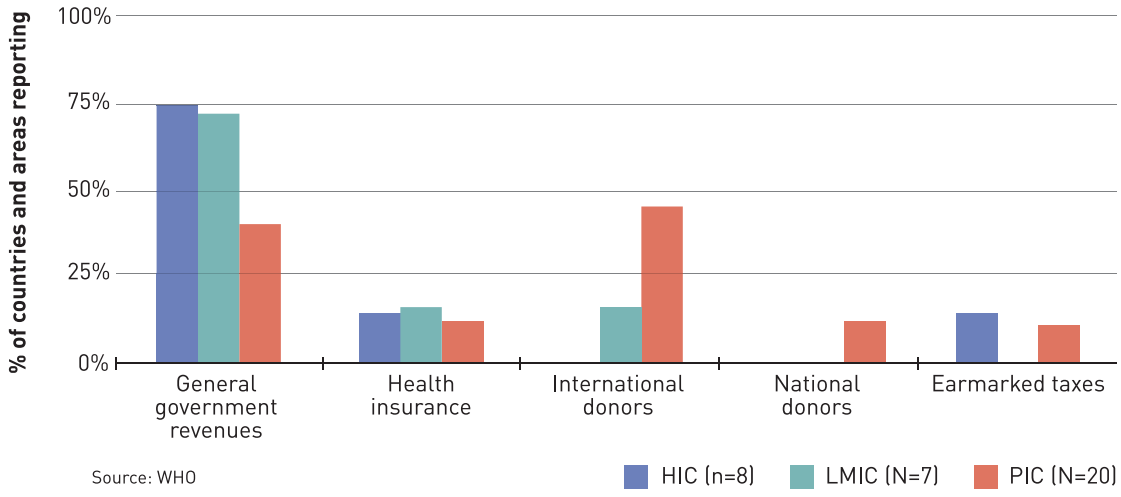
In the Western Pacific Region, 33 of the 35 countries and areas reported having a unit, branch or department responsible for NCDs within the ministry of health or its equivalent. More than half (66%) of countries and areas in the Region reported having at least 6–10 full-time technical staff on NCDs. Since 2015, Kiribati has institutionalized an NCD unit, while Fiji, Guam, Mongolia, New Caledonia and Niue have increased the number of full-time equivalent technical or professional staff in the NCD unit.

Funding mechanisms

The most-funded NCD or risk factor activities/functions are health care and treatment (34/35) and health promotion (34/35), followed by primary prevention (33/35), early detection/screening (32/35) and surveillance, monitoring and evaluation (31/35) as reported in the survey. The least-funded NCD activities/functions are research (24/35), capacity-building (27/35) and palliative care (27/35). The availability of funding increased in all the NCD activities/functions asked about in the survey, with the most for primary prevention; early detection/screening; surveillance, monitoring and evaluation; and palliative care, for which Fiji, Hong Kong SAR (China), the Lao People's Democratic Republic, Niue and Vanuatu indicated positive change in the allocation.

In decreasing order of frequency, the following are reported to be the major sources of funding for NCDs in the Western Pacific Region: general government revenues (54%), international donors (29%), health insurance (11%), earmarked taxes (8%) and national donors (6%). General government revenues are the major sources of funding for NCDs and their risk factors in HICs (6/8) and LMICs (5/7). In PICs, international donors remain the major source of funding for NCDs and risk factors (9/18) **(Fig. 1)**. Cambodia, New Caledonia, Niue and Vanuatu have reported change of major sources of funding from international and national donors to general government revenues and earmarked taxes.

Fig. 1. Major sources of funding for NCDs and their risk factors



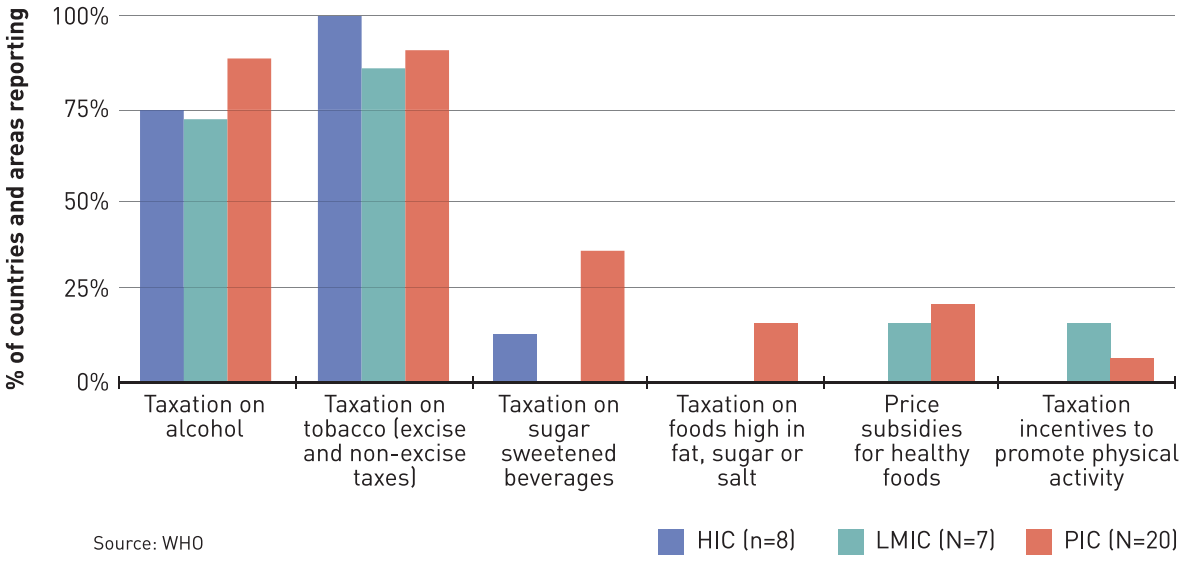
Fiscal interventions

Thirty-three of the 35 countries and areas in the Region reported at least one fiscal intervention **(Fig. 2)**. Taxation on tobacco is the most reported fiscal intervention (32/35), followed by taxation on alcohol (28/35). Three fourths of the HICs, LMICs and PICs in the Region have existing fiscal measures on both alcohol and tobacco.

While fiscal interventions related to physical activity and diet are the least-reported fiscal interventions in the Region, a few countries in the Region have newly enacted taxation on sugar-sweetened beverages (Brunei Darussalam and Marshall Islands); taxation on foods high in fat, sugar or salt (French Polynesia); and price subsidies for healthy foods (Fiji, Marshall Islands and French Polynesia) since 2015.

When asked whether any of the fiscal interventions are allocated for health promotion or health service, one third of the countries and areas in the Region reported the allocation (13/35).

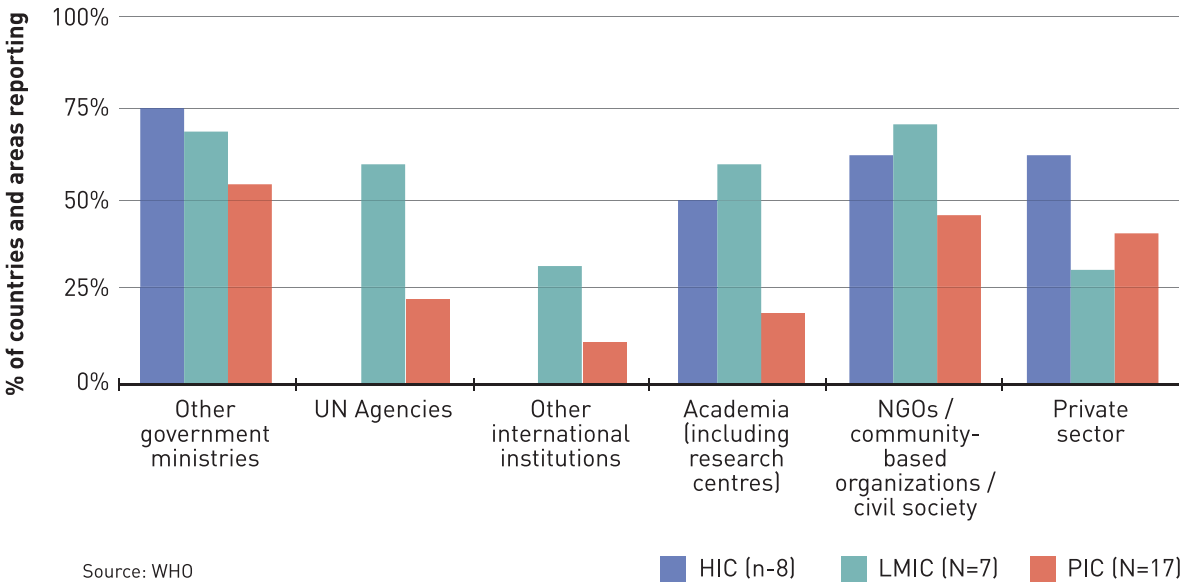
Fig. 2. Percentage of countries and areas with fiscal interventions to address NCD risk factors



Multisectoral commissions, agencies or mechanisms

Almost half of the countries and areas in the Region (49%) reported having a national multisectoral commission, agency or mechanism to oversee NCD engagement, policy coherence and accountability of sectors beyond health; however, only 11 are operational while three are under development and three are not in effect. The most common members of the national multisectoral commission are other non-health government ministries (11/35), followed by nongovernmental organizations (NGOs) (7/35) and the private sector (7/35) **(Fig. 3)**.

Fig. 3. Percentage of countries and areas with members in their national multisectoral commission, agency or mechanism



Source: WHO

B. Status of NCD-relevant policies, strategies and action plans

National policies, strategies and action plans

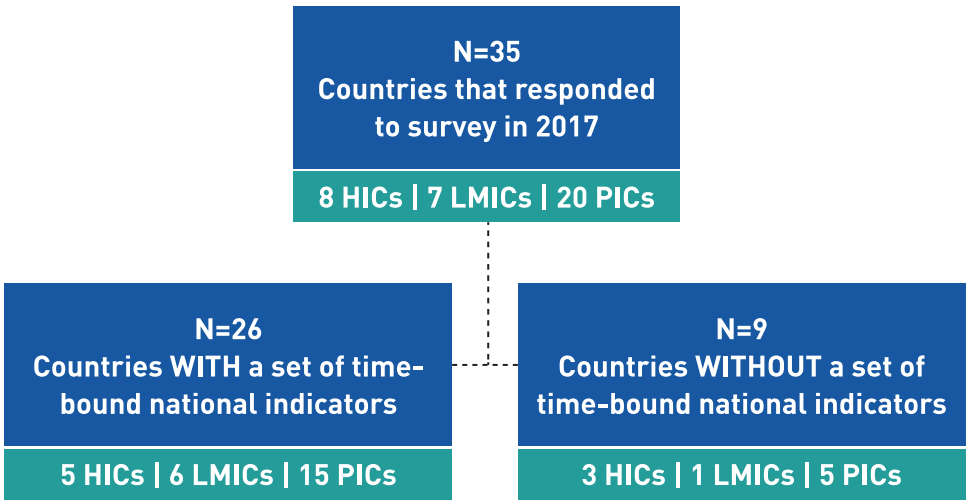
In the Western Pacific Region, 31 of the 35 countries and areas (8/8 HICs, 6/7 LMICs, 17/20 PICs) reported that NCDs are included in their national health plans, while only 19 countries and areas (4/8 HICs, 5/7 LMICs, 10/20 PICs) reported that NCDs are included in their national development plans.

Thirty out of the 35 countries and areas that fully responded to the survey reported having a national integrated NCD policy, strategy or action plan, however, only 25 are operational. Of the 25 operational integrated NCD policies, strategies or action plans, 22 are reported to be multisectoral in nature.

All countries and areas that responded as having an operational national integrated NCD policy, strategy or action plan addressed unhealthy diet and physical inactivity, while only 22 and 24 countries and areas addressed harmful use of alcohol and tobacco, respectively. For detection, treatment and care of NCDs, almost all of the operational NCD policies, strategies or action plans addressed early detection, treatment and care for diabetes and cardiovascular disease (CVD) (21/25), followed by cancer (20/25) and chronic respiratory diseases (CRDs) (13/25). Palliative care – as part of the operational NCD policy, strategy or action plan – is covered in 10 of the 25 countries and areas (3/7 HICs, 3/6 LMICs and 4/12 PICs).

Three fourths of the countries and areas in the Region (26/35) reported having time-bound national targets and indicators for NCDs based on the nine voluntary global targets from the *WHO Global Monitoring Framework for NCDs* **(Fig. 4)**.

Fig. 4. Number of countries and areas with a set of time-bound national targets and indicators for NCDs



Source: WHO

Specific policies, strategies and action plans

Table 2 shows that more than half of the countries and areas had an integrated or specific policy on the major NCDs and risk factors except for CRDs (40%). Policies, strategies or action plans addressing the NCD risk factors were widely prevalent in the Region, with at least 75% of the countries and areas addressing the harmful use of alcohol, unhealthy diet, physical inactivity and tobacco, as well as the major NCDs such as cancer and diabetes.

Table 2. Percentage of countries with a policy, plan or strategy addressing the major NCDs and risk factors

	% of countries/areas with NCD policy, strategy or action plan that integrates an NCD or risk factor				% of coutries/areas with a specific policy, strategy or action plan on an NCD or risk factor			
	HICs	LMICs	PICs	Total	HICs	LMICs	PICs	Total
Cardiovascular disease	75%	86%	55%	66%	25%	29%	25%	26%
Cancer or particular cancer types	75%	86%	50%	63%	88%	86%	60%	71%
Diabetes	75%	86%	55%	66%	50%	43%	35%	40%
Chronic respiratory disease	50%	71%	25%	40%	13%	29%	0%	9%
Harmful use of alcohol	63%	86%	60%	66%	75%	57%	15%	37%
Physical inactivity	88%	86%	60%	71%	75%	57%	15%	37%
Tobacco use	75%	86%	60%	69%	88%	43%	45%	54%
Unhealthy diet	88%	86%	60%	71%	88%	43%	30%	46%

Source: WHO

Overweight and obesity (29%) and oral health (40%) were the risk factors least addressed in the Region.

Research policy or plan

Almost half of the countries and areas in the Region (15/35) have a policy or plan for NCD-related research that includes community-based research and evaluation of the impact of interventions and policies, however, two are not operational research policies.

Policies and strategies to reduce unhealthy diets

In the Western Pacific Region, 10 countries and areas reported having a policy to reduce the impact of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt. Slightly more countries reported policies that were voluntary/self-regulated compared to those with government regulation (six versus four countries/areas). Governments were also reported to oversee enforcement and complaints in seven countries and areas. None of these countries/areas reported inclusion of steps to address the effects of cross-border marketing of foods and non-alcoholic beverages on children.

Eight out of the 35 countries and areas (five HICs and three LMICs) reported implementing a national policy that limits saturated fatty acids and virtually eliminates industrially produced trans-fats in the food supply. Voluntary or self-regulated policies (three HICs and two LMICs) were more predominant compared to some that were government-legislated (two HICs and one of the LMICs). None of the PICs reported having such a policy.

Policies to reduce population salt consumption were reported to be implemented in seven HICs, three LMICs and four PICs. Of all the 14 countries with salt-reduction policies, public awareness programmes are the most common strategy (12/14), followed by nutrition labelling (10/14) and product reformulation by industry across the food supply (8/14). Regulation of salt content of foods is the least implemented strategy on salt reduction in the Region (6/14).

National public awareness programmes

National public awareness programmes on diet are more predominant (25/35) than national public awareness programmes on physical activity (16/35). PICs have the least number of awareness programmes on both diet and physical activity, with only half and one third, respectively, of the PICs reporting such a programme.

C. Health information systems, surveillance and survey for NCDs and their risk factors

Surveillance responsibility

Surveillance is an important component in the prevention and control of NCDs. Only two HICs and four PICs reported having an office within the ministry of health dedicated exclusively to NCD surveillance. Most of the countries and areas in the Region reported that the responsibility for NCD surveillance is shared across several offices, departments and administrative divisions within the health ministry, with five out of eight HICs and 12 out of 20 PICs having such a mechanism. One HIC, four LMICs and four PICs reported that the responsibility lies within an office/department/division within the health ministry that is not exclusively dedicated to NCD surveillance.

Civil and vital registration systems reporting mortality by cause

Thirty-two of the 35 countries and areas that responded to the survey reported having a system for collecting mortality data by cause of death on a routine basis **(Table 3)**. Of these, 30 have a civil/vital registration system, while 14 have a sample registration system; these are mostly LMICs (3/7) and PICs (9/20). Almost all the countries and areas (31/32) with a system for collecting mortality data can disaggregate the data by age and gender (31/32), while 23 countries and areas can report their mortality data by other sociodemographic variables.

Table 3. Countries and areas with a system for collecting mortality data

No.	Country/area	System for collecting mortality data by cause of death on a routine basis	Civil/vital registration	Sample registration
HIGH-INCOME COUNTRIES AND AREAS				
1	Australia	Yes	Yes	No
2	Brunei Darussalam	Yes	Yes	Yes
3	Hong Kong SAR (China)	Yes	Yes	No
4	Japan	Yes	Yes	No
5	Macao SAR (China)	Yes	Yes	Yes
6	New Zealand	Yes	Yes	No
7	Republic of Korea	Yes	Yes	No
8	Singapore	Yes	Yes	No

Table 3. Countries and areas with a system for collecting mortality data (continued)

No.	Country/area	System for collecting mortality data by cause of death on a routine basis	Civil/vital registration	Sample registration
LOW- AND MIDDLE-INCOME COUNTRIES				
9	Cambodia	No		Yes
10	China	Yes	Yes	Yes
11	Lao People's Democratic Republic	No		
12	Malaysia	Yes	Yes	No
13	Mongolia	Yes	Yes	Yes
14	Philippines	Yes	Yes	No
15	Viet Nam	No		
PACIFIC ISLAND COUNTRIES AND AREAS				
16	American Samoa	Yes	Yes	
17	Cook Islands	Yes	Yes	Don't know
18	Fiji	Yes	Yes	Yes
19	French Polynesia	Yes	Yes	No
20	Guam	Yes	Yes	Yes
21	Kiribati	Yes	Yes	Yes
22	Marshall Islands	Yes	Yes	Don't know
23	Micronesia (Federated States of)	Yes	Yes	Yes
24	Nauru	Yes	Yes	Yes
25	New Caledonia	Yes	Yes	No
26	Niue	Yes	Yes	No
27	Northern Mariana Islands	Yes	Yes	Don't know
28	Palau	Yes	Yes	Yes
29	Papua New Guinea	Yes	Don't know	Yes
30	Samoa	Yes	Yes	No
31	Solomon Islands	Yes	No	No
32	Tokelau	Yes	Yes	No
33	Tonga	Yes	Yes	No
34	Tuvalu	Yes	Yes	Yes
35	Vanuatu	Yes	Yes	Yes

Source: WHO

System for recording patient information

Thirty-one out of 35 countries and areas in the Region (7/8 HICs, 6/7 LMICs, 18/20 PICs) reported having a system for recording patient information that includes NCD status **(Table 4)**. Of these, 24 countries and areas indicated that electronic medical records/health records system were used. More than half (18/31) reported having national coverage and these are mainly HICs (4/8) and PICs (13/20), with very few LMICs (1/6).

Table 4. Countries and areas with a system for recording patient information that includes NCD status

No.	Country/area	System for recording patient information	Electronic medical records/ health records systems	Coverage
HIGH-INCOME COUNTRIES AND AREAS				
1	Australia	Yes	Yes	National
2	Brunei Darussalam	Yes	Yes	National
3	Hong Kong SAR (China)	Yes	Yes	Subnational
4	Japan	No		
5	Macao SAR (China)	Yes	Yes	Subnational
6	New Zealand	Yes	No	National
7	Republic of Korea	Yes	Yes	Subnational
8	Singapore	Yes	Yes	National
LOW- AND MIDDLE-INCOME COUNTRIES				
9	Cambodia	Yes	No	Subnational
10	China	Yes	Yes	Subnational
11	Lao People's Democratic Republic	No		
12	Malaysia	Yes	Yes	Subnational
13	Mongolia	Yes	Yes	National
14	Philippines	Yes	Yes	Subnational
15	Viet Nam	Yes	Yes	Subnational

Table 4. Countries and areas with a system for recording patient information that includes NCD status (continued)

No.	Country/area	System for recording patient information	Electronic medical records/ health records systems	Coverage
PACIFIC ISLAND COUNTRIES AND AREAS				
16	American Samoa	Yes	Yes	National
17	Cook Islands	Yes	Yes	National
18	Fiji	No		
19	French Polynesia	Yes	Yes	National
20	Guam	Yes	Yes	Subnational
21	Kiribati	Yes	No	National
22	Marshall Islands	Yes	Yes	Subnational
23	Micronesia (Federated States of)	Yes	Yes	National
24	Nauru	Yes	No	National
25	New Caledonia	Yes	Yes	National
26	Niue	Yes	Yes	National
27	Northern Mariana Islands	Yes	Yes	Subnational
28	Palau	Yes	Yes	Subnational
29	Papua New Guinea	No		
30	Samoa	Yes	Yes	National
31	Solomon Islands	Yes	No	National
32	Tokelau	Yes	No	National
33	Tonga	Yes	Yes	National
34	Tuvalu	Yes	Yes	Subnational
35	Vanuatu	Yes	No	National

Source: WHO

Facility survey

Only six countries (two HICs, two LMICs and two PICs) reported having conducted a facility survey to assess the availability of services and readiness for NCDs, and these surveys were all conducted in the past five years. Brunei Darussalam, the Lao People's Democratic Republic and the Republic of Korea had national coverage of the facility survey, while Solomon Islands, Tuvalu and Viet Nam had subnational coverage.

Disease registries

All HICs, six LMICs and 15 PICs reported having a cancer registry **(Table 5)**. Population-based cancer registries are available in seven out of eight HICs, five out of six LMICs and three out of 15 PICs.

In comparison, diabetes registries are present in 23 countries and areas in the Region (5/8 HICs, 6/7 LMICs and 12/20 PICs). Of these registries, only five are population-based registries on diabetes.

Table 5. Countries and areas with cancer and diabetes registries

No.	Country/Area	Cancer registry	Diabetes registry
HIGH-INCOME COUNTRIES AND AREAS			
1	Australia	Yes, population-based	Yes, population-based
2	Brunei Darussalam	Yes, population-based	No
3	Hong Kong SAR (China)	Yes, population-based	Yes, hospital-based
4	Japan	Yes, population-based	No
5	Macao SAR (China)	Yes, hospital-based	No
6	New Zealand	Yes, population-based	Yes, other
7	Republic of Korea	Yes, population-based	Yes, hospital-based
8	Singapore	Yes, population-based	Yes, population-based
LOW- AND MIDDLE-INCOME COUNTRIES			
9	Cambodia	No	Yes, hospital-based
10	China	Yes, population-based	Yes, population-based
11	Lao People's Democratic Republic	Yes, other	Yes, hospital-based
12	Malaysia	Yes, population-based	Yes, other
13	Mongolia	Yes, population-based	Yes, population-based
14	Philippines	Yes, population-based	Yes, other
15	Viet Nam	Yes, population-based	No

Table 5. Countries and areas with cancer and diabetes registries (continued)

No.	Country/Area	Cancer registry	Diabetes registry
PACIFIC ISLAND COUNTRIES AND AREAS			
16	American Samoa	Yes, hospital-based	No
17	Cook Islands	Yes, hospital-based	Yes, hospital-based
18	Fiji	Yes, hospital-based	No
19	French Polynesia	Yes, other	No
20	Guam	Yes, population-based	No
21	Kiribati	No	Yes, hospital-based
22	Marshall Islands	Yes, hospital-based	Yes, hospital-based
23	Micronesia (Federated States of)	Yes, hospital-based	Yes, other
24	Nauru	No	Yes, other
25	New Caledonia	Yes, other	No
26	Niue	Yes, hospital-based	Yes, hospital-based
27	Northern Mariana Islands	Yes, population-based	No
28	Palau	Yes, population-based	Yes, hospital-based
29	Papua New Guinea	Yes, hospital-based	No
30	Samoa	No	No
31	Solomon Islands	Yes, hospital-based	Yes, hospital-based
32	Tokelau	No	Yes, hospital-based
33	Tonga	Yes, hospital-based	Yes, population-based
34	Tuvalu	No	Yes, hospital-based
35	Vanuatu	Yes, other	Yes, hospital-based

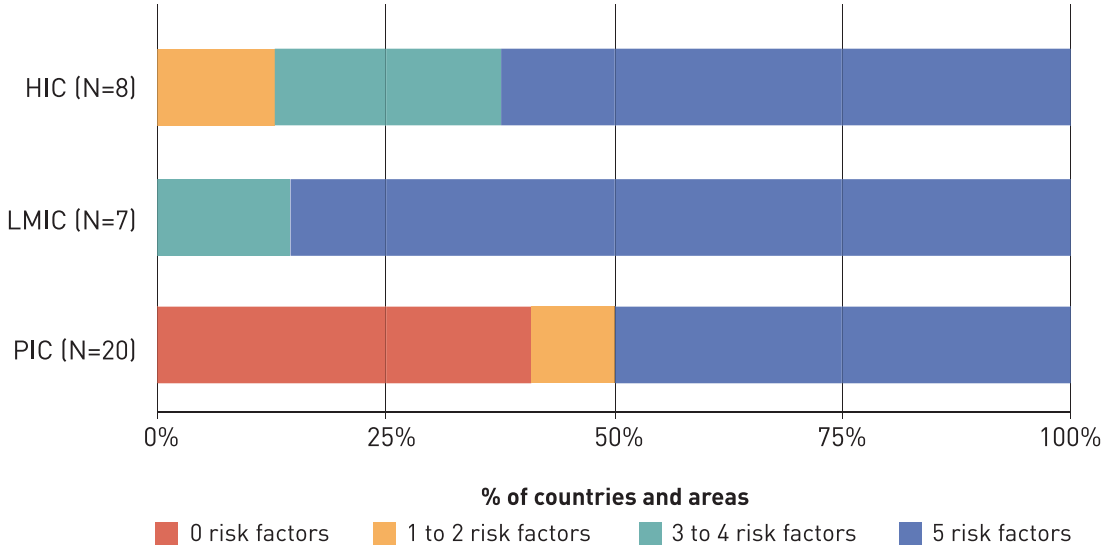
Source: WHO

Risk factor surveys

Adolescent survey

Twenty-one countries and areas in the Region (5/8 HICs, 6/7 LMICs and 10/20 PICs) have collected recent information (i.e. for the last five years) on the five NCD risk factors (harmful alcohol use, low fruit and vegetable consumption, physical inactivity, tobacco use, overweight and obesity) among adolescents **(Fig. 5)**. Two fifths of the PICs do not have a recent national adolescent risk factor survey. For half of the countries and areas that reported having collected information on overweight and obesity in adolescents, the data were self-reported.

Fig. 5. Percentage of countries and areas covering 0–5 risk factors in recent, national adolescent NCD risk factor surveys

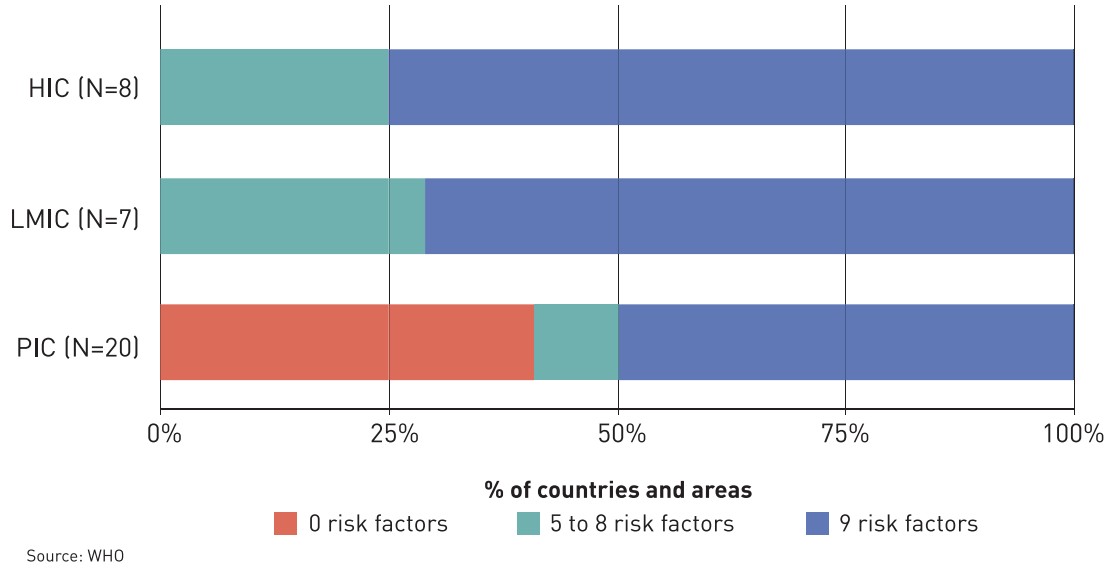


Source: WHO

Adult survey

In terms of adults, 21 countries and areas in the Region (6/8 HICs, 5/7 LMICs and 10/20 PICs) have collected recent information on the main nine NCD risk factors (harmful alcohol use, low fruit and vegetable consumption, physical inactivity, tobacco use, overweight and obesity, raised blood pressure, raised blood glucose, raised cholesterol, and sodium intake) **(Fig. 6)**. Most HICs and LMICs have collected data on all nine main risk factors, while one third of the PICs do not have a recent national adult risk factor survey.

Fig. 6. Percentage of countries and areas covering 0–9 risk factors in recent, national adult NCD risk factor surveys



Source: WHO

When considering surveillance activity by risk factor, surveys on tobacco and alcohol are the most common in both adult and adolescent surveys. The least-reported risk factor in adult risk factor surveys is salt/sodium intake.

D. Capacity for NCD early detection, treatment and care within the health system

NCD-related guidelines and referral criteria

Evidence-based national guidelines/protocols/standards for the management of diabetes are the most commonly available guideline in the Western Pacific Region (31/35) followed by guidelines on CVDs (28/35) **(Table 6)**. Guidelines for the management CRDs are the least available, with only half of HICs, LMICs and PICs reporting having the guideline. Guidelines for the management of diabetes (19/35) and CVDs (18/35) were the most utilized guidelines in at least 50% of health-care facilities in countries and areas of the Region.

Table 6. Availability and full implementation of evidence-based clinical guidelines/protocols/ standards for the management (diagnosis and treatment) of major NCDs

Clinical guidelines	HICs (N=8)		LMICs (N=7)		PICs (N=20)		Total (N=35)	
	Protocol (%)	Utilization* (%)	Protocol (%)	Utilization* (%)	Protocol (%)	Utilization* (%)	Protocol (%)	Utilization* (%)
CVD	88%	50%	86%	57%	70%	55%	77%	54%
Diabetes	88%	50%	86%	57%	90%	60%	89%	57%
Cancer	63%	50%	86%	43%	45%	35%	57%	40%
CRD	50%	25%	57%	29%	55%	40%	54%	34%

** Utilization in at least 50% of health facilities.*

Source: WHO

Countries and areas were also asked if the guidelines include criteria for the referral of patients from primary care to a higher level of care. Almost 80% of existing guidelines on CVD, diabetes and cancer have referral criteria, while that for CRDs have the least, with 70% of existing guidelines having referral criteria. A higher percentage of LMICs have referral guidelines than HICs and PICs in all disease categories.

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

The majority of the countries and areas in the Western Pacific Region reported having the basic technologies to measure blood pressure, height, weight and blood glucose generally available in both the public and private health sectors **(Table 7)**. The least available tests in the Region are those used to measure diabetes complications, asthma and chronic obstructive pulmonary disease (COPD). More than half of the countries and areas in the Region have the basic technologies for early detection, diagnosis and monitoring of CVDs, such as those for measuring blood pressure and total cholesterol and urine strips for albumin assay.

Table 7. Percentage of countries and areas with basic technologies for early detection, diagnosis and monitoring of NCDs generally available* in the primary care facilities of the public and private health sector

Activity	HICs (N=8)		LMICs (N=7)		PICs (N=20)		Total (N=35)	
	Public sector	Private sector	Public sector	Private sector	Public sector	Private sector	Public sector	Private sector
Overweight and obesity								
Measuring of weight	100%	100%	86%	86%	95%	65%	94%	77%
Measuring of height	100%	100%	86%	86%	90%	55%	91%	71%
Diabetes mellitus								
Blood glucose measurement	100%	100%	71%	86%	90%	70%	89%	80%
Oral glucose tolerance test	100%	100%	43%	57%	40%	25%	54%	49%
HbA1c test	100%	100%	43%	57%	55%	40%	63%	57%
Dilated fundus examination	100%	88%	29%	43%	30%	30%	46%	46%
Foot vibration perception by tuning fork	100%	88%	29%	43%	30%	45%	46%	54%
Foot vascular status by Doppler	88%	75%	14%	29%	15%	15%	31%	31%
Urine strips for glucose and ketone measurement	100%	100%	57%	71%	50%	45%	63%	63%
Cardiovascular disease								
Blood pressure measurement	100%	100%	100%	100%	95%	70%	97%	83%
Total cholesterol measurement	100%	100%	57%	86%	60%	50%	69%	69%
Urine strips for albumin assay	100%	100%	57%	86%	45%	40%	60%	63%
Asthma and COPD								
Peak flow measurement spirometry	100%	75%	29%	43%	35%	35%	49%	46%

** Defined as present in 50% or more of health-care facilities.*

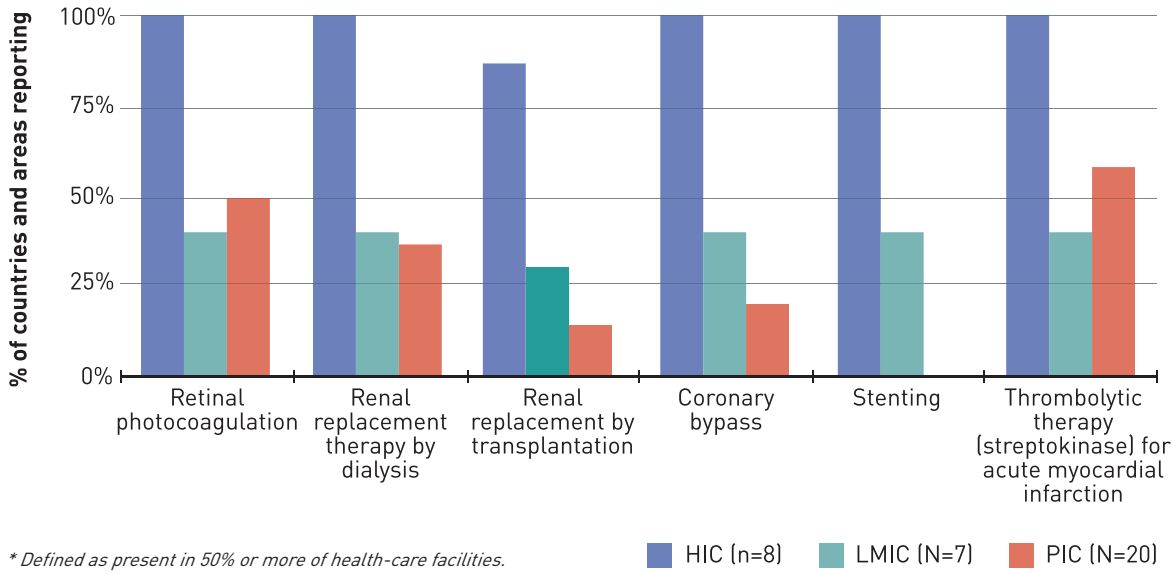
Source: WHO

While the availability of basic technologies for early detection, diagnosis and monitoring of NCDs such as the measurement of height, weight, blood pressure, blood glucose and HbA1c are generally available in the primary care facilities of the public and private sectors in the Region, there is variation in their availability in HICs, LMICs and PICs; HbA1c and total cholesterol measurement were reported to be not generally available in one third of the LMICs and PICs.

Procedures for treating NCDs

All HICs reported to have NCD treatment procedures (such as retinal photocoagulation, renal replacement therapy by dialysis, coronary bypass, stenting and thrombolytic therapy for acute myocardial infarction) generally available in the publicly funded health system, except for renal replacement by transplantation, with one area not having it generally available **(Fig. 7)**. Almost half of the LMICs reported to have NCD treatment procedures except for renal replacement by transplantation. Of all the procedures for the treatment of NCDs, thrombolytic therapy for acute myocardial infarction and retinal photocoagulation were reported to be generally available in most PICs.

Fig. 7. Percentage of countries and areas with procedures for treating NCDs generally available* in the public health system



** Defined as present in 50% or more of health-care facilities.*

Source: WHO

Availability of medicine in the public health sector

Availability of NCD-related medicines varies significantly in the Region among country groups, with aspirin (100 mg) and thiazide diuretics being the most available of all the medicines asked about in the survey **(Table 8)**. Nicotine replacement therapy and oral morphine were reported to be generally available in just a third and half, respectively, of the countries and areas in the Region. Three of eight HICs, none of the seven LMICs and four of the PICs have all these NCD medicines generally available in the primary care facilities of the public health sector in their countries.

Table 8. Percentage of countries and areas with medicines generally available* in the primary care facilities of the public health sector

Medicines	HICs (N=8)	LMICs (N=7)	PICs (N=20)	Total (N=35)
Insulin	100%	43%	70%	71%
Aspirin (100mg)	100%	86%	90%	91%
Metformin	100%	71%	85%	86%
Thiazide diuretics	100%	86%	85%	89%
ACE inhibitors	100%	71%	75%	80%
Calcium channel blockers	100%	71%	80%	83%
Beta blockers	100%	86%	80%	86%
Statins	100%	57%	75%	77%
Oral morphine	63%	43%	45%	49%
Steriod inhaler	100%	43%	55%	63%
Bronchodilator	100%	57%	80%	80%
Sulphonylurea(s)	100%	57%	80%	80%
Benzathine penicillin injection	63%	71%	85%	77%
Nicotine replacement therapy	88%	0%	25%	34%

** Defined as present in 50% or more of pharmacies*
Source: WHO

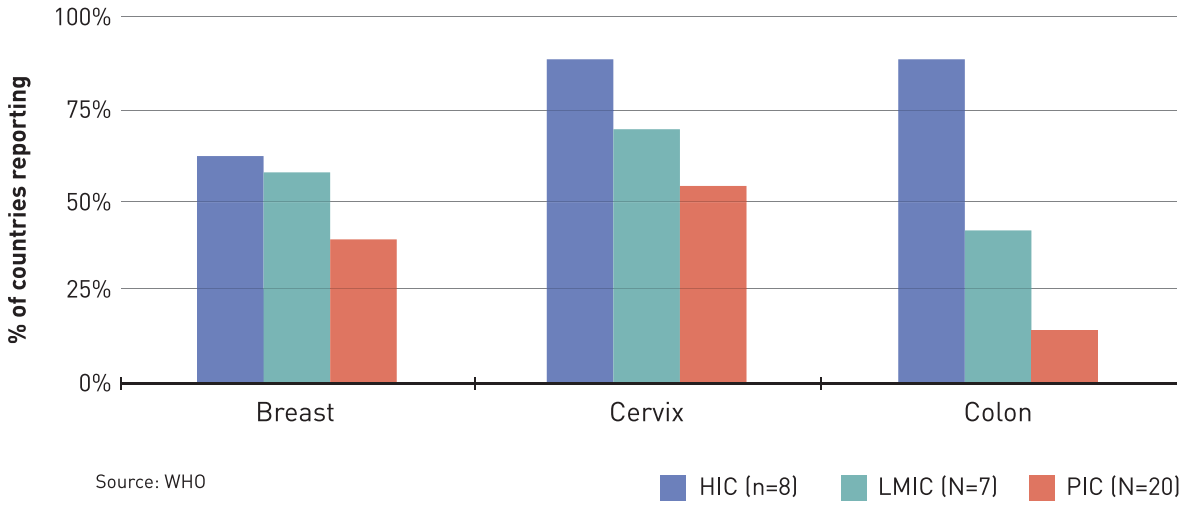
Availability of tests and procedures for cancer screening, diagnosis and treatment

In the early detection and treatment of cancers, a national screening programme is essential. In the Region, screening programmes for cervical and breast cancers were reported to be the most prevalent in HICs, LMICs and PICs **(Fig. 8)**. Three out of four countries that have screening programmes for cancers of the breast and cervix reported these as organized, population-based screening.

Mammography is the most widely used method to screen for breast cancer as reported by 13 countries and areas (mostly HICs), while clinical breast exam is the most widely used in four countries and areas. Pap smear is the most common method used for cervical cancer screening in 18 countries and areas in the Region, while three countries use visual inspection and one area reported human papillomavirus (HPV) testing as the most widely used screening method.

Only one fourth of the countries and areas reporting to have a breast cancer screening programme indicated that more than half of the target population is covered by the screening programme. For cervical and colon cancer screening, more than half of the target population is covered in 40% of the countries and areas that reported to have a screening programme. Screening coverage of more than 50% of the target population is mostly in HICs.

Fig. 8. Percentage of countries and areas with national screening programme by cancer site



HPV vaccination programmes are present in the Region (7/8 HICs, 3/7 LMICs and 12/20 PICs). At least 50% of the targeted population is covered by the HPV vaccination programme in five HICs, one of the LMICs and four PICs.

Only half of the countries and areas in the Western Pacific Region (8/8 HICs, 4/7 LMICs and 5/20 PICs) reported that cancer centres or cancer departments at tertiary level were generally available in the public sector. Pathology services for cancer diagnosis are generally available in 22 of the 35 countries and areas in the Region (8/8 HICs, 2/7 LMICs and 12/20 PICs). Treatment procedures, specifically cancer surgery (19/35), subsidized chemotherapy (16/35) and radiotherapy (15/35), are also available, with all HICs and less than half of the LMICs and PICs having these treatments generally available.

Other NCD services

Palliative care is generally available (reaches 50% or more patients) in more than half of the countries and areas in the Region (8/8 HICs, 2/7 LMICs and 13/20 PICs). Community- or home-based palliative care is generally available in all HICs, one of seven LMICs and 12 of 20 PICs, while palliative care, as provided in primary health care, is generally available in five of eight HICs, two of seven LMICs and nine of 20 PICs.

Cardiovascular risk stratification is available at primary care facilities in 26 of 35 countries and areas (5/8 HICs, 15/20 LMICs and 6/7 PICs) in the Western Pacific Region, but coverage of more than half of the target population occurs only in 13 countries and areas (four HICs, seven LMICs and two PICs). Among the countries with cardiovascular risk stratification available, the most widely used chart is the WHO/International Society of Hypertension (ISH) risk prediction charts.

Provision of care for acute stroke is slightly more prevalent in the public sector facilities in seven of eight HICs, three of seven LMICs and 14 of 20 PICs, than for rehabilitation of stroke patients, which was reported as being generally available in seven HICs, four LMICs and 10 PICs.

Only one fourth of the HICs, none of the LMICs and three fourths of the PICs reported to have a register of patients who have rheumatic fever and rheumatic heart disease. Most of these countries and areas (15/17) reported that they have a system for follow-up and recall to deliver long-term penicillin prophylaxis.

CHAPTER 3

KEY FINDINGS AND PROGRESS IN COUNTRY CAPACITY FOR THE PREVENTION AND CONTROL OF NCDs

A. Key findings

Public health infrastructure, partnerships and multisectoral collaboration for NCDs and their risk factors

Majority of the countries and areas in the Region (33/35) have an NCD unit in place, with more than half (23/35) having at least six to 10 full-time technical staff for NCD. Funding for NCD activities is most commonly available for health care and treatment, health promotion, primary prevention and early detection/screening. General government revenues are the major sources of funding in the Region, while tobacco taxes are the most reported fiscal intervention, followed by alcohol taxes. Almost a third of the countries and areas in the Region (11/35) have an operational national multisectoral commission for NCDs.

Status of NCD-relevant policies, strategies and action plans

NCDs are included in most national health plans (31/35) in the Region; however, only half have included NCDs in their national development plans. Three fourths of the countries and areas in the Region (27/35) have operational multisectoral national policies and plans integrating the major NCDs and risk factors. A significant proportion of countries and areas in the Region also have stand-alone policies – in addition to the integrated NCD policy – that address cancer (25/35) mainly for the NCDs and tobacco control (19/35) for the NCD risk factors.

Health information systems, surveillance and surveys for NCDs and their risk factors

Civil/vital registration systems are available in majority of the countries and areas in the Region; however, only a small proportion of these meet the acceptable criteria for a functioning system that can generate reliable cause-specific mortality data on a routine basis. Periodic national adult risk factor surveys for the main nine NCD risk factors (harmful alcohol use, low fruit and vegetable consumption, physical inactivity, tobacco use, overweight and obesity, raised blood pressure, raised blood glucose, raised blood cholesterol and high

sodium intake) are conducted in most of the countries and areas in the Region (21/35) and the least collected information is on salt/sodium intake. Almost half of the countries and areas in the Region have a population-based cancer registry (15/35) while only five countries have a population-based diabetes registry.

Capacity for early detection, treatment and care within the health system

Evidence-based national guidelines, protocols or standards for the management of diabetes and CVDs are the most commonly available guidelines in the Region; however, the utilization of these guidelines in at least 50% of health facilities is present in at least half of the countries and areas in the Region. Majority of the countries and areas in the Region have cost-effective basic technologies such as those that measure weight, height, blood pressure and blood glucose. Aspirin and thiazide diuretics are the most available NCD medicines in the primary care facilities of the public health sector, while nicotine replacement therapy and oral morphine are the least available. The most common cancer screening programmes in the Region are those for breast and cervical cancers. While CVD risk stratification exists in 26 of the 35 countries in the Region, population coverage is suboptimal, with only 13 countries and areas covering more than half of the primary care facilities offering such service in countries.

B. Progress in country capacity for the prevention and control of NCDs

In comparison with previous rounds, the response rate increased in the fifth round of the NCD CCS in 2017, with 35 countries and areas participating in the survey compared to 32 countries and areas in 2015. All HICs and LMICs in the Region responded to the survey, while 20 of the 21 PICs responded. **Table 9** presents information from the five rounds of the NCD CCS on selected indicators that may be compared from 2004 to 2017. Noting that there are varying numbers of responding countries and areas in each round of the survey, slight increases and decreases may be observed in the reporting of some indicators. A more robust validation process was initiated for 2015 and was also implemented in 2017.

Some progress may be observed from 2015 to 2017 in the number of countries and areas with a national NCD unit and on having a stand-alone risk factor–specific or NCD-specific policy. Surveillance systems on NCD risk factors have also improved, with almost all the countries and areas collecting information on most of the NCD risk factors, except for the measurement of total cholesterol.

Table 9. Comparison of country capacity indicators in 2004, 2010, 2013, 2015 and 2017

Year of survey	2004	2010	2013	2015	2017
Number of tools sent	37	37	37	36	36
Number of responses	28	35	36	32	35*
Response rate	78%	94%	97%	89%	97%
NCD policy and programme infrastructure					
Number of countries with a national NCD entity	14 (50%)	32 (91%)	36 (100%)	29 (91%)	33 (94%)
Number of countries with an integrated NCD policy/strategy or action plan	15 (54%)	28 (80%)	33 (92%)	28 (88%)	27 (77%)
Number of countries with policies, strategies, action plans specific to:					
Tobacco control	22 (79%)	29 (83%)	31 (86%)	24 (75%)	24 (69%)
Harmful use of alcohol	12 (43%)	19 (54%)	22 (61%)	15 (47%)	19 (54%)
Nutrition/Unhealthy diet	17 (61%)	23 (66%)	25 (69%)	20 (63%)	19 (54%)
Physical activity	9 (32%)	21 (60%)	23 (64%)	13 (41%)	15 (43%)
Overweight and obesity	-	18 (51%)	21 (58%)	9 (28%)	13 (37%)
Cancer	12 (43%)	23 (66%)	26 (72%)	21 (66%)	26 (74%)
Surveillance and monitoring					
Number of countries with surveillance system for:					
Tobacco use	17 (61%)	31 (89%)	36 (100%)	32 (100%)	35 (100%)
Harmful use of alcohol	13 (46%)	29 (83%)	34 (94%)	32 (100%)	35 (100%)
Unhealthy diet	12 (43%)	30 (86%)	35 (97%)	32 (100%)	35 (100%)
Physical inactivity	12 (43%)	27 (77%)	36 (100%)	32 (100%)	35 (100%)
Diabetes	18 (64%)	28 (80%)	34 (94%)	31 (97%)	35 (100%)
Hypertension	17 (61%)	29 (83%)	34 (94%)	30 (94%)	35 (100%)
Overweight and obesity	15 (54%)	30 (86%)	35 (97%)	32 (100%)	35 (100%)
Dyslipidaemia	10 (29%)	25 (71%)	31 (86%)	28 (88%)	33 (94%)
Clinical interventions					
Number of countries with clinical protocols or guidelines for:					
Diabetes	18 (64%)	33 (94%)	33 (92%)	28 (88%)	31 (89%)
Cancer	12 (43%)	23 (66%)	26 (72%)	22 (69%)	20 (57%)
Availability of statins	-	24 (69%)	31 (86%)	25 (78%)	27 (77%)

** In the 2015 and 2017 CCS, a more rigorous validation process was employed during data collection; hence, only 27 of the 35 countries and areas completely validated their submissions. This is higher compared to the validation in 2015, where only 15 of the 32 responding countries and areas were fully validated.*

Source: WHO

CHAPTER 4

TEN PROGRESS MONITORING INDICATORS

WHO published an *NCD Progress Monitor* in 2015 and in 2017. These outline the progress of countries in implementation of the four time-bound commitments included in the 2014 United Nations Outcome Document on NCDs, specifically on the 10 progress monitoring indicators **(Fig. 9)**.

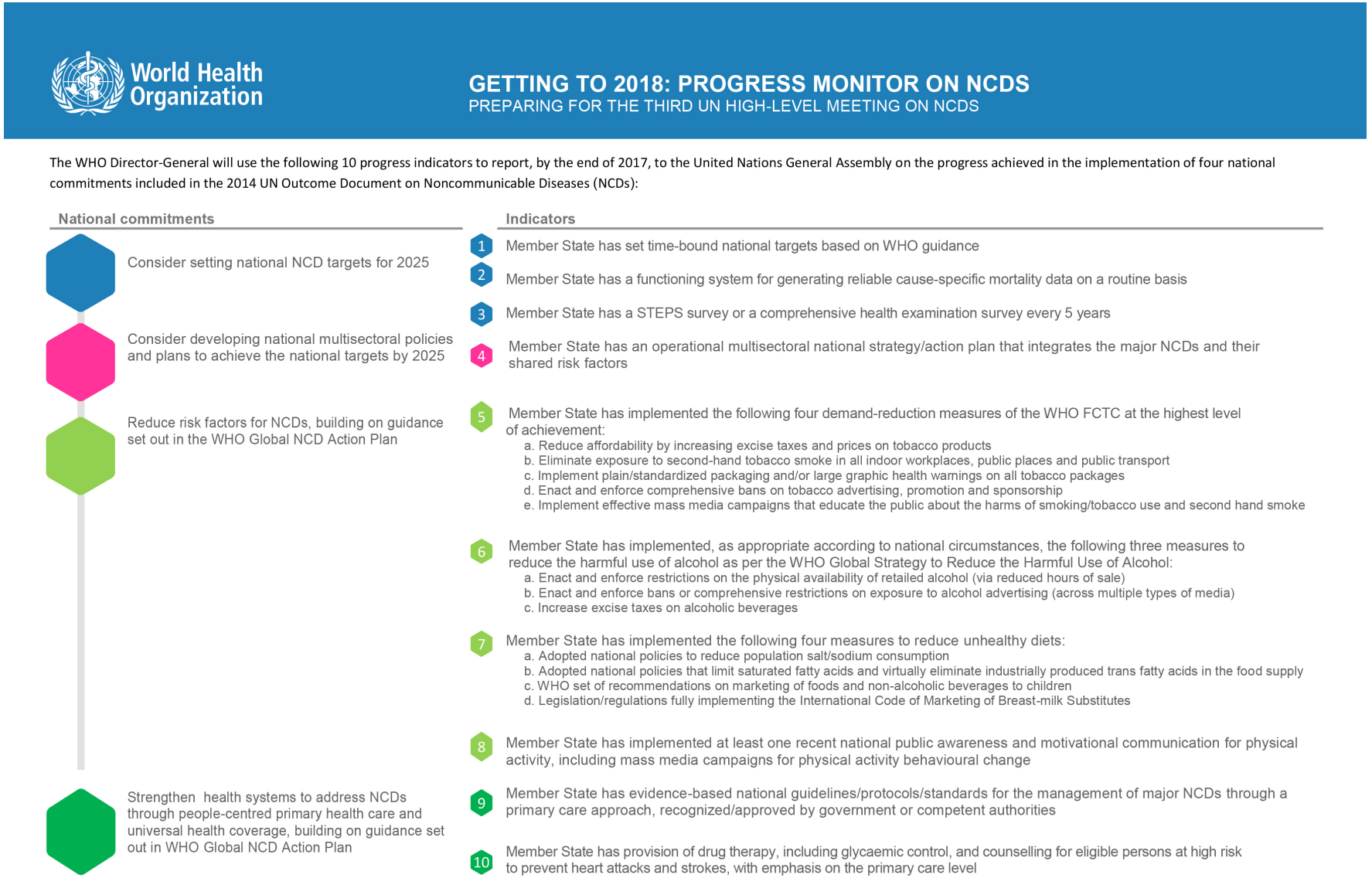
In addition to the 27 Member States with country profiles included in the *NCD Progress Monitor 2017*, the eight areas in the Region that participated in the survey were also reviewed and assessed and included in the summary in **Table 10**. For each indicator, the following symbols denote achievement:

● = fully achieved, ◐ = partially achieved, ○ = not achieved, * = no data, DK = don't know

The data used in the assessment of the NCD progress monitor indicators were primarily from the 2017 NCD CCS and additional sources from the WHO mortality database, *WHO Report on the Global Tobacco Epidemic, WHO Global Survey on Alcohol and Health,* and the *Marketing of Breast-milk Substitutes: National Implementation of the International Code Status Report 2016.* A detailed description of the indicators and country status are presented in Annex 2.

In the time-bound commitment on setting NCD targets for 2025, countries and areas in the Region have made considerable progress in having a set of time-bound NCD targets based on the *NCD Global Monitoring Framework for NCDs*, with 14 countries and areas that have fully achieved this indicator, while 12 have partially achieved it. Reliable cause-specific mortality data are generated from a functioning system on a routine basis mostly in HICs (7/8) that have fully achieved the indicator, while only four LMICs have partially achieved it; none of the LMICs have fully achieved this indicator. In the PICs, only one country has fully achieved the indicator on mortality while two countries have partially achieved the requirements of this indicator. Most LMICs (6/7) have conducted a periodic adult NCD risk factor survey in the last five years that collected information on harmful use of alcohol, physical inactivity, tobacco use, raised blood glucose/diabetes, raised blood pressure/hypertension, overweight/obesity and salt/sodium intake, while only half of HICs (4/8) and a fifth of PICs (4/21) have fully achieved the NCD surveillance indicator.

Fig. 9. Progress monitoring indicators on NCDs



Source: http://www.who.int/nmh/events/2015/ncd-handout.pdf

Table 10. Achievement status of the NCD progress monitoring indicators in the Western Pacific Region, 2017

No.	Country / Area	PROGRESS MONITORING INDICATOR																		
		1	2	3	4	5A	5B	5C	5D	5E	6A	6B	6C	7A	7B	7C	7D	8	9	10
HIGH-INCOME COUNTRIES AND AREAS																				
1	Australia	◐	●	◐	◐	◐	●	●	◐	●	◐	○	◐	◐	●	●	○	●	●	DK
2	Brunei Darrussalam	●	●	●	●	NA	●	●	◐	○	●	●	●	DK	○	○	○	●	◐	●
3	Hong Kong SAR (China)	○	●	●	●	◐	●	●	●	●	◐	○	○	◐	●	●	○	●	◐	●
4	Japan	●	●	●	●	◐	○	◐	○	○	◐	○	◐	◐	○	○	○	●	DK	DK
5	Macao SAR (China)	○	*	◐	●	*	*	*	*	*	*	*	*	◐	○	○	*	●	◐	◐
6	New Zealand	○	●	◐	○	◐	●	●	◐	●	◐	○	◐	◐	●	●	○	○	●	●
7	Republic of Korea	●	●	●	◐	◐	◐	◐	○	●	◐	○	◐	●	●	●	◐	●	◐	●
8	Singapore	◐	●	◐	◐	◐	◐	●	◐	●	●	○	●	●	●	●	○	●	●	DK
LOW- AND MIDDLE-INCOME COUNTRIES																				
1	Cambodia	◐	○	●	○	○	●	●	◐	●	○	○	◐	○	○	○	◐	○	○	○
2	China	●	◐	●	●	◐	○	◐	◐	●	◐	●	◐	●	●	○	◐	○	●	○
3	Lao People's Democratic Republic	◐	○	◐	●	○	●	●	◐	NR	◐	●	◐	○	○	○	◐	○	●	○
4	Malaysia	●	◐	●	◐	◐	○	●	◐	●	◐	◐	◐	●	●	●	○	●	●	●
5	Mongolia	●	◐	●	●	○	●	●	●	○	◐	○	◐	●	●	●	◐	●	◐	○
6	Philippines	○	◐	●	○	◐	◐	●	◐	●	◐	○	◐	○	○	○	●	●	◐	○
7	Viet Nam	●	○	●	●	○	◐	●	◐	●	◐	○	◐	○	○	○	●	○	●	○
PACIFIC ISLAND COUNTRIES AND AREAS																				RIES
1	American Samoa	◐	*	◐	*	*	*	*	*	*	*	*	*	DK	DK	DK	*	-	-	DK
2	Cook Islands	◐	◐	◐	●	◐	◐	◐	◐	○	NR	NR	NR	○	○	○	○	○	●	●
3	Fiji	●	●	◐	◐	○	◐	●	◐	●	NR	NR	NR	○	○	○	●	●	◐	◐
4	French Polynesia	○	*	◐	○	*	*	*	*	*	*	*	*	○	○	●	*	●	●	◐
5	Guam	●	*	◐	●	*	*	*	*	*	*	*	*	◐	○	○	*	●	◐	◐
6	Kiribati	◐	◐	●	○	○	◐	◐	●	●	◐	○	◐	○	○	○	○	●	◐	DK
7	Marshall Islands	●	○	○	○	◐	●	○	○	○	◐	○	●	○	○	○	○	○	○	○
8	Federated States of Micronesia	◐	○	◐	○	◐	○	○	○	○	NR	NR	NR	○	○	○	NR	○	◐	○
9	Nauru	●	○	◐	●	◐	●	◐	◐	○	NR	NR	NR	◐	○	○	NR	○	●	◐
10	New Caledonia	○	*	◐	○	*	*	*	*	*	*	*	*	-	○	-	*	-	-	◐
11	Niue	○	○	◐	○	●	○	○	○	NR	NR	NR	NR	○	○	○	NR	●	●	◐
12	Commonwealth of the Northern Mariana Islands	○	*	●	○	*	*	*	*	*	*	*	*	○	○	DK	*	●	◐	●
13	Palau	◐	○	◐	◐	◐	◐	○	◐	NR	NR	NR	NR	NR	NR	NR	●	NR	●	●
14	Papua New Guinea	◐	○	◐	◐	○	●	○	◐	○	NR	NR	NR	○	○	○	◐	○	◐	○
15	Samoa	○	○	●	○	◐	◐	●	◐	NR	●	○	●	○	○	○	○	○	◐	○
16	Solomon Islands	●	○	●	●	○	◐	●	◐	NR	NR	NR	NR	○	○	○	◐	○	◐	○
17	Tokelau	◐	*	◐	○	*	*	*	*	*	*	*	*	○	○	○	*	●	DK	●
18	Tonga	●	○	◐	●	◐	◐	◐	◐	●	NR	NR	NR	○	○	○	NR	●	◐	○
19	Tuvalu	◐	○	●	○	◐	◐	◐	●	○	NR	NR	NR	○	○	○	○	○	◐	◐
20	Vanuatu	●	○	◐	●	◐	○	●	●	○	◐	○	●	◐	○	●	○	○	◐	○
21	Wallis and Futuna	NR	*	NR	NR	*	*	*	*	*	*	*	*	NR	NR	NR	*	NR	NR	NR
Fully achieved		14	8	15	14	1	10	15	5	13	3	3	5	5	8	9	4	18	12	9
Partially achieved		12	6	19	7	18	12	8	18	0	14	1	12	8	0	0	7	0	17	8
Not achieved		9	14	1	13	8	6	5	5	10	1	14	1	18	25	22	13	14	2	13

○ = not achieved ◐ = partially achieved ● = fully achieved — = documentation not available
* = no data DK = don't know NR = no response NA = not applicable

Fourteen countries and areas have developed an operational multisectoral national strategy or action plan that integrates all the major NCDs and their risk factors, while seven countries and areas have partially achieved this indicator, integrating at least two of the four major NCDs and two of the four main NCD risk factors in their NCD strategies or action plans.

Implementation of plain or standardized packaging and/or large graphic warnings on all tobacco packages remains the most widespread demand-reduction measure of the WHO Framework Convention on Tobacco Control (WHO FCTC) in the Region, with 15 and 8 countries and areas fully and partially achieving this indicator, respectively. Effective public mass media campaigns on the harms of smoking and second-hand smoke are the second most common demand-reduction measure of the Convention, while the elimination of exposure to second-hand tobacco smoke places third. More work is needed on tobacco taxation and advertising in countries and areas in the Region.

For alcohol harm reduction, most of the regulations on commercial and public availability (14/35) and taxation (12/35) of alcohol have been partially achieved; only three countries in the Region have fully achieved these alcohol indicators. Bans or comprehensive restrictions on exposure to alcohol advertising are the least achieved alcohol reduction measure, with only three countries that have fully achieved this indicator and one country partially achieving it.

Among the measures to reduce unhealthy diets, policies to reduce the impact on children of marketing of foods and non-alcoholic beverages and policies that limit saturated fatty acids are the most common approaches adopted in the Region. However, countries and areas in the Region have to implement more legislations or policies on unhealthy diet, such as on implementation of the code on breast-milk substitutes and reduction of population salt/sodium consumption.

Of all the NCD progress monitoring indicators, having a national public awareness programme on physical activity is the most widely implemented intervention in the Region, with half of the countries and areas (18/35) implementing a programme within the past five years.

Under health systems strengthening to address NCDs through people-centred primary health care and universal health coverage, evidence-based guidelines for the management of the major NCDs are prevalent in the Region, with a third of the countries and areas in the Region (12/35) having guidelines on all the major NCDs while almost half (17/35) have guidelines on at least two of the four major NCDs. Provision of drug therapy and counselling for eligible persons at high risk to prevent heart attacks and strokes has also advanced in the Region, with nine countries and areas that have fully achieved this indicator and eight countries and areas meeting the partially achieved assessment.

Overall, public awareness programmes on diet and/or physical activity remain the most widely implemented and fully achieved indicator (18/35) amongst the 10 progress monitoring indicators in the Western Pacific Region. A significant third of the countries and areas in the Region have fully achieved the indicators on having NCD targets, integrated NCD policy, plain/standardized packaging of tobacco products and periodic NCD risk factor surveys, with a noteworthy number of countries and areas partially achieving these indicators as well. Some progress is also noted on the policies that reduce the impact on marketing of unhealthy foods and non-alcoholic beverages to children, as well as on limiting saturated fatty acids, in countries and areas in the Region. While more countries and areas have yet to implement the recommended interventions for health systems strengthening to address NCDs, significant progress was observed on the provision of drug therapy and counselling, as well as having evidence-based guidelines on the management of the major NCDs, with more countries and areas fully and partially achieving these indicators from 2015 to 2017.

CHAPTER 5

REGIONAL RESPONSE AND WAY FORWARD

A. Regional response

WHO supported Member States of the Region in developing multisectoral action plans or strategies for NCD prevention and control. National plans were endorsed in eight countries: Cook Islands, Fiji, Nauru, Palau, Papua New Guinea, Tonga, Vanuatu and Viet Nam. A joint mission of the United Nations Interagency Task Force on NCD prevention and control was dispatched to Tonga in 2015, to Mongolia in 2015 and 2016, and to Viet Nam in 2016. In June 2017, the United Nations Global Joint Programme on Cervical Cancer Prevention and Control conducted a mission in Mongolia to develop and sustain high-quality comprehensive cervical cancer control programmes.

Four countries were selected for accelerated implementation of multisectoral action plans to reduce risk factors and manage NCD cases at the primary care level with integrated support and expertise from the three organizational levels of WHO. This is supported by the "One WHO" NCD mechanism. Mongolia, the Philippines, Tonga and Viet Nam have committed to making fast-track progress in 2017 and 2018 towards achieving the nine voluntary global targets for NCDs by 2025 and the NCD-related targets of the Sustainable Development Goals by 2030.

The Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD), launched in 2013, is the first and only regional leadership programme on NCD prevention and control. Recent topics covered by LeAd-NCD include childhood obesity and physical activity.

Capacity-building for cancer control is a priority in the Western Pacific Region and the yearly Workshop on Leadership and Capacity-Building for Cancer Control (CanLEAD) that also started in 2013 has focused on cervical cancer and early cancer diagnosis. Since the second workshop, this initiative has expanded to include global participants in 2016 and 2017.

To emphasize prevention and strengthen initiatives to address NCD risk factors, national Health Promotion Leadership (ProLead) workshops were held in China in 2015, Macao SAR (China) in 2015 and 2016, and the Northern Pacific (Guam, Federated States of Micronesia, Commonwealth of the Northern Mariana Islands and Palau) in 2016 and 2017.

Action on risk factors is a priority for all countries.

Technical assistance was provided on tobacco control efforts and was focused on three areas as per the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)*. For strengthening sustainable institutional capacity, subregional preparatory meetings were held before the Seventh Conference of the Parties and workshop on the Protocol to Eliminate Illicit Trade in Tobacco Products, as well as a workshop on the *Protocol to Eliminate Illicit Trade in Tobacco Products* that led to the signing of a memorandum of understanding between WHO and the Oceania Customs Organisation to prevent illicit trade in the Pacific. Countries in the Region were also supported in the development and enactment of legislations and regulations based on the MPOWER package. In terms of enforcement of tobacco control measures, working with relevant stakeholders is continuously being supported.

Technical support on the implementation of the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children was provided for the development of policy in the Philippines. A background document was also developed that led to the endorsement of the resolution on *Protecting Children from the Harmful Impact of Food Marketing*. PICs (Nauru, Kiribati, Tuvalu and Solomon Islands) were also supported in the inclusion of nutrition-related questions, which include questions on the consumption of sugar-sweetened beverages. Salt-reduction activities are also gaining popularity as a means to meet the commitment to the associated global targets on salt/sodium and raised blood pressure. Countries particularly supported by the Regional Office in salt-reduction activities include China, Federated States of Micronesia, Mongolia and Viet Nam. Brunei Darussalam and Malaysia have piloted a technical package developed by WHO headquarters to increase population physical activity.

Healthy Settings initiatives were also intensified in the Region, including health-promoting schools (Cambodia, Fiji, Tonga and Viet Nam), healthy cities (Cambodia, China and the Philippines), healthy islands and villages (Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Solomon Islands and Vanuatu), and healthy restaurants (Brunei Darussalam).

WHO continues to support Member States in the implementation of the Package of Essential NCD Interventions (PEN). Beyond this, the Regional Office has pioneered new approaches to NCD management to address local demand and low-resource settings. In collaboration with WHO headquarters, the Global HEARTS initiative – an expansion of PEN – was launched at the General Assembly in September 2016 and is currently being demonstrated in one district in the Philippines. Results from this demonstration site will be shared in 2018. The HEARTS package has also been introduced in the Mekong countries and PICs.

A milestone innovation of the Region that has the potential for global use is the NCD education manual for primary health care professionals and patients, developed in collaboration with the Ministry of Health and Welfare of the Republic of Korea, consisting of 15 modules with simple and user-friendly information on the prevention and control of hypertension and diabetes for health workers in primary health-care facilities.

WHO is at the forefront of the development of HeartCare, also another product with potential for scaled-up use. HeartCare is a software application to be used at the primary level to identify individuals at high risk for CVD and to provide standardized counselling and management, while at the same time establishing a central database.

To further strengthen capacity in countries in addressing pain management and palliative care, the WHO Collaborating Centre for Training in Hospice and Palliative Care in Seoul, Republic of Korea – the Research Institute for Hospice and Palliative Care, Catholic University of Korea College of Nursing – conducts International Workforce Training Workshops with participation from Member States of the Western Pacific and African Regions.

Surveillance systems to monitor NCD risk factors and disease trends have been strengthened for planning, implementation, reporting and dissemination of NCD risk factor surveys such as the WHO STEPwise approach to surveillance (STEPS) survey and the Global School-based Student Health Survey (GSHS). Instruments for NCD surveillance at the subnational level, particularly in cities and islands, have been developed and piloted in the Philippines. Known as "local integration options for NCD-essential surveillance systems" (LIONESS), the instruments include NCD risk factor surveys for adolescents, schools, adults and health facilities.

The Region has been a pathfinder in the use of technology for improvement of NCD surveillance. For example, Cambodia was the first country in the Region to use new technology for data collection on the STEPS survey with the Android-based eSTEPS. Tonga, during their third national STEPS, piloted the first objective measurement of physical activity in the world, aimed at a sample of 750 participants wearing pedometers for five consecutive days.

To ensure high-quality, reliable NCD data, a regional workshop has been held on NCD surveillance and monitoring every two years since 2014 to update progress on the four time-bound national commitments and the nine voluntary global targets for NCD.

Cancer registration was also strengthened in the Region, with workshops organized from 2014 onwards in Cambodia, Fiji, French Polynesia, the Lao People's Democratic Republic, Nauru, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Tonga and Viet Nam. In-country training support for cancer registration was also provided from 2014 to 2016 to Brunei Darussalam, Fiji, Papua New Guinea and Viet Nam.

B. Way forward

As Member States recall the commitments they agreed to during the 2011 High-level Meeting on NCDs, some countries and areas are to be commended on their progress thus far. However, looking at the overall current status in the Region, bolder actions are still needed from governments to meet the global target on the reduction of premature NCD mortality.

Development of coherent policies across government sectors through a Health in All Policies approach to address NCDs is recommended. Dialogues with lawmakers and with sectors beyond health and non-state actors are crucial to the development, implementation and enforcement of legislations and regulations related to NCDs and their risk factors.

Member States are encouraged to consider prioritizing and accelerating the implementation – according to national context – of the most cost-effective, affordable and evidence-based interventions that address the NCD risk factors. Increased financing is also critical in the implementation of these interventions and is an urgent issue governments should put in place.

Provision of essential population-level, people-centred public health functions, including that for the prevention and management of NCDs, is fundamental to achieving universal health coverage. Strengthening the surveillance and monitoring systems in countries is also crucial as they enable the reporting of progress against the global targets for NCDs.

In the third UN High-level Meeting on NCDs later this year, Member States will once again renew their commitments on NCD prevention and control. Governments may also consider evaluating their current efforts and plans to ensure that their national policies, strategies and actions are well aligned to achieve the global target of reducing premature mortality from NCDs by one third by 2030.

The unwavering political commitment of the Member States in the Western Pacific Region is anticipated to make all these actions possible, along with the continuous support provided by WHO.

CHAPTER 6

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ANNEX 1

NCD COUNTRY CAPACITY SURVEY 2017 QUESTIONNAIRE

2017
Country Profile of Capacity and Response to Noncommunicable Diseases (NCDs)

MODULES:

I PUBLIC HEALTH INFRASTRUCTURE, PARTNERSHIPS AND MULTISECTORAL COLLABORATION FOR NCDs AND THEIR RISK FACTORS

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

III HEALTH INFORMATION SYSTEMS, MONITORING, SURVEILLANCE AND SURVEYS FOR NCDs AND THEIR RISK FACTORS

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

Purpose

- The purpose of this survey is to gauge your country's capacity for responding to noncommunicable diseases. It will guide Member States, WHO Regional Offices and WHO HQ in planning future actions and technical assistance required to address NCDs and their risk factors. This is also the basis for ongoing assessment of changes in country capacity and response.
- The information collected through this survey will also be used to produce some of the indicators that Member States have agreed to monitor and will be held accountable to the United Nations General Assembly (UNGA) and World Health Assembly (WHA);
- 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.
- The four main types of noncommunicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.
- The main risk factors for NCDs are harmful use of alcohol, tobacco use, unhealthy diet, and physical inactivity. Capacity assessment related to some specific risk factors is also captured in other topic-specific assessments – e.g. for tobacco through the WHO Report on the Global Tobacco Epidemic.

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 table provided to indicate the names and titles of all of those who have completed the survey and which sections they have completed. Please also add any additional information on other sources you may have consulted in developing your response.
- 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.
- In order to validate responses, documentation will be requested for affirmative responses throughout the questionnaire. Please make every effort to provide electronic copies of the requested documentation. If documentation has been provided previously and is available in the NCD Document Repository (https://extranet.who.int/ncdccs/documents), please indicate this. If you are unable to provide electronic copies through the provided links, please ask your regional focal point for an alternative means to submit documentation.

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

Additional information sources consulted:

I. Public health infrastructure, partnerships and multisectoral collaboration for NCDs and their risk factors

This module includes questions related to the presence of a unit or division in the ministry of health dedicated to NCDs and risk factors, staff and funding. It also includes an assessment of the existence of fiscal interventions as incentives to influence health behaviour and/or to raise funds for health-related activities. Finally, it assesses the existence of a formal multisectoral mechanism to coordinate NCD-related activities in sectors outside of health. Responses to these questions enable reporting against NCD Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

1) Is there a unit/branch/department in the ministry of health or equivalent with responsibility for NCDs and their risk factors?

Yes No Don't know

IF NO: Go to Question 2

1a) Please indicate the number of full-time-equivalent technical/professional staff in the unit/branch/department.

0
1
2-5
6 - 10
11 or more
Don't know

2) Is there funding allocated in the government budget for the following NCD and risk factor activities/functions?

i) Primary prevention	Yes	No	Don't know
ii) Health promotion	Yes	No	Don't know
iii) Early detection/screening	Yes	No	Don't know
iv) Health care and treatment	Yes	No	Don't know
v) Surveillance, monitoring and evaluation	Yes	No	Don't know
vi) Capacity building	Yes	No	Don't know
vii) Palliative care	Yes	No	Don't know
viii) Research	Yes	No	Don't know

If at least one Yes to above questions:

2a) What are the major sources of regular funding for NCDs and their risk factors?

More than one can apply, rank order them where:

1=Largest source; 2=Next largest; 3=Others

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

3) Is your country implementing any of the following fiscal interventions? (for taxes, please respond "Yes" only if excise taxes and/or special VAT/sales tax rates are applied)

taxation on alcoholic beverages	Yes	No	Don't know
taxation on tobacco (excise and non-excise taxes)	Yes	No	Don't know
taxation on sugar sweetened beverages	Yes	No	Don't know
taxation on foods high in fat, sugar or salt	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
others (specify)	Yes	No	Don't know

If Yes to at least one of the above, other than price subsidies:

3a) Are any of these funds earmarked for health promotion or health service provision?

Yes No Don't know

4) Is there a national multisectoral commission, agency or mechanism to oversee NCD engagement, policy coherence and accountability of sectors beyond health?

Yes No Don't know

IF NO: Go to MODULE II

4a) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational or under development:

4b) Please provide name: _____

4c) Which of the following are members?

(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

IF "Private Sector" is one of the members:

4d) Is the tobacco industry's participation to the consultations and decision making process excluded from the national multisectoral commission?

Yes No Don't know

II. Status of NCD-relevant policies, strategies and action plans

This module includes questions relating to the presence of policies, strategies, or action plans - the questions differentiate between integrated policies/strategies/action plans that address several risk factors or diseases, and policies/strategies/action plans that address a specific disease or risk factor. Additional questions address the existence of specific policies related to the cost-effective interventions for NCDs. Responses to these questions enable reporting against NCD Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

1a) Are NCDs included in the outcomes or outputs of your current national health plan?

Yes No Don't know

1b) Are NCDs included in the outcomes or outputs of your current national development agenda?

Yes No Don't know

2) Are there a set of time-bound national targets for NCDs based on the 9 voluntary global targets from the WHO Global Monitoring Framework for NCDs?

Yes No Don't know

If Yes:

2a) Are there a set of national indicators for these targets based on the indicators from the WHO Global Monitoring Framework for NCDs?

Yes No Don't know

II A: INTEGRATED POLICIES, STRATEGIES, AND ACTION PLANS

3) 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: Go 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
Is it multisectoral?	Yes	No	Don't know
Is it multi-stakeholder?	Yes	No	Don't know

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

3a) Title: _____

3b) Does it address one or more of the following major risk factors?

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

3c) Does it include early detection, treatment and care for:

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

3d) Does it include palliative care for patients with NCDs?

Yes No Don't know

3e) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

3e-ii) What year will it expire? _____

II B: POLICIES, STRATEGIES, ACTION PLANS FOR SPECIFIC KEY NONCOMMUNICABLE DISEASES

The questions in this sub-section only refer to policies, strategies and action plans that are specific to key NCDs. If your integrated policy, strategy or action plan addresses the NCD, you do not need to re-enter that information.

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

Yes No Don't know

IF NO: Go 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

4a) Write the title _____

4b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

4b-ii) What year will it expire? _____

5) Is there a policy, strategy, or action plan for cancer or some particular cancer types in your country?

Yes for all cancers or cancer in general
Yes but only for specific cancers (specify: _____)
No
Don't know

IF NO: Go to Question 6

If yes, provide the following for the general cancer policy/strategy/action plan or, if there isn't one, for the most important specific cancer policy/strategy/action plan:

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) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

5b-ii) What year will it expire? _____

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

Yes No Don't know

IF NO: Go 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

6a) Write the title _____

6b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

6b-ii) What year will it expire? _____

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

Yes No Don't know

IF NO: Go 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

7a) Write the title _____

7b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

7b-ii) What year will it expire? _____

8) Is there a policy, strategy, or action plan for oral health in your country?

Yes No Don't know

IF NO: Go to Question 9

If yes:

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

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

8a) Write the title _____

8b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

8b-ii) What year will it expire? _____

9) Is there a policy, strategy, or action plan for another non-communicable disease of importance in your country?

Yes No Don't know

IF NO: Go 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

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: _____

9a) Write the title _____
9b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:
9b-i) What was the first year of implementation? _____
9b-ii) What year will it expire? _____

II C: POLICIES, ACTION PLANS, STRATEGIES FOR NCD RISK FACTORS

The questions in this sub-section only refer to policies, strategies and action plans that are specific to an NCD risk factor. If your integrated policy, strategy or action plan addresses the risk factor, you do not need to re-enter that information.

10) 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: Go 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

10a) Write the title _____

10b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:
10b-i) What was the first year of implementation? _____
10b-ii) What year will it expire? _____

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

Yes No Don't know

IF NO: Go 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) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

11b-ii) What year will it expire? _____

12) Is there a policy, strategy, or action plan for reducing physical inactivity and/or promoting physical activity in your country?

Yes No Don't know

IF NO: Go 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

12a) Write the title _____

12b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

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

12b-ii) What year will it expire? _____

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

Yes No Don't know

IF NO: Go to Question 14

If yes:

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

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

13a) Write the title _____

13b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

13b-i) What was the first year of implementation? _____

13b-ii) What year will it expire? _____

14) Is there a policy, strategy, or action plan for reducing unhealthy diet related to NCD and/or promoting a healthy diet in your country?

Yes No Don't know

IF NO: Go to Question 15

If yes:

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

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

14a) Write the title _____

14b) Indicate its stage:

Operational
Under development
Not in effect
Don't know

If Operational:

14b-i) What was the first year of implementation? _____

14b-ii) What year will it expire? _____

II D: SELECTED COST-EFFECTIVE POLICIES FOR NCDS AND RELATED RISK FACTORS

NB: Only selected policies are captured here as information on some policy measures, e.g. for tobacco and alcohol, are included in other assessment tools.

15) Is there a policy and/or plan on NCD-related research including community-based research and evaluation of the impact of interventions and policies?

Yes No Don't know

IF NO: Go to Question 16

If yes:

15a) Indicate its stage:

Operational
Under development
Not in effect
Don't know

16) 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: Go to Question 17

If yes:

16a) Are the policies:

Voluntary/self-regulating
Government legislation
Don't know

16b) Who is responsible for overseeing enforcement and complaints?

Government
Food Industry
Independent regulator
Other, please specify: _____

16c) Do they include steps taken to address the effects of cross-border marketing of food and non-alcoholic beverages on children?

Yes No Don't know

16c-i) If yes, please provide details: _____

17) 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 NO: Go to Question 18

17a) If yes, are the policies:

Voluntary/self-regulating
Government legislation
Don't know

18) Is your country implementing any policies to reduce population salt consumption?

Yes No Don't know

IF NO: Go to Question 19

18a) Are these targeted at:

Product reformulation by industry across the food supply	Yes	No	Don't know
Regulation of salt content of food	Yes	No	Don't know
Public awareness programme	Yes	No	Don't know
Nutrition labeling	Yes	No	Don't know

18b) If yes to product reformulation or regulation of salt content, is the policy:

Voluntary/self-regulating
Government legislation
Don't know

19) Has your country implemented any national public awareness programme on diet within the past 5 years?

Yes No Don't know

IF NO: Go to Question 20

19a) If yes, please provide details of the public awareness programme(s):

_____

20) Has your country implemented any national public awareness programme on physical activity within the past 5 years?

Yes No Don't know

IF NO: Go to MODULE III

20a) If yes, please provide details of the public awareness programme(s):

_____

III. Health information systems, monitoring, surveillance and surveys for NCDs and their risk factors

The questions in this module assess surveillance 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. Responses to these questions enable reporting against NCD Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

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

An office/department/administrative division within the 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

III A: 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)

2) Does your country have a system for collecting mortality data by cause of death on a routine basis?

Yes No Don't know

IF NO: Go to Question 3

IF YES:

2a) Is there a civil/vital registration system? Yes No Don't know

2b) Is there a sample registration system? Yes No Don't know

2c) What is the latest year for which data are available? _____

2d) 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

3) Does your country have a cancer registry?

Yes No Don't know

IF NO: Go to Question 4

IF YES:

3a) Are the data collected population-based, hospital-based, or other?

population-based

hospital-based

Other (specify: _____)

Don't know

3b) Is the coverage of the registry national or subnational?

National (covers the whole population of the country)

Subnational (covers only the population of a defined region, not the whole country)

Don't know

3c) What is the latest year for which data are available?

_____

4) Does your country have a diabetes registry?

Yes No Don't know

IF NO: Go to Question 5

IF YES:

4a) Are the data collected population-based, hospital-based, or other?

population-based

hospital-based

Other (specify: _____)

Don't know

4b) Is the coverage of the registry national or subnational?

National (covers the whole population of the country)
Subnational (covers only the population of a defined region, not the whole country)
Don't know

4c) Does the registry include data on any chronic complications which are updated as the patient's complications status changes?

Yes No Don't know

4d) What is the latest year for which data are available?

_____

5) Does your country have a system for recording patient information that includes NCD status?

Yes No Don't know

IF NO: Go to Question 6

IF YES:

5a) Is it an electronic medical records/health records system?

Yes No Don't know

5b)What is the coverage of the system?

National (covers the whole population of the country)
Subnational (covers only the population of a defined region or regions or only certain segments of the population)
Don't know

6) Has your country conducted a survey of facilities to assess service availability and readiness for NCDs?

Yes No Don't know

IF NO: Go to Question 7

6a) Year of last survey _____

6b) Coverage of last survey:

National Subnational Don't know

III B: RISK FACTOR SURVEILLANCE

	7a) Harmful alcohol use	7b) Low fruit and vegetable consumption	7c) Physical inactivity	7d) Tobacco use
7) Have population-based surveys of risk factors (may be a single RF or multiple) been conducted in your country for any of the following: **(Please fill in all columns, start in the first row, going left to right, and then continue left to right across the second row.)** **For the questions on surveys on adolescents, please include here only surveys specifically targeting adolescents (i.e. do not repeat adult surveys that may have covered part of the adolescent age range).**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** Yes No Don't know **IF YES:** **i-1) Was it:** National Subnational Don't know **i-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **i-3) When was the last survey conducted? (give year) _____** **ii) Was there a survey on adults?** Yes No Don't know **IF YES:** **ii-1) Was it:** National Subnational Don't know **ii-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **ii-3) When was the last survey conducted? (give year) _____**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** Yes No Don't know **IF YES:** **i-1) Was it:** National Subnational Don't know **i-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **i-3) When was the last survey conducted? (give year) _____** **ii) Was there a survey on adults?** Yes No Don't know **IF YES:** **ii-1) Was it:** National Subnational Don't know **ii-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **ii-3) When was the last survey conducted? (give year) _____**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** Yes No Don't know **IF YES:** **i-1) Was it:** Measured Self-reported Don't know **i-2) Was it:** National Subnational Don't know **i-3) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **i-4) When was the last survey conducted? (give year) _____** **ii) Was there a survey on adults?** Yes No Don't know **IF YES:** **ii-1) Was it:** Measured Self-reported Don't know **ii-2) Did it assess physical activity for work/in the household, for transport and during leisure time?** Yes No Don't know **ii-3) Was it:** National Subnational Don't know **ii-4) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **ii-5) When was the last survey conducted? (give year) _____**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** Yes No Don't know **IF YES:** **i-1) Was it:** National Subnational Don't know **i-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **i-3) When was the last survey conducted? (give year) _____** **ii) Was there a survey on adults?** Yes No Don't know IF YES: **ii-1) Was it:** National Subnational Don't know **ii-2) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **ii-3) When was the last survey conducted? (give year) _____**

7) cont.	7e) Raised blood glucose/ diabetes	7f) Raised total cholesterol	7g) Raised blood pressure/ Hypertension	7h) Overweight and obesity	7i) Salt / Sodium intake
	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was it:** Measured Self-reported Don't know **ii) Was it:** National Subnational Don't know **iii) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **iv) When was the last survey conducted? (give year) ______**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was it:** Measured Self-reported Don't know **ii) Was it:** National Subnational Don't know **iii) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **iv) When was the last survey conducted? (give year) ______**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was it:** Measured Self-reported Don't know **ii) Was it:** National Subnational Don't know **iii) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **iv) When was the last survey conducted? (give year) ______**	Yes No Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** Yes No Don't know **IF YES:** **i-1) Was it:** Measured Self-reported Don't know **i-2) Was it:** National Subnational Don't know **i-3) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **i-4) When was the last survey conducted? (give year) ______** **ii) Was there a survey on adults?** Yes No Don't know **IF YES:** **ii-1) Was it:** Measured Self-reported Don't know **ii-2) Was it:** National Subnational Don't know **ii-3) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **ii-4) When was the last survey conducted? (give year) ________**	Yes No Don't know **IF NO: Go to MODULE IV.** **IF YES:** **i) Was it:** Measured by 24-hr urine collection Measured by 12-hr urine collection Measured by spot urine collection Measured by combination of methods Self-reported Don't know **ii) Was it:** National Subnational Don't know **iii) How often is the survey conducted?** Ad hoc Every 1 to 2 years Every 3 to 5 years Other Don't know **iv) When was the last survey conducted? (give year) ______**

IV. Capacity for NCD early detection, treatment and care within the health system

The questions in this module assess the health care systems capacity related to NCD early detection, treatment and care within the health care sector. Specific questions focus on availability of guidelines or protocols to treat major NCDs, and the tests, procedures and equipment related to NCDs within the health-care system. It also assesses the availability of palliative care services for NCDs. Responses to these questions enable reporting against NCD Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

1) Please indicate whether evidence-based national guidelines/protocols/standards are available for the management (diagnosis and treatment) of each of the major NCDs through a primary care approach recognized/approved by government or competent authorities. Where guidelines/protocols/standards are available, please indicate their implementation status, when they were last updated and whether they contain standard criteria for the referral of patients from primary care to a higher level of care (secondary/tertiary).

	Cardiovascular Disease	Diabetes	Cancer	Chronic Respiratory Disease
1a) Are they available?	Yes No Don't know	Yes No Don't know	Yes (specify cancer types) No Don't know	Yes No Don't know
1b) Are they being utilized in at least 50% of health care facilities	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know
1c) When were they last updated?	_____	_____	_____	_____
1d) Do they include referral criteria?	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know

2) Indicate the availability of the following basic technologies for early detection, diagnosis/ monitoring of NCDs in the primary care facilities of the public and private health sector where: Generally available=1; Generally not available = 2, Don't know = 3.

** Generally available: in 50% or more of health care facilities Generally not available: in less than 50% of health care facilities*	**Availability in the primary care facilities of the public health sector (1, 2, or 3)**	**Availability in the primary care facilities of the private health sector (1, 2, or 3)**
Overweight and obesity		
2a) Measuring of weight	_____	_____
2b) Measuring of height	_____	_____
Diabetes mellitus		
2c) Blood glucose measurement	_____	_____
2d) Oral glucose tolerance test	_____	_____
2e) HbA1c test	_____	_____
2f) Dilated fundus examination	_____	_____
2g) Foot vibration perception by tuning fork	_____	_____
2h) Foot vascular status by Doppler	_____	_____
2i) Urine strips for glucose and ketone measurement	_____	_____
Cardiovascular disease		
2j) Blood pressure measurement	_____	_____
2k) Total cholesterol measurement	_____	_____
2l) Urine strips for albumin assay	_____	_____
Asthma and chronic obstructive pulmonary disease		
2m) Peak flow measurement spirometry	_____	_____

3) Please indicate if there is a national screening program targeting the general population for the following cancers and, if yes, provide details.

	Initial screening method (indicate only one, the most widely used)	**Population targeted by the program**	**Type of program**	**Screening coverage**
Breast Yes No Don't know If NO: Go to next row	Clinical breast exam Mammography screening Don't know	Women aged ..... to ..... Other, specify: Don't know	Organised population-based screening Opportunistic screening Don't know	Less than 10% 10% to 50% more than 50% but less than 70% 70% or more Don't know
Cervix Yes No Don't know If NO: Go to next row	Visual inspection PAP smear HPV test Don't know	Women aged ..... to ..... Other, specify: Don't know	Organised population-based screening Opportunistic screening Don't know	Less than 10% 10% to 50% more than 50% but less than 70% 70% or more Don't know

	Initial screening method (indicate only one, the most widely used)	Population targeted by the program	Type of program	Screening coverage
Colon Yes No Don't know If NO: Go to next row	Faecal test Colonoscopy/ sigmoidoscopy Don't know	People aged ..... to ..... Other, specify: Don't know	Organised population-based screening Opportunistic screening Don't know	Less than 10% 10% to 50% more than 50% but less than 70% 70% or more Don't know
Other cancer type(s) Yes No Don't know If NO: Go to next row				

4) Please indicate if early detection of the following cancers by means of rapid identification of the first symptoms is integrated into primary health care services and if there is a clearly defined referral system from primary care to secondary / tertiary care for suspect cases (in low- and middle-income countries this set of measures may be designated as an "early diagnosis" programme):

	Breast	Cervix	Colon	Other cancer type(specify: _____)
Programme/ guidelines to strengthen early diagnosis of first symptoms at primary health care level	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know
Clearly defined referral system from primary care to secondary and tertiary care	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know

5) Is there a national HPV vaccination programme under implementation?

Yes No Don't know

If NO: Go to Question 6.

If yes, please provide the following details of the programme:

5a) Who is targeted by the programme?

Girls aged ____ to ____

Other (specify: _____)

Don't know

5b) What year did the programme begin? _____

5c) What is the immunization coverage of the programme?

Less than 10%
10% to 50%
More than 50% but less than 70%
70% or more
Don't know

6) Describe the availability* of the medicines below in the primary care facilities of 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	Availability*
6a) Insulin	
6b) Aspirin (100 mg)	
6c) Metformin	
6d) Thiazide diuretics	
6e) ACE Inhibitors	
6f) Calcium channel blockers	
6g) Beta blockers	
6h) Statins	
6i) Oral morphine	
6j) Steroid inhaler	
6k) Bronchodilator	
6l) Sulphonylurea(s)	
6m) Benzathine penicillin injection	
6n) Nicotine replacement therapy	

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

** Generally available: reaches 50% or more patients in need*
Generally not available: reaches less than 50% of patients in need

Procedure name	Availability*
7a) Retinal photocoagulation	
7b) Renal replacement therapy by dialysis	
7c) Renal replacement by transplantation	
7d) Coronary bypass	
7e) Stenting	
7f) Thrombolytic therapy (streptokinase) for acute myocardial infarction	

8) Detail the availability* of cancer diagnosis and treatment services in the public sector:

** Generally available: reaches 50% or more patients in need*
Generally not available: reaches less than 50% of patients in need

Service	Availability*
Cancer centres or cancer departments at tertiary level	Generally available Generally not available Don't know
Pathology services (laboratories)	Generally available Generally not available Don't know
Cancer surgery	Generally available Generally not available Don't know
Subsidized chemotherapy	Generally available Generally not available Don't know
Radiotherapy	Generally available Generally not available Don't know

9) How many pathology laboratories for cancer diagnosis are there in the country?

(If you don't know the exact number, just give an interval, for example "between 2 and 5".)

Number of public laboratories: _____ Don't know
Number of private laboratories: _____ Don't know

PALLIATIVE CARE FOR PATIENTS WITH NCDS:

10) Indicate the availability* of palliative care for patients with NCD in the public health system:

** Generally available: reaches 50% or more patients in need*
Generally not available: reaches less than 50% of patients in need

10a) In primary health care facilities:
Generally available
Generally not available
Don't know

10b) In community or home-based care:
Generally available
Generally not available
Don't know

CARDIOVASCULAR DISEASE:

11) What proportion of primary health care facilities are offering cardiovascular risk stratification for the management of patients at high risk for heart attack and stroke?

None
Less than 25%
25% to 50%
More than 50%
Don't know

If more than none:

11a) Which CVD risk scoring chart is used?

WHO/ISH risk prediction charts
Others (specify _____)
Don't know

12) Indicate the availability* of services for stroke in the public health system:

** Generally available: reaches 50% or more patients in need*
Generally not available: reaches less than 50% of patients in need

12a) Provision of care for acute stroke:

Generally available
Generally not available
Don't know

12b) Rehabilitation for stroke patients:

Generally available
Generally not available
Don't know

13) Is there a register of patients who have had rheumatic fever and rheumatic heart disease?

Yes
No
Don't know

IF YES:

13a) Are there systems for follow-up/recall to deliver long-term penicillin prophylaxis?

Yes
No
Don't know

GLOSSARY

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 cases in a certain region or a certain hospital. The first aim is to count cancer cases to get an idea of the magnitude of the problem. WHO advises national coverage by population-based registry in small countries only.

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

Cardiovascular diseases: A group of disorders of the heart and blood vessels that includes coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism.

Cardiovascular risk assessment: Use of risk prediction charts to indicate the risk of a fatal or non-fatal major cardiovascular event in the next 5 to 10 years. Based on the assessment people can be stratified into different levels of risk, which will help in management and follow-up.

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 with a defined purpose.

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.

Cross-border marketing: Marketing originating in one country that crosses national borders through broadcast media and internet, print media, sponsorship of events and programmes or any other media or communication channel. It includes both in-flowing and out-flowing cross-border marketing.

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.

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 different sectors, such as health, agriculture, education, finance, infrastructure, transport, trade, etc.

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

Multistakeholder: Involving stakeholders from across the public sector, civil society, NGOs and the private sector.

National Cancer Screening Programme: A government-endorsed programme where screening is offered. NGO-led programmes or national recommendations to go for screening at one's own cost, do not qualify as national screening programmes.

National focal point, unit or department:

i. ***National focal point:*** the person responsible for the prevention and control of chronic diseases 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, for example, national health human resources, population demographics, health expenditures, and 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 chronic diseases, or major risk factors common to chronic diseases.
iii ***Surveillance:*** The systematic collection of data (through survey or registration) on risk factors, chronic diseases and their determinants for continuous analysis, interpretation and feed-back.

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

National policy, strategy, action plan:

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.

National protocols/guidelines/standards for chronic diseases and conditions:
A recommended evidence-based course of action to prevent a chronic disease or condition or to treat or manage a chronic disease or condition aiming to prevent complications, improve outcomes and quality of life of patients.

NGO: Non governmental organization.

Noncommunicable diseases (NCDs): 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.

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 and is no longer under development, but for various reasons is not being implemented.

Nutrition labelling: A description intended to inform consumers of the nutritional properties of food. Nutrition labelling consists of two components: (a) nutrient declaration; (b) supplementary nutrition information.

Operational: A policy, strategy or plan of action which is being used and implemented in the country, and has resources and funding available to implement it. Also applies to a multisectoral commission/ mechanism which is functional and meets on a regular basis.

Palliative care: Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

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 health care: Refers to core functions of a nation's health system. Encompassing front-line health service delivery (primary care) as well as health system structure; governance and financing; the intersectoral policy environment; and social determinants of health, primary health care provides essential health interventions according to a community's needs and expectations.

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: Refers to the process of changing the composition of processed foods to be healthier and reduce the salt content.

Public awareness programme: A comprehensive effort that includes multiple components (messaging, grassroots outreach, media relations, government affairs, budget, etc.) to help increase public understanding about the importance of an issue.

Public health sector: Publicly funded health care sector.

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.

Risk factors associated with noncommunicable diseases
The four main risk factors for NCDs 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 instance, in India more than 4,000 rural and 2,000 urban sample units, with a total of more than 6 million persons, 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.

Screening: Measures preformed across an apparently healthy population in order to identify individuals who are at high risk or in the early stages of disease, but do not yet have symptoms.

Screening coverage: The proportion of people in the population targeted by the programme who actually received screening in the time frame defined by the programme. (For example, if a country recommend mammography screening every 2 years for women aged 50 to 60. The screening coverage is the number of women aged 50 to 60 who benefitted from mammography thanks to the programme in the past 2 years, divided by the total number of women aged 50 to 60 in the country.)

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

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

Taxation incentives to promote physical activity: 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 (adds hydrogen to) unsaturated fatty acids. Trans fats, then, are 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.

VAT/Sales Tax: "Value-added tax" (VAT) is a "multi-stage" tax on all consumer goods and services applied proportionally to the price the consumer pays for a product. Although manufacturers and wholesalers also participate in the administration and payment of the tax all along the manufacturing/distribution chain, they are all reimbursed through a tax credit system, so that the only entity who pays in the end is the final consumer. Most countries that impose a VAT do so on a base that includes any excise tax and customs duty. Example: VAT representing 10% of the retail price. Some countries, however, impose sales taxes instead. Unlike VAT, sales taxes are levied at the point of retail on the total value of goods and services purchased.

ANNEX 2

INDICATOR DEFINITIONS AND SPECIFICATIONS

STATUS OF COUNTRIES AND AREAS

INDICATOR 1

Member State has set time-bound national targets based on WHO guidance

Definition	Country has set national NCD targets. The NCD-related targets should be time-bound and based on the nine voluntary global targets and the WHO Global Monitoring framework.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool - The NCD CCS is completed by a team at the country level to ensure that a comprehensive response is compiled. This indicator is considered fully achieved if a country responds "Yes" to the question "Are there a set of time-bound national targets for NCDs based on the nine voluntary global targets from the WHO Global Monitoring Framework for NCDs", and provides the needed supporting documentation. Targets must be time-bound, based on the nine global targets, and need to address NCD mortality, as well as key risk factors in the country and/or health systems. This indicator is considered partially achieved if the country responds "Yes" to the question "Are there a set of time-bound national targets for NCDs based on the nine voluntary global targets from the WHO Global Monitoring Framework for NCDs", but the targets do not cover two of the three areas addressed in the nine global targets (including mortality or they are not time-bound.
Data validation process	Countries are asked to submit a copy of their targets when submitting their response to the NCD CCS. WHO will confirm that document provided is indeed a set of national NCD targets, addressing NCD mortality, as well as key risk factors in the country, and/or health systems, based on the nine global targets, and that these targets are time-bound (e.g. include such language as "by 2025"). Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 1. Country or area has set time-bound national targets and indicators based on WHO guidance

No.	Country / Area	2015	2017
1	Australia	Partially achieved	Partially achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Not achieved	Not achieved
4	Japan	Fully achieved	Fully achieved
5	Macao SAR (China)	Not achieved	Not achieved
6	New Zealand	Not achieved	Not achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*4 (50%)*	*3 (38%)*
1	Cambodia	Partially achieved	Partially achieved
2	China	Fully achieved	Fully achieved
3	Lao People's Democratic Republic	Partially achieved	Partially achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Not achieved	Not achieved
7	Viet Nam	Fully achieved	Fully achieved
	% Fully Achieved: LMICs (N=7)	*4 (57%)*	*4 (57%)*
1	American Samoa	No data	Partially achieved
2	Cook Islands	No data	Partially achieved
3	Fiji	Fully achieved	Fully achieved
4	French Polynesia	Not achieved	Not achieved
5	Guam	Fully achieved	Fully achieved
6	Kiribati	Partially achieved	Partially achieved
7	Marshall Islands	Fully achieved	Fully achieved
8	Micronesia (Federated States of)	Partially achieved	Partially achieved
9	Nauru	Not achieved	Fully achieved
10	New Caledonia	–	Not achieved
11	Niue	Partially achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	Not achieved
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Partially achieved	Partially achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Fully achieved	Fully achieved
17	Tokelau	No data	Partially achieved
18	Tonga	Fully achieved	Fully achieved
19	Tuvalu	Fully achieved	Partially achieved
20	Vanuatu	Not achieved	Fully achieved
21	Wallis and Futuna Islands	–	No data
	% Fully Achieved: PICs (N=21)	*6 (29%)*	*7 (33%)*
	TOTAL (N = 36)	14 (39%)	14 (39%)

– = documentation not available

INDICATOR 2 — Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis

Definition	Country has a vital registration system that captures deaths and the causes of death routinely. The International form of Medical Certificate of the Death is completed by certifiers. The International Classification of Diseases (ICD) is used to code the causes of death. The data compiled are made available to policy-makers and researchers.
Data collection tool and achievement criteria	The WHO collects mortality date, including cause of death, from civil registration systems in the WHO mortality database through a routine annual call for data. Data are considered to generate reliable cause-specific mortality data on a routine basis if: • Data from the five most recent reporting years are, on average, at least 70% usable. Usability is calculated as (Completeness (%))*(1-Proportion Garbage)[1]. • At least five years of cause-of-death data have been reported to the WHO in the last 10 years. • The most recent year of data reported to the WHO is no more than five years old. This indicator is considered fully achieved if the country meets all of the above criteria. The indicator is considered partially achieved if the country does not meet all of the above criteria but has submitted same vital registration data to WHO.
Data validation process	Data submitted are verified and inconsistencies are referred back to countries to resolve.
Expected frequency of data collection	Yearly
Links to tool	http://www.who.int/healthinfo/tool_cod_2010.pdf

[1] For further details, see page 5 of the following document: http://www.who.int/healthinfo/global_burden_disease/GlobalCOD_method_2000_2015.pdf

Indicator 2: Country or area has a functioning system for generating reliable cause-specific mortality data on a routine basis

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Fully achieved
2	Brunei Darussalam	Partially achieved	Fully achieved
3	Hong Kong SAR (China)	Fully achieved*	Fully achieved*
4	Japan	Fully achieved	Fully achieved
5	Macao SAR (China)	No data	No data
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*6 (75%)*	*7 (88%)*
1	Cambodia	Not achieved	Not achieved
2	China	Partially achieved	Partially achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Partially achieved	Partially achieved
6	Philippines	Fully achieved	Partially achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*1 (14%)*	*0 (0%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	Partially achieved
3	Fiji	Partially achieved	Fully achieved
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Partially achieved	Partially achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Not achieved	Not achieved
10	New Caledonia	No data	No data
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Not achieved	Not achieved
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	Not achieved	Not achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	No data
18	Tonga	Not achieved	Not achieved
19	Tuvalu	Not achieved	Not achieved
20	Vanuatu	Not achieved	Not achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*0 (0%)*	*1 (5%)*
	TOTAL (N = 36)	7 (19%)	8 (22%)

* Revised based on additional inputs from national focal point.

INDICATOR 3 — Member State has a STEPS survey or a comprehensive health examination survey every 5 years

Definition	Country has completed a STEPS survey or another risk factor survey which includes physical measurements and biochemical assessments covering the key behavioural and metabolic risk factors for NCDs. Country must indicate that survey frequency is at least every 5 years.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is considered fully achieved if the country responded "Yes" to each of the following for adults: "Have surveys of risk factors (may be a single RF or multiple) been conducted in your country for all of the following:" "Harmful alcohol use" (optional for the Member States where there is a ban on alcohol), "Physical inactivity", "Tobacco use", "Raised blood glucose/diabetes", "Raised blood pressure/ hypertension", "Overweight and obesity", and "Salt / Sodium intake". For risk factors "Raised blood glucose/diabetes", "Raised blood pressure/hypertension", and "Overweight and obesity", the data must be measured, not self-reported. Additionally, for each risk factor, the country must indicate that the last survey was conducted in the past 5 years (i.e. 2012 or later for the 2017 CCS survey responses) and must respond "Every 1–2 years" or "Every 3–5 years" to the subquestion "How often is the survey conducted?". The country must also provide the needed supporting documentation. This indicator is considered partially achieved if the country responds that at least three, but not all, of the above risk factors are covered, or the surveys were conducted more than five years ago but less than ten years ago.
Data validation process	Countries are asked to submit a copy of their survey report(s) when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification. Data are also checked against the STEPS tracking system which records details of STEPS survey undertaken by countries.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 3: Country or area has a STEPS survey or a comprehensive health examination survey every 5 years

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Partially achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Partially achieved	Fully achieved*
4	Japan	Fully achieved	Fully achieved
5	Macao SAR (China)	Partially achieved	Partially achieved
6	New Zealand	Fully achieved	Partially achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*6 (75%)*	*4 (50%)*
1	Cambodia	Fully achieved	Fully achieved
2	China	Fully achieved	Fully achieved
3	Lao People's Democratic Republic	Fully achieved	Partially achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Fully achieved	Fully achieved
7	Viet Nam	Fully achieved*	Fully achieved
	% Fully Achieved: LMICs (N=7)	*7 (100%)*	*6 (86%)*
1	American Samoa	No data	Partially achieved
2	Cook Islands	No data	Partially achieved
3	Fiji	Fully achieved	Partially achieved
4	French Polynesia	Partially achieved	Partially achieved
5	Guam	Partially achieved	Partially achieved
6	Kiribati	Not achieved	Fully achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Partially achieved	Partially achieved
9	Nauru	Not achieved	Partially achieved
10	New Caledonia	Partially achieved	Partially achieved
11	Niue	Partially achieved	Partially achieved
12	Northern Mariana Islands (Commonwealth of the)	Partially achieved	Fully achieved
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Partially achieved	Partially achieved
15	Samoa	No data	Fully achieved
16	Solomon Islands	Partially achieved	Fully achieved
17	Tokelau	No data	Partially achieved
18	Tonga	Partially achieved	Partially achieved
19	Tuvalu	Partially achieved	Fully achieved
20	Vanuatu	Partially achieved	Partially achieved
21	Wallis and Futuna Islands	Partially data	No response
	% Fully Achieved: PICs (N=21)	*1 (5%)*	*5 (24%)*
	TOTAL (N = 36)	14 (39%)	15 (42%)

* Revised based on additional inputs from national focal point.

INDICATOR 4

Member State has an operational multisectoral national strategy/action plan that integrates the major NCDs and their shared risk factors

Definition	Country has a multisectoral, national integrated NCD and risk factor policy/ strategy/action plan that addresses the four main NCDs (cardiovascular diseases, diabetes, cancer, chronic respiratory diseases) and their main risk factors (tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol). "Multisectoral" refers to engagement with one or more government sectors outside of health. "Operational" refers to a policy, strategy or action plan which is being used and implemented in the country, and has resources and funding available to implement it.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is considered fully achieved if the country responded "Yes" to the questions "Does your country have a national NCD policy, strategy or action plan which integrates several NCDs and their risk factors?" and to the subquestion " Is it multisectoral?". Countries also had to respond "operational" to the subquestion "Indicate its stage" and "Yes" to all of the subquestions pertaining to the four main risk factors and four main NCDs: "Does it address one or more of the following major risk factors?" "Harmful use of alcohol" (optional for the Member States where there is a ban on alcohol), "Unhealthy diet", "Physical inactivity", "tobacco" (all four must have "Yes") and "Does it combine early detection, treatment and care for:" "Cancer", "Cardiovascular diseases", " Chronic respiratory diseases" and "Diabetes" (all four must have "Yes"). Country must also provide the needed supporting documentation. This indicator is considered partially achieved if the country responded "Yes" to the questions "Does your country have a national NCD policy, strategy or action plan which integrates several NCDs and their risk factors?" and to the subquestion " Is it multisectoral?". Countries also have to respond "operational" to the subquestion "Indicate its stage" and "Yes" to at least two of the four main risk factors and at least two of the 4 main NCDs.
Data validation process	Countries are asked to submit a copy of their policy/ strategy/action plan when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 4: Country or area has an operational multisectoral national strategy/action plan that integrates the major NCDs and their shared risk factors

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Partially achieved
2	Brunei Darussalam	Partially achieved	Fully achieved
3	Hong Kong SAR (China)	Fully achieved	Fully achieved
4	Japan	Fully achieved	Fully achieved
5	Macao SAR (China)	Fully achieved	Fully achieved
6	New Zealand	Not achieved	Not achieved
7	Republic of Korea	Partially achieved	Partially achieved
8	Singapore	Not achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*4 (50%)*	*4 (50%)*
1	Cambodia	Not achieved	Not achieved
2	China	Fully achieved	Fully achieved
3	Lao People's Democratic Republic	Not achieved	Fully achieved
4	Malaysia	Not achieved	Partially achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Fully achieved	Not achieved
7	Viet Nam	Fully achieved	Fully achieved
	% Fully Achieved: LMICs (N=7)	*4 (57%)*	*4 (57%)*
1	American Samoa	No data	No data
2	Cook Islands	No data	Fully achieved
3	Fiji	Partially achieved	Partially achieved
4	French Polynesia	Not achieved	Not achieved
5	Guam	Fully achieved	Fully achieved
6	Kiribati	Fully achieved	Not achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Fully achieved	Not achieved
9	Nauru	Not achieved	Fully achieved
10	New Caledonia	Not achieved	Not achieved
11	Niue	Partially achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	Not achieved
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Not achieved	Partially achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Fully achieved	Fully achieved
17	Tokelau	No data	Not achieved
18	Tonga	Partially achieved	Fully achieved
19	Tuvalu	Not achieved	Not achieved
20	Vanuatu	Not achieved	Fully achieved
21	Wallis and Futuna Islands	Not achieved	No response
	% Fully Achieved: PICs (N=21)	*4 (19%)*	*6 (29%)*
	TOTAL (N = 36)	12 (33%)	14 (39%)

INDICATOR 5A

Member State has implemented measures to reduce affordability by increasing excise taxes and prices on tobacco products

Definition	Country has total taxes set at a level that accounts for more than 75% at the retail price of tobacco products.
Data collection tool and achievement criteria	Data collected from government for the production of the WHO Report on the Global Tobacco Epidemic. Total taxes (including excise tax, value added / sales tax, import duties (where applicable) and any other taxes levied) are calculated as a proportion of the price of the tobacco product. Currently this is calculated in relation to the most sold brand of cigarettes. This indicator is considered fully achieved if the country has total taxes more than 75% of the price of the most sold brand of cigarettes. This indicator is considered partially achieved if the country has total taxes from 51% up to 75% of the retail price of the most sold brand of cigarettes.
Data validation process	WHO assessment is shared with national authorities for review and approval.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/tobacco/global_report/ http://www.who.int/tobacco/global_report/2017/technical_note_I.pdf?ua=1

Indicator 5A: Country or area has implemented measures to reduce affordability by increasing excise taxes and prices on tobacco products

No.	Country / Area	2015	2017
1	Australia	Not achieved	Partially achieved
2	Brunei Darussalam	Partially achieved	Not applicable
3	Hong Kong SAR (China)	Fully achieved*	Partially achieved*
4	Japan	Partially achieved	Partially achieved
5	Macao SAR (China)	No data	No data
6	New Zealand	Partially achieved	Partially achieved
7	Republic of Korea	Partially achieved	Partially achieved
8	Singapore	Partially achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*1 (13%)*	*0 (0%)*
1	Cambodia	Not achieved	Not achieved
2	China	Not achieved	Partially achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Not achieved	Not achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*0 (0%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	Partially achieved
3	Fiji	Not achieved	Not achieved
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Fully achieved	Not achieved
7	Marshall Islands	Not achieved	Partially achieved
8	Micronesia (Federated States of)	Not achieved	Partially achieved
9	Nauru	No data	Partially achieved
10	New Caledonia	No data	No data
11	Niue	Not achieved	Fully achieved
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	Not achieved	Partially achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	No data
18	Tonga	Partially achieved	Partially achieved
19	Tuvalu	Not achieved	Partially achieved
20	Vanuatu	Not achieved	Partially achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*1 (5%)*	*1 (5%)*
	TOTAL (N = 36)	2 (6%)	1 (3%)

* Revised based on additional inputs from national focal point.

INDICATOR 5B

Member State has implemented measures to eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport

Definition	Country has all public places completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation). "Completely" means that smoking is not permitted, with no exemptions allowed, except in residences and indoor places that serve as equivalents to long-term residential facilities, such as prisons and long-term health and social care facilities such as psychiatric units and nursing homes. Ventilation and any form of designated smoking rooms and/or areas do not protect from the harms of second-hand tobacco smoke, and the only laws that provide protection are those that result in the complete absence of smoking in all public places.
Data collection tool and achievement criteria	Legal instruments are analysed for the production of the *WHO Report on the Global Tobacco Epidemic*. Legislation is assessed to determine whether smoke-free laws provided for a complete indoor smoke-free environment at all times, in all the facilities of each of the following eight places: health-care facilities; educational facilities other than universities; universities; government facilities; indoor offices and workplaces not considered in any other category; restaurants or facilities that serve mostly food; cafés, pubs and bars or facilities that serve mostly beverages; public transport. This indicator is considered fully achieved if all public places in the country are completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation). The indicator is considered partially achieved if three to seven public places are completely smoke-free, or the law allows designated smoking rooms with strict technical requirements in five or more place.
Data validation process	WHO assessment is shared with national authorities for review and approval
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/tobacco/global_report/ http://www.who.int/tobacco/global_report/2017/technical_note_I.pdf?ua=1

Indicator 5B: Country or area has implemented measures to eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public tranport

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Fully achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Fully achieved*	Fully achieved*
4	Japan	Not achieved	Not achieved
5	Macao SAR (China)	Partially achieved*	No data
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	Not achieved	Partially achieved
8	Singapore	Partially achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*4 (50%)*	*4 (50%)*
1	Cambodia	Partially achieved	Fully achieved
2	China	Not achieved	Not achieved
3	Lao People's Democratic Republic	Partially achieved	Fully achieved
4	Malaysia	Not achieved	Not achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Partially achieved	Partially achieved
	% Fully Achieved: LMICs (N=7)	*1 (14%)*	*3 (43%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	Partially achieved
3	Fiji	Partially achieved	Partially achieved
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Partially achieved	Partially achieved
7	Marshall Islands	Fully achieved	Fully achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Fully achieved	Fully achieved
10	New Caledonia	No data	No data
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Fully achieved	Fully achieved
15	Samoa	Partially achieved	Partially achieved
16	Solomon Islands	Partially achieved	Partially achieved
17	Tokelau	No data	No data
18	Tonga	Not achieved	Partially achieved
19	Tuvalu	Partially achieved	Partially achieved
20	Vanuatu	Not achieved	Not achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*3 (14%)*	*3 (14%)*
	TOTAL (N = 36)	8 (22%)	10 (28%)

* Revised based on additional inputs from national focal point.

INDICATOR 5C

Member State has implemented plain/standardized packaging and/or large graphic health warnings on all tobacco packages

Definition	Country mandates plain / standardized packaging and/or large graphic warnings with all appropriate characteristics. Appropriate characteristics for large graphic warnings include: • specific health warnings mandated; • appearing on individual packages as well as on any outside packaging and labelling used in retails sale; • describing specific harmful effects of tobacco use on health; • are large, clear, visible and legible (e.g. specific colours and font style and sizes are mandated); • rotating health warnings and/or messages; • pictures or pictograms; and • written in (all) the principal language(s) of the country. Appropriate characteristics for plain/standardized packaging include: • restrictions or prohibitations on the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style; • standardized shape, size and materials of tobacco packaging; and • no advertising or promotion inside or attached to the package or tobacco product.
Data collection tool and achievement criteria	Legislation is assessed to determine the size of the warnings (the front and back of the cigarette pack are averaged to calculate the percentage of the total pack surface area covered by warnings) and warning characteristics. The indicator is considered fully achieved if the country has plain/standardized packaging and/or large graphic health warnings which are defined as covering on average at least 50% of the front and back of the package with all appropriate characteristics as detailed above. The indicator is considered partially achieved if there are medium-size warnings, which are defined as covering on average between 30 and 49% of the front and back of package, with some or all appropriate characteristics, or large warnings that are missing some appropriate characteristics.
Data validation process	WHO assessment is shared with national authorities for review and approval
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/tobacco/global_report/ http://www.who.int/tobacco/global_report/2017/technical_note_I.pdf?ua=1

Indicator 5C: Country or area has implemented plain/standardized packaging and/or large graphic health warnings on all tobacco packages

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Fully achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Fully achieved*	Fully achieved*
4	Japan	Partially achieved	Partially achieved
5	Macao SAR (China)	Fully achieved*	No data
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	Partially achieved	Partially achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*6 (75%)*	*5 (63%)*
1	Cambodia	Partially achieved	Fully achieved
2	China	Partially achieved	Partially achieved
3	Lao People's Democratic Republic	Partially achieved	Fully achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Fully achieved	Fully achieved
7	Viet Nam	Fully achieved	Fully achieved
	% Fully Achieved: LMICs (N=7)	*4 (57%)*	*6 (86%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	Partially achieved
3	Fiji	Fully achieved	Fully achieved
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Partially achieved	Partially achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Partially achieved	Partially achieved
10	New Caledonia	No data	No data
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Not achieved	Not achieved
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	Fully achieved	Fully achieved
16	Solomon Islands	Fully achieved	Fully achieved
17	Tokelau	No data	No data
18	Tonga	Partially achieved	Partially achieved
19	Tuvalu	Partially achieved	Partially achieved
20	Vanuatu	Fully achieved	Fully achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*4 (19%)*	*4 (19%)*
	TOTAL (N = 36)	14 (19%)	15 (42%)

* Revised based on additional inputs from national focal point.

INDICATOR 5D

Member State has enacted and enforced comprehensive bans on tobacco advertising, promotion and sponsorship

Definition	Country has a ban on all forms of direct and indirect advertising. Direct advertising bans include: national television and radio; local magazines and newspapers; billboards and outdoor advertising; and point of sale. Indirect advertising bans include: free distribution of tobacco products in the mail or through other means; promotional discounts; non-tobacco products identified with tobacco brand names (brand stretching); brand names of non-tobacco products used for tobacco products (brand sharing); appearance of tobacco brands (products placement) or tobacco products in television and/or films; and sponsorship (contributions and/or publicity of contributions).
Data collection tool and achievement criteria	Legislation is assessed to determine whether the law completely bans all forms of direct and indirect tobacco advertising, promotion and sponsorship. This indicator is considered fully achieved if the country has a ban on all forms of direct and indirect advertising. This indicator is considered partially achieved if the country has a ban on national TV, radio and print media, but not on all other forms of direct and /or indirect advertising.
Data validation process	WHO assessment is shared with national authorities for review and approval
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/tobacco/global_report/ http://www.who.int/tobacco/global_report/2017/technical_note_I.pdf?ua=1

Indicator 5D: Country or area has enacted and enforced comprehensive bans on tobacco advertsing, promotion and sponsorship

No.	Country / Area	2015	2017
1	Australia	Partially achieved	Partially achieved
2	Brunei Darussalam	Partially achieved	Partially achieved
3	Hong Kong SAR (China)	Fully achieved*	Fully achieved*
4	Japan	Not achieved	Not achieved
5	Macao SAR (China)	Fully achieved*	No data
6	New Zealand	Partially achieved	Partially achieved
7	Republic of Korea	Not achieved	Not achieved
8	Singapore	Partially achieved	Partially achieved
	% Fully Achieved: HICs (N=8)	*2 (25%)*	*1 (13%)*
1	Cambodia	Partially achieved	Partially achieved
2	China	Partially achieved	Partially achieved
3	Lao People's Democratic Republic	Partially achieved	Partially achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Partially achieved	Fully achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Partially achieved	Partially achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*1 (14%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	Partially achieved
3	Fiji	Partially achieved	Partially achieved
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Fully achieved	Fully achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Partially achieved	Partially achieved
10	New Caledonia	No data	No data
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Partially achieved	Partially achieved
14	Papua New Guinea	Partially achieved	Partially achieved
15	Samoa	Partially achieved	Partially achieved
16	Solomon Islands	Partially achieved	Partially achieved
17	Tokelau	No data	No data
18	Tonga	Partially achieved	Partially achieved
19	Tuvalu	Fully achieved	Fully achieved
20	Vanuatu	Fully achieved	Fully achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*3 (14%)*	*3 (14%)*
	TOTAL (N = 36)	5 (14%)	5 (14%)

* Revised based on additional inputs from national focal point.

INDICATOR 5E

Member State has implemented effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke

Definition	Country has implemented a national anti-tobacco mass media campaign designed to support tobacco control, of at least three weeks duration with all appropriate characteristics. Appropriate characteristics include: • Campaign was part of a comprehensive tobacco control programme. • Before the campaign, research was undertaken or reviewed to gain a thorough understanding of the target audience. • Campaign communications materials were pre-tested with the target audience and refined in line with campaign objectives. • Air time (radio, television) and/or placement (billboards, print advertising, etc.) was obtained by purchasing or securing it using either the organization's own internal resources or an external media planner or agency (this information indicates whether the campaign adopted a thorough media planning and buying process to effectively and efficiently reach its target audience). • The implementing agency worked with journalists to gain publicity or news coverage for the campaign. • Process evaluation was undertaken to assess how effectively the campaign has been implemented. • An outcome evaluation process was implemented to assess campaign impact. • The campaign was aired on television and/or radio.
Data collection tool and achievement criteria	Eligible campaigns are assessed according to the appropriate characteristics to determine whether it signifies the use of a comprehensive communication approach. This indicator is considered fully achieved if the country has a campaign conducted with at least seven appropriate characteristics including airing on television and/or radio. This indicator is considered partially achieved if the country has a campaign conducted with one to six of the appropriate characteristics.
Data validation process	WHO assessment is shared with national authorities for review and approval
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/tobacco/global_report/ http://www.who.int/tobacco/global_report/2017/technical_note_I.pdf?ua=1

Indicator 5E: Country or area has implemented effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke

No.	Country / Area	2017
1	Australia	Fully achieved
2	Brunei Darussalam	Not achieved
3	Hong Kong SAR (China)	Fully achieved*
4	Japan	Not achieved
5	Macao SAR (China)	No data
6	New Zealand	Fully achieved
7	Republic of Korea	Fully achieved
8	Singapore	Fully achieved
	% Fully Achieved: HICs (N=8)	*5 (63%)*
1	Cambodia	Fully achieved
2	China	Fully achieved
3	Lao People's Democratic Republic	No response
4	Malaysia	Fully achieved
5	Mongolia	Not achieved
6	Philippines	Fully achieved
7	Viet Nam	Fully achieved
	% Fully Achieved: LMICs (N=7)	*5 (71%)*
1	American Samoa	No data
2	Cook Islands	Not achieved
3	Fiji	Fully achieved
4	French Polynesia	No data
5	Guam	No data
6	Kiribati	Fully achieved
7	Marshall Islands	Not achieved
8	Micronesia (Federated States of)	Not achieved
9	Nauru	Not achieved
10	New Caledonia	No data
11	Niue	No response
12	Northern Mariana Islands (Commonwealth of the)	No data
13	Palau	No response
14	Papua New Guinea	Not achieved
15	Samoa	No response
16	Solomon Islands	No response
17	Tokelau	No data
18	Tonga	Fully achieved
19	Tuvalu	Not achieved
20	Vanuatu	Not achieved
21	Wallis and Futuna Islands	No data
	% Fully Achieved: PICs (N=21)	*3 (14%)*
	TOTAL (N = 36)	13 (36%)

* Revised based on additional inputs from national focal point.

INDICATOR 6A

Member State has enacted and enforced restrictions on the physical availablility of retailed alcohol (via reduced hours of sale)

Definition	Country has a licensing system or monopoly on retail sales of beer, wine, spirits. Country has restrictions for on-/off-premise sales of beer, wine, spirits regarding hours, days and locations of sales. Country has legal age limits for being sold and served alcoholic beverages.
Data collection tool and achievement criteria	Data is collected through the WHO Global Survey on Alcohol and Health. This indicator is considered fully achieved if: • a licensing system or monopoly exists on retail sales of beer, wine, and spirits; • restrictions exist for on-and off-premise sales of beer, wine, and spirits regarding hours and locations of sales and restrictions exist for off-premise sales of beer, wine, and spirits regarding days of sales; and • legal age limits for being sold and served alcoholic beverages are 18 years or above for beer, wine, and spirits.
Data validation process	Focal points, officially nominated by the Ministry of Health, respond to the Global Survey on Alcohol and Health. Responses are reviewed and validated by WHO, and subsequently endorsed by the Member States.
Expected frequency of data collection	Every 3-4 years
Links to tool	http://www.who.int/entity/substance_abuse/activities/survey_alcohol_health_2016.pdf?ua=1

Indicator 6A: Country or area has enacted and enforced restrictions on the physical availability of retail alcohol (via reduced hours of sale)

No.	Country / Area	2015	2017
1	Australia	Partially achieved	Partially achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Partially achieved*	Partially achieved*
4	Japan	Partially achieved	Partially achieved
5	Macao SAR (China)	No data	No data
6	New Zealand	Fully achieved*	Partially achieved
7	Republic of Korea	Partially achieved	Partially achieved
8	Singapore	Partially achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*2 (25%)*	*2 (25%)*
1	Cambodia	Not achieved	Not achieved
2	China	Partially achieved	Partially achieved
3	Lao People's Democratic Republic	Partially achieved	Partially achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Partially achieved	Partially achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Partially achieved	Partially achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*0 (0%)*
1	American Samoa	No data	No data
2	Cook Islands	Fully achieved	No response
3	Fiji	Partially achieved	No response
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Partially achieved	Partially achieved
7	Marshall Islands	No data	Partially achieved
8	Micronesia (Federated States of)	Partially achieved	No response
9	Nauru	Partially achieved	No response
10	New Caledonia	No data	No data
11	Niue	Partially achieved	No response
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Partially achieved	No response
14	Papua New Guinea	Fully achieved	No response
15	Samoa	No data	Fully achieved
16	Solomon Islands	No data	No response
17	Tokelau	No data	No data
18	Tonga	Fully achieved	No response
19	Tuvalu	Fully achieved	No response
20	Vanuatu	No data	Partially achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*4 (19%)*	*1 (5%)*
	TOTAL (N = 36)	6 (17%)	3 (8%)

* Revised based on additional inputs from national focal point.

INDICATOR 6B

Member State has enacted and enforced bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)

Definition	Country has regulatory or co-regulatory frameworks for alcohol advertising through different channels (public service/national TV, commercial/private TV, national radio, local radio, print media, billboards, points of sale, cinema, internet, social media). Country has a detection system for infringements on marketing restrictions.
Data collection tool and achievement criteria	Data is collected through the WHO Global Survey on Alcohol and Health. This indicator is considered fully achieved if: • restrictions exist on alcohol advertising for beer, wine, and spirits through all channels; and • detection system exists for infringements on marketing restrictions. This indicator is considered partially achieved if there are restrictions on at least public service/national TV, national radio and billboards but no detection system exists for infringements.
Data validation process	Focal points, officially nominated by the Ministry of Health, respond to the Global Survey on Alcohol and Health. Responses are reviewed and validated by WHO, and subsequently endorsed by the Member States.
Expected frequency of data collection	Every 3-4 years
Links to tool	http://www.who.int/entity/substance_abuse/activities/survey_alcohol_health_2016.pdf?ua=1

Indicator 6B: Country or area has enacted and enforced bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)

No.	Country / Area	2015	2017
1	Australia	Partially achieved	Not achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Partially achieved*	Not achieved*
4	Japan	Not achieved	Not achieved
5	Macao SAR (China)	No data	No data
6	New Zealand	Partially achieved	Not achieved
7	Republic of Korea	Not achieved	Not achieved
8	Singapore	Not achieved	Not achieved
	% Fully Achieved: HICs (N=8)	*1 (13%)*	*1 (13%)*
1	Cambodia	Not achieved	Not achieved
2	China	Not achieved*	Fully achieved
3	Lao People's Democratic Republic	Not achieved	Fully achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Partially achieved	Not achieved
6	Philippines	Partially achieved	Not achieved
7	Viet Nam	Partially achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*2 (29%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	No response
3	Fiji	Not achieved	No response
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Not achieved	Not achieved
7	Marshall Islands	No data	Not achieved
8	Micronesia (Federated States of)	Partially achieved	No response
9	Nauru	No data	No response
10	New Caledonia	No data	No data
11	Niue	Not achieved	No response
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Not achieved	No response
14	Papua New Guinea	Partially achieved	No response
15	Samoa	No data	Not achieved
16	Solomon Islands	No data	No response
17	Tokelau	No data	No data
18	Tonga	Not achieved	No response
19	Tuvalu	Partially achieved	No response
20	Vanuatu	No data	Not achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*0 (0%)*	*0 (0%)*
	TOTAL (N = 36)	1 (3%)	3 (8%)

* Revised based on additional inputs from national focal point.

INDICATOR 6C

Member State has increased excise taxes on alcoholic beverages

Definition	Country has excise tax on beer, wine, spirits. Country adjusts level of taxation for inflation for alcoholic beverages.
Data collection tool and achievement criteria	Data is collected through the WHO Global Survey on Alcohol and Health. This indicator is considered fully achieved if: • excise tax on all alcoholic beverages (beer, wine, and spirits) is implemented; • there are no tax incentives or rebates for production of other alcoholic beverages; and • adjustments of level of taxation for inflation for beer, wine, and spirits is implemented. This indicator is considered partially achieved if there is excise tax on alcoholic beverages as specified above.
Data validation process	Focal points, officially nominated by the Ministry of Health, respond to the Global Survey on Alcohol and Health. Responses are reviewed and validated by WHO, and subsequently endorsed by the Member States.
Expected frequency of data collection	Every 3-4 years
Links to tool	http://www.who.int/entity/substance_abuse/activities/survey_alcohol_health_2016.pdf?ua=1

Indicator 6C: Country or area has increased excise taxes on alcoholic beverages

No.	Country / Area	2015	2017
1	Australia	Not achieved	Partially achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Not achieved*	Not achieved*
4	Japan	Partially achieved	Partially achieved
5	Macao SAR (China)	No data	No data
6	New Zealand	Fully achieved	Partially achieved
7	Republic of Korea	Partially achieved	Partially achieved
8	Singapore	Partially achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*2 (25%)*	*2 (25%)*
1	Cambodia	Partially achieved	Partially achieved
2	China	Partially achieved*	Partially achieved
3	Lao People's Democratic Republic	Not achieved	Partially achieved
4	Malaysia	Partially achieved	Partially achieved
5	Mongolia	Partially achieved	Partially achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Partially achieved	Partially achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*0 (0%)*
1	American Samoa	No data	No data
2	Cook Islands	Partially achieved	No response
3	Fiji	Partially achieved	No response
4	French Polynesia	No data	No data
5	Guam	No data	No data
6	Kiribati	Not achieved	Partially achieved
7	Marshall Islands	No data	Fully achieved
8	Micronesia (Federated States of)	Not achieved	No response
9	Nauru	No data	No response
10	New Caledonia	No data	No data
11	Niue	Not achieved	No response
12	Northern Mariana Islands (Commonwealth of the)	No data	No data
13	Palau	Not achieved	No response
14	Papua New Guinea	Partially achieved	No response
15	Samoa	No data	Fully achieved
16	Solomon Islands	No data	No response
17	Tokelau	No data	No data
18	Tonga	Partially achieved	No response
19	Tuvalu	Fully achieved	No response
20	Vanuatu	No data	Fully achieved
21	Wallis and Futuna Islands	No data	No data
	% Fully Achieved: PICs (N=21)	*1 (5%)*	*3 (14%)*
	TOTAL (N = 36)	3 (8%)	5 (14%)

* Revised based on additional inputs from national focal point.

INDICATOR 7A

Member State has adopted national policies to reduce population salt/sodium consumption

Definition	Country has implemented national policies to reduce population salt/sodium consumption, including reformulation of food products; establishment of a supportive environment in public institutions to enable lower sodium options to be provided; behaviour change communication and mass media campaigns; and front-of-pack labelling.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure that a comprehensive response is compiled. This indicator is considered fully achieved if the country responds "Yes" to the question "Is your country implementing any policies to reduce population salt consumption?" and to the subquestions "Are these targeted at: product reformulation by industry across the food supply; regulation of salt content of food; public awareness programme; nutrition labelling? (must have "Yes" to product reformulation by industry across the food supply and/or regulation of salt content of food, and "Yes" to public awareness programme and nutrition labelling"). Country must also provide the needed supporting documentation. This indicator is considered partially achieved if the country responds "Yes" to the question "Is your country implementing any policies to reduce population salt consumption?", and "Yes" to at least one of the four subquestions "Are these targeted at: product reformulation by industry across the food supply; regulation of salt content of food; public awareness programme; nutrition labelling?".
Data validation process	Countries are asked to submit a copy of their policy(ies) when submitting their response to the NCD CCS. Responses are cross-validated with data obtained through the Global Nutrition Policy Review and the WHO Global database on the Implementation of Nutrition Action (GINA). Where discrepancies are noted, these are referred back to the country for clarification and modification
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 7A: Country or area has adopted national policies to reduce population salt/sodium consumption

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Partially achieved
2	Brunei Darussalam	Not achieved	DK
3	Hong Kong SAR (China)	Fully achieved	Partially achieved
4	Japan	–	Partially achieved
5	Macao SAR (China)	Not achieved	Partially achieved
6	New Zealand	Fully achieved	Partially achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*5 (63%)*	*2 (25%)*
1	Cambodia	Not achieved	Not achieved
2	China	Fully achieved	Fully achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	–	Fully achieved
5	Mongolia	Not achieved	Fully achieved
6	Philippines	Not achieved	Not achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*1 (14%)*	*3 (43%)*
1	American Samoa	No data	DK
2	Cook Islands	No data	Not achieved
3	Fiji	Fully achieved	Not achieved
4	French Polynesia	Not achieved	Not achieved
5	Guam	Fully achieved	Partially achieved
6	Kiribati	–	Not achieved
7	Marshall Islands	–	Not achieved
8	Micronesia (Federated States of)	Fully achieved	Not achieved
9	Nauru	Not achieved	Partially achieved
10	New Caledonia	–	–
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	Not achieved
13	Palau	Fully achieved	No response
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	Not achieved
18	Tonga	Not achieved	Not achieved
19	Tuvalu	Fully achieved	Not achieved
20	Vanuatu	Not achieved	Partially achieved
21	Wallis and Futuna Islands	Not achieved	No response
	% Fully Achieved: PICs (N=21)	*5 (24%)*	*0 (0%)*
	TOTAL (N = 36)	11 (31%)	5 (14%)

DK=don't know; – =documentation not available

INDICATOR 7B

Member State adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply

Definition	Country has implemented a policy(ies) to limit saturated fatty acids and virtually eliminate industrially produced trans-fats in the food supply.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is considered fully achieved if the country responds "Yes" to the question "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?", and provides the needed supporting documentation.
Data validation process	Countries are asked to submit a copy of their policy(ies) when submitting their response to the NCD CCS. Responses are cross-validated with data obtained through the Global Nutrition Policy Review and the WHO Global database on the Implementation of Nutrition Action (GINA). Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 7B: Country or area adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Fully achieved
2	Brunei Darussalam	Not achieved	Not achieved
3	Hong Kong SAR (China)	Not achieved	Fully achieved
4	Japan	–	Not achieved
5	Macao SAR (China)	Not achieved	Not achieved
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	–	Fully achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*3 (38%)*	*5 (63%)*
1	Cambodia	Not achieved	Not achieved
2	China	Not achieved	Fully achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Not achieved	Fully achieved
5	Mongolia	Not achieved	Fully achieved
6	Philippines	Not achieved	Not achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*0 (0%)*	*3 (43%)*
1	American Samoa	No data	Don't know
2	Cook Islands	No data	Not achieved
3	Fiji	Not achieved	Not achieved
4	French Polynesia	Not achieved	Not achieved
5	Guam	Not achieved	Not achieved
6	Kiribati	Not achieved	Not achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Not achieved	Not achieved
10	New Caledonia	Not achieved	Not achieved
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	Not achieved
13	Palau	Not achieved	No response
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	Not achieved
18	Tonga	Not achieved	Not achieved
19	Tuvalu	Not achieved	Not achieved
20	Vanuatu	Not achieved	Not achieved
21	Wallis and Futuna Islands	Not achieved	No response
	% Fully Achieved: PICs (N=21)	*0 (0%)*	*0 (0%)*
	TOTAL (N = 36)	3 (8%)	8 (22%)

– =documentation not available; DK = don't know

INDICATOR 7C

Member State has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children

Definition	Country has implemented a policy(ies) 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.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is considered fully achieved if the country responds "Yes" to the question "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?", and provides the needed supporting documentation.
Data validation process	Countries are asked to submit a copy of their policy(ies) when submitting their response to the NCD CCS. Responses are cross-validated with data obtained through the Global Nutrition Policy Review and the WHO Global database on the Implementation of Nutrition Action (GINA). Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 7C: Country or area has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children

No.	Country / Area	2015	2017
1	Australia	Not achieved	Fully achieved
2	Brunei Darussalam	Not achieved	Not achieved
3	Hong Kong SAR (China)	Not achieved	Fully achieved
4	Japan	Not achieved	Not achieved
5	Macao SAR (China)	Not achieved	Not achieved
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*3 (38%)*	*5 (63%)*
1	Cambodia	Not achieved	Not achieved
2	China	Not achieved	Not achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Not achieved	Fully achieved
6	Philippines	Not achieved	Not achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*1 (14%)*	*2 (29%)*
1	American Samoa	No data	DK
2	Cook Islands	No data	Not achieved
3	Fiji	Fully achieved	Not achieved
4	French Polynesia	Not achieved	Fully achieved
5	Guam	Not achieved	Not achieved
6	Kiribati	–	Not achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Not achieved	Not achieved
10	New Caledonia	Not achieved	–
11	Niue	Not achieved	Not achieved
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	DK
13	Palau	Not achieved	No response
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	Not achieved
18	Tonga	Not achieved	Not achieved
19	Tuvalu	Not achieved	Not achieved
20	Vanuatu	–	Fully achieved
21	Wallis and Futuna Islands	Not achieved	No response
	% Fully Achieved: PICs (N=21)	*1 (5%)*	*2 (10%)*
	TOTAL (N = 36)	5 (14%)	9 (25%)

DK= don't know; – =documentation not available

INDICATOR 7D

Member State has legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes

Definition	Country has implemented legislation/regulations that fully implement the International Code of Marketing of Breast-milk Substitutes.
Data collection tool and achievement criteria	Copies of legislation and regulations on the International Code of Marketing of Breast-milk Substitutes are compiled by WHO every two years. In 2015/16, countries were asked to submit copies. Additionally, copies of legislation were obtained from UNICEF and IBFAN/ICDC and legal databases (Lexis/Nexis and FAO-LEX), EUR-LEX, national gazettes and internet search engines. This indicator is considered fully achieved if the country is assessed as having national legal measures categorized as "full provisions in law", whereby countries have enacted legislations or adopted regulations, decrees or other legally binding measures encompassing all or nearby all provisions of the Code and subsequent WHA resolutions. This indicator is considered partially achieved if the country is assessed as having national legal measures categorized as "many provisions in law" or "few provisions in law", whereby countries have enacted legislation or adopted regulations, decrees or other legally binding measures encompassing many or few provisions of the Code and subsequent WHA resolutions.
Data validation process	WHO, UNICEF, and IBFAN/ICDC analyse all legislation and regulations to determine which provisions of the Code were covered. All three organizations agree upon the categorization based on the provisions included.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/nutrition/publications/infantfeeding/code_report2016/en/

Indicator 7D: Country or area has legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Not achieved
2	Brunei Darussalam	Not achieved	Not achieved
3	Hong Kong SAR (China)	Not achieved	Not achieved*
4	Japan	Not achieved	Not achieved
5	Macao SAR (China)	Not achieved	No data
6	New Zealand	Fully achieved	Not achieved
7	Republic of Korea	Not achieved	Partially achieved
8	Singapore	Not achieved	Not achieved
	% Fully Achieved: HICs (N=8)	*2 (25%)*	*0 (0%)*
1	Cambodia	Fully achieved	Partially achieved
2	China	Not achieved	Partially achieved
3	Lao People's Democratic Republic	Not achieved	Partially achieved
4	Malaysia	Fully achieved	Not achieved
5	Mongolia	Fully achieved	Partially achieved
6	Philippines	Fully achieved	Fully achieved
7	Viet Nam	Fully achieved	Fully achieved
	% Fully Achieved: LMICs (N=7)	*5 (71%)*	*2 (29%)*
1	American Samoa	No data	No data
2	Cook Islands	No data	Not achieved
3	Fiji	Fully achieved	Fully achieved
4	French Polynesia	Fully achieved	No data
5	Guam	Not achieved	No data
6	Kiribati	–	Not achieved
7	Marshall Islands	Not achieved	Not achieved
8	Micronesia (Federated States of)	–	No response
9	Nauru	Not achieved	No response
10	New Caledonia	–	No data
11	Niue	Not achieved	No response
12	Northern Mariana Islands (Commonwealth of the)	Not achieved	No data
13	Palau	Fully achieved	Fully achieved
14	Papua New Guinea	Fully achieved	Partially achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Fully achieved*	Partially achieved
17	Tokelau	No data	No data
18	Tonga	Not achieved	No response
19	Tuvalu	DK	Not achieved
20	Vanuatu	Not achieved	Not achieved
21	Wallis and Futuna Islands	Not achieved	No data
	% Fully Achieved: PICs (N=21)	*5 (24%)*	*2 (10%)*
	TOTAL (N = 36)	12 (33%)	4 (11%)

* Revised based on additional inputs from national focal point; – = documentation not available; DK = don't know

INDICATOR 8	Member State has implemented at least one recent national public awareness programme and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change
Definition	Country has implemented at least one recent (within the past 5 years) national public awareness programme on physical activity.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is considered fully achieved if the country responds "Yes" to the following question. "Has your country implemented any national public awareness programme on physical activity within five years?", and provides the needed supporting documentation.
Data validation process	Countries are asked to submit a copy of any documentation of the programme and/or a link to the programme website when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 8: Country or area has implemented at least one recent national public awareness programme and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change

No.	Country / Area	2015	2017
1	Australia	Fully achieved	Fully achieved
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	Fully achieved	Fully achieved
4	Japan	Fully achieved	Fully achieved
5	Macao SAR (China)	Fully achieved	Fully achieved
6	New Zealand	Fully achieved*	Not achieved
7	Republic of Korea	Fully achieved	Fully achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*8 (100%)*	*7 (88%)*
1	Cambodia	Fully achieved	Not achieved
2	China	Fully achieved	Not achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Fully achieved	Fully achieved
6	Philippines	Fully achieved	Fully achieved
7	Viet Nam	Fully achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*6 (86%)*	*3 (43%)*
1	American Samoa	No data	–
2	Cook Islands	No data	Not achieved
3	Fiji	Fully achieved	Fully achieved
4	French Polynesia	Fully achieved	Fully achieved
5	Guam	Fully achieved	Fully achieved
6	Kiribati	Fully achieved	Fully achieved
7	Marshall Islands	–	Not achieved
8	Micronesia (Federated States of)	Fully achieved	Not achieved
9	Nauru	Fully achieved	Not achieved
10	New Caledonia	Fully achieved	–
11	Niue	Fully achieved	Fully achieved
12	Northern Mariana Islands (Commonwealth of the)	Fully achieved	Fully achieved
13	Palau	–	No response
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	–	Not achieved
17	Tokelau	No data	Fully achieved
18	Tonga	Fully achieved	Fully achieved
19	Tuvalu	Fully achieved	Not achieved
20	Vanuatu	–	Not achieved
21	Wallis and Futuna Islands	Fully achieved	No response
	% Fully Achieved: PICs (N=21)	*12 (57%)*	*8 (38%)*
	TOTAL (N = 36)	26 (72%)	18 (50%)

* Revised based on additional inputs from national focal point; – =documentation not available

INDICATOR 9

Member State has evidence-based national guidelines/ protocols/standards for the management of major NCDs through a primary care approach, recognized/approved by government or competent authorities

Definition	Government approved evidence-based national guidelines/protocols/ standards for the management (diagnosis and treatment) of the four main NCDs – cardiovascular diseases, diabetes, cancer and chronic respiratory diseases.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is based on the number of countries who indicate that national guidelines/protocols/standards exist for all four NCDs (cardiovascular diseases, diabetes, cancer and chronic respiratory diseases). The indicator is considered fully achieved if national guidelines/protocols/ standards exist for all four NCDs (cardiovascular diseases, diabetes, cancer and chronic respiratory diseases), and the country provides the needed supporting documentation. This indicator is considered partially achieved if the country has guidelines/ protocols/standards for at least two of the four NCDs (cardiovascular diseases, diabetes, cancer and chronic respiratory diseases), but not for all four.
Data validation process	Countries are asked to submit a copy of the guidelines/protocols/ standards when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 9: Country or area has evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach, recognized/approved by government or competent authorities

No.	Country / Area	2015	2017
1	Australia	Partially achieved	Fully achieved
2	Brunei Darussalam	Fully achieved	Partially achieved
3	Hong Kong SAR (China)	Partially achieved	Partially achieved
4	Japan	–	DK
5	Macao SAR (China)	Partially achieved	Partially achieved
6	New Zealand	Fully achieved*	Fully achieved
7	Republic of Korea	Fully achieved	Partially achieved
8	Singapore	Fully achieved	Fully achieved
	% Fully Achieved: HICs (N=8)	*4 (50%)*	*3 (38%)*
1	Cambodia	Not achieved	Not achieved
2	China	Fully achieved	Fully achieved
3	Lao People's Democratic Republic	Not achieved	Fully achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Partially achieved	Partially achieved
6	Philippines	Partially achieved	Partially achieved
7	Viet Nam	Fully achieved*	Fully achieved
	% Fully Achieved: LMICs (N=7)	*3 (43%)*	*4 (57%)*
1	American Samoa	No data	–
2	Cook Islands	No data	Fully achieved
3	Fiji	Partially achieved	Partially achieved
4	French Polynesia	Not achieved	Fully achieved
5	Guam	Fully achieved	Partially achieved
6	Kiribati	–	Partially achieved
7	Marshall Islands	–	Not achieved
8	Micronesia (Federated States of)	Partially achieved	Partially achieved
9	Nauru	DK	Fully achieved
10	New Caledonia	–	–
11	Niue	Not achieved	Fully achieved
12	Northern Mariana Islands (Commonwealth of the)	–	Partially achieved
13	Palau	Fully achieved	Fully achieved
14	Papua New Guinea	–	Partially achieved
15	Samoa	No data	Partially achieved
16	Solomon Islands	Partially achieved*	Partially achieved
17	Tokelau	No data	DK
18	Tonga	Partially achieved	Partially achieved
19	Tuvalu	Partially achieved	Partially achieved
20	Vanuatu	Partially achieved	Partially achieved
21	Wallis and Futuna Islands	Partially achieved	No response
	% Fully Achieved: PICs (N=21)	*2 (20%)*	*5 (24%)*
	TOTAL (N = 36)	9 (25%)	12 (33%)

* Revised based on additional inputs from national focal point; – =documentation not available; DK = don't know

INDICATOR 10

Member State has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level

Definition	Country has provision of drug therapy (including glycaemic control for diabetes, mellitus and control of hypertension using a total risk approach), and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥30%, or ≥20%) of a fatal and non-fatal cardiovascular event in the next 10 years.
Data collection tool and achievement criteria	WHO NCD Country Capacity Survey tool – The NCD CCS is completed by a team at the country level to ensure a comprehensive response is compiled. This indicator is based on the number of countries who respond "more than 50%" to the question "What proportion of primary health care facilities are offering cardiovascular risk stratification for the management of patients at high risk for heart attack and stroke?". Additionally, countries must have said all the following drugs were "generally available" in the primary care facilities of the public health sector: insulin, aspirin, metformin, thiazide diuretics, ACE inhibitors, CC blockers, statins, and sulphonylurea(s). The indicator is considered fully achieved if the country reports that more than 50% of primary health care facilities are offering cardiovascular risk stratification for the management of patients at high risk for heart attack and stroke and that all drugs listed above were generally available in the primary care facilities of the public health sector. This indicator is considered partially achieved if the country reports that between 25% to 50% of primary health care facilities are offering cardiovascular risk stratification for the management of patients at high risk for heart attack and stroke and that all drugs listed above were generally available in the primary care facilities of the pubic health sector.
Data validation process	NCD focal points, officially nominated by the Ministry of Health, provide the official response to WHO through the NCD Country Capacity Survey tool.
Expected frequency of data collection	Every two years
Links to tool	http://www.who.int/ncds/surveillance/ncd-capacity/en/

Indicator 10: Country or area has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level

No.	Country / Area	2015	2017
1	Australia	DK	DK
2	Brunei Darussalam	Fully achieved	Fully achieved
3	Hong Kong SAR (China)	DK	Fully achieved
4	Japan	DK	DK
5	Macao SAR (China)	Not achieved	Partially achieved
6	New Zealand	Fully achieved	Fully achieved
7	Republic of Korea	Not achieved	Fully achieved
8	Singapore	Dk	DK
	% Fully Achieved: HICs (N=8)	*2 (25%)*	*4 (50%)*
1	Cambodia	Not achieved	Not achieved
2	China	Not achieved	Not achieved
3	Lao People's Democratic Republic	Not achieved	Not achieved
4	Malaysia	Fully achieved	Fully achieved
5	Mongolia	Not achieved	Not achieved
6	Philippines	Not achieved	Not achieved
7	Viet Nam	Not achieved	Not achieved
	% Fully Achieved: LMICs (N=7)	*1 (14%)*	*1 (14%)*
1	American Samoa	No data	DK
2	Cook Islands	No data	Fully achieved
3	Fiji	Not achieved	Partially achieved
4	French Polynesia	Partially achieved	Partially achieved
5	Guam	Partially achieved	Partially achieved
6	Kiribati	No data	DK
7	Marshall Islands	DK	Not achieved
8	Micronesia (Federated States of)	Not achieved	Not achieved
9	Nauru	Partially achieved	Partially achieved
10	New Caledonia	Not achieved	Partially achieved
11	Niue	Partially achieved	Partially achieved
12	Northern Mariana Islands (Commonwealth of the)	DK	Fully achieved
13	Palau	Fully achieved	Fully achieved
14	Papua New Guinea	Not achieved	Not achieved
15	Samoa	No data	Not achieved
16	Solomon Islands	Not achieved	Not achieved
17	Tokelau	No data	Fully achieved
18	Tonga	Not achieved	Not achieved
19	Tuvalu	Not achieved	Partially achieved
20	Vanuatu	Not achieved	Not achieved
21	Wallis and Futuna Islands	Not achieved	No response
	% Fully Achieved: PICs (N=21)	*1 (5%)*	*4 (19%)*
	TOTAL (N = 36)	4 (11%)	9 (25%)

DK = don't know

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