Regional workshop on strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD)

09–13 December 2013
Saitama, Japan
Participants of the Regional workshop on strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD)
Saitama, Japan, 09–13 December 2013
REPORT

REGIONAL WORKSHOP ON STRENGTHENING LEADERSHIP AND ADVOCACY FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES (LeAd-NCD)

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC
National Institute of Public Health, Saitama, Japan
9–13 December 2013

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NOTE

The views expressed in this report are those of the participants in the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) and do not necessarily reflect the policies of the Organization.

This report has been prepared for the World Health Organization Regional Office for the Western Pacific for the use of governments from Member States in the Region and for those who participated in the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) from 9 to 13 December 2013.
SUMMARY

Prevention and control of noncommunicable diseases (NCDs) requires skills and competencies in multisectoral planning, risk reduction through policy/regulation and fiscal interventions, health system strengthening and surveillance and monitoring. There is a high demand for NCD prevention and control capacity-building programmes, but there are very limited opportunities.

Recognizing these issues, the World Health Organization (WHO) Regional Office for the Western Pacific, along with Japan’s National Institute of Public Health and experts, developed a five-day Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control on Noncommunicable Diseases (LeAd-NCD). The workshop was held at the National Institute of Public Health in Saitama, Japan, from 9 to 13 December 2013, with the following objectives:

1. to strengthen skills and competencies for NCD prevention and control in selected institutions in the Region;

2. to identify options and approaches for capacity-building at country level through national institutes; and

3. to finalize the LeAd-NCD course based on the feedback and input from the workshop.

The five-day workshop comprised sessions on the sharing of journeys and expectations, NCD surveillance, approaches to NCD risk reduction, NCD management, prioritization of interventions, NCD advocacy, leadership for NCD, and the plan for NCD capacity-building. The workshop built capacity for NCD prevention and control in the national institutes of public health and schools of public health of the participating countries. The programme can be adapted and rolle Leadership and advocacy are key elements in strengthening NCD prevention and control. The objectives of the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) were met, and the participants obtained the necessary information and skills to further enhance leadership and advocacy in NCD prevention and control in their countries.

Leadership and advocacy are key elements in strengthening NCD prevention and control. The objectives of the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) were met, and the participants obtained the necessary information and skills to further enhance leadership and advocacy in NCD prevention and control in their countries.

Recommendations include the following:

1. The content and organization of the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of NCDs (LeAd-NCD) can be adapted for capacity-building within countries.

2. National institutes and public health training centres can be considered as appropriate training institutions for NCD prevention and control.
(3) Capacity-building programmes for NCD prevention and control can be incorporated in the pre-service and in-service training programmes for health professionals.

(4) Capacity-building in non-health sectors is needed and can be provided as per the national context.

(5) Technical support for NCD capacity-building at national and subnational levels can be sought from WHO.
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Key words

Keywords: Chronic disease-prevention and control / Health promotion / Capacity building / Regional health planning
INTRODUCTION

1.1 Background

Noncommunicable diseases (NCDs) are the leading cause of death in the Western Pacific Region. Premature mortality (deaths before 70 years of age) accounts for 50% of deaths due to NCDs in low- and middle-income countries of the Region and demonstrates the impact of the NCD epidemic on productivity and development.

NCD prevention and control requires skills and competencies in multisectoral planning, risk reduction through policy/regulation and fiscal interventions, health system strengthening and surveillance and monitoring. There is a high demand for NCD prevention and control capacity-building programmes, but there are very limited opportunities.

Since 2005, the World Health Organization (WHO) Regional Office for the Western Pacific has worked with the National Institute of Public Health (NIPH) in Japan on a capacity-building programme for NCD prevention and control. From 2005 to 2009, the programme trained a total of 86 participants from the ministries of health of 14 Member States. However, it was recognized that there is a need to develop the capacity of national institutes to provide NCD prevention and control training within countries.

WHO, along with the NIPH and experts, developed a five-day course on leadership and advocacy for NCD prevention and control. The Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) was held in Saitama, Japan from 9 to 13 December 2013. It is expected that the LeAd-NCD programme will lead to development of national institutions offering training programmes for NCD prevention and control. Participants of the programme are expected to become lead facilitators for national capacity-building programmes.

1.2 Objectives

(1) To strengthen skills and competencies for NCD prevention and control in selected institutions in the Region.

(2) To identify options and approaches for capacity-building at country level through national institutes.

(3) To finalize the LeAd-NCD course based on the feedback and input from the workshop.

1.3 Participants

The workshop was attended by 19 representatives of national institutes of public health and schools of public health in Brunei Darussalam, Cambodia, China, Fiji, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines and Viet Nam. Staff members from the WHO Regional Office for the Western Pacific, China and Papua New Guinea provided secretariat support for the workshop. A list of participants, temporary advisers, resource persons and secretariat members is given in Annex 1.
1.4 Organization

The workshop comprised eight sessions in addition to the opening and closing sessions. Sessions were designed according to different aspects of prevention and control of NCDs: sharing journeys and expectations, NCD surveillance, approaches to NCD risk reduction, NCD management, prioritization of interventions, NCD advocacy, leadership for NCD, and plans for NCD capacity-building. A full outline of the programme is provided in Annex 2. A workbook was also developed to support the sessions and to guide the group work and skill-building activities (Annex 4).

1.5 Opening session

Dr Yukio Matsutani, President of NIPH, Japan, welcomed the participants and presented a brief review of the public health situation in Japan. He informed them that the basic goals of the second term of Health Japan 21, which started in 2013, include extending healthy life expectancy and decreasing health disparities, among others.

Dr Kazushi Yamauchi, Director of the Office of International Cooperation, Ministry of Health, Labour and Welfare, Japan, also addressed the participants and highlighted the priorities for NCD prevention and control in the Region.

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, delivered the opening address and expressed his appreciation to the Ministry of Health, Labour and Welfare of Japan for their continued support of the capacity-building programme for NCD prevention and control in the Western Pacific. Dr Shin stressed that the programme has a history of providing high-quality training for ministries of health and national institutes throughout the Region and he is hopeful that the LeAd-NCD course will become a brand for the Region in NCD prevention and control.

Dr Hai-Rim Shin, Team Leader, Noncommunicable Diseases and Health Promotion (NHP), WHO Regional Office for the Western Pacific, presented the global and regional mandates on NCD prevention and control.

2. PROCEEDINGS

2.1 Session 1 – Sharing journeys and setting expectations

Participants presented the current status of NCD prevention and control capacity-building in their institutions, highlighting limitations and opportunities. The main limitations are lack of human resources, insufficient national coordination and inadequate infrastructure. Opportunities are provided through the Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020) and the capacity of the institutions in human resource development and other areas.

The presentations were followed by a series of group activities that allowed the participants to assess their country's situation in NCD prevention and control and to reflect on their personal journey as professionals working for NCD prevention and control. The sessions were facilitated by Dr Annette David, Senior Partner of Health Partners, LLC Guam.
2.2  Session 2 – NCD surveillance

Dr Cherian Varghese, Senior Medical Officer, NCD, WHO Regional Office for the Western Pacific, presented the global monitoring framework, including indicators and a set of voluntary global targets for the prevention and control of NCDs.

Ms Marie Clem Carlos, Technical Assistant, NHP, WHO Regional Office for the Western Pacific, then presented an overview of the WHO risk factor tools such as the STEPwise approach to Surveillance (STEPS) and the Global School-based Student Health Survey (GSHS).

Dr Hai-Rim Shin presented the important elements of a national cancer control programme and how cancer registration plays a big part in it. She differentiated the three types of cancer registries: population-based registry, hospital-based registry and pathology registry, and explained how information from these registries is utilized. She also added the relevance of vital registration systems in improving population mortality data collection.

Dr Nobou Nishi, Chief of the Center for International Collaboration and Partnership, National Institute of Health and Nutrition, Japan, presented an overview of the Japan National Health and Nutrition Survey, tracing its history from 1945. The survey’s structure and organization, items collected and linkage of the survey in monitoring Health Japan 21 outcomes were presented.

Dr Eri Osawa, Senior Researcher, Department of International Health and Collaboration, NIPH, demonstrated Japan’s radio calisthenics programme, which is popular among Japanese students and workers. Radio exercise, which originated from the United States of America, was started in Japan in 1928 for health promotion after being modified to Japanese style.

Participants conducted an NCD risk factor survey using a shortened WHO STEPS tool, which helped them to learn about NCD surveillance. In addition, participants assessed the current and ongoing surveys related to NCD risk factors and data management capacity at national level and the use of data for NCD prevention and control.

2.3  Session 3 – Approaches to NCD risk reduction

Dr Cherian Varghese presented the different interventions for NCD risk reduction. He expanded on the very cost-effective interventions for NCD prevention and control with illustrations from the Region. The importance of upstream interventions and working with non-health sectors are critical for NCD risk reduction.

Dr Hai-Rim Shin discussed the concept of Health in All Policies (HiAP) and discussed various settings-based approaches for NCD prevention and control. The key elements of HiAP, along with drivers for achieving HiAP and the role of the health sector, were presented. Dr Shin also noted that healthy settings (e.g. schools and workplaces) and healthy cities could be platforms for multiple risk factor interventions. The importance of health promotion foundations was also presented.

During a group exercise, participants developed a scheme for NCD prevention and control in the workplace (Annex 3). Eight out of 10 institutions identified a health department or a health institute for this exercise.
2.4 Session 4 – NCD management

The session started with a presentation by Dr Tetsuji Yokoyama, Director of the Department of Health Promotion, NIPH, Japan, on the final evaluation of the first term of Health Japan 21 and plans for the next 10 years. Dr Yokoyama indicated that about 60% of the indicators had improved, and that 18% had achieved their goals. Based on the experience, the second term of Health Japan 21 was developed and started in 2013.

Dr Cherian Varghese then presented the management aspect of NCDs. He started by analysing the current constraints in supply and demand of health systems, with respect to NCD services. Low-resource settings are more focused on acute care and communicable disease management and should re-orientate towards chronic care with a people-centred approach. The WHO package of essential NCD interventions (WHO PEN) offers a set of cost-effective interventions that can be introduced at primary care level and contains generic drugs and minimal technology. An important component of this package is the identification and management of total cardiovascular risk using the WHO and International Society of Hypertension (ISH) risk prediction charts. Dr Varghese also stressed on the need for continuing care in the community, referral systems and financial protection.

During the activity that followed, participants were asked to identify their own cardiovascular risk using the scoring system. Ms Marie Clem Carlos presented the results of the participant's health survey and discussed the options for risk factor surveys and risk reduction.

Dr Midori Ishikawa, Senior Researcher, Department of Health Promotion, NIPH, Japan, and Dr Miki Miyoshi, Head of the Section of International Nutrition, Research and Development Center for International Collaboration and Partnership, National Institute of Health and Nutrition, Japan, presented how the Japanese Food Guide Spinning Top works.

Following the presentations and activity, the participants visited the First Institute of Health Promotion and Practice. The institute was established in 1939 and was initially used for health examination for tuberculosis. Dr Akira Okayama, Director of the Institute, presented the national scheme of prevention of cardiovascular disease in Japan. Dr Okayama covered cardiovascular epidemiology and demonstrated the trends in mortality. He also presented the details of screening high-risk persons. The participants were taken through the different sections of the institute to witness various screening procedures.

2.5 Session 5 – Prioritization of interventions

After addressing the burden, surveillance and risk factors of NCDs, participants were taken through a series of activities, facilitated by Dr Annette David, to prioritize interventions and to systematically develop action plans. Using a matrix that factored in magnitude, feasibility and cost as criteria for assessment, priority interventions were identified. Barriers to the identified interventions were explored through a spidergram. Key problems were then further analysed through a problem–solution tree. Potential solutions were identified and were ranked by importance and feasibility. An action plan for one of the priority interventions was developed, indicating the role of health and non-health sectors, resources needed, monitoring components and time frame.
2.6 **Session 6 – NCD advocacy**

Dr Annette David presented an overview of the elements of effective NCD advocacy. This presentation was followed by a set of activities that included target audience identification, stakeholder mapping through an influence-interest grid, and development of messages about the key benefits. A marketplace activity and role play helped the participants to get the critical feedback on developing advocacy messages. The session ended with a World Café showcasing various advocacy tools and applications from around the world.

2.7 **Session 7 – Leadership for NCD**

Participants worked in groups to identify characteristics of leadership using an affinity diagram. The importance of advocacy and communication skills, partnership development and teamwork were noted as essential qualities for NCD leaders.

2.8 **Session 8 – Plan for NCD capacity-building**

The final session focused on developing a plan for capacity-building in the institutions represented in the workshop. Participants used a template to identify essential elements of a national workshop, namely, the structure, stakeholders, endorsement from ministries, potential participants and expected outcomes. Opportunities for attracting a wider audience, such as the open classroom of the Universiti Brunei Darussalam, were considered. The scope and need for a regional network for capacity-building for NCD prevention and control was discussed. The participants suggested WPR Network for Noncommunicable Diseases (WIN-NCD) as a possible name for the network.

2.8.1 **Evaluation**

An evaluation of the workshop was conducted using a structured questionnaire and a scale of 1–10 (with 10 being the highest score) to indicate participants’ impression of the workshop (Annex 4). The overall impression of the workshop was high (45% of participants rated the workshop as 10, while 15% rated it as 9). Participants also valued the information learnt in the sessions and from the experiences of other countries.

2.7 **Closing session**

Dr Kazushi Yamauchi, Director, Office of the International Cooperation, Ministry of Health, Labour and Welfare, Japan, addressed the participants in the closing session and highlighted the importance of NCD prevention and control for Japan and the Region.

Dr Hai-Rim Shin closed the workshop by thanking participants for their active involvement. Dr Shin acknowledged the support of the Ministry of Health, Labour and Welfare of the Government of Japan and the collaboration and partnership of NIPH, Japan. It was also informed that WHO would continue to support Member States in the Region as they build national capacity for NCD prevention and control.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

Leadership and advocacy are key elements in strengthening NCD prevention and control. The objectives of the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) were met, and the participants obtained the necessary information and skills to further enhance leadership and advocacy in NCD prevention and control in their countries.

3.2 Recommendations

(1) The content and organization of the Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of NCDs (LeAd-NCD) can be adapted for capacity-building within countries.

(2) National institutes and public health training centres can be considered as appropriate training institutions for NCD prevention and control.

(3) Capacity-building programmes for NCD prevention and control can be incorporated in the pre-service and in-service training programmes for health professionals.

(4) Capacity-building in non-health sectors is needed and can be provided as per the national context.

(5) Technical support for NCD capacity-building at national and subnational levels can be sought from WHO.
ANNEX 1

LIST OF TEMPORARY ADVISERS, RESOURCE PERSONS AND SECRETARIAT

1. TEMPORARY ADVISERS

Dr Shrish Naresh ACHARYA, Consultant Physician, Internal Medicine, Colonial War Memorial Hospital, Medical Unit, Waimanu Road, Suva Fiji, Tel. No.: (679) 9242397, Fax No.: (679) 3303232, E-mail: shrish.acharya@health.gov.fj

Dr Tahir ARIS, Director, Institute of Public Health, Ministry of Health, Bangsar, 50590, Kuala Lumpur Malaysia, Tel. No.: (603) 22979400, Fax No.: (603) 22821005, E-mail: tahir.a@moh.gov.my

Dr CHHEA Chhorvann, Deputy Director, National Institute of Public Health, No. 2, St 289, Toul Kork, Phnom Penh, Cambodia, Tel. No.: (855) 12503844, Fax No.: (855) 23880346, E-mail: cchhorvann@niph.org.kh

Dr CHHENG Kannarath, Deputy Director, National Institute of Public Health, No. 2, St 289, Toul Kork, Phnom Penh, Cambodia, Tel. No.: (855) 12936685, Fax No: (855) 23880346, Email: ckannarath@niph.org.kh

Dr FENG Lian-gui, Deputy Director, Chongqing Center for Disease Control and Prevention, No. 8, Changjiang 2nd Road, Yuzhong District, Chongqing China, Tel. No.: (8623) 68803833, Fax No.: (8623) 68803303, E-mail: 812047347@qq.com

Professor Jonathan GUEVARRA, Assistant Professor, Department of Health Promotion and Education, College of Public Health, University of the Philippines Manila, 625 Pedro Gil Street, Ermita Manila, Philippines, Tel. No.: (63) 5260811; mobile: (63) 9498455684, Fax No.: (63) 5211394 E-mail: jpguevarra@gmail.com; jpguevarra2@up.edu.ph

Dr Renato G. JOSEF, Assistant Professor, Department of Environmental and Occupational Health College of Public Health, University of the Philippines Manila, 625 Pedro Gil Street, Ermita Manila 1000, Philippines, Tel. No.: (63) 9199981028; (63) 5247102; (63) 5265966, Fax No.: (63) 5237745, E-mail: rgjosef@up.edu.ph; renatojosef@yahoo.com.ph

Dr Norhayati KASSIM, Senior Medical Officer and Head, Health Promotion Centre, Ministry of Health, Commonwealth Drive, Bandar Seri Begawan, BB 3910, Brunei Darussalam, Tel. No.: (673) 2384220, Fax No.: (673) 2384223, E-mail: norhayati.kassim@moh.gov.bn

Dr NGUYEN Thi Thi Tho, Head of Division for Noncommunicable Disease Control Prevention, Deputy Chief of Department of Community Health and Prevention Network Coordination, National Institute of Hygiene and Epidemiology, No 1 Yersin Street, Hai Ba Trung District, Hanoi, Viet Nam, Tel. No.: (844) 9710791, Fax No.: (844) 9718490, E-mail: poemhnvn@yahoo.com

Dr Chimedsuren OCHIR, Dean, School of Public Health, Health Sciences University, Zorig Street – 3, Ulaanbaatar, Mongolia, Tel. No.: (976) 11 329126, Fax No.: (976) 11 321731, E-mail: chimedsuren@hsum-ac.mn; suren_och@yahoo.com

Dr Ilisapeci Kubuabola-SAMISONI, Assistant Professor – Epidemiology, School of Public Health and Primary Care, College of Medicine, Nursing and Health Sciences, Fiji National University, Suva, Fiji Tel. No.: (679) 3233814, Fax No.: (679) 3233243; Mobile no.: (679) 9222145, E-mail: ilisapeci.kubuabola@fnu.ac.fj
2. RESOURCE PERSONS

Dr Annette DAVID, Senior Partner for health consulting services, Health Partners, LLC, P.O. Box 9969, Tamuning, Guam 96931, Tel. No.: 1 (671) 6465227 or 5228, Fax No.: 1 (671) 6465226, E-mail: amdavidmd@yahoo.com; amdavid@guam.net

Dr Nobuyuki HYOI, Director, Department of International Health and Collaboration, National Institute of Public Health, 2-3-6, Minami, Wako-shi, Saitama, Japan 351-0194, Tel. No.: (8148) 4586152 (Direct), Fax No.: (8148) 4692768, E-mail: hyoi@niph.go.jp

Dr Tomofumi SONE, Director, Department of International Health and Collaboration, National Institute of Public Health, 2-3-6, Minami, Wako-shi, Saitama 351-0197, Japan Tel. No.: (8148) 4586159, Fax No.: (8148) 4692768, E-mail: sonetom@niph.go.jp

3. SECRETARIAT

Dr Hai-Rim SHIN, Team Leader, Noncommunicable Diseases and Health Promotion, Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, U.N. corner Taft Avenue 1000 Manila, Philippines, Tel. No.: (632) 528 9860, Fax No: (632) 526 0279, E-mail: shinh@wpro.who.int

Dr Cherian VARGHESE, Senior Medical Officer, Noncommunicable Diseases, Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, U.N. corner Taft Avenue 1000 Manila, Philippines, Tel. No.: (632) 528 9866, Fax No: (632) 521 1036, E-mail: varghesec@wpro.who.int,
Ms Marie Clem CARLOS, Technical Assistant, Noncommunicable Diseases and Health Promotions, Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, U.N. corner Taft Avenue 1000 Manila, Philippines, Tel. No.: (632) 528 9881, Fax No: (632) 521 1036, E-mail: carlosma@wpro.who.int

Ms HE Jing, National Programme Officer, WHO Representative, China, 401, Dongwai Diplomatic Office Building, 23, Dongzhimenwai Dajie, Chaoyang District, 100600 Beijing, China, Tel. No.: (8610) 6532 7189 Fax No.: (8610) 6532-2359, E-mail: hej@wpro.who.int

Mrs Jessica Mara YAIPUPU, Technical Officer, WHO Papua New Guinea, 4th Floor, AOPi Centre P.O. Box 5896, Boroko, Waigani Drive, Port Moresby, Papua New Guinea, Tel. No.: (675) 3257827, Fax No.: (675) 3250568, E-mail: yaipupuj@wpro.who.int
PROGRAMME OF ACTIVITIES

Monday, 9 December 2013

08:30-09:00  Registration

09:00-09:30  Scope, structure and objectives of the course  Dr Cherian Varghese
Senior Medical Officer
Noncommunicable Diseases
WHO Regional Office
for the Western Pacific

09:30-10:00  Introduction and facility tour  Dr Tomofumi Sone
Director for Planning and Coordination
National Institute of Public Health
Ministry of Health, Labour and Welfare,
Japan

10:00-10:30  Coffee break

10:30-11:30  (1) Opening session

  Welcome address  Dr Yukio Matsutani
President
National Institute of Public Health, Japan

Dr Kazushi Yamauchi
Director
Office of International Cooperation
Ministry of Health, Labour and Welfare,
Japan

  Opening address

  Introduction of participants
  Group photo

11:30-12:00  Global and regional mandates on NCD prevention and control  Dr Shin Young-soo
Regional Director
WHO Regional Office
for the Western Pacific

12:00-13:00  Lunch break

Dr Hai-Rim Shin
Team Leader
Noncommunicable Diseases and Health Promotion
WHO Regional Office
for the Western Pacific
(2) Sharing journeys and setting expectations

13:00-15:00
Country presentations on current status of NCD capacity building

Moderators:
Dr Hai-Rim Shin/
Dr Cherian Varghese

Group 1: Cambodia, the Lao People's Democratic Republic, Viet Nam
Group 2: Fiji, Papua New Guinea
Group 3: Brunei Darussalam, China, Malaysia, Mongolia, Philippines

15:00-15:30
Mobility break

15:30-17:00
Group work
Activity 1.1 Where are we in the NCD epidemic?
Activity 1.2 Where are you on your NCD journey?
Activity 1.3 Photovoice of your NCD 'environment'

Dr Annette David
Senior Partner
Health Partners, LLC

18:00-19:30
Reception

Tuesday, 10 December 2013

09:00-09:10
Recap of Day 1

(3) NCD surveillance

09:10-10:00
Global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of NCDs

Dr Cherian Varghese/
Ms Marie Clem Carlos
Technical Assistant
Noncommunicable Diseases and Health Promotion
WHO Regional Office for the Western Pacific

10:00-10:15
Demonstration of Japanese radio physical exercise

Dr Eri Osawa
Senior Researcher
Department of International Health and Collaboration,
National Institute of Public Health, Japan

10:15-10:30
Mobility break

10:30-11:00
Cancer registration

Dr Hai-Rim Shin

11:00-11:30
Overview of the Japan National Health and Nutrition Survey

Dr Nobuo Nishi
Chief, Center for International Collaboration and Partnership
National Institute of Health and Nutrition, Japan

11:30-12:00
Group work
Activity 2.1 Data to action

Dr Annette David

12:00-13:00
Lunch break
(4) Approaches to NCD risk reduction

13:00-13:40  Interventions for NCD risk reduction  Dr Cherian Varghese
13:40-14:20  Health-in-All-Policies and settings-based approaches  Dr Hai-Rim Shin
14:20-15:00  Activity 2.2 Developing an approach for NCD prevention and control in the workplace  Dr Cherian Varghese
15:00-15:30  Mobility break
15:30-16:15  Working with other sectors  Dr Annette David
16:15-17:30  Activity 2.3 Participant's health survey

Wednesday, 11 December 2013

09:00-09:10  Recap of Day 2

(5) NCD management

09:10-09:40  Final Evaluation of Health Japan 21 and the revision for the next 10 years  Dr Tetsuji Yokoyama
Department Director
Department of Health Promotion
National Institute of Public Health, Japan

09:40-10:10  Management of NCDs  Dr Cherian Varghese

10:10-10:30  Mobility break

10:30-10:50  Results of participant's health survey  Ms Marie Clem Carlos

10:50-12:00  Group work  Dr Cherian Varghese
  Activity 3.1 Know and manage your risk

12:00-13:00  Lunch break

13:00-13:45  Assess your daily diet using "Japanese Food Guide Spinning Top"  Dr Midori Ishikawa
Senior Researcher
Department of Health Promotion
National Institute of Public Health, Japan

Dr Miki Miyoshi
Head
Section of International Nutrition
Research and Development Center for International Collaboration and Partnership
National Institute of Health and Nutrition, Japan

14:00-17:30  Site visit
National scheme of prevention for Cardiovascular diseases in Japan  Dr Akira Okayama
Director, The first institute of health promotion and practice
Japan Anti-Tuberculosis Association
Thursday, 12 December 2013

09:00-09:10 Recap of Day 3

(6) Prioritization of interventions

09:10-10:00 Group work
  Activity 4.1.1 Selecting the priority very cost-effective intervention (VCEI)
  Activity 4.1.2 Understanding barriers to the implementation of intervention: The spidergram
  Dr Annette David

10:00-10:30 Mobility break

10:30-12:00 Activity 4.1.3 Problem-solution tree
  Activity 4.1.4 Action plan for the priority intervention

12:00-13:00 Lunch break

(7) NCD advocacy

13:00-15:00 Communication and advocacy workshop
  Activity 4.2.1 Who’s my audience? NCD Stakeholder mapping: The influence and interest grid
  Activity 4.2.2 Developing key benefits and messages
  Activity 4.2.3 Marketplace: Who’s buying your advocacy message?
  Dr Annette David

15:00-15:30 Mobility break

15:30-17:00 Activity 4.2.4 Effectively communicating the message of my prioritized intervention: Role-play
  Activity 4.2.5 World Café: Showcasing countries’ advocacy tools and apps

Friday, 13 December 2013

09:00-09:10 Recap of Day 4

(8) Leadership for NCD

09:10-10:00 Group work
  Activity 5.1 The Affinity Diagram
  Dr Cherian Varghese

10:00-10:30 Mobility break

(9) Plan for NCD capacity-building

10:30-12:00 Group work
  Activity 5.2 Developing a plan for NCD capacity-building
  Dr Hai-Rim Shin/Dr Cherian Varghese

12:00-13:00 Lunch break

13:00-15:00 Country presentations and discussion

15:00-15:30 (10) Closing session
  National Institute of Public Health, Japan
  WHO Regional Office for the Western Pacific

15:30 Coffee
A. Questionnaire

Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD)
National Institute of Public Health, Saitama, Japan, 9-13 December 2013

EVALUATION FORM

Questionnaire 1 – Overall impression

Please rate your experience of the meeting by giving your score on a scale of 1-10 (1 being the lowest and 10 the highest in terms of success).

A. The participation in this meeting was
Comments, if any.

B. The facilitation in this meeting was
Comments, if any.

C. The leadership in this meeting was
Comments, if any.

D. Travel arrangement for the meeting was
Comments, if any.

E. Facilities of this meeting was
Comments, if any.

F. Accommodation for this meeting was
Comments, if any.

G. Meals of this meeting were
Comments, if any.

H. The overall impression of this meeting was
Comments, if any.
Questionnaire 2 – What have you achieved?

Rate the workshop by giving your score on a scale of 1-10 (1 being the lowest and 10 the highest in terms of success).

Session 2: Sharing journeys and setting expectations

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session

Session 3: NCD surveillance

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session

Session 4: Approaches to NCD risk reduction

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session

Session 5: NCD management

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session

Site visit
a. Please indicate a specific learning that you gained
b. Please indicate your comments and suggestions to improve this session

Session 6: Prioritization of interventions

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session

Session 7: NCD advocacy

a. to understand the objectives of the session
b. to exchange views and information in the discussions
c. Please indicate a specific learning that you gained
d. Please indicate your comments and suggestions to improve this session
Session 8: Leadership for NCD

1. to understand the objectives of the session
2. to exchange views and information in the discussions
3. Please indicate a specific learning that you gained
4. Please indicate your comments and suggestions to improve this session

Session 9: Plan for NCD capacity-building

1. to understand the objectives of the session
2. to exchange views and information in the discussions
3. Please indicate a specific learning that you gained
4. Please indicate your comments and suggestions to improve this session

Questionnaire 3 – Comments and suggestions

Please let us know your comments and suggestions. Please provide a maximum of 3 comments per question.

A. How can you further strengthen NCD capacity building in your country?
B. What are the additional technical support/information/materials that will help you to do this work?
B. Results

**QUESTIONNAIRE 1**

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**QUESTIONNAIRE 2**

**Session 2: Sharing journeys and setting expectations**

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**Session 3: NCD surveillance**

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| b. to exchange views and information in the discussions | 20%| 25%| 50%| 5%|

**Session 4: Approaches to NCD risk reduction**

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| b. to exchange views and information in the discussions | 20%| 35%| 40%| 5%|

**Session 5: NCD management**

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**Session 6: Prioritization of interventions**

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**Session 7: NCD advocacy**

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**Session 8: Leadership for NCD**

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**Session 9: Plan for NCD capacity-building**

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| b. to exchange views and information in the discussions | 21%| 42%| 32%| 5%|
WHO Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD)

National Institute of Public Health, Saitama, Japan
9-13 December 2013

Participant's Workbook

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

National Institute of Public Health
Ministry of Health, Labour and Welfare
Saitama, Japan
WHO Regional Workshop on Strengthening Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD)

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Participant's Workbook

Name: ________________________________
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ANNEX 3: Individual Interventions (WHO PEN)

ANNEX 4. WHO PEN protocols

ANNEX 5: Menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases

ANNEX 6: Comprehensive global monitoring framework, including 25 indicators, and a set of nine voluntary global targets for the prevention and control of NCDs
INTRODUCTION

Noncommunicable diseases (NCDs) and their four main risk factors are a major and growing threat to health and development in the Western Pacific. NCDs are responsible for 80% of all deaths in a region that is home to more than one quarter of the world’s population. Of particular concern is the high proportion of premature mortality from NCDs (deaths before 70 years of age) in several low- and middle-income countries (LMIC). Thus, preventing and controlling NCD is an urgent priority for all countries in the Region.

Crucially, most of the drivers of NCD and their risk factors lie outside the health sector. The health sector alone cannot adequately prevent and control NCD; multisectoral action through ‘whole-of-government’ and ‘whole-of-society’ approach is required. This implies the need to broaden capacity building beyond the health sector to effectively implement the very cost effective interventions identified by WHO for NCD prevention and control.

The High-level Meeting of the General Assembly on the prevention and control of NCDs in September 2011 firmly placed NCD prevention and control as a global priority. In response to this, the global and regional action plans for the prevention and control of NCDs are also in place and calls for national multisectoral action plans.

Building upon the success of the Japan-WHO International Visitors Programme (JWIVP) for NCD Prevention and Control, this 5-day NCD capacity building course – Leadership and Advocacy for NCD (LeAd-NCD) - was developed to assist NCD stakeholders of diverse backgrounds to systematically apply leadership and advocacy strategies to reinforce current national capacity to effectively counter the NCD epidemic. The course is intended to guide participants to think strategically about aligning and prioritizing action areas in their national plans to ensure progress in achieving national objectives and contribute towards successful implementation of the Global and Regional Action Plans.

This workbook is intended for countries to use at the national and subnational levels, as part of a capacity building process for NCDs. Member States can translate and further adapt the course and learning exercises to best meet their needs as they establish and expand political and programme capacity to definitively take action against NCDs.

REGIONAL WORKSHOP ON STRENGTHENING LEADERSHIP AND ADVOCACY FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES (LeAd-NCD)
National Institute of Public Health, Saitama, Japan
9 to 13 December 2013

TENTATIVE PROGRAMME OF ACTIVITIES

Monday, 9 December 2013

08:30-09:00 Registration

09:00-09:30 Scope, structure and objectives of the course
Dr Cherian Varghese
Senior Medical Officer
Noncommunicable Diseases
WHO Regional Office for the Western Pacific

09:30-10:00 Introduction and facility tour
Dr Tomofumi Sone
Director for Planning and Coordination
National Institute of Public Health
Ministry of Health, Labour and Welfare, Japan

10:00-10:30 Coffee break

10:30-11:30 (1) Opening session

Welcome address
Dr Yukio Matsutani
President
National Institute of Public Health, Japan

Opening address
Dr Kazushi Yamauchi
Director
Office of International Cooperation
Ministry of Health, Labour and Welfare, Japan

Introduction of participants
Group photo

11:30-12:00 Global and regional mandates on NCD prevention and control
Dr Shin Young-soo
Regional Director
WHO Regional Office for the Western Pacific

12:00-13:00 Lunch break

Dr Hai-Rim Shin
Team Leader
Noncommunicable Diseases and Health Promotion
WHO Regional Office for the Western Pacific
(2) Sharing journeys and setting expectations

13:00-15:00  Country presentations on current status of NCD capacity building

Moderators:  Dr Hai-Rim Shin/
Dr Cherian Varghese

Group 1: Cambodia, the Lao People's Democratic Republic, Viet Nam
Group 2: Fiji, Papua New Guinea
Group 3: Brunei Darussalam, China, Malaysia, Mongolia, Philippines

15:00-15:30  Mobility break

15:30-17:00  Group work
*Activity 1.1 Where are we in the NCD epidemic?*
*Activity 1.2 Where are you on your NCD journey?*
*Activity 1.3 Photovoice of your NCD 'environment'*

Dr Annette David
Senior Partner
Health Partners, LLC

18:00-19:30  Reception

Tuesday, 10 December 2013

09:00-09:10  Recap of Day 1

(3) NCD surveillance

09:10-10:00  Global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of NCDs

Dr Cherian Varghese/
Ms Marie Clem Carlos
Technical Assistant
Noncommunicable Diseases and Health Promotion
WHO Regional Office for the Western Pacific

10:00-10:15  Demonstration of Japanese radio physical exercise

Dr Eri Osawa
Senior Researcher
Department of International Health and Collaboration,
National Institute of Public Health, Japan

10:15-10:30  Mobility break

10:30-11:00  Cancer registration

Dr Hai-Rim Shin

11:00-11:30  Overview of the Japan National Health and Nutrition Survey

Dr Nobuo Nishi
Chief, Center for International Collaboration and Partnership
National Institute of Health and Nutrition, Japan

11:30-12:00  Group work
*Activity 2.1 Data to action*

Dr Annette David

12:00-13:00  Lunch break
(4) Approaches to NCD risk reduction

13:00-13:40 Interventions for NCD risk reduction  
Dr Cherian Varghese

13:40-14:20 Health-in-All-Policies and settings-based approaches  
Dr Hai-Rim Shin

14:20-15:00 Activity 2.2 Developing an approach for NCD prevention and control in the workplace  
Dr Cherian Varghese

15:00-15:30 Mobility break

15:30-16:15 Working with other sectors  
Dr Annette David

16:15-17:30 Activity 2.3 Participant's health survey

Wednesday, 11 December 2013

09:00-09:10 Recap of Day 2

(5) NCD management

09:10-09:40 Final Evaluation of Health Japan 21 and the revision for the next 10 years  
Dr Tetsuji Yokoyama  
Department Director  
Department of Health Promotion  
National Institute of Public Health, Japan

09:40-10:10 Management of NCDs  
Dr Cherian Varghese

10:10-10:30 Mobility break

10:30-10:50 Results of participant's health survey  
Ms Marie Clem Carlos

10:50-12:00 Group work  
Activity 3.1 Know and manage your risk  
Dr Cherian Varghese

12:00-13:00 Lunch break

13:00-13:45 Assess your daily diet using "Japanese Food Guide Spinning Top"  
Dr Midori Ishikawa  
Senior Researcher  
Department of Health Promotion  
National Institute of Public Health, Japan

Dr Miki Miyoshi  
Head  
Section of International Nutrition Research and Development  
Center for International Collaboration and Partnership  
National Institute of Health and Nutrition, Japan

14:00-17:30 Site visit  
National scheme of prevention for Cardiovascular diseases in Japan  
Dr Akira Okayama  
Director, The first institute of health promotion and practice  
Japan Anti-Tuberculosis Association
Thursday, 12 December 2013

09:00-09:10 Recap of Day 3

(6) Prioritization of interventions

09:10-10:00 Group work
   Activity 4.1.1 Selecting the priority intervention
   Activity 4.1.2 Understanding barriers to the implementation of intervention:
      The spidergram

Dr Annette David

10:00-10:30 Mobility break

10:30-12:00 Activity 4.1.3 Problem-solution tree
   Activity 4.1.4 Action plan for the priority intervention

12:00-13:00 Lunch break

(7) NCD advocacy

13:00-15:00 Communication and advocacy workshop
   Activity 4.2.1 Who is my audience? NCD Stakeholder mapping: The influence and interest grid
   Activity 4.2.2 Developing key benefits and messages
   Activity 4.2.3 Marketplace: Who’s buying my advocacy message?

Dr Annette David

15:00-15:30 Mobility break

15:30-17:00 Activity 4.2.4 Effectively communicating the message of my prioritized intervention: Role-play
   Activity 4.2.5 World Café: Showcasing countries’ advocacy tools and apps

Friday, 13 December 2013

09:00-09:10 Recap of Day 4

(8) Leadership for NCD

09:10-10:00 Group work
   Activity 5.1 The Affinity Diagram

Dr Cherian Varghese

10:00-10:30 Mobility break

(9) Plan for NCD capacity-building

10:30-12:00 Group work
   Activity 5.2 Developing a plan for NCD capacity-building

Dr Hai-Rim Shin / Dr Cherian Varghese

12:00-13:00 Lunch break

13:00-15:00 Country presentations and discussion

15:00-15:30 (10) Closing session

National Institute of Public Health, Japan
WHO Regional Office for the Western Pacific

15:30 Coffee
DAY 1: SHARING JOURNEYS AND SETTING EXPECTATIONS

ACTIVITY 1.1: Where are we in the NCD epidemic?

BACKGROUND:

Underlying determinants of health, such as globalization, urbanization, population ageing and social determinants, contribute to countries’ health status and can give rise to environments that promote unhealthy lifestyles (e.g. tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol). These common risk factors underlie NCD. Unchecked, they give rise to intermediate risk factors such as raised blood pressure, raised blood glucose, unhealthy lipid profiles, obesity and impaired lung function. In turn, the intermediate risk factors predispose individuals to noncommunicable diseases – principally cardiovascular disease (heart disease and stroke), cancer, chronic respiratory disease and diabetes.

OBJECTIVES:

1. To assess my country’s status in relation to the NCD causation pathway; and,
2. To learn about the country situation of other participants.

INSTRUCTIONS:

1. Think about your country/community’s situation in relation to the underlying determinants, common modifiable risk factors, intermediate risk factors and diseases in the NCD risk continuum.
2. In the graphic below, note down key information or observations about each stage in the continuum.
   a. Underlying determinants:
      i. How old is your population?
      ii. How globalized is your society?
      iii. How urbanized is your population?
      iv. What are the key social determinants that actively affect health in your country?
   b. Modifiable risk factors: Indicate the population prevalence for poor nutrition, physical inactivity, current tobacco consumption and harmful alcohol use.
   c. Intermediate risk factors: Indicate the population prevalence for high blood pressure, elevated blood sugar, raised cholesterol levels and overweight/obesity in your population.
   d. Indicate which of the fatal four NCD are in the top 10 causes of mortality in your country, and their rank. Do you have mortality data for these NCDs? If available, indicate the disease prevalence of each NCD.
3. Where along the continuum is your country/community situated?
4. This assessment requires current data; do you have sufficient data to make the assessment?
5. What stands out in your assessment? Which stage in the NCD risk continuum is most prominent?
What stands out in your assessment?
Which stage in the NCD risk continuum is most prominent?
How does data availability affect your assessment?
ACTIVITY 1.2: Where are you on your NCD journey?

INSTRUCTIONS:

1. A set of pictures will be provided. Select the one that best captures where you are in your NCD journey.
2. Share your reflections with the group.

List down your expectations from this workshop.

1.
2.
3.
ACTIVITY 1.3: Photovoice of your NCD ’environment’

BACKGROUND:

Photovoice is a community-based participatory research and advocacy approach first described in the published literature by Caroline Wang and Mary Ann Burris in 1994. They define it as “…a process by which people can identify, represent, and enhance their community through a specific photographic technique.

It entrusts cameras to the hands of people to enable them to act as recorders, and potential catalysts for social action and change, in their own communities. It uses the immediacy of the visual image and accompanying stories to furnish evidence and to promote an effective, participatory means of sharing expertise to create healthful public policy.”

OBJECTIVES:

1. To enable participants to reflect on their environment and its impact on the NCD epidemic and efforts at prevention and control;
2. To visually document their observations using digital photographs to “tell the story” for promoting awareness and critical dialogue about NCD; and,
3. To become familiar with an alternative participatory technique for community NCD advocates to reach policy makers through the emotional appeal of images of photography by way of exhibit and publication.

INSTRUCTIONS:

1. In this exercise, we would like you to capture your "environment" which is very critical in NCD prevention and control.
2. Using your camera, please capture the advertisements, promotion materials and campaigns in your country on the 4 risk factors (tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity).
3. The photos can include various types of advertisements and promotion of tobacco/alcohol/unhealthy diet, counter campaigns, parks and cycle lanes for physical activity promotion, labeling on foods, etc.
4. Please also try to capture settings which promote healthy behaviors such as in schools, parks and workplaces.
5. Collate all these, catalogue them accordingly and bring them to the meeting.
6. Working in country teams, put together the best 10-15 photos for a team presentation. Prepare a 5-minute presentation using the pictures as a powerpoint or as a video clip.
7. Be creative. You can add captions, commentary, music, etc., to make your presentation more compelling.
8. Teams will present their combined photo presentation.
9. How did you feel about the process of using visual images versus words/text to communicate a health story?
10. How useful do you think is the Photovoice technique as an alternative means for advocacy when you return to your country/community?
DAY 2: NCD SURVEILLANCE

ACTIVITY 2.1  How is my data? Data mapping

INTRODUCTION:
High quality health statistics are essential for planning and implementing health policy in all country settings. NCD risk factor data are crucial for predicting the future burden of chronic diseases in populations and also for identifying potential interventions to reduce the future burden. Mortality data and disease registries indicate the current magnitude of the health impact and can serve as baselines to monitor progress. Country capacity data are useful for gauging readiness to take action against NCD and to guide resource allocation and program development decisions. Moreover, WHO Member States have agreed upon a set of 9 voluntary targets and 25 indicators to monitor progress; having the data to address these monitoring targets and indicators will facilitate reporting.

OBJECTIVES:
- To systematically review national and subnational data sources and determine what data is available; and,
- To identify data gaps that may need to addressed to improve current knowledge and understanding of the NCD epidemic in your country.

INSTRUCTIONS:
- Working as a team, reflect upon the WHO global voluntary targets and indicators for monitoring NCD and identify data sources to capture these indicators in your country using the table below.
- Identify those indicators for which little or no data exist. These are your data gaps.
ACTIVITY 2.2  Data to action

OBJECTIVES:

1. To assess the process of reporting surveys, use of data presentation tools, developing policy advocacy materials, and dissemination of results.

INSTRUCTION:

1. Consider the most recent survey on NCD in your country.
2. Working as a country group, answer the questions and complete the table.

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<td>Have you done any analysis?</td>
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<td>Are you aware of any other data sets in your country?</td>
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<td>Do you think survey results and data sets are used adequately?</td>
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<td>Are there limitations in the way you utilize these data?</td>
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<td>How can the quality of data be improved?</td>
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<td>What needs to be done for better utilization of data?</td>
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<td>How are the data disseminated to relevant stakeholders?</td>
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ACTIVITY 2.3  Developing an approach for NCD prevention and control in the workplace

BACKGROUND:
Workplaces are very suitable for NCD risk reduction, early detection and to facilitate compliance to management. Environmental changes, as well as health services, in the workplace can be strengthened through the participation of management and employees.

OBJECTIVES:
1. To learn about settings-based approach as a platform for NCD prevention and control.
2. To identify the process measures for healthy workplace.

INSTRUCTIONS:
1. As a country team, consider a workplace in your country with more than 500 employees.
2. Identify the actions required for NCD prevention and control as part of overall health workplace programme. A scheme for developing a healthy workplace is shown below.
ACTIVITY 2.4  Participants’ Health Survey

BACKGROUND:

Prevalence information on NCD risk factors is essential to NCD prevention and control. This is often obtained through population-based surveys. The data from these surveys provide powerful evidence to drive policy formulation, programme development, and to monitor progress.

The information that individuals provide when completing NCD risk factor surveys can also be used for a personalized assessment of NCD risk.

This activity will familiarize you with the process of undergoing a risk factor survey. The data you provide will enable you to estimate your personal risk and assist you in devising a behavior modification plan for better health.

OBJECTIVES:

1. To learn about NCD risk factor assessment using a simplified WHO tool;
2. To obtain information on your health status; and
3. To design a behavior modification plan to reduce your NCD risk based on the results.

INSTRUCTIONS:

1. Each participant will be given a printed questionnaire (Annex 1). Please note that this is an anonymous survey and hence personal identification is not needed.
2. Select a partner from a different country. Working as a pair, administer the tool to each other.
3. For each question, encircle the number corresponding to your partner’s response. For open ended questions, enter the information provided .
4. Submit the completed tools once finished.

Privacy Policy: Individual information on the demonstration will be treated as highly sensitive information and no personal identifiers will be included in the response forms.
DAY 3: NCD MANAGEMENT

BACKGROUND:

The WHO/ISH risk prediction charts (Annex 2) indicate 10-year risk of a fatal or nonfatal major cardiovascular event (myocardial infarction or stroke), according to age, sex, blood pressure, smoking status, total blood cholesterol and presence or absence of diabetes mellitus for 14 WHO epidemiological sub-regions. There are two sets of charts. One set (14 charts) can be used in settings where blood cholesterol can be measured. The other set (14 charts) is for settings in which blood cholesterol cannot be measured. Both sets are available in colour and shades of black on a compact disc. The charts can only be used in countries of the specific WHO epidemiological sub-region.

The charts provide approximate estimates of cardiovascular disease (CVD) risk in people who do not have established coronary heart disease, stroke or other atherosclerotic disease. They are useful as tools to help identify those at high cardiovascular risk, and to motivate patients to change behaviour and, when appropriate, to take antihypertensive, lipid-lowering drugs and aspirin.

ACTIVITY 3.1: Know and manage your risk

OBJECTIVE:

1. To determine my 10-year cardiovascular risk using the WHO/ISH risk prediction charts.

INSTRUCTIONS:

1. Be ready with the following information
   - Presence or absence of diabetes
   - Gender
   - Smoker or non-smoker
   - Age
   - Systolic blood pressure (SBP)
   - Total blood cholesterol (if in mg/dl divide by 38 to convert to mmol/l) (IF NOT AVAILABLE USE RELEVANT CHARTS)

2. Note what is the category of your country
   - **Western Pacific - A**: Australia*, Brunei Darussalam, Japan, New Zealand*, Singapore
   - **Western Pacific - B**: Cambodia, China, Cook Islands, Democratic People’s Republic of Korea, Fiji, Kiribati, Lao People’s Democratic Republic, Malaysia, Marshall Islands, Micronesia(Federated States of), Mongolia, Nauru, Niue, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam

3. Identify which figure to use

<table>
<thead>
<tr>
<th>Blood cholesterol information</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WPR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>B</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
4. USING THE CHART

<table>
<thead>
<tr>
<th><strong>Step 1</strong></th>
<th>Select the appropriate chart depending on the presence or absence of diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 2</strong></td>
<td>Select male or female tables</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td>Select smoker or non-smoker boxes</td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td>Select age group box (if age is 50-59 years select 50, if 60-69 years select 60 etc)</td>
</tr>
<tr>
<td><strong>Step 5</strong></td>
<td>Within this box find the nearest cell where the individuals systolic blood pressure (mm Hg) and total blood cholesterol level (mmol/l) cross.</td>
</tr>
</tbody>
</table>

The colour of the cell indicates the 10-year risk of combined myocardial infarction and stroke risk (fatal and non-fatal)

- **Green**: <10%
- **Yellow**: 10% to <20%
- **Orange**: 20% to <30%
- **Red**: 30% to <40%
- **Deep Red**: ≥ 40%

**Your 10-year cardiovascular risk:**

______________________________________________

After identifying your risk, please see Annex 3 for the recommended individual interventions for each level of risk. Please write a health plan based on your risk (you can refer to Annex 4).
DAY 4: PRIORITY ZATION OF INTERVENTIONS AND ACTION PLAN ON RISK FACTORS

BACKGROUND:

WHO has developed an evidence-based menu of policy options and cost-effective interventions (Annex 5) for the prevention and control of major noncommunicable diseases, to assist Member States in implementing actions to achieve the nine voluntary global targets.

The list is not exhaustive but is intended to provide information and guidance on effectiveness and cost-effectiveness of interventions based on current evidence, and to act as the basis for future work to develop and expand the evidence base on policy measures and individual interventions. According to WHO estimates, policy interventions in objective 3 and individual interventions to be implemented in primary care settings in objective 4, listed in bold, are very cost-effective and affordable for all countries. However, they have not been assessed for specific contexts of individual countries. When selecting interventions for prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

OBJECTIVES:

1. To determine which intervention is most appropriate given the current NCD situation based on (1) magnitude of the NCD burden; (2) feasibility of implementation based on resource and capacity levels in the country; and, (3) the cost if nothing is done.

2. To conduct a set of prioritization exercises in selecting one key intervention in NCD prevention and control as the starting point for action against NCD in the immediate future.

3. To identify key actions and develop an action plan to catalyze implementation of the priority intervention.


3 WHO-CHOICE (http://www.who.int/choice/en/).

4 Disease control priorities in developing countries (http://www.dcp2.org/pubs/DCP).

5 Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.
4.1: PRIORITIZATION OF INTERVENTIONS

ACTIVITY 4.1.1: Selecting the priority intervention

INSTRUCTIONS:

1. Assign a score for each of the following criteria for every intervention listed on the page next page, on a scale of 0 to 5.
   a. Magnitude of the problem – based on the prevalence of the risk factor/disease relevant to the action area (refer to your NCD causation pathway map)
   b. Feasibility of implementation – significant chance for successful implementation (based on the feasibility exercise gauging political support and programme capacity above)
   c. Potential cost to society – based on the projected cost for health care and productivity losses of the risk factor/disease is not acted upon (Note: You will need to make an educated guess about this one!)

2. Add up the 3 individual scores to arrive at a final prioritization score. The highest possible score is 15, while the lowest possible score is 0.

3. Select the intervention with the highest prioritization score.

  Note: In some cases, the highest scoring interventions are already being implemented in a country. In this case, you will need to make a judgment call about which intervention to select.
<table>
<thead>
<tr>
<th>NCD very cost-effective intervention</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Magnitude of the problem (M)</td>
</tr>
<tr>
<td>Reduce affordability of tobacco products by increasing tobacco excise taxes</td>
<td></td>
</tr>
<tr>
<td>Create by law completely smoke-free environments in all indoor workplaces, public places and public transport</td>
<td></td>
</tr>
<tr>
<td>Warm people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns</td>
<td></td>
</tr>
<tr>
<td>Ban all forms of tobacco advertising, promotion and sponsorship</td>
<td></td>
</tr>
<tr>
<td>Regulating commercial and public availability of alcohol</td>
<td></td>
</tr>
<tr>
<td>Restricting or banning alcohol advertising and promotions</td>
<td></td>
</tr>
<tr>
<td>Using pricing policies such as excise tax increases on alcoholic beverages</td>
<td></td>
</tr>
<tr>
<td>Reduce salt intake</td>
<td></td>
</tr>
<tr>
<td>Replace trans fats with unsaturated fats</td>
<td></td>
</tr>
<tr>
<td>Implement public awareness programmes on diet and physical activity</td>
<td></td>
</tr>
<tr>
<td>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%) of a fatal and nonfatal cardiovascular event in the next 10 years</td>
<td></td>
</tr>
<tr>
<td>Acetylsalicylic acid for acute myocardial infarction</td>
<td></td>
</tr>
<tr>
<td>Prevention of liver cancer through hepatitis B immunization</td>
<td></td>
</tr>
<tr>
<td>Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] (or Pap smear (cervical cytology), if very cost-effective), linked with timely treatment of pre-cancerous lesions</td>
<td></td>
</tr>
</tbody>
</table>

**PRIORITY INTERVENTION:**
ACTIVITY 4.1.2: Understanding barriers to the implementation of intervention: The spidergram

BACKGROUND:

Successful implementation of an NCD intervention requires a number of distinct but interacting components. All components are needed, but in reality, not all components may be present or not all are at optimal condition. Identifying the weakest component/s to an intervention can guide NCD stakeholders to the “first steps” that are needed to get implementation underway.

INSTRUCTIONS:

The spidergram’s eight legs each represent an essential component for successful implementation for your priority intervention. Some of these components are necessary for all of the intervention. However, there may be components that are specific to certain interventions. For example, “law enforcement capacity” may be relevant for implementing bans on smoking in public places, but not for preventing liver cancer by hepatitis B immunization, where “health workforce capacity” is more relevant. Thus, one of the legs of the spidergram is left blank for you to identify an important component that is specific for your priority intervention.

1. For each of the legs of the spidergram, representing individual components for successful implementation of your priority intervention, indicate the current situation using a blue marker, on a scale of 1 to 5, where 1 represents the absence or complete lack of the component and 5 represents the best possible status of the component. As an example, for the component “political support,” the scale could be interpreted as:

   1. No political support, with no existing policy
   2. Very weak political support, with initial efforts towards a policy and no visible champions
   3. Minimal political support, with evolving policies and potential champions emerging
   4. Growing political support, with evolving and/or established policy and a few high profile champions
   5. Strong political support, with established policy that is well enforced and many high profile champions

2. Next, using a red marker, indicate the level of change you believe is possible to achieve for each component if action is to occur within the next year.

3. Connect all the blue dots using your blue marker.

4. Connect the red dots using your red marker.

5. Select the most critical component, for which action is needed immediately. This could be the component with the greatest possible increase in rating if action is taken within one year, or the component with the lowest ranking across all eight legs. Use your best judgment for making this selection. Identify the specific problem associated with that component. In the example below, the component “political support” was chosen as the most critical component requiring immediate action because it had both the lowest score for current status and the largest potential improvement if action is taken within 1 year. The specific problem identified was “no existing policy on trans fat.”
NCD INTERVENTION: Replacing trans fat with polyunsaturated fat in food

CURRENT STATUS  AFTER 1 YEAR

COMPONENT CHOSEN and SPECIFIC PROBLEM associated with component:

Political support – no existing policy on trans fat
Worksheet

PRIORITY INTERVENTION:

![Radar chart showing various components of a health program with levels from 0 to 5. Components include Media Support, Political Support, Community Support, Partnerships for Multisectoral Action, Data, Health System Infrastructure, NCD Programme Capacity, and Capacity. The chart compares the current status and after 1 year.](image-url)
ACTIVITY 4.1.3: Problem-solution tree

INSTRUCTIONS:

1. To use the problem-solution tree, identify the specific problem associated with the component. Write this in the box provided.
2. Identify the direct and indirect causes of the specific problem. This can be achieved by asking the question “why?” several times until all possible causes/roots of the problem are exhausted.
3. Draw arrows to show the relationships of the causes among one another and their pathways toward the problem. Once all possible causes are considered, identify possible solutions to address these causes.

Below is a simplified example. Five causes of lack of policy on trans fats were identified, with arrows showing their relationships and pathways. Possible solutions were written inside the thought bubbles. Develop a problem-solution tree stating the specific problem, its causes, and possible solutions. Note that the more detailed the analysis is, the greater is the probability of identifying effective solutions.
Worksheet

Develop a problem-solution tree stating the specific problem, its causes, and possible solutions. Note that the more detailed the analysis is, the greater is the probability of identifying effective solutions.

COMPONENT/S CHOSEN and SPECIFIC PROBLEM associated with component/s:
ACTIVITY 4.1.4: Action plan for the priority intervention

BACKGROUND:
The effective solutions identified through the problem solution tree become the basis of an action plan for successful implementation of your NCD intervention. While all the solutions are likely necessary and will need to be carried out, it makes sense to prioritize which solutions to focus on first.

INSTRUCTIONS:

1. List down the solutions that you identified in Activity 4.3 on the blank table provided.

2. Discuss with your country team members the impact (I) and feasibility (F) of each of the solutions, relative to achieving progress in implementing your priority intervention. For each solution, assign a score within the range of 1 to 5, with 1 being the lowest and 5 being the highest.

   Impact – significant progress in implementing the NCD intervention is expected if this is carried out

   Feasibility – opportunities, resources, timing and support favour success

3. Multiply the scores for (I) and (F).

4. Choose the top 3 scoring solutions. Create an action plan using Table 6.6.2 as your template of an Action Plan for the chosen solutions.

Below is the scoring table for the trans-fat example.

<table>
<thead>
<tr>
<th>Solution</th>
<th>Important (I)</th>
<th>Feasible (F)</th>
<th>I x F</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create monitoring mechanism for trans fat contents</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Conduct small-scale local studies on trans fat</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Conduct activities to create/increase awareness on health risks of trans fat</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td><strong>Conduct trainings on policy development</strong></td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Review of studies on trans fat from similar settings</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
Follow the instructions on the previous page and use the blank tables below.

Scoring sheet for proposed solutions

<table>
<thead>
<tr>
<th>Solution</th>
<th>Important (I)</th>
<th>Feasible (F)</th>
<th>I x F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Action plan for the top three selected solutions addressing the priority interventions

### Solution 1:

<table>
<thead>
<tr>
<th>Description</th>
<th>Health</th>
<th>Other Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources available/ needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Solution 2:

<table>
<thead>
<tr>
<th>Description</th>
<th>Health</th>
<th>Other Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources available/ needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Health</td>
<td>Other Sectors</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>Who is responsible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources available/ needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2: NCD ADVOCACY

BACKGROUND:

Change doesn’t happen in a vacuum. Effective leaders understand the importance of identifying their target audience/s and developing a communication objective and strategic approach for each audience, to engage them in the process of change. In addition, messages highlighting key benefits, support points and desired action responses need to be tailored for specific audiences, for greatest impact.

These are particularly critical in NCD prevention and control, where behavioral changes at a population level are required together with cultural change.

ACTIVITY 4.2.1: Who is my audience? NCD Stakeholder mapping: The influence and interest grid

OBJECTIVE:

- To identify and segment target audiences and design messages highlighting key benefits, supporting points and desired action responses

INSTRUCTIONS:

- Identify all the audiences you need to reach to achieve meaningful change in the NCD intervention you have chosen. You can refer to your action plan table to assist you in listing these stakeholders.
- Situate each stakeholder group on the influence – interest grid below. This grid attempts to gauge each audience’s standing with regards to their ability to influence the process of change as well as their interest in the particular NCD intervention you want to improve. Ideally, your primary audience should be in the upper outer right hand quadrant of the grid—that is, highly influential and highly interested in your NCD intervention. Sometimes, however, your critical audience may be highly influential but not highly interested; this is where advocacy is especially vital—how do you convince highly influential but uninterested stakeholders to gain interest in your NCD intervention?
- Based on the grid results, select your primary audience/group.
- Choose a representative member of the key audience and create a socio-demographic profile for this person (This person could be a member of the community, a policy-maker, a decision-maker, a sectoral head or a partner. What does this person consider of value? What are the motivations of this person?).
- Develop a profile of this individual and note this down in a short descriptive paragraph.  
  - What is the primary audience’s socio-demographic profile?
  - How is this person best contacted?
  - Who does this person listen to?
  - Who and what can influence this target?
  - What is this person’s position on the intervention?
INFLUENCE – INTEREST GRID WORKSHEET

INFLUENCE (Ability to make change happen)

Powerful influence

Weak influence

INTEREST IN THE ISSUE

Opposed to the issue

Highly interested and supportive

Socio-demographic profile of a representative member of the target audience
ACTIVITY 4.2.2: Developing key benefits and messages

INSTRUCTIONS:

1. Using the table below, list your primary audience/s.

2. Identify the key benefits of your intervention in NCD prevention and control to the audience/s.

3. What are your communication objectives?
   - Awareness?
   - Understanding?
   - Acceptance?
   - Action?
   - Sustained actions?

4. Develop your key messages to the selected audience. Pick one of your most exciting/interesting/relevant data facts on NCDs from the NCD surveillance data in your country. Make the numbers “tell a story.” How can you use this fact to move your selected audience?

5. What are the effective channels of communication for the audience? Be creative.

6. How will you know if you are successful in communicating your key message? What indicators will you use? These should reflect whether the desired action response was achieved or not.

<table>
<thead>
<tr>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication objective</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
ACTIVITY 4.2.3: Marketplace: Who’s buying my advocacy message?

OBJECTIVE:

1. To test key benefits, messages and channels of communication for your selected advocacy audience in a competitive marketplace

INSTRUCTIONS:

1. Scenario: Your selected advocacy audience is coming to an NCD Marketplace. You and the other country teams will be competing for their NCD investment dollars. Each country team is considered an advocacy team.

2. Using the results from the previous advocacy exercises, create an advocacy strategy to promote your NCD intervention to your NCD audience, who are the NCD buyers or investors.

3. Sales teams have a total of 5 minutes to complete their advocacy pitch to the team of NCD buyers/investors. You can use any audio-visual means of communication to get your advocacy message across clearly and compellingly.

4. NCD buyers/investors have a fixed amount of money to invest in any and all NCD interventions that catch their interest. The buyers’ team will go around the room together to listen to all sales teams.

5. At the end of all the teams’ advocacy presentations, buyers will individually decide how much of their money they will want to invest in any of the NCD intervention. A poster for each advocacy team will be set up in the investment area. The buyers will individually affix their investment dollars to the teams that they have selected. Criteria for buyers:
   a. Which advocacy strategy caught your attention?
   b. Which advocacy strategy sustained your attention?
   c. Which advocacy strategy presented compelling evidence for urgent action?
   d. Which advocacy strategy convinced you that investment would result in significant gains?
   e. Which intervention would you invest money on?

6. Once the investment decisions are all in, come back together as a plenary group and discuss the results. What advocacy strategies were effective in getting buyers to invest? Which strategies were less effective? What are the practical take-home lessons on advocacy from this exercise?
ACTIVITY 4.2.4: Effectively communicating the message of my prioritized intervention: Role-play

OBJECTIVE:

1. To practice effective communications for the NCD prioritized intervention.

INSTRUCTIONS:

1. Scenario: This is a public hearing on your NCD prioritized intervention. The hearing is being held by your legislature to provide all stakeholders an opportunity to provide feedback on a possible bill for that intervention.
2. Volunteers will select from a set of roles. They will have 10 minutes to study their roles.
3. Facilitators will oversee the conduct of the role-play. Allow 15 minutes for the role-play.
4. After the role-play, re-convene the entire group and discuss what they observed.
   a. What were effective communications strategies?
   b. What were less effective communications strategies?
   c. Was there conflict among the different roles? How was conflict resolved?
   d. What messages were effective? What made these messages effective?
   e. What are the practical take-home lessons from this activity?
ACTIVITY 4.2.5: World Café: Showcasing countries’ advocacy tools and apps

OBJECTIVES:

1. To provide an opportunity for country teams to share their advocacy tools, materials and products with other participants
2. To stimulate ideas for potential advocacy products and approaches based on the work of other countries within the Western Pacific

INSTRUCTIONS:

1. Bring the samples of your advocacy materials and products.
2. You will be assigned table space for display. Arrange your materials on your assigned tables and make your displays as attractive as possible.
3. Be prepared to answer questions from other participants on your advocacy display. Anticipate that questions will be asked about the process of developing the materials, production costs, target audiences, effectiveness, etc.
4. Go through the other display tables and ask your own questions. Take note of promising ideas that you can take back home with you.
DAY 5: LEADERSHIP FOR NCD

ACTIVITY 5.1: The Affinity Diagram

OBJECTIVE:

1. To identify the qualities of a good leader.

INSTRUCTIONS:

1. Using metacards, each member of the group will list down qualities that a good leader should possess.
2. The qualities/characteristics identified may be written on individual metacards and posted on a board that can be viewed by everyone.
3. Group the qualities identified according to which are most related to one another. Assign a main heading to the issues grouped together.
4. The main headings will be the general qualities identified.
5. An example of qualities of a teacher is provided below. Share and discuss your affinity diagram for qualities of a good leader with the other groups.

---

**CONTENT**
- Prepared lesson plans
- Good knowledge of subject matter
- Clear objectives

**MANAGEMENT AND ORGANIZATION**
- Engaging personality
- Manages student's behaviour
- Encourages interactions

**PROFESSIONALISM**
- Sets house rules
- Can promote positive behaviours and change

**PERSONALITY**
- Having patience and good sense of humour
- People person and enjoys working with wide range of people

---
Develop an affinity diagram on leadership.
ACTIVITY 5.2: Developing a plan for NCD capacity building

OBJECTIVE:

1. To develop an NCD capacity building plan.

INSTRUCTIONS:

1. Review the results of all of your previous worksheets.
2. Complete the template below.

<table>
<thead>
<tr>
<th>Guide questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td></td>
</tr>
<tr>
<td>Name of Institute</td>
<td></td>
</tr>
<tr>
<td>Stakeholders</td>
<td></td>
</tr>
<tr>
<td>Endorsement from the Ministry of Health / Funding and resources</td>
<td></td>
</tr>
<tr>
<td>Objectives of the course</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
</tr>
<tr>
<td>Structure, facilitators</td>
<td></td>
</tr>
<tr>
<td>Potential participants</td>
<td></td>
</tr>
<tr>
<td>Technical support needed from WHO</td>
<td></td>
</tr>
<tr>
<td>Expected outcome</td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX 1. Participant’s Health Survey Questionnaire

#### Demographic Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>Sex</td>
<td>Male 1&lt;br&gt;Female 2</td>
</tr>
<tr>
<td>C2</td>
<td>How old are you?</td>
<td>Years _______</td>
</tr>
<tr>
<td>C3</td>
<td>In total, how many years have you spent at school and in full-time study (excluding pre-school)?</td>
<td>Years _______</td>
</tr>
<tr>
<td>C4</td>
<td>What is your marital status?</td>
<td>Never married 1&lt;br&gt;Currently married 2&lt;br&gt;Separated 3&lt;br&gt;Divorced 4&lt;br&gt;Widowed 5&lt;br&gt;Cohabitating 6&lt;br&gt;Refused 88</td>
</tr>
<tr>
<td>C5</td>
<td>How many people older than 18 years, including yourself, live in your household?</td>
<td>Number of people _______</td>
</tr>
</tbody>
</table>

#### Step 1   Behavioural Measurements

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>Do you currently smoke any tobacco products, such as cigarettes, cigars or pipes?</td>
<td>Yes 1&lt;br&gt;No (If No, go to A1) 2</td>
</tr>
<tr>
<td>T2</td>
<td>Do you currently smoke tobacco products daily?</td>
<td>Yes 1&lt;br&gt;No 2</td>
</tr>
<tr>
<td>T3</td>
<td>How old were you when you first started smoking?</td>
<td>Age (years)</td>
</tr>
<tr>
<td>T4</td>
<td>During the past 12 months, have you tried to stop smoking?</td>
<td>Yes 1&lt;br&gt;No 2</td>
</tr>
<tr>
<td>Code</td>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>T5</td>
<td>In the last 30 days, how often did you see any &quot;advertisements or signs promoting&quot; tobacco products?</td>
<td>Daily 1, Almost daily 2, Sometimes 3, Rarely 4, Never 5</td>
</tr>
<tr>
<td></td>
<td>Alcohol Consumption</td>
<td></td>
</tr>
<tr>
<td>A1</td>
<td>During the past 12 months, how frequently have you had at least one standard alcoholic drink?</td>
<td>Daily 1, 5-6 days per week 2, 3-4 days per week 3, 1-2 days per week 4, 1-3 days per month 5, Less than once a month 6, None 7</td>
</tr>
<tr>
<td>A2</td>
<td>Have you consumed any alcohol within the past 30 days?</td>
<td>Yes 1, No 2</td>
</tr>
<tr>
<td>A3</td>
<td>During the past 30 days, how many times did you have six or more standard drinks in a single drinking occasion?</td>
<td>Number of occasions</td>
</tr>
<tr>
<td>A4</td>
<td>In the last 30 days, how often did you see any alcohol advertisements?</td>
<td>Daily 1, Almost daily 2, Sometimes 3, Rarely 4, Never 5</td>
</tr>
<tr>
<td></td>
<td>Diet</td>
<td></td>
</tr>
<tr>
<td>D1</td>
<td>In a typical week, on how many days do you eat fruit?</td>
<td>Number of days</td>
</tr>
<tr>
<td>D2</td>
<td>How many servings of fruit do you eat on one of those days?</td>
<td>Number of servings</td>
</tr>
<tr>
<td>D3</td>
<td>In a typical week, on how many days do you eat vegetables?</td>
<td>Number of days</td>
</tr>
<tr>
<td>D4</td>
<td>How many servings of vegetables do you eat on one of those days?</td>
<td>Number of servings</td>
</tr>
<tr>
<td>Code</td>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>P1</td>
<td>In a typical week, how many days do you do moderate-intensity activities as part of your work?</td>
<td>Number of days</td>
</tr>
<tr>
<td>P2</td>
<td>How much time do you spend doing moderate-intensity activities (activities that require moderate physical effort and cause small increases in breathing or heart rate) on a typical day? (including work, travel to and from places,</td>
<td>Hours : minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hrs</td>
</tr>
</tbody>
</table>

**History of Raised Blood Pressure**

| H1   | Have you ever had your blood pressure measured by a doctor or other health worker? | Yes 1 | No 2 |
| H2   | Have you ever been told by a doctor or other health worker that you have raised blood pressure or hypertension in the past 12 months? | Yes 1 | No 2 |
| H3   | In the past two weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor or other health worker? | Yes 1 | No 2 |

**History of Diabetes**

| H4   | Have you ever had your blood sugar measured by a doctor or other health worker? | Yes 1 | No 2 |
| H5   | Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes in the past 12 months? | Yes 1 | No 2 |
| H6   | In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor or other health worker? | Yes 1 | No 2 |

**History of Raised Total Cholesterol**

<p>| H7   | Have you ever had your cholesterol (fat levels in your blood) measured by a doctor or other health worker? | Yes 1 | No 2 |
| H8   | Have you ever been told by a doctor or other health worker that you have raised cholesterol in the past 12 months? | Yes 1 | No 2 |
| H9   | In the past two weeks, have you taken any oral treatment (medication) for raised total cholesterol prescribed by a doctor or other health worker? | Yes 1 | No 2 |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10</td>
<td>Have you ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident)?</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H11</td>
<td>Are you currently taking aspirin regularly to prevent or treat heart disease?</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H12</td>
<td>Are you currently taking statins (Lovastatin/Simvastatin/Atorvastatin or any other statin) regularly to prevent or treat heart disease?</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
</tbody>
</table>

**Lifestyle advices**

During the past three years, has a doctor or other health worker advised you to do any of the following?

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>H13a</td>
<td>Quit using tobacco or don’t start</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H13b</td>
<td>Reduce salt in your diet</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H13c</td>
<td>Eat at least five servings of fruit and/or vegetables each day</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H13d</td>
<td>Reduce fat in your diet</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H13e</td>
<td>Start or do more physical activity</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>H13f</td>
<td>Maintain a healthy body weight or lose weight</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
</tbody>
</table>

**Cervical cancer screening (for women only)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CX1</td>
<td>Have you ever had a screening test for cervical cancer, using any of these methods described above?</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
</tr>
</tbody>
</table>
## Step 2  Physical Measurements

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Blood pressure</strong></td>
<td></td>
</tr>
<tr>
<td>M1a</td>
<td>Reading 1</td>
<td>Systolic (mmHg)</td>
</tr>
<tr>
<td>M1b</td>
<td></td>
<td>Diastolic (mmHg)</td>
</tr>
<tr>
<td>M2a</td>
<td>Reading 2</td>
<td>Systolic (mmHg)</td>
</tr>
<tr>
<td>M2b</td>
<td></td>
<td>Diastolic (mmHg)</td>
</tr>
<tr>
<td>M3a</td>
<td>Reading 3</td>
<td>Systolic (mmHg)</td>
</tr>
<tr>
<td>M3b</td>
<td></td>
<td>Diastolic (mmHg)</td>
</tr>
<tr>
<td></td>
<td><strong>Height and Weight</strong></td>
<td></td>
</tr>
<tr>
<td>M4</td>
<td>Height</td>
<td>In Centimetres (cm)</td>
</tr>
<tr>
<td>M5</td>
<td>Weight</td>
<td>In Kilograms (kg)</td>
</tr>
<tr>
<td>M6</td>
<td>Body mass index (BMI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Waist</strong></td>
<td></td>
</tr>
<tr>
<td>M7</td>
<td>Waist circumference</td>
<td>In Centimetres (cm)</td>
</tr>
</tbody>
</table>
Western Pacific

WHO sub-regions WPR A, WPR B

Charts in colour for use in settings where total blood cholesterol can be measured

Figure 1. WHO/ISH risk prediction chart for WPR A
Figure 2. WHO/ISH risk prediction chart for WPR B

Charts in colour for use in settings where total blood cholesterol cannot be measured

Figure 3. WHO/ISH risk prediction chart for WPR A
Figure 4. WHO/ISH risk prediction chart for WPR B
Figure 1. WHO/ISH risk prediction chart for WPR A. 10-year risk of a fatal or non-fatal cardiovascular event by gender, age, systolic blood pressure, total blood cholesterol, smoking status and presence or absence of diabetes mellitus.

This chart can only be used for Australia, Brunei Darussalam, Japan, New Zealand, and Singapore (sub-region A), in settings where blood cholesterol can be measured.
Figure 2. WHO/ISH risk prediction chart for WPR B. 10-year risk of a fatal or non-fatal cardiovascular event by gender, age, systolic blood pressure, total blood cholesterol, smoking status and presence or absence of diabetes mellitus.

### WPR B People with Diabetes Mellitus

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male</th>
<th>Smoker</th>
<th>Female</th>
<th>Non-smoker</th>
<th>Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
</tr>
<tr>
<td>60</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
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<tr>
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<td>![Chart]</td>
</tr>
<tr>
<td>40</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
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<td>![Chart]</td>
</tr>
</tbody>
</table>

### WPR B People without Diabetes Mellitus

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male</th>
<th>Smoker</th>
<th>Female</th>
<th>Non-smoker</th>
<th>Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
</tr>
<tr>
<td>60</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
</tr>
<tr>
<td>50</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
</tr>
<tr>
<td>40</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
<td>![Chart]</td>
</tr>
</tbody>
</table>

Risk Level: 
- **<10%**
- **10% to <20%**
- **20% to <30%**
- **30% to <40%**
- **≥40%**

This chart can only be used for Cambodia, China, Cook Islands, Republic of Korea, Fiji, Kiribati, Lao People’s Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Viet Nam (sub-region B), in settings where blood cholesterol can be measured.
Figure 3. WHO/ISH risk prediction chart for WPR A. 10-year risk of a fatal or non-fatal cardiovascular event by gender, age, systolic blood pressure, smoking status and presence or absence of diabetes mellitus.

This chart can only be used for Australia, Brunei Darussalam, Japan, New Zealand, and Singapore (sub-region A), in settings where blood cholesterol can be measured.
Figure 4. WHO/ISH risk prediction chart for WPR B. 10-year risk of a fatal or non-fatal cardiovascular event by gender, age, systolic blood pressure, smoking status and presence or absence of diabetes mellitus.

### WPR B People with Diabetes Mellitus

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-smoker</td>
<td>Smoker</td>
</tr>
<tr>
<td>70</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>60</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>50</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>40</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
</tbody>
</table>

### WPR B People without Diabetes Mellitus

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-smoker</td>
<td>smoker</td>
</tr>
<tr>
<td>70</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>60</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>50</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
<tr>
<td>40</td>
<td><img src="chart" alt="" /></td>
<td><img src="chart" alt="" /></td>
</tr>
</tbody>
</table>

Risk Level: 
- <10%<br>- 10% to <20%<br>- 20% to <30%<br>- 30% to <40%<br>- ≥40%

This chart can only be used for Cambodia, China, Cook Islands, Republic of Korea, Fiji, Kiribati, Lao People’s Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Viet Nam (sub-region B), in settings where blood cholesterol can be measured.
### Prevention of CVD in people with CVD risk factors (according to individual total risk*)

#### Risk < 10%

- Individuals in this category are at low risk. Low risk does not mean "no" risk.
- Conservative management focusing on lifestyle interventions is suggested.

#### Risk 10%–20%

- Individuals in this category are at moderate risk of fatal or non-fatal vascular events.
- Monitor risk profile every 3–6 months.

#### Risk 20% to <30%

- Individuals in this category are at high risk of fatal or non-fatal vascular events.
- Monitor risk profile every 3–6 months.

#### Risk > 30%

- Individuals in this category are at very high risk of fatal or non-fatal vascular events.
- Monitor risk profile every 3–6 months.

---

### SMOKING CESSATION

- All nonsmokers should be encouraged not to start smoking.
- All smokers should be strongly encouraged to quit smoking by a health professional and supported in their efforts to do so.
- It is suggested that those who use other forms of tobacco be advised to stop.

### DIETARY CHANGES

- All individuals should be strongly encouraged to reduce total fat and saturated fat intake.
- Total fat intake should be reduced to about 30% of calories, saturated fat to less than 10% of calories, trans-fatty acids intake should be reduced as much as possible or eliminated and most dietary fat should be polyunsaturated (up to 10% of calories) or monounsaturated (10–15% of calories).
- All individuals should be strongly encouraged to reduce daily salt intake by at least one third and, if possible, to <5 g or <9 g per day.
- All individuals should be encouraged to eat at least 400 g a day of a range of fruits and vegetables as well as whole grains and pulses.

### PHYSICAL ACTIVITY

- All individuals should be strongly encouraged to take at least 30 minutes of moderate physical activity (e.g. brisk walking) a day, through leisure time, daily tasks and work-related physical activity.

### WEIGHT CONTROL

- All individuals who are overweight or obese should be encouraged to lose weight through a combination of a reduced-energy diet (dietary advice) and increased physical activity.

### ALCOHOL INTAKE

- Individuals who take more than 3 units of alcohol per day should be advised to reduce alcohol consumption.

### ANTIHYPERTENSIVE DRUGS

- All individuals with blood pressure at or above 160/100 mmHg, or lesser degree of raised blood pressure with target organ damage, should have drug treatment and specific lifestyle advice to lower their blood pressure and risk of cardiovascular disease.

### LIPID-LOWERING DRUGS (STATINS)

- All individuals with blood pressure below 160/100 mmHg, or with no target organ damage need to be managed according to the cardiovascular risk (10 year risk of cardiovascular event <10%, 10 to <20%, 20 to <30%, ≥30%)

### HYPOGLYCAEMIC DRUGS

- Individuals with persistent fasting blood glucose >6 mmol/l despite diet control should be given metformin.

### DRUGS THAT ARE NOT RECOMMENDED

- Hormone replacement, vitamins B, C, E and folic acid supplements are not recommended for reduction of cardiovascular risk.

---

**Source:** WHO Prevention of CVD, Guidelines for assessment and management of CVD risk (2007)


---

*Excluding people with established coronary artery disease, cerebrovascular disease and peripheral vascular disease.*
ANNEX 4. WHO PEN protocols

Prevention of Heart Attacks, Strokes and Kidney Disease through Integrated Management of Diabetes and Hypertension (Best Buy)

When could this Protocol be used?

- The protocol is for assessment and management of cardiovascular risk using hypertension, diabetes mellitus (DM) and tobacco use as entry points
- It could be used for routine management of hypertension and DM and for screening, targeting the following categories of people:
  - age > 40 years
  - smokers
  - waist circumference (≥ 90 cm in women ≥100 cm in men)
  - known hypertension
  - known DM
  - history of premature CVD in first degree relatives
  - history of DM or kidney disease in first degree relatives

Follow instructions given in Action 1 to Action 4, step by step

FIRST VISIT

Action 1. Ask about:

- Diagnosed heart disease, stroke, TIA, DM, kidney disease
- Angina, breathlessness on exertion and lying flat, numbness or weakness of limbs, loss of weight, increased thirst, polyuria, puffiness of face, swelling of feet, passing blood in urine etc
- Medicines that the patient is taking
- Current tobacco use (yes/no) (answer yes if tobacco use during the last 12 months)
- Alcohol consumption (yes/no) (if ‘Yes’, frequency and amount)
- Occupation (sedentary or active)
- Engaged in more than 30 minutes of physical activity at least 5 days a week (yes/no)
- Family history of premature heart disease or stroke in first degree relatives

References

World Health Organization. *Scaling up action against noncommunicable diseases. How much will it cost?, 2011*
WHO PEN Protocol 1
Prevention of Heart Attacks, Strokes and Kidney Disease through Integrated Management of Diabetes and Hypertension (Best Buy)

**FIRST VISIT**

**Action 2. Assess (physical exam and blood and urine tests):**
- Waist circumference
- Measure blood pressure, look for pitting oedema
- Palpate apex beat for haemming and displacement
- Auscultate heart (rhythm and murmurs)
- Auscultate lungs (bilateral basal crepitations)
- Examine abdomen (tender liver)
- In DM patients examine feet; sensations, pulses, and ulcers
- Urine ketones (in newly diagnosed DM) and protein
- Total cholesterol
- Fasting or random blood sugar (diabetes= fasting blood sugar≥7 mmol/l (126 mg/dl)) or random blood sugar ≥11.1 mmol/l (200 mg/dl))

(Point of care devices can be used for testing blood sugar if laboratory facilities are not available)

**Action 3. Estimate cardiovascular risk (in those not referred):**
- Use the WHO/ISH risk charts relevant to the WHO subregion (Annex and CD)
- Use age, gender, smoking status, systolic blood pressure, DM (and plasma cholesterol if available)
- If age 50-59 years select age group box 50, if 60-69 years select age group box 60 etc., for people age < 40 years select age group box 40
- If cholesterol assay cannot be done use the mean cholesterol level of the population or a value of 5.2 mmol/l to calculate the cardiovascular risk
- If the person is already on treatment, use pretreatment levels of risk factors (if information is available to assess and record the pretreatment risk. Also assess the current risk using current levels of risk factors)
- Risk charts underestimate the risk in those with family history of premature vascular disease, obesity, raised triglyceride levels

**Action 4: Referral criteria for all visits:**
- BP ≥200/>120 mm Hg (urgent referral)
- BP ≥140 or ≥ 90 mmHg in people < 40 yrs (to exclude secondary hypertension)
- Known heart disease, stroke, transient ischemic attack, DM, kidney disease (for assessment, if this has not been done)
- New chest pain or change in severity of angina or symptoms of transient ischemic attack or stroke
- Target organ damage (e.g. angina, claudication, haemming apex, cardiac failure)
- Cardiac murmurs
- Raised BP ≥140/90 ( in DM above 130/ 80mmHg) while on treatment with 2 or 3 agents

- Any proteinuria
- Newly diagnosed DM with urine ketones 2+ or in lean persons of <30 years
- Total cholesterol >8mmol/l
- DM with poor control despite maximal metformin with or without sulphonylurea
- DM with severe infection and/or foot ulcers
- DM with recent deterioration of vision or no eye exam in 2 years
- High cardiovascular risk

If referral criteria are not present go to Action 5
## WHO PEN Protocol 1

**Prevention of Heart Attacks, Strokes and Kidney Disease through Integrated Management of Diabetes and Hypertension (Best Buy)**

### Action 5. Counsel all and treat as shown below

<table>
<thead>
<tr>
<th>Risk &lt; 20%</th>
<th>Risk 20 to &lt;30%</th>
<th>Risk &gt; 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Important practice points</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consider drug treatment for following categories</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional actions for individuals with DM:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk &lt; 20%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsel on diet, physical activity, smoking cessation and avoiding harmful use of alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- If risk &lt; 10% follow up in 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- If risk 10 - &lt; 20% follow up every 3 months until targets are met, then 6-9 months thereafter</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk 20 to &lt;30%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsel on diet, physical activity, smoking cessation and avoiding harmful use of alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Persistent BP ≥ 140/90 mm Hg consider drugs (see below ** Antihypertensive medications**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Follow-up every 3-6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk &gt; 30%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsel on diet, physical activity, smoking cessation and avoiding harmful use of alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Persistent BP ≥ 130/80 mm Hg consider drugs (see below ** Antihypertensive medications**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give a statin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Follow-up every 3 months, if there is no reduction in cardiovascular risk after six months of follow up refer to next level</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk &gt; 30%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give an antihypertensive for those with BP ≥ 130/80 mmHg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give a statin to all with type 2 DM aged ≥ 40 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give Metformin for type 2 DM if not controlled by diet only (FBS&gt;7mmol/l), and if there is no renal insufficiency, liver disease or hypoxia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Titrate metformin to target glucose value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give a sulfonylurea to patients who have contraindications to metformin or if metformin does not improve glycaemic control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Give advise on foot hygiene, nail cutting, treatment of calluses, appropriate footwear and assess feet at risk of ulcers using simple methods (inspection, pin-prick sensation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Angiotensin converting enzyme inhibitors and/or low-dose thiazides are recommended as first-line treatment of hypertension. Beta-blockers are not recommended for initial management but can be used if thiazides or angiotensin converting enzyme inhibitors are contraindicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Follow up every 3 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Important practice points**

- All patients with established DM and cardiovascular disease (coronary heart disease, myocardial infarction, transient ischaemic attacks, cerebrovascular disease or peripheral vascular disease), renal disease. If stable, should continue the treatment already prescribed and be considered as with risk >30%
- People with albuminuria, retinopathy, left ventricular hypertrophy
- All individuals with persistent raised BP≥ 160/100 mmHg; antihypertensive treatment
- All individuals with total cholesterol at or above 8 mmol/l (320 mg/dl); lifestyle advice and statins

**Antihypertensive medications**

- If under 55 years low dose of a thiazide diuretic and/or angiotensin converting enzyme inhibitor
- If over 55 years calcium channel blocker and/or low dose of a thiazide diuretic
- If intolerant to angiotensin converting enzyme inhibitor or for women in child bearing age consider a beta blocker
- Thiazide diuretics and/or long-acting calcium channel blockers are more appropriate as initial treatment for certain ethnic groups. Medications for compelling indications should be prescribed, regardless of race/ethnicity
- Test serum creatinine and potassium before prescribing an angiotensin converting enzyme inhibitor

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### Risk categories

- **Risk < 20%**
- **Risk 20 to <30%**
- **Risk > 30%**
WHO PEN Protocol 1
Prevention of Heart Attacks, Strokes and Kidney Disease through Integrated Management of Diabetes and Hypertension (Best Buy)

Advice to patients and family

- Avoid table salt and reduce salty foods such as pickles, salty fish, fast food, processed food, canned food and stock cubes
- Have your blood glucose level, blood pressure and urine checked regularly

Advice specific for DM

- Advise overweight patients to reduce weight by reducing their food intake.
- Advise all patients to give preference to low glycaemic-index foods (e.g., beans, lentils, oats and unsweetened fruit) as the source of carbohydrates in their diet
- If you are on any DM medication that may cause your blood glucose to go down too low carry sugar or sweets with you
- If you have DM, eyes should be screened for eye disease (diabetic retinopathy) by an ophthalmologist at the time of diagnosis and every two years thereafter, or as recommended by the ophthalmologist
- Avoid walking barefoot or without socks
- Wash feet in lukewarm water and dry well especially between the toes
- Do not cut calluses or corns, and do not use chemical agents on them
- Look at your feet every day and if you see a problem or an injury, go to your health worker

Repeat

- Ask about: new symptoms, adherence to advise on tobacco and alcohol use, physical activity, healthy diet, medications etc
- Action 2 Assess (Physical exam)
- Action 3 Estimate cardiovascular risk
- Action 4 Refer if necessary
- Action 5 Counsel all and treat as shown in protocol
## WHO PEN Protocol 2

### Health Education and Counseling on Healthy Behaviours (to be applied to ALL)

<table>
<thead>
<tr>
<th>Educate your patient to</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Take regular physical activity</td>
</tr>
<tr>
<td>- Eat a “heart healthy” diet</td>
</tr>
<tr>
<td>- Stop tobacco and avoid harmful use of alcohol</td>
</tr>
<tr>
<td>- Attend regular medical follow-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Take regular physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Progressively increase physical activity to moderate levels (such as brisk walking); at least 30 minutes per day on 5 days of the week</td>
</tr>
<tr>
<td>- Control body weight and avoid overweight by reducing high calorie food and taking adequate physical activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stop Tobacco and avoid harmful use of Alcohol:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Encourage all non-smokers not to start smoking</td>
</tr>
<tr>
<td>- Strongly advise all smokers to stop smoking and support them in their efforts</td>
</tr>
<tr>
<td>- Individuals who use other forms of tobacco should be advised to quit</td>
</tr>
<tr>
<td>- Alcohol abstinence should be reinforced.</td>
</tr>
<tr>
<td>- People should not be advised to start taking alcohol for health reasons</td>
</tr>
<tr>
<td>- Advise patients not to use alcohol when additional risks are present, such as:</td>
</tr>
<tr>
<td>- driving or operating machinery</td>
</tr>
<tr>
<td>- pregnant or breast feeding</td>
</tr>
<tr>
<td>- taking medications that interact with alcohol</td>
</tr>
<tr>
<td>- having medical conditions made worse by alcohol</td>
</tr>
<tr>
<td>- having difficulties in controlling drinking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eat a heart healthy diet</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salt (sodium chloride)</strong></td>
</tr>
<tr>
<td>- Restrict to less than 5 grams (1 teaspoon) per day</td>
</tr>
<tr>
<td>- Reduce salt when cooking, limit processed and fast foods</td>
</tr>
<tr>
<td><strong>Fruits and vegetables</strong></td>
</tr>
<tr>
<td>- 5 servings (400-500 grams) of fruits and vegetable per day</td>
</tr>
<tr>
<td>- 1 serving is equivalent to 1 orange, apple, mango, banana or 3 tablespoons of cooked vegetables</td>
</tr>
<tr>
<td><strong>Fatty food</strong></td>
</tr>
<tr>
<td>- Limit fatty meat, dairy fat and cooking oil (less than two tablespoons per day)</td>
</tr>
<tr>
<td>- Replace palm and coconut oil with olive, soya, corn, rapeseed or safflower oil</td>
</tr>
<tr>
<td>- Replace other meat with chicken (without skin)</td>
</tr>
<tr>
<td><strong>Fish</strong></td>
</tr>
<tr>
<td>- Eat fish at least 3 times per week, preferably oily fish such as tuna, mackerel, salmon</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adherence to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If the patient is prescribed a medicine/s:</td>
</tr>
<tr>
<td>- teach the patient how to take it at home:</td>
</tr>
<tr>
<td>- explain the difference between medicines for long-term control (e.g. blood pressure) and medicines for quick relief (e.g. for wheezing)</td>
</tr>
<tr>
<td>- tell the patient the reason for prescribing the medicine/s</td>
</tr>
<tr>
<td>- Show the patient the appropriate dose</td>
</tr>
<tr>
<td>- Explain how many times a day to take the medicine</td>
</tr>
<tr>
<td>- Label and package the tablets</td>
</tr>
<tr>
<td>- Check the patient’s understanding before the patient leaves the health centre</td>
</tr>
<tr>
<td>- Explain the importance of:</td>
</tr>
<tr>
<td>- keeping an adequate supply of the medications</td>
</tr>
<tr>
<td>- the need to take the medicines regularly as advised even if there are no symptoms</td>
</tr>
</tbody>
</table>
WHO PEN Protocol 2
Health Education and Counseling on Healthy Behaviours; Counselling on Cessation of Tobacco use

A1: ASK
Do you use tobacco?

A2: ADVISE
YES
Advise to quit in a clear, strong and personalized manner
“Tobacco use increases the risk of developing a heart attack, stroke, lung cancer and respiratory diseases. Quitting tobacco use is the one most important thing you can do to protect your heart and health, you have to quit now.”

NO
Reinforce message that tobacco increases risk of heart disease

A3: ASSESS
Are you willing to make a quit attempt now?

YES
Assist in preparing a quitting plan
Set quit date
Inform family and friends
Ask for their support
Remove cigarettes/tobacco
Remove objects/articles that prompt you to smoke
Arrange follow up visit*

NO

A4: ASSIST

A5: ARRANGE
At follow-up visit
Congratulate success and reinforce
If patient has relapsed, consider more intensive follow-up and support from family

* Ideally second follow-up visit is recommended within the same month and every month thereafter for 4 months and evaluation after 1 year. If not feasible, reinforce counseling whenever the patient is seen for blood pressure monitoring.

Promote motivation to quit
Provide information on health hazards of tobacco and give leaflet to the patient
## ANNEX 5: Menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases

<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Raise public and political awareness, understanding and practice about prevention and control of NCDs</td>
<td>Contribute to all 9 voluntary global targets</td>
<td>– WHO global status report on NCDs 2010</td>
</tr>
<tr>
<td>• Integrate NCDs into the social and development agenda and poverty alleviation strategies</td>
<td></td>
<td>– WHO fact sheets</td>
</tr>
<tr>
<td>• Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learnt and best practices</td>
<td></td>
<td>– Global atlas on cardiovascular disease prevention and control 2011</td>
</tr>
<tr>
<td>• Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels</td>
<td></td>
<td>– IARC GLOBOCAN 2008</td>
</tr>
<tr>
<td>• Implement other policy options in objective 1 (see paragraph 21)</td>
<td></td>
<td>– Existing regional and national tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and regional committees</td>
</tr>
</tbody>
</table>

| **Objective 2**        |                          |           |
| • Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies | Contribute to all 9 voluntary global targets | – UN Secretary-General’s Note A/67/373 |
| • Assess national capacity for prevention and control of NCDs |                          | – NCD country capacity survey tool |
| • Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement |                          | – NCCP Core Capacity Assessment tool |
| • Implement other policy options in objective 2 (see paragraph 30) to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases |                          | – Existing regional and national tools |
|                         |                          | – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and regional committees |
### Menu of policy options

<table>
<thead>
<tr>
<th>Objective 3&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco use</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years</td>
<td>– The WHO FCTC and its guidelines</td>
</tr>
<tr>
<td>- Implement WHO FCTC (see paragraph 36). Parties to the WHO FCTC are required to implement all obligations under the treaty in full; all Member States that are not Parties are encouraged to look to the WHO FCTC as the foundational instrument in global tobacco control</td>
<td>– MPower capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC</td>
<td></td>
</tr>
<tr>
<td>- Reduce affordability of tobacco products by increasing tobacco excise taxes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
<td>– WHO reports on the global tobacco epidemic</td>
</tr>
<tr>
<td>- Create by law completely smoke-free environments in all indoor workplaces, public places and public transport&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td>– Recommendations on the marketing of foods and non-alcoholic beverages to children (WHA63.14)</td>
</tr>
<tr>
<td>- Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td>– Global strategy on diet, physical activity and health, (WHA57.17)</td>
</tr>
<tr>
<td>- Ban all forms of tobacco advertising, promotion and sponsorship&lt;sup&gt;3&lt;/sup&gt;</td>
<td>At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context</td>
<td>– Global recommendations on physical activity for health</td>
</tr>
<tr>
<td><strong>Harmful use of alcohol</strong></td>
<td>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances</td>
<td>– Global strategy to reduce the harmful use of alcohol (WHA63.13)</td>
</tr>
<tr>
<td>- Implement the WHO global strategy to reduce harmful use of alcohol (see objective 3, paragraphs 42, 43) through actions in the recommended target areas including:</td>
<td></td>
<td>– WHO global status reports on alcohol and health 2011, 2013</td>
</tr>
<tr>
<td>- Strengthening awareness of alcohol-attributable burden; leadership and political commitment to reduce the harmful use of alcohol</td>
<td></td>
<td>– WHO guidance on dietary salt and potassium</td>
</tr>
<tr>
<td>- Providing prevention and treatment interventions for those at risk of or affected by alcohol use disorders and associated conditions</td>
<td></td>
<td>– Existing regional and national tools</td>
</tr>
<tr>
<td>- Supporting communities in adopting effective approaches and interventions to prevent and reduce the harmful use of alcohol</td>
<td></td>
<td>– Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and</td>
</tr>
<tr>
<td>- Implementing effective drink–driving policies and countermeasures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Regulating commercial and public availability of alcohol&lt;sup&gt;4&lt;/sup&gt;</td>
<td>A 25% relative reduction in overall mortality from</td>
<td></td>
</tr>
<tr>
<td>- Restricting or banning alcohol advertising and promotions&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<sup>1</sup> In addressing each risk factor, Member States should not rely on one single intervention, but should have a comprehensive approach to achieve desired results.

<sup>2</sup> Tobacco use: Each of these measures reflects one or more provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). The measures included in this Appendix are not intended to suggest a prioritization of obligations under the WHO FCTC. Rather, these measures have been proven to be feasible, affordable and cost-effective and are intended to fulfill the criteria established in the chapeau paragraph of Appendix 3 for assisting countries to meet the agreed targets as quickly as possible. The WHO FCTC includes a number of other important provisions, including supply-reduction measures and those to support multisectoral action, which are part of any comprehensive tobacco control programme.

Some interventions for management of noncommunicable diseases that are cost-effective in high-income settings, which assume a cost-effective infrastructure for diagnosis and referral and an adequate volume of cases, are not listed under objective 4, e.g. pacemaker implants for atrioventricular heart block, defibrillators in emergency vehicles, coronary revascularization procedures, and carotid endarterectomy.

<sup>3</sup> Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

<sup>4</sup> Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.
<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Using pricing policies such as excise tax increases on alcoholic beverages</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
<td>regional committees</td>
</tr>
<tr>
<td>• Reducing the negative consequences of drinking and alcohol intoxication, including by regulating the drinking context and providing consumer information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reducing the public health impact of illicit alcohol and informally produced alcohol by implementing efficient control and enforcement systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing sustainable national monitoring and surveillance systems using indicators, definitions and data collection procedures compatible with WHO’s global and regional information systems on alcohol and health</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unhealthy diet and physical inactivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement the WHO Global Strategy on Diet, Physical Activity and Health (see objective 3, paragraphs 40–41)</td>
<td>A 10% relative reduction in prevalence of insufficient physical activity</td>
<td></td>
</tr>
<tr>
<td>• Increase consumption of fruit and vegetables</td>
<td>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances</td>
<td></td>
</tr>
<tr>
<td>• To provide more convenient, safe and health-oriented environments for physical activity</td>
<td>Halt the rise in diabetes and obesity</td>
<td></td>
</tr>
<tr>
<td>• Implement recommendations on the marketing of foods and non-alcoholic beverages to children (see objective 3, paragraph 38–39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement the WHO global strategy for infant and young child feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reduce salt intake</strong>&lt;sup&gt;5,6&lt;/sup&gt;</td>
<td>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
<td></td>
</tr>
<tr>
<td><strong>Replace trans fats with unsaturated fats</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>A 30% relative reduction in mean population intake of salt/sodium intake</td>
<td></td>
</tr>
<tr>
<td><strong>Implement public awareness programmes on diet and physical activity</strong>&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Replace saturated fat with unsaturated fat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Manage food taxes and subsidies to promote healthy diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement other policy options listed in objective 3 for addressing unhealthy diet and physical inactivity</td>
<td></td>
<td></td>
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</tbody>
</table>

**Objective 4**

<p>| | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>• Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda</td>
<td>An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private</td>
<td></td>
</tr>
<tr>
<td>• Explore viable health financing mechanisms and innovative economic tools supported by evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– WHO World health reports 2010, 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Prevention and control of noncommunicable diseases: Guidelines for primary health care in low-resource settings; diagnosis and management of type 2 diabetes and Management</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>5</sup> Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

<sup>6</sup> And adjust the iodine content of iodized salt, when relevant.
<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>interventions to address behavioural risk factors</td>
<td>facilities</td>
<td>of asthma and chronic obstructive pulmonary disease 2012</td>
</tr>
<tr>
<td>• Train health workforce and strengthen capacity of health system particularly at primary care level to address the prevention and control of noncommunicable diseases</td>
<td>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
<td>Guideline for cervical cancer: Use of cryotherapy for cervical intraepithelial neoplasia</td>
</tr>
<tr>
<td>• Improve availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities</td>
<td></td>
<td>Guideline for pharmacological treatment of persisting pain in children with medical illnesses</td>
</tr>
<tr>
<td>• Implement other cost-effective interventions and policy options in objective 4 (see paragraph 48) to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred primary health care and universal health coverage</td>
<td></td>
<td>Scaling up NCD interventions, WHO 2011</td>
</tr>
<tr>
<td>• Develop and implement a palliative care policy using cost-effective treatment modalities, including opioids analgesics for pain relief and training health workers</td>
<td>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances</td>
<td>WHO CHOICE database</td>
</tr>
<tr>
<td>• Develop and implement a palliative care policy using cost-effective treatment modalities, including opioids analgesics for pain relief and training health workers</td>
<td></td>
<td>WHO Package of essential noncommunicable (PEN) disease interventions for primary health care including costing tool 2011</td>
</tr>
</tbody>
</table>

### Cardiovascular disease and diabetes

- **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%) of a fatal and nonfatal cardiovascular event in the next 10 years**

- **Acetylsalicylic acid for acute myocardial infarction**

- **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 moderate risk (≥ 20%) of a fatal and nonfatal cardiovascular event in the next 10 years**

- **Detection, treatment and control of hypertension and diabetes, using a total risk approach**

- **Secondary prevention of rheumatic fever and rheumatic heart disease**

- **Acetylsalicylic acid, atenolol and thrombolytic therapy (streptokinase) for acute myocardial infarction**

- **Treatment of congestive cardiac failure with ACE inhibitor, beta-blocker and diuretic**

- **Cardiac rehabilitation post myocardial infarction**

- **Anticoagulation for medium- and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation**

- **Low-dose acetylsalicylic acid for ischemic stroke**

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7 Policy actions for prevention of major noncommunicable diseases are listed under objective 3.

8 Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

60
<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes</strong>¹</td>
<td></td>
<td>(2011)</td>
</tr>
<tr>
<td>• Lifestyle interventions for preventing type 2 diabetes</td>
<td></td>
<td>– OneHealth tool</td>
</tr>
<tr>
<td>• Influenza vaccination for patients with diabetes</td>
<td></td>
<td>– Enhancing nursing and midwifery capacity to contribute to the prevention, treatment and management of noncommunicable diseases</td>
</tr>
<tr>
<td>• Preconception care among women of reproductive age including patient education and intensive glucose management</td>
<td></td>
<td>– Existing regional and national tools</td>
</tr>
<tr>
<td>• Detection of diabetic retinopathy by dilated eye examination followed by appropriate laser photocoagulation therapy to prevent blindness</td>
<td></td>
<td>– Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and regional committees</td>
</tr>
<tr>
<td>• Effective angiotensin-converting enzyme inhibitor drug therapy to prevent progression of renal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care of acute stroke and rehabilitation in stroke units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interventions for foot care: educational programmes, access to appropriate footwear; multidisciplinary clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong>⁹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prevention of liver cancer through hepatitis B immunization¹⁰</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] (or Pap smear (cervical cytology), if very cost-effective),² linked with timely treatment of pre-cancerous lesions⁴</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vaccination against human papillomavirus, as appropriate if cost-effective and affordable, according to national programmes and policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population-based cervical cancer screening linked with timely treatment¹¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population-based breast cancer and mammography screening (50–70 years) linked with timely treatment⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population-based colorectal cancer screening, including through a fecal occult blood test, as appropriate, at age &gt;50, linked with timely treatment⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral cancer screening in high-risk groups (e.g. tobacco users, betel-nut chewers) linked with timely treatment⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic respiratory disease</strong>¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to improved stoves and cleaner fuels to reduce indoor air pollution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cost-effective interventions to prevent occupational lung diseases, e.g. from exposure to silica, asbestos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment of asthma based on WHO guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Influenza vaccination for patients with chronic obstructive pulmonary disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

⁹ Policy actions for prevention of major noncommunicable diseases are listed under objective 3.
¹⁰ Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.
¹¹ Screening is meaningful only if associated with capacity for diagnosis, referral and treatment.
<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Voluntary global targets</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 5</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| • Develop and implement a prioritized national research agenda for noncommunicable diseases | Contribute to all 9 voluntary global targets | – Prioritized research agenda for the prevention and control of noncommunicable diseases 2011  
– World Health Report 2013  
– Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21)  
– Existing regional and national tools  
– Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and regional committees |
| • Prioritize budgetary allocation for research on noncommunicable disease prevention and control | | |
| • Strengthen human resources and institutional capacity for research | | |
| • Strengthen research capacity through cooperation with foreign and domestic research institutes | | |
| • Implement other policy options in objective 5 (see paragraph 53) to promote and support national capacity for high-quality research, development and innovation | | |
| **Objective 6**        |                          |           |
| • Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plan | Contribute to all 9 voluntary global targets | – Global monitoring framework  
– Verbal autopsy instrument  
– STEPwise approach to surveillance  
– Global Tobacco Surveillance System  
– Global Information System on Alcohol and Health  
– Global school-based student health survey, ICD-10 training tool  
– Service Availability and Readiness (SARA) assessment tool  
– IARC GLOBOCAN 2008  
– Existing regional and national tools  
– Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and regional committees |
| • Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation | | |
| • Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors, and monitoring national response | | |
| • Integrate noncommunicable disease surveillance and monitoring into national health information systems | | |
| • Implement other policy options in objective 6 (see paragraph 59) to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control | | |
# ANNEX 6

## Appendix 2

### Comprehensive global monitoring framework, including 25 indicators, and a set of nine voluntary global targets for the prevention and control of noncommunicable diseases

<table>
<thead>
<tr>
<th>Framework element</th>
<th>Target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality and morbidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature mortality from noncommunicable disease</td>
<td>(1) A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases</td>
<td>(1) Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases.</td>
</tr>
<tr>
<td>Additional indicator</td>
<td>(2) Cancer incidence, by type of cancer, per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use of alcohol</td>
<td>(2) At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context</td>
<td>(3) Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context.</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>(3) A 10% relative reduction in prevalence of insufficient physical activity</td>
<td>(6) Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily.</td>
</tr>
<tr>
<td>Salt/sodium intake</td>
<td>(4) A 30% relative reduction in mean population intake of salt/sodium</td>
<td>(7) Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent).</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years</td>
<td>(8) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.</td>
</tr>
<tr>
<td>Biological risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raised blood pressure</td>
<td>(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances</td>
<td>(11) Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) and mean systolic blood pressure.</td>
</tr>
<tr>
<td>Diabetes and obesity</td>
<td>(7) Halt the rise in diabetes and obesity</td>
<td>(12) Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(13) Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and</td>
</tr>
</tbody>
</table>

1. Countries will select indicator(s) of harmful use as appropriate to national context and in line with WHO’s global strategy to reduce the harmful use of alcohol and that may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality, among others.

2. In WHO’s global strategy to reduce the harmful use of alcohol the concept of the harmful use of alcohol encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

3. WHO’s recommendation is less than 5 grams of salt or 2 grams of sodium per person per day.

4. Countries will select indicator(s) appropriate to national context.
### Framework element

<table>
<thead>
<tr>
<th>Target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>obese – two standard deviations body mass index for age and sex</td>
</tr>
<tr>
<td></td>
<td>(14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m² for overweight and body mass index ≥ 30 kg/m² for obesity)</td>
</tr>
<tr>
<td>Additional indicators</td>
<td>(15) Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years¹</td>
</tr>
<tr>
<td></td>
<td>(16) Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day</td>
</tr>
<tr>
<td></td>
<td>(17) Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration</td>
</tr>
</tbody>
</table>

### National systems response

| Drug therapy to prevent heart attacks and strokes | (8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes |
| Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases | (9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities |
| Additional indicators | (18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes |
| | (19) Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities |
| | (20) Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer |
| | (21) Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes |
| | (22) Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies |
| | (23) 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 |
| | (24) Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants |
| | (25) Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies |

¹ Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations.