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Acknowledgements

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We would also like to acknowledge the significant contribution and support of the National Institute of public health, Japan and the Ministry of Health, Labour and Welfare, Government of Japan for NCD capacity building in the region.
REGIONAL MEETING ON PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

Convened by:
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC
and the
NATIONAL INSTITUTE OF PUBLIC HEALTH, JAPAN

Saitama, Japan, 3–5 August 2009
Tokyo, Japan, 6–7 August 2009
SUMMARY

The burden of chronic Noncommunicable disease (NCD) has been increasing rapidly in the Western Pacific Region and is projected to increase further, placing enormous pressure on country health systems and budgets. In May 2008, the World Health Assembly adopted the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. The Western Pacific Regional Action Plan (RAP) for Noncommunicable Diseases, which brings together the various strategies and interventions in a regional context, was endorsed by the Regional Committee for the Western Pacific in September 2008.

National-level capacity strengthening is essential to address the challenges of NCD prevention and control. With financial support from the Government of Japan, the WHO Regional Office for the Western Pacific and the National Institute of Public Health, Japan, organized a meeting to review the work of Member States in NCD prevention and control and to encourage senior policy-makers from Member States to scale up NCD interventions. The meeting was held in two parts: (1) a review of progress and an opportunity for ongoing training for previous participants, held in Saitama, Japan from 3 to 5 August 2009 (fifth in a series of training programmes that began in 2005); and (2) a dialogue that included policy-makers on next steps, held in Tokyo, Japan, from 6 to 7 August 2009.

The meeting objectives were for participants, by the end of the meeting, to have:

1. reviewed country progress against the Regional Action Plan for NCD and identified gaps in action, capacity and resources needed to strengthen NCD prevention and control;
2. identified key actions to achieve the goals of the Regional Action Plan for NCD at the national level using an integrated approach to NCD prevention and control;
3. mobilized the commitment of senior policy-makers for strategic national activities in NCD prevention and control and;
4. established a mechanism for ongoing policy dialogue and sharing of experiences in NCD prevention and control.

The workshop consisted of technical presentations, country presentations, group exercises and plenary discussions. Participants reviewed country progress against the objectives of the Regional Action Plan (RAP), assessed the strength of political support and programme capacity needed to attain those objectives and prioritized action areas for the near future. They also identified barriers and countermeasures to progress in achieving the goals of the RAP, selected strategies for progressing an integrated approach, and considered how best to use advocacy, surveillance and information exchange in achieving the goals of the RAP at national and regional levels. The participants became acquainted with progress, opportunities and challenges within countries and the Region for achieving progress in NCD prevention and control and finally produced concrete recommendations on how best to ensure implementation of the RAP at the national and regional levels within the near future and ensure a mechanism for monitoring progress and exchanging lessons learnt.
Recommendations, brought together in the ‘Saitama Call to Action’, included:

- supporting the establishment of national priority areas in NCD prevention and control;
- developing and scaling up integrated comprehensive policies and approaches to NCD prevention and control;
- strengthening health systems for NCD prevention and control through primary health care, and exploring links with communicable diseases to leverage resources;
- building on healthy settings, such as Healthy Cities and Healthy Islands;
- building and strengthening regional and national capacity-building for NCD prevention and control, giving consideration to using the participatory, tools-based learning course that has evolved over the five years of the Japan WHO International Visitors Programme as an option;
- jointly developing an evaluation framework to monitor progress in achieving the objectives of the NCD RAP;
- fostering national, subregional and regional multisectoral partnerships to address and advance NCD prevention and control; and
- identifying a national mechanism to coordinate NCD prevention and control.
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INTRODUCTION

WHO Regional Office for the Western Pacific and the National Institute of Public Health, Japan, with financial support from the Government of Japan, jointly organized the Regional Meeting on Prevention and Control of Noncommunicable Diseases (NCD) which was held in Saitama, Japan, from 3 to 5 August 2009, and in Tokyo, Japan, from 6 to 7 August 2009. The purpose of the meeting was to review the work of Member States in NCD prevention and control and to encourage senior policy-makers from Member States to scale up NCD interventions. The meeting was held in two parts: (1) a review of progress and an opportunity for ongoing training for previous participants (it was the fifth in a series of training programmes that began in 2005); and (2) a dialogue that included policy-makers on next steps.

Objectives

The meeting objectives were for participants, by the end of the meeting, to have:

1. reviewed country progress against the Regional Action Plan for NCD and identified gaps in action, capacity and resources needed to strengthen NCD prevention and control;
2. identified key actions to achieve the goals of the Regional Action Plan for NCD at the national level using an integrated approach to NCD prevention and control;
3. mobilized the commitment of senior policy-makers for strategic national activities in NCD prevention and control and;
4. established a mechanism for ongoing policy dialogue and sharing of experiences in NCD prevention and control.
The objective of day 1 was for participants to review country progress against the objectives of the Regional Action Plan for Noncommunicable Diseases, assess the strength of political support and programme capacity needed to attain those objectives and prioritize action areas for the near future.

Opening

Participants were welcomed to the meeting by Dr Kenji Hayashi, President of the National Institute of Public Health. He highlighted the major contribution of NCD to death and disease in the Western Pacific, noting that, in Japan, 60% of all deaths are attributable to chronic disease and that one-third of the total health budget is being spent on chronic disease. He called on participants to use the meeting as an opportunity for learning and sharing.

Dr Linda Milan, Director, Office of the Regional Director, WHO Western Pacific Regional Office, delivered opening remarks on behalf of the WHO Regional Director. At this, the fifth of a series of meeting focusing on capacity-building, she invited participants to bring out the themes of appreciation, evaluation and celebration. To appreciate the visionary partnership of the Government of Japan and WHO in creating an effective model for building capacity and fostering leadership for NCD. She relayed feedback from previous meetings that allowed participants to evaluate the cumulative success of the Japan-WHO International Visitors Program (JWIVP). Over two-thirds (72%) of supervisors of past course participants had reported that they had observed improvements in their units or organizations as a result of their staff members’ participation at the JWIVP. Finally she encouraged participants to celebrate the capacity that had been built through what was called the ‘Saitama NCD capacity-building model’.

Dr Jeffrey Koplan, Vice-President for Global Health and Director, Emory Global Health Institute, Emory University, United States of America, challenged the notion that behaviour change is impossible by asking people to raise their hands if they had quit smoking or had a diet that was different from that of their parents. Many had. He noted the major shifts in the physical and cultural environment as regards smoking to

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**PROCEEDINGS**

<table>
<thead>
<tr>
<th>Day</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 – 3</td>
<td>5th Japan WHO International Visitors Programme</td>
</tr>
<tr>
<td>Day 4 – 5</td>
<td>Regional Meeting on NCD prevention and control</td>
</tr>
</tbody>
</table>
further illustrate his point. He went on to say that, when we think of global health, we need to include NCD because demographical and epidemiological transitions have made chronic diseases the leading causes of death. Deaths from NCD will continue to increase unless interventions are made in a comprehensive manner through community health promotion, school-based programmes, legislation and other strategies. To succeed, willpower, perseverance and patience are needed.

Where are we now? (Sessions 1–2)

In these sessions, participants considered their expectations for the meeting and mapped out the position of their countries in relation to the Regional Action Plan (RAP).

<table>
<thead>
<tr>
<th>RAP objective</th>
<th>Action area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To raise the priority accorded to noncommunicable diseases in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments.</td>
<td>ADVOCACY</td>
</tr>
<tr>
<td>2. To establish and strengthen national policies and plans for the prevention and control of noncommunicable diseases.</td>
<td>NATIONAL NCD POLICIES AND PLANS</td>
</tr>
<tr>
<td>3. To promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol.</td>
<td>POPULATION-BASED LIFESTYLE INTERVENTIONS</td>
</tr>
<tr>
<td>4. To promote research for the prevention and control of noncommunicable diseases</td>
<td>RESEARCH</td>
</tr>
<tr>
<td>5. To promote partnerships for the prevention and control of noncommunicable diseases.</td>
<td>PARTNERSHIPS</td>
</tr>
<tr>
<td>6. To monitor noncommunicable diseases and their determinants and evaluate progress at the national, regional and global levels</td>
<td>MONITORING AND EVALUATION</td>
</tr>
</tbody>
</table>

Participant countries are at various stages in their readiness to act on NCD prevention and control. However, there is acknowledgement in all countries that there is much to be done, that it is possible to learn from other countries and that capacity-building is the key to progress.

In session 2, countries plotted high and low points in NCD prevention and control since 2005, when the first JWIVP was held. Policy implementation was frequently mentioned as a high point. For example, Tonga and Samoa mentioned the introduction of their tobacco control acts in 2004 and 2008, respectively. Low-point themes included health reforms and other factors that have negatively affected NCD capacity, and lack of government support. For example, Cambodia mentioned their poor research laboratory capacity. Significant global and regional high points were noted in the release of the global and regional NCD action plans.

Getting a handle on political support and programme capacity for NCD prevention and control (sessions 3–5)

Two factors profoundly influence a country’s ability to take action on the RAP objectives: political support and programme capacity. As part of session 3, participants were invited to use a progress-assessment grid to determine where their programmes are in relation to political support and programme capacity. A summary of their findings is presented in Figure 1.
Ideally, all objectives would have strong political support and strong programme capacity, putting them in the upper right-hand quadrant. As can be seen from Figure 1, in many countries, this is the case as regards advocacy, policy and population interventions. Monitoring and evaluation, on the other hand, was frequently described as having weak political support and programme capacity. Programme capacity is also weak for research in most countries, although in some it has strong political support.

Overall political support and programme capacity were further quantified for each country in session 4 on a scale of 0 to 4, where 0 indicates no political support (no existing policies) or programme capacity (no programme objectives) and 4 indicates strong political support (with established policies and good engagement of multisectoral stakeholders and/or high profile champions or strong programme capacity (with established programme objectives fully implemented by a programme unit/department with sufficient material and financial resources. A summary is provided in Figure 2.
The spidergram indicates that, on average, there is moderate political support and programme capacity for most of the objectives. For policy and monitoring and evaluation, there is more political support than for programme capacity, suggesting that the biggest gains may be made by improving programme capacity in these areas. For research and partnerships, programme capacity is stronger than political support, suggesting that effort should be put into garnering political support in these areas. All areas, however, would benefit from boosts in capacity and political support.

To complete workshop activities on day 1, participants were invited to vote for their top three areas where action was most needed. The overall results are summarized in Table 2.

**TABLE 2:** Areas where action is most needed in the next two years

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>Policy</th>
<th>Population interventions</th>
<th>Research</th>
<th>Partnerships</th>
<th>Monitoring and evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>11</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

The key areas were identified as policy, population interventions and monitoring and evaluation and it was agreed that, for day 2 of the workshop, Cambodia, the Lao People’s Democratic Republic and Viet Nam would progress work on Policy; the Pacific island countries would progress work on Population interventions; and China, Malaysia, Mongolia and the Philippines would progress work on Monitoring and evaluation.

**Summary and output of day 1**

The planned output of an overview of country progress and assessment of political support and programme capacity in relation to the NCD RAP, and development of a list of priority action areas was achieved. At the end of day 1, each country could point to three or four areas for action to improve NCD prevention and control and explain why they were considered priorities. Collectively, this information is also useful for development agencies to identify what areas require most support across the Region.

In the process, there was healthy discussion over whom the priorities were for and why a set of agreed regional objectives needed prioritization. It was noted that (1) the training was primarily designed to
help countries come up with a list of practical actions that could be taken to help them move towards the comprehensive approach to NCD prevention and control outlined in the RAP; (2) as a train-the-trainer meeting, most of the concrete actions would be developed in-country; and (3) while the priorities provide a useful guide for directing support across the Region, all six regional action plan objectives are important and the exercise simply identified an achievable starting point.

**Day 2**

The objective for day 2 was for participants, using the information from day 1, to identify barriers and countermeasures to progress in achieving the goals of the RAP and to select strategies for progressing an integrated approach to NCD prevention and control.

**Integrated approaches to NCD prevention and control**

Day 2 got underway with presentations by Dr Cherian Varghese, Technical Officer, Noncommunicable Diseases, WHO Regional Office for the Western Pacific, and Dr Pekka Jousilahti, Secretary-General, National Institute for Health and Welfare, Finland, on strengthening health systems for integrated approaches to NCD and on the North Karelia project in Finland—an example of an integrated NCD programme. In the discussion following the health systems presentation, the importance of a strong and well-functioning health system for managing NCD was emphasized. Unlike those with communicable diseases, those with NCD need care for the remainder of their lives and therefore that care needs to be very patient-centred (considering all aspects of the patient's health—spiritual, emotional, physical—as well as the needs of family members or carers) and health promotion needs to be integrated into every aspect of care. Participants were impressed with the information that quality evaluation and monitoring had yielded in the North Karelia programme and they noted that, in the early years of the project, it was local integrated action that had snowballed into the lower Coronary Heart Disease (CHD) risk factors and mortality now seen throughout Finland.

**Success stories and emerging good practice**

Participants became presenters in this session, which focused on real life examples of integrated NCD programmes in a variety of settings: the Healthy City of Marikina, the Philippines; the Healthy Island of Fiji; the Healthy Province of Changchun and the Healthy City of Shanghai, China; and a Healthy Community called ‘Proactive’ in Malaysia. The Marikina programme demonstrates all components of the regional action plan (advocacy, policy, population interventions, partnerships, monitoring and evaluation, research) and has seen a significant increase in investment as a result of the Healthy Cities initiative.

Fiji conceptualized the Healthy Islands approach to health promotion in 1995 and a strong partnership has evolved between the Health Ministry and the Regional Development Ministry that allows them to achieve both health and community development goals. Co-funding arrangements are even being worked out. A key to engaging other stakeholders (e.g. schools) in the Healthy Islands initiative has been engaging them early and aligning health objectives with stakeholder objectives.

The Changchun and Shanghai programmes both have ambitious health goals and have been effective because of a strong and well connected government structure. They also demonstrate the value of good planning and clear identification of roles and responsibilities.
Malaysia has a growing diabetes problem. In 2006, diabetes prevalence was 15%, with a newly diagnosed prevalence rate of 5.4%. “Proactive” was initiated by a local clinic and is a community mobilization programme for weight management. With no additional resources and using dietitians to provide lifestyle advice and support and weight loss competitions, the clinic has succeeded in helping participants to lose weight.

These real-life examples provided both motivation and information for action on NCD prevention and control in a variety of settings. There is a need, however, for good impact evaluation to assess sustainability (can the programme produce long-term health benefits?) and reach (can it be transferred to another location?).

Identifying and understanding barriers to progress and countering them.

Participants worked in groups to identify and understand barriers to progress and to come up with practical solutions. The groups were as follows:

- **Group 1**: Pacific island countries (Population interventions)
- **Group 2**: China, Malaysia, Mongolia and the Philippines (Monitoring and evaluation)
- **Group 3**: Cambodia, the Lao People’s Democratic Republic and Viet Nam (Policy)

The outcome of a series of identification, voting and analysis processes was the identification and prioritization of a barrier to each of the areas of focus, three causes underlying those barriers and countermeasures for these causes and, finally, some practical steps for implementing the countermeasures. Tables 3 to 5 summarize the outcome.

**TABLE 3: Practical steps for advancing action on population interventions**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Causes</th>
<th>Counter measures</th>
<th>Practical step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak political support and leadership</td>
<td>Lack of training</td>
<td>Organize training (programmes, courses, etc)</td>
<td>Online training qualification</td>
</tr>
<tr>
<td></td>
<td>No planning</td>
<td>Include monitoring and evaluation in planning framework</td>
<td>Short-term training locally</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Short-term training overseas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Short-term attachments overseas</td>
</tr>
<tr>
<td></td>
<td>Lack of creativity to advocate</td>
<td>Ability to advocate creatively</td>
<td>Develop monitoring and evaluation (with training) template</td>
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<td></td>
<td></td>
<td></td>
<td>M&amp;E training (local)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>M&amp;E training (overseas)</td>
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<td></td>
<td></td>
<td></td>
<td>Parliamentary champions</td>
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<td></td>
<td></td>
<td></td>
<td>Increasing partnerships with other stakeholders (media, NGOs, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Train CEOs / Permanent secretaries in advocacy</td>
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<td></td>
<td></td>
<td></td>
<td>Hire advocacy specialist</td>
</tr>
</tbody>
</table>

Online training was considered particularly attractive in the Pacific because, in most countries, this could be done in English and a Pacific online network is already in place. Online training also helps people avoid the costs associated with the travel that is often required for other types of training course.
TABLE 4: Practical steps for advancing action on monitoring and evaluation

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Causes</th>
<th>Counter measures</th>
<th>Practical step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of feasible, sustained, timely M&amp;E in NCD</td>
<td>No framework for NCD</td>
<td>Develop framework for NCD M&amp;E</td>
<td>WHO to organize research workshop</td>
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<td></td>
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<td></td>
<td>WHO to develop initial draft of framework</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Hire a consultant to do the framework</td>
</tr>
<tr>
<td></td>
<td>No well established indicators</td>
<td>Establish well developed indicators for NCD</td>
<td>Consultative workshops</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Adapt existing ones from other regions</td>
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<tr>
<td></td>
<td>No human resource capacity</td>
<td>Develop a training programme for capacity-building</td>
<td>Develop training modules</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Develop online course</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WHO to do capacity-building for countries</td>
</tr>
</tbody>
</table>

It was noted in the discussion of practical steps for taking action on monitoring and evaluation that, in addition to WHO, a number of other agencies may be able to provide training support including NIPH, the Secretariat of the Pacific Community (SPC), the Australian Agency for International Development (AusAID), the New Zealand Agency for International Development (NZAid) and the World Bank.

TABLE 5: Practical steps for advancing action on policy

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Causes</th>
<th>Counter measures</th>
<th>Practical step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of political awareness</td>
<td>No NCD surveillance systems</td>
<td>Developing surveillance system</td>
<td>Strengthen existing system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Develop new registries</td>
</tr>
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<td></td>
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<td></td>
<td>STEPs</td>
</tr>
<tr>
<td></td>
<td>No internal pressure</td>
<td>Advocacy for partnership/ international support</td>
<td>Use Technical Working Group meeting</td>
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<td></td>
<td></td>
<td></td>
<td>Show successful case studies</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Raise the issue in international meetings (RCM / WHA / National Forum for NCD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High-level political meeting</td>
</tr>
<tr>
<td></td>
<td>No training specifically in policy advocacy</td>
<td>Training on policy advocacy</td>
<td>Training abroad</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>External TA</td>
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<td></td>
<td></td>
<td></td>
<td>Local TA</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Standard materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In-service training</td>
</tr>
</tbody>
</table>

Participants from Cambodia and the Lao People’s Democratic Republic mentioned that their countries are in the very early stages of taking action on NCD and therefore saw value in external training because other countries in the Region have experience from which they can learn. It was noted that WHO may be able to facilitate this type of mentorship arrangement. They also noted that, in their countries, international organizations hold significant sway with ministers and they should therefore highlight the need for action on NCD in their interactions with government.
Summary and output of day 2

By the end of day 2, participants had produced a set of practical and specific actions to advance the priority areas of population interventions, policy and monitoring and evaluation, thus achieving the expected output.

Taking these actions should help countries to achieve stronger political support for NCD policies as well as programme interventions and monitoring and evaluation. They should also help improve capacity-building in policy and advocacy as well as in the specific areas of economic analysis (cost-effectiveness) and programme planning. The process of arriving at these actions reminded participants of the interrelated nature of the six objectives. Often a problem in one area (e.g. improved advocacy) can be overcome by strengthening another (e.g. a good monitoring and evaluation system to provide the data to use for advocacy).

Day 3

The objective of Day 3 was for participants to consider how best to use advocacy, surveillance and information exchange in achieving the goals of the RAP at national and regional levels.

Marketing of foods and non-alcoholic beverages to children

Capacity-building in advocacy was one of the underlying aims of the Saitama meeting and the timing of the meeting coincided with a request from WHO for Member States to comment on a working document on the marketing of food and non-alcoholic beverages to children. The working document outlines policy options, specifications and processes that countries could use to reduce marketing to children. Mr Godfrey Xuereb, Technical Officer, Department of Chronic Disease and Health Promotion, WHO Headquarters introduced the document, explaining its history, context and purpose, and invited comments from participants. From the discussion, it became clear that a variety of marketing techniques are being used by the food industry in Member States. Given the effectiveness of food marketing, the question of how health promoters can be just as effective in their messages was raised? There was consensus that powerful messaging is possible on low budgets because health promoters are close to their target markets and understand their needs and wants well. The end of the consultation period for Member States is August 2009 and global dialogues have been organized for late August with NGOs and the private sector.

Monitoring and surveillance

In addition to encouraging participants to monitor NCD morbidity, mortality and risk factors, Dr Varghese introduced the session by encouraging participants to monitor prevention and control efforts. He emphasized the importance of repeated surveys so that trends and impacts can be assessed, giving the example of smoking rates and CVD deaths in the United States of America.

Participants then went into working groups to identify indicators to gauge progress in achieving the objectives of the RAP. Group one focused on population interventions and advocacy, group two on monitoring and evaluation, as well as research, and group three on policy and partnerships. A summary of the indicators proposed and selected priority indicators is shown in Table 6.
### TABLE 6: Summary of indicators to gauge progress in achieving RAP objectives

<table>
<thead>
<tr>
<th>Action area in NCD RAP</th>
<th>Indicators proposed by sub-group</th>
<th>Selected priority indicator</th>
</tr>
</thead>
</table>
| Advocacy               | 1. Number of sector policies with NCD components  
                           2. Appointed national NCD coordinator  
                           3. Multisectoral national NCD coordinating committee | Number of sector(s) policies with NCD components |
| National NCD policies and plans | 1. Integrated NCD policy  
                                2. Policy development agency  
                                3. Guidelines for implementation | Integrated NCD policy |
| Population-based lifestyle interventions | 1. Number of healthy lifestyle settings in-country  
                                     2. National NCD plan is integrative and multisectoral  
                                     3. Approved NCD activities are resourced and supported | Number of healthy lifestyle settings in-country |
| Research               | 1. Number of national and international NCD reports  
                                2. Number of evidence-based NCD research grants  
                                3. Number of evidence-based policies and strategies | Number of national and international NCD reports |
| Partnerships           | 1. Interministerial working group  
                                2. Mechanism for partnership  
                                3. Public-private-government alliances | Interministerial working group |
| Monitoring and evaluation | 1. Country M&E plan developed, institutionalized in the health system and implemented  
                                2. Regularity of surveys, including STEPs  
                                3. Human resource capacity for M&E | Country M&E plan developed, institutionalized in the health system and implemented (policy, funds, people, system) |

The priority measure identified for advocacy was the number of sectoral policies with NCD components. This would clearly indicate that advocacy aimed at other sectors has been successful. The presence of an integrated NCD policy was considered the best indicator of NCD policies and plans. At the national level, the number (and quality) of healthy settings was the priority indicator identified for measuring population interventions and the number of national and international research reports as an indicator of NCD research. The establishment of an interministerial working group was considered a primary indicator of successful partnership. A staged indicator marked by the development, institutionalization and implementation of a monitoring and evaluation plan was selected for monitoring and evaluation.

It was noted that selecting indicators is not a simple process. There are many questions that need to be addressed: What should we measure? Are we interested in quality, quantity or both? Where should the measurements be done (regional, national, within nation, province)? And, critically, what do we mean by success? It was noted that success or progress in the Pacific was getting politicians to talk about NCD, but this might not be considered success at a global level. In response to this, the point was made that it is the reality on the ground that counts and countries and agencies should be oriented towards that.
**Reflections on workshop tools and recommendations for future capacity-building strategies in the Region.**

As the workshop had a train-the-trainer focus, this session provided participants with the opportunity to reflect on the workshop and the tools (the Saitama model of capacity-building) used to provide recommendations for future capacity-building strategies in the Region. Overall, participants found the workshop and the tools valuable and at least two of the countries represented (China and Mongolia) had plans to use the Saitama model for national and provincial meetings.

**Agreement on the content of presentations to senior policy-makers on day 4 of the meeting and the path forward for NCD prevention and control.**

At the end of this session, participants agreed that the first steps towards implementation of the RAP required:

1. integrated approaches through healthy settings and health systems strengthening;
2. attention being given to monitoring and evaluation (initiated by WHO);
3. application of the Saitama NCD capacity-building model at national and subnational levels.

**Summary and output of day 3**

The goal of day 3 was to develop recommendations on: (1) core indicators for monitoring progress in achieving RAP objectives; and, (2) strategies and tools for future NCD capacity-building; as well as (3) to identify key strategic actions for NCD prevention and control.

Table 6 summarizes the output for (1) and a process has been put in place to refine the Saitama model (workshop and tools) for future NCD capacity-building. Finally three presentations were prepared that identified key strategic actions for NCD prevention and control in the areas of policy, population-based interventions and monitoring and evaluation.
Akasaka, Tokyo was the venue for days 4 and 5 of the meeting. As well as the change of venue, the number of participants increased to include senior policy-makers from the countries represented at the meeting and special guests, including Dr Shin Young-soo, WHO Regional Director for the Western Pacific, and Sir George Alleyne, United Nations Secretary General’s Special Envoy for HIV/AIDS in the Caribbean and Director Emeritus of the WHO Regional Office for the Americas. The goal at the end of day 4 was for participants to have become acquainted with progress, opportunities and challenges within countries and the Region for achieving progress in NCD prevention and control.

Opening

Dr Milan, Director, Office of the Regional Director, WHO Western Pacific Regional Office, welcomed the second part of the meeting by elaborating on her themes of appreciation, evaluation and celebration introduced on day one, and added elevation. Given the presence of senior policy-makers from the countries represented, she called on participants to elevate the importance of acting quickly and agreeing on how to best scale up action on the RAP.

Dr Shinozaki, President Emeritus of National Institute of Public Health, then outlined his country’s commitment to NCD prevention and control by highlighting Health Japan 21, an initiative that aims to create “a society in which everyone is able to lead a healthy and happy life” and to address cancer, cardiovascular disease (CVD) and stroke, which are Japan’s leading causes of death. The nine goals of the initiative focus on nutrition, physical activity, mental health, tobacco, alcohol, dental health, diabetes, CVD and cancer. He described the JWIVP as a platform for increasing capacity and leadership and expressed his hope that the meeting could establish a mechanism for ongoing dialogue and review and would mobilize the commitment of policy-makers to action on NCD prevention and control plans.

Professor Mohammed Hassar, an executive member of the International Association of Public Health Institutes (IANPHI) then took the opportunity to describe the roles and functions of IANPHI.

Dr Masato Mugitani, Ministry of Health, Labour and Welfare, Japan, reiterated the message that NCD are a major issue in Japan and developing nations and need urgent attention.

Dr Shin Yong-soo, WHO Regional Director for the Western Pacific Region, delivered the opening address. Dr Shin said that the JWIVP had served as a learning laboratory for countries throughout the Region and that its 67 graduates had played a leading role in addressing NCDs. He saw NCD as a critical health and development priority, accounting for over 90% of DALYS and 60% of DALYS in developed and developing countries, respectively. Moreover, more than half of NCD-related deaths occur in those under 70 years of age. Every one of the major risk factors for NCD is preventable, but levels of NCD remain unacceptably high. There is a need to address unhealthy behaviours that are not necessarily the result of a lack of education, but because of unhealthy environments. He offered the RAP as a comprehensive blueprint for progress in NCD prevention and control.
prevention and control. He challenged participants to be creative in their recommendations at the end of the meeting and encouraged them to draw on examples of good practice, such as healthy settings and the capacity-building process used for the JWIVP.

Participants were then treated to a presentation by the keynote speaker, Sir George Alleyne, United Nations Secretary-General's Special Envoy on HIV/AIDS in the Caribbean and Director Emeritus of the WHO Regional Office for the Americas. He spoke of the challenges of NCD prevention and control and then on overcoming those challenges. While most would be familiar with figures on NCD prevalence, Sir George went over the data to remind participants how many people are suffering and dying and to ask why the world seems so inattentive? He argued that due recognition would come with a mention of NCDs in the Millennium Development Goals (#6) and outlined a plan for getting it on the agenda of high-level meetings, such as the Commonwealth Heads of Government Meeting (CHOGM). To overcome the challenges of NCD, there is a need for committed and effective leaders—leaders with vision, values and vigour.

Appointment of Chairperson and Co-Chairperson

Ms Justina Langidrik from the Marshall Islands was elected Chairperson and Dr Khurelbaatar Nyamdavaa, State Secretary, Ministry of Health, Mongolia, was elected Co-Chairperson.

Global and regional action plans and their implementation

Dr Fiona Adshead, Director, Department of Chronic Disease and Health Promotion, WHO Headquarters, reviewed the content of the Global Strategy for the Prevention and Control of Noncommunicable and provided strategic guidance on implementation, noting that the World Economic Forum is now predicting NCDs will have a high negative impact on economic production and suggesting this type of information should be used for advocacy. She highlighted the need to act on prevention and the need to do this from a settings approach, the importance of linking chronic diseases to development and social determinants of health, to assessing risk and acting in primary care (linking communicable and noncommunicable programmes). Action on salt and tobacco is very cost-effective and she mentioned regional plans for an emerging network on salt in South-East Asia.

Dr Annette David then spoke to how the regional plan integrated with the global plan and reviewed the first three days of the meeting to describe how participants had arrived at policy, population-based interventions and monitoring and evaluation as the areas identified for first steps in scaling up NCD prevention and control.

Representatives of the groups that had discussed these issues in the previous three days then gave presentations to the senior policy-makers on why they thought the areas of policy, population interventions and monitoring and evaluation should be acted on first and outlined practical actions that could be taken.

Feedback from senior policy-makers and technical advisors

Feedback was very appreciative of the work that had occurred over the previous three days and the capacity-building that had occurred through the JWIVP over five years. Discussion revolved around the importance of creating an environment that is conducive to healthy behaviours and this was summarized by the Chairperson, who said that healthy choices need to be easy choices.
Summary and output of day 4

By the end of Day 4, participants were acquainted with progress, opportunities and challenges within countries and the Region for achieving progress in NCD prevention and control. They had also discussed and considered first steps for RAP implementation.

Day 5

The final day of the conference aimed to draw the previous days together into concrete recommendations on how best to ensure implementation of the RAP at the national and regional levels within the near future and ensure a mechanism for monitoring progress and exchanging lessons learnt within the Region.

Emerging best practice in the Region

In this session, recent experiences and efforts in NCD prevention and control from Australia, Japan, the Republic of Korea and New Zealand were described. Clearly, developed and developing countries in the Region have the burden of NCD in common and, while lessons may be learnt from developed countries’ experiences, everyone is looking for strategies that work and can be sustained. A theme in the presentations was the value of monitoring and evaluation. All four presenters showed trends in NCD prevalence and risk factors and had developed interventions based on that information. The presenter from New Zealand described an operational surveillance programme that was successful because health centres were being given additional reimbursement where risk-factor assessment was done in patients most likely to be at risk (such as Pacific and Maori patients). Also, all saw the value of partnerships, but described challenges in establishing and maintaining them for coordinated action.

Development of key recommendations

Concurrent working group sessions were conducted to develop key recommendations for actions at the regional and national level to drive progress in NCD prevention and control within the next two years (2010–2012). Participants then came together in two plenary sessions, one to reach agreement on the wording of the recommendations and the others to finalize them. Both sessions were facilitated by Sir George Alleyne.

Meeting conclusion

Sir George Alleyne captured the sentiment at the end of the second part of the meeting by describing it as the end of a perfect two days. Perfect in terms of enthusiasm, quality and outcome. The feeling was that there is now a shared vision of what can and should be done and that this should be taken back to countries. Participants should, in the words of Sir George “be the drum majors”.

Output of day 5

The output for day 5 was a set of recommendations on advancing the goals of the NCD RAP within the next two years. These have been brought together as the “Saitama Call for Action”.
RECOMMENDATIONS

Saitama Call To Action

The participants of the Regional Meeting on NCD Prevention and Control, organized by the National Institute of Public Health of Japan and the WHO Western Pacific Regional Office, with support from the Government of Japan, have identified NCD policies, population interventions and monitoring and evaluation as the priority areas for advancing the implementation of the Western Pacific Regional Action Plan for Noncommunicable Diseases.

Member States and WHO are urged to:

- support the establishment of national priority areas in NCD prevention and control;
- develop and scale up integrated comprehensive policies and approaches to NCD prevention and control;
- strengthen health systems for NCD prevention and control through primary health care, and explore links with communicable diseases to leverage resources;
- build on healthy settings, such as Healthy Cities and Healthy Islands;
- build and strengthen regional and national capacity-building for NCD prevention and control, give consideration to using the participatory, tools-based learning course that has evolved over the five years of the Japan WHO International Visitors Programme as an option;
- jointly develop an evaluation framework to monitor progress in achieving the objectives of the Western Pacific Regional Action Plan for Noncommunicable Diseases NCD;
- foster national, subregional and regional multisectoral partnerships to address and advance NCD prevention and control; and
- identify a national mechanism to coordinate NCD prevention and control.

The following are identified as “first steps” towards implementation of the Western Pacific Regional Action Plan for Noncommunicable Diseases.

NCD Policy:

- Strengthen and reorient national health systems to promote NCD surveillance and research to enhance the evidence for policy.
- Build capacity for NCD policy development, advocacy and resource mobilization.
- Advocate to international and national partners to prioritize and act on NCD prevention and control.
- For WHO: Support Member States and partners to prioritize NCD prevention and control and provide
guidance in the development of appropriate policies.
Annexure

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Building Capacity for NCD Prevention and Control

REPORT: REGIONAL MEETING ON PREVENTION AND CONTROL OF NCD

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Noncommunicable diseases are a critical health and development issue for the Western Pacific Region. A key component to realizing progress in NCD within the Region is sufficient capacity at the national level to implement effective strategies for NCD prevention and control. The JWIVP anticipated this and provided an effective regional mechanism to strengthen capacity and build leadership for NCD.

The course evolved and improved over the years, and served as a complementary mechanism linked to the achievement of the WHO global NCD goal through concrete applications of lessons and skills learned, with implementation of action plans expected upon return of the participants to their countries. Over time, the course content changed from a predominantly technical set of topic areas to a more practical mix that included advocacy, networking and health systems, indicative of the shift towards a more integrative model, consistent with the move from vertical towards horizontal approaches in NCD prevention and control. During the last JWIVP, the importance of policy interventions and of linking national actions to the WHO Regional Action Plan on NCD prevention and control were highlighted.

Participant selection was effective, as overall, 76% of participants were national-level public health professionals, and 29% of all participants were senior-level officials. Senior-level national public health officers hold the greatest potential for influencing NCD policy and programmes within countries.

Two independent evaluation mechanisms—(1) the JWIVP evaluation survey conducted annually from 2006–2009 and (2) Ms Machiyama’s evaluation questionnaires in 2007—indicated high overall participant satisfaction with the programme. In general, participant feedback on the appropriateness and usefulness of each of the 4 educational approaches used was highly favorable, with positive feedback increasing over time. This indicates that while course delivery was good to begin with, further improvements occurred with each succeeding year. Majority of participants judged the mix of theory and practice to be appropriate for both years when this indicator was assessed.

All participants in both years attributed an increase in their interest and knowledge of NCD prevention and control to their attendance at the JWIVP. All participants also perceived the course to have contributed to increasing their capacity as NCD programme managers. In line with these findings, all participants also agreed that the JWIVP met their expectations, with the proportion of participants who strongly agreed with the statement rising from 32% in 2007 to 54% in 2008.

Over 80% of the respondents reported making positive changes both in their personal life and in their approaches to NCD work after attending the JWIVP. These self-reported changes in personal and work-related behaviours were corroborated by the supervisors; over 90% of supervisors agreed that they observed the positive changes in the programme participants, and believed that these changes could be attributed to attendance at the JWIVP.
Nearly all (97%) of the respondents stated that they had made contributions that resulted in organizational and/or national progress in NCD. Because the information is self-reported, caution is required in interpreting the results. However, corroboration is provided by the respondents’ supervisors, of which 72% reported that they observed changes in their unit/organization as a result of their staff members’ participation at the JWIVP. All of the supervisors who responded to the survey indicated that they would willingly send another staff member to future iterations of the JWIVP.

Suggestions made by participants to further strengthen the JWIVP in the future clustered around two thematic areas:

1. Greater involvement of representatives of other sectors, and addressing the relationship of public health to other sectors in the discussions – Participants clearly recognized the multi-sectoral nature of NCD work, and indicated that the course could be strengthened by broadening discussions to cover the role of other sectors and expanding the faculty to include individuals representing other sectors, such as trade and the private sector.

2. More time allotted to interactive sessions, particularly cross-country sharing of experiences – Numerous participants affirmed the value of learning from each other during interactive sessions, not just of success but also of failures and lessons learned, and expressed the desire to see more of these types of discussions in future versions of the JWIVP. Participants also recognized the value of maintaining relationships with other participants as an informal network for NCD support.

Clearly, the JWIVP fulfilled its function of facilitating capacity enhancement for NCD prevention and control among a key set of influential national and subnational programme managers. Given the increasing burden of NCD in the Western Pacific, and in light of the recent endorsement of the Global and Regional NCD Plans of Action, the following recommendations are made:

- Consider ongoing and expanded support to sustain NCD regional capacity building, with an emphasis on promoting cost-effective, evidence-based, integrated approaches to NCD prevention and control, building on existing regional initiatives such as Healthy Settings, Healthy Cities and Healthy Islands, and consistent with the stated objectives and strategies outlined in the Global and Regional NCD Plans of Action.

- Explore how to utilize this regional mechanism to foster the development of a systematic strategy to monitor and assess Member States’ progress in achieving the goals and objectives of the Global and Regional NCD Plans of Action.

- Examine the utility of adapting this capacity building model for national and subnational NCD capacity enhancement activities, and implement suitably adapted versions to expand the NCD workforce within countries.
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Noncommunicable diseases (NCD) represent a critical challenge to public health and development in the Western Pacific.

Estimates indicate that over three-fourths of deaths in the region are attributable to NCD, compared to 14% of deaths caused by communicable diseases.\(^1\) Currently, about 26,500 people die every day from noncommunicable diseases in the Region, with over 20,000 of these deaths occurring in the Region’s developing countries.\(^2\) Noncommunicable diseases, notably heart problems, cancer, stroke and chronic obstructive pulmonary diseases (COPD), account for almost 8 out of every 10 deaths in the Western Pacific Region\(^3\).

Moreover, NCD represent 92% of the burden of disease in disability-adjusted life years (DALYs) in Western Pacific Region-A nations (WPR-A: Australia, Brunei Darussalam, Japan, New Zealand, Singapore) and approximately 63% in Western Pacific Region-B nations (WPR-B: Cambodia, China, Cook Islands, Fiji, Kiribati, the Lao People’s Democratic Republic, Malaysia, Marshall Islands, Micronesia, Mongolia, Nauru, Niue, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.). Moreover, WPR-B nations have more than a quarter of the global total burden of disease in DALYs for malignant neoplasms, and close to a third of the global total in respiratory disorders. WPR-B nations also have a fifth of the global total burden of disease in DALYs for diabetes and cardiovascular disease.\(^4\)

Globalization and urbanization serve as conduits for the promotion of unhealthy lifestyles (e.g. tobacco and alcohol use, unhealthy diets, and physical inactivity) and environmental changes (e.g. indoor and outdoor air pollution) that underlie noncommunicable diseases. Ironically, every one of the risk factors for NCD, with the exception of age and heredity, is preventable. In addition, the evidence base for effective interventions is growing. Yet, the prevalence of these risk factors in the Western Pacific Region remains unacceptably high, and, in many countries, continues to increase.

The health care costs related to noncommunicable diseases are significant. On top of the direct health care costs, the economic impact of early death and disability, and lost productivity due to noncommunicable diseases contribute to the Region’s burden of poverty, can retard national development and can further widen the health inequities within and across countries.

At the global level, WHO Member States adopted a global strategy in 2000 for the prevention and control of noncommunicable diseases during the Fifty-third World Health Assembly. The Global Strategy on Diet, Physical Activity and Health was endorsed in 2002. In 2003, the WHO Framework Convention on Tobacco Control, developed from 1999 to 2003, was ready for signature by Member States. The treaty came into force

At the regional level, Regional Committee resolutions WPR/RC51.R5 (2000) and WPR/RC57.R4 (2006) called for action to combat noncommunicable diseases and their related risk factors. Various related regional action plans were developed over the past decade, sharing a focus on policy and planning, surveillance, health promotion and clinical prevention. At the request of the Pacific Ministers of Health in their meeting in Vanuatu, March 2007, WHO developed the Pacific Framework for the Prevention and Control of Noncommunicable Diseases to guide Pacific island countries and areas in addressing noncommunicable diseases. Subsequently, the Regional Office for the Western Pacific pursued the development of an expanded strategy document to include all Western Pacific Member States and areas. In the meantime, WHO Member States endorsed the global NCD action plan at the Sixty-first World Health Assembly in May 2008. The expanded regional strategy was further revised into a regional action plan to operationalize the global action plan within the Western Pacific context. The Fifty-ninth Regional Committee endorsed this regional action plan in September 2008, and it currently serves as the regional template to guide the efforts of Western Pacific Member States and Areas for NCD prevention and control.

A key component to realizing progress in NCD within the Region is sufficient capacity at the national level to implement effective strategies for NCD prevention and control. Anticipating this, the Government of Japan and WHO jointly developed the first International Visitors Programme (JWIVP) on NCD Prevention and Control in 2005 as a means to strengthen capacity and build leadership for NCD. There have been five such programmes conducted annually from 2005–2009. This report contains the results of a systematic review of the conduct, impact and outcomes of the JWIVP.

The experiences and the results arising from this NCD capacity building partnership effort of the Government of Japan and WHO is unique, and could be potentially relevant to other programme areas in public health. Thus, this review has value both as a retrospective assessment of the utility of this approach to NCD capacity building and as a prospective guide for similar collaborative undertakings in support of a broader health agenda.
Objectives

This review was conceptualized as a way to objectively assess the conduct, impact and outcomes arising from the JWIVP. The specific objectives include:

1. To systematically review the evolution of the JWIVP from its inception in 2005 up until 2009 by going over and analyzing all relevant project documentation;
2. To critically assess the various feedback from course participants and apply these to evaluate the value of the JWIVP in building NCD capacity and leadership; and,
3. To use the information derived above in formulating recommendations for future NCD capacity building efforts for the Region.

Participants at the 1st JWIVP, 4–9 April 2005, Saitama, Japan
Methodology

A desk review of the four JWIVP sessions from 2005–2008 was carried out by Dr Annette David which was augmented with additional observations following the 2009 JWIVP.

From 2006 to 2008, all participants completed a post-programme evaluation instrument, with responses entered into an electronic database. The summary results of this evaluation exercise were made available for the review (although the actual databases were unavailable). In addition, in 2007, WHO commissioned an evaluation report from Dr Kazuyo Machiyama, who served as a Short-term Professional under the NCD programme at WHO’s Office for the Western Pacific. Ms Machiyama developed a survey instrument that was sent to previous course participants. The survey included both process and outcome indicators. The responses to the survey were likewise reviewed, and incorporated into the overall analysis. A post-programme evaluation was also conducted in 2009, but the evaluation instrument was different from that used in 2006–2008. The final results of this evaluation were likewise included in the review.

The review process attempted to include both formative (process) and summative (outcome) assessments, based on the materials made available for the desk review. The formative evaluation looked at the implementation of the program and identified its strengths and potential areas for improvement. The summative evaluation was intended to assess the extent to which participants reportedly introduced changes in their own NCD programmes and increased the likelihood of enhancing national support for interventions (both policies and programmes) to prevent and control NCD as a result of their attendance at the JWIVP.

As a desk review, the information utilized for the analysis and recommendations was limited to programme documentation which was available to the consultant. Thus, information that was not documented, or unavailable for review, would have been missed. Additionally, the post-programme JWIVP evaluation instruments and evaluation survey conducted by Ms Machiyama contained voluntarily reported feedback from the participants, and are subject to all of the biases of self-reported information.

A key component to realizing progress in NCD within the Region is sufficient capacity at the national level to implement effective strategies for NCD prevention and control.
Limitations

The evaluation survey had a relatively low response rate, especially at the supervisors’ level. Respondents may have been more likely to view the JWIVP programme positively; this needs to be considered when reviewing the survey results.

Because of the magnitude of NCD work, many external variables exert considerable impact on countries’ progress or lack thereof in preventing and controlling NCD. Political, socio-cultural and economic factors and multiple stakeholders, including multilateral and bilateral donors and technical assistance partners, all interact to determine the effectiveness and extent of countries’ NCD efforts and can readily overshadow the influence of participation at the JWIVP. Thus, while it is possible to make conjectures about the potential contribution of the JWIVP on national capacity building and leadership for NCD, it may not be as easy to determine the actual extent of its impact on national NCD efforts.
Results

Evolution of the JWIVP

The Japan-WHO International Visitors Programme on Noncommunicable Disease Prevention and Control (JWIVP) arose as a collaborative capacity building initiative of the Ministry of Health, Labour and Welfare (MHLW) of Japan, the Japanese National Institute of Public Health (NIPH) and the WHO Regional Office for the Western Pacific (WHO-WPRO). The first JWIVP was held in 2005 at the NIPH campus in Saitama, Japan. This was followed by four successive annual programmes, also held in Saitama, Japan, spanning the years 2006–2009.

Participant Profile

From 2005 to 2009, a total of 86 participants from 14 WPR Member States attended the JWIVP. (Note: This excludes Secretariat members comprised of WHO country and regional staff and NIPH staff.) Figure 1 graphs the annual attendance by number of WPR participants and countries represented. There were 3 participants representing 3 Member States from WHO’s Region of South East Asia (SEAR) in 2005 and 1 SEAR participant in 2007. In 2007, 3 WHO Country staff members were included as participants. The number of participants increased annually from 2005 to 2007, with a slight decrease in 2008 and 2009. The countries represented increased over time.

FIGURE 1. Number of Participants and Countries Represented at JWIVP, 2005–2009

<table>
<thead>
<tr>
<th>Year</th>
<th>WPR Participants</th>
<th>WPR Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>25</td>
<td>10</td>
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<tr>
<td>2006</td>
<td>20</td>
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<tr>
<td>2007</td>
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<td>20</td>
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<tr>
<td>2008</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>2009</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: *In 2005, there were an additional 3 participants representing 3 countries in WHO’s South East Asia Region (SEAR). **In 2007, there was an additional participant representing 1 country from WHO SEAR.
Figure 2 depicts the composition of the JWIVP participants by level of work coverage over time. The percentage of subnational and other participants increased in 2007 and 2008. Overall, however, the majority of participants were national-level public health professionals.

**FIGURE 2.** Percentage composition of JWIVP participants by level of coverage, 2005–2009

Note: “Other” includes private sector, academe and international organizations operating within countries.

Figure 3 delineates the composition of participants by level of seniority. Senior-level participants decreased from 46% of all participants in 2005 to 20% of all participants in 2008. This reflects the change in selection criteria for participants, with subnational participants considered for inclusion beginning in 2007. However, in 2009, senior level officials comprised over 30% of participants, reflecting the shift in orientation for the last JWIVP.

**FIGURE 3.** Percentage composition of JWIVP participants by seniority, 2005–2009

Note: “Senior-level” includes Deputy Director, Director, Director-General and Vice-Minister

Overall, 76% of participants were national-level public health professionals, and 29% of all participants were senior-level officials. This is significant because senior-level national public health officers hold the greatest potential for influencing NCD policy and programmes within countries.
Course Objectives and Design

The JWIVP was originally designed to serve as a venue for enhancing the capacity of senior programme managers in NCD prevention and control. A review of the course objectives reveals 4 changes were made from 2005 to 2009:

1. In 2006, after WHO Headquarters recommended the global goal of a 2% annual reduction in NCD mortality, the objective on strengthening national interventions was directly linked to the achievement of this goal, likely in an effort to begin to align the course with the evolving global action plan.

2. In 2007, the objectives were adjusted to include not just senior programme managers working at the national level but also sub-national senior NCD programme officers, broadening the participant base.

3. In 2008, the objective on NCD work plans changed from a focus on internal work plans between WHO and national counterparts towards external work plans intended for implementation by the national and sub-national participants upon return to their countries.

4. In 2009, the programme objectives were definitively linked to the Regional Action Plan on NCD prevention and control, with an emphasis on engaging senior policy makers and using policy interventions and integrated approaches.

Overall, 3 of every 4 JWIVP participants worked at the national level, and 1 out of 3 were senior-level public health officials.
The chart below depicts the changing course objectives over the 5-year period. The changes indicate that as the course evolved over the years, it was increasingly viewed not as a stand-alone undertaking but rather, as a complementary mechanism that was undisputedly linked to the achievement of the WHO global NCD goal and eventually, the WHO Regional NCD Action Plan objectives, through concrete applications of lessons and skills learned, with implementation of action plans expected upon return of the participants to their countries.

**TABLE 1.** The evolution of the JWIVP course objectives, 2005–2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| 2005 | To showcase the Japan experience and review global, regional and national experiences in NCD program management  
To strengthen national NCD approaches among participating countries by encouraging a critical approach, formal networking and a community of practice  
To develop action plans for follow-up action within and between the selected countries |
| 2006 | To train senior health managers working at national level in the methods of integrated prevention and control of NCD  
To develop an understanding of the national interventions needed to achieve the global goal of 2% annual reduction in NCD mortality  
To develop detailed work plans for the collaboration between WHO and national counterparts in NCD over 2006–2007 |
| 2007 | To train senior health managers in the methods of integrated prevention and control of NCD  
To develop an understanding of the national interventions needed to achieve the global goal of 2% annual reduction in NCD mortality  
To develop detailed work plans for the collaboration between WHO and national counterparts in NCD over 2007–2008 |
| 2008 | To train senior health managers in the methods of integrated prevention and control of NCD  
To develop an understanding of the national interventions needed to achieve the global goal of 2% annual reduction in NCD mortality  
To develop a plan of action for implementation on return to their work stations, applying the skills and knowledge acquired during training |
| 2009 | To review country progress against the Regional Action Plan  
To identify key actions to achieve the NCD RAP goals at the national levels using an integrated approach  
To mobilize the commitment of senior policy leaders for NCD  
To establish ongoing policy dialogue in NCD prevention and control |

Note: The objectives in **bold** indicate where changes were made for the particular year.
The week-long course design was comprised of an innovative mix of didactic (theoretical) and interactive sessions (group work), field visits (study tours) and experiential opportunities (self health promotion programme) that showcased new and emerging evidence in NCD prevention and control as well as creative approaches to NCD from Japan and other countries. Table 2 lists the course content for each year that an evaluation was conducted. Core topic areas such as risk factor management, promotion of healthy lifestyles and environments, clinical interventions, NCD surveillance and data systems, networking and national NCD planning and policies were constant throughout the 4 iterations of the JWIVP. In 2007, sessions on advocacy and the integration of NCDs into health systems strengthening were included into the curriculum. In 2008, the role of other sectors including the private sector, particularly industry, was introduced. This expansion from a predominantly technical set of content areas to include advocacy, networking and health systems is indicative of the shift towards a more integrative model, and is consistent with the move from vertical towards horizontal approaches in chronic disease prevention and control.

As the course evolved over the years, it was increasingly viewed not as a stand-alone undertaking but rather, as a complementary mechanism that was undisputedly linked to the achievement of the WHO global NCD goal through concrete applications of lessons and skills learned, with implementation of action plans expected upon return of the participants to their countries.
Throughout the years, relevant global and regional policies were discussed, including the Global Strategy on Diet, Physical Activity and Health, the WHO international Framework Convention on Tobacco Control, and, in 2008, the then draft version of the WHO Western Pacific Regional Action Plan (RAP) for NCD. By 2009, the course emphasis was solidly linked to the RAP, which had been endorsed by the Regional Committee Meeting in 2008.

Interactive sessions enabled the participants to familiarize themselves with tools and exercises for national NCD strategic planning. Time was allotted for country presentations of progress, allowing participants to become familiar with strategies and interventions being implemented by their colleagues in different country settings.

Special sessions from Japanese faculty highlighted some of the unique approaches to NCD prevention and control in Japan. This was complemented by an experiential component where participants actively engaged in healthy lifestyle activities designed by NIPH, including dietary regulation and daily exercise, with pre-and post-physiologic measurements to document the efficacy of these activities.

The course content changed radically in 2009, because during this last year, the focus was on assessing country progress and strategizing priority actions for national implementation of the Regional Action Plan. Thus, the programme schedule utilized in 2006–2008 no longer applied in 2009. Instead, facilitators used a set of tools to guide participants in systematically analyzing their country situation, identifying gaps in national NCD capacity and selecting priority areas for immediate action to enable the attainment of the RAP objectives. The efficacy of policy interventions and the importance of adopting integrated approaches to NCD prevention and control were highlighted.
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<th>2006</th>
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<td>• Health Japan 21</td>
<td>• The Challenge of NCD in the Western Pacific</td>
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<td>• Regional FCTC Implementation</td>
<td>• Implementing National NCD Policy and NPAN in the Pacific</td>
<td>• The Direction of NCD Policy in Japan</td>
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<td>• Life course Approach to Health Promotion Policy Making</td>
<td>• NCD Planning – Theory and Execution</td>
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<td>• Towards a Regional NCD Prevention and Control Strategy</td>
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<td>• Health Promotion Planning and Decision Making</td>
<td>• Health Lifestyle Promotion in China</td>
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<td>• Community-based intervention (Nutrition)</td>
<td>• Community-based Interventions in Japan</td>
<td>• Healthy Settings in Japan</td>
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<td>• NCD Risk Factors – Tobacco, Alcohol, Diet and Physical Activity Screening</td>
<td>• Cost-effective Public Health Interventions for NCD Prevention and Control</td>
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<td></td>
<td>• Smoking cessation for young people</td>
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<td>• Chiyoda case study on tobacco control</td>
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<td>• Alcohol: Genetic Epidemiology</td>
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<td>Risk Factor Management/Prevention</td>
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<td>• Oral Health</td>
<td>• Community based CVD prevention in Finland</td>
<td>• Community-based CVD Prevention: 30-year Experience from Finland</td>
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<td>• Nutrition, Obesity and Diabetes in Japan</td>
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<td>• Case Study on CVD prevention</td>
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<td>• Global Survey on NCD Capacity Assessment</td>
<td>• Stepwise Surveillance in the Western Pacific</td>
<td>• Surveillance, Monitoring and Evaluation for Effective NCD Control</td>
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<td></td>
<td></td>
<td>• Discussion on Networking</td>
<td>• Working with Industry and Across Different Sectors</td>
</tr>
<tr>
<td>Advocacy</td>
<td>• Advocacy for Action</td>
<td></td>
<td>• Advocacy and Social Mobilization for Health</td>
</tr>
<tr>
<td>NCD and Health Systems Strengthening</td>
<td>• Making Health Systems Work for NCD</td>
<td>• NCD Prevention and Health Sector Reform in Japan</td>
<td>• Making Health Systems Work for NCD</td>
</tr>
</tbody>
</table>
Feedback from Participants: Course Evaluation Results

From 2006 to 2009, an evaluation of the programme was required of all participants. This evaluation was conducted electronically, using a questionnaire developed by the programme faculty. The evaluation questionnaire in 2006 to 2008 used a Likert scale to address key process indicators, soliciting feedback on the course content, relevance, utility and delivery, with additional questions on the adequacy of course materials and logistic arrangements. A section using open-ended questions, provided the participants the opportunity to provide recommendations to improve future iterations of the JWIVP. In 2007, questions regarding benefits derived from the JWIVP were added to the questionnaire. In 2009, an entirely different survey instrument was used.

Process Indicators, 2006–2008

Course Content

The course content differed for each year. Figure 4 shows the participants’ feedback on the appropriateness and Figure 5 depicts the percentage of participants who voted to reduce or increase the amount of time devoted to the various content areas in future courses. Figure 6 represents feedback on the adequacy of the reference materials provided to participants to complement the topic presentations.

For the years 2007 and 2008, for which data is available, an overwhelming majority (96% and 95%, respectively) of participants judged the course contents to be appropriate for the objectives of the JWIVP (Figure 4). Figure 5 shows that the course content improved markedly over time, with the percentage of participants favoring an increase in the emphasis given to the content areas for future workshops rising from 28% in 2006 to 94% in 2008. Consistent with this finding, the feedback on adequacy of materials provided to participants to supplement the course content also improved significantly over time.

FIGURE 4. Participant feedback on appropriateness JWIVP course content

Note: In 2006, this question was not asked.
In reviewing the responses to the open-ended questions, certain themes emerged with regards to comments on the course content. The expertise of the lecturers and the appropriate selection and organization of topic areas were repeatedly noted. Several participants also remarked upon the practical nature of the content areas, and the balance achieved between theory, evidence, and experience, particularly in relation to actual country experiences.

“The course brought all of the important evidence-based information to improve the implementation of NCD programmes; it is also well-organized.”

“Theory, evidence and way of health promotion are well balanced.”

“Every intervention that was introduced was followed up with the story of the successful intervention in WPRO countries. This sets a good example to show that prevention works!”
Course Delivery

Figures 7–10 demonstrate the participants’ feedback on the delivery of the course, specifically as it relates to each of the 4 educational approaches utilized:

1. didactic/theoretical sessions;
2. interactive/group sessions;
3. field visits/study tours; and,
4. experiential/self health promotion programme.

Figure 11 portrays participant reactions to the appropriateness of the mix of theory and practice in the JWIVP.

In general, participant feedback on the appropriateness and usefulness of each of the 4 approaches was highly favorable, with positive feedback increasing over time. This indicates that while course delivery was good to begin with, further improvements occurred with each succeeding year. Majority of participants judged the mix of theory and practice to be appropriate for both years when this indicator was assessed.

**FIGURE 7.** Appropriateness of didactic/theoretical component of JWIVP

**FIGURE 8.** Utility of interactive/group work

Note: In 2006, this question was not asked.
The responses to the open-ended questions provide further proof of the high level of approval for the course delivery/educational approaches used for the JWIVP. The experiential/self health promotion programme component received the most number of positive comments, indicating its popularity amongst
the participants. Also highly regarded was the interactive component, which provided the opportunity for participants to learn from each other’s experiences.

“The flow of the course was very systematic, covering all systems areas for NCD prevention and control. There were a lot of opportunities to learn from each other.”

“The course had positive methods which attract the learner’s participation.”

“I feel that the sharing of experiences from the Asian countries was good for us.”

“I found the health promotion programme to be the best, particularly the health checks as so often as health professionals we are so busy in checking others that we forget to check ourselves. We are actually the best health promotion tools available – being role models and ‘walking the talk.’”

Other Process Indicators
While there was no specific question in the JWIVP evaluation instrument to gauge the participants’ reaction to the learning environment, numerous comments from the open-ended section of the questionnaire indicated a high approval rating for the environment provide by the NIPH. Participants also positively commented upon the efficient and friendly assistance provided by the programme secretariat, both faculty and assistants.

“Thank you for a very well organized and planned workshop. Thank you for looking after us so well.”

“Secretaries are friendly and helpful.”

“Good selection of main lecturers.”

“The environment at NIPH was very conducive to learning.”

“The facility at the institute is excellent. The availability of internet access is very helpful.”

Areas for Improvement
Participants in 2006 and 2007 were asked about suggestions to enhance and improve future versions of the course. A number of the comments referred to logistic and administrative issues, and were specific to participants who necessitated long travel times to get to Japan, and will not be mentioned further. The substantive comments clustered around 2 themes:

1. Greater involvement of representatives of other sectors, and addressing the relationship of public health to other sectors in the discussions – Participants clearly recognized the multi-sectoral nature of NCD work, and indicated that the course could be strengthened by broadening discussions to cover the role of other sectors and expanding the faculty to include individuals representing other sectors, such as trade and the private sector.

“Include other sectors as presenters – to give us in health an overview of potential partners given that most of the factors that influence health are outside the health sector…We need to understand who and how potential partners work so we can truly collaborate across sectors to address NCD issues.”
“I would have liked to see more sessions on advocacy and social marketing especially on the more practical aspects – i.e. how to build effective partnerships with other sectors”

2. More time allotted to interactive sessions, particularly cross-country sharing of experiences – Numerous participants affirmed the value of learning from each other during interactive sessions, not just of success but also of failures and lessons learned, and expressed the desire to see more of these types of discussions in future versions of the JWIVP. Participants also recognized the value of maintaining relationships with other participants as an informal network for NCD support.

“…organize group discussions that will enable (participants) to learn and share experiences; this will enrich experiences of developed and developing countries.”

“…include more focus group discussions to draw out on common regional background,…and start the process informally towards a regional network.”

“(Include)…learning from mistakes that we have all encountered in our work.”

Outcome Indicators, 2006–2008

The JWIVP evaluation instrument queried participants in 2007 and 2008 about their perceptions regarding the course’s contribution to changes in their knowledge and interest in NCD, to enhancing their capacity as NCD programme officers and whether the course met their expectations. Figures 12–15 graphically depict the results of feedback to these questions.

All participants in both years attributed an increase in their interest and knowledge of NCD prevention and control to their attendance at the JWIVP. All participants also perceived the course to have contributed to increasing their capacity as NCD programme managers. In line with these findings, all participants also agreed that the JWIVP met their expectations, with the proportion of participants who strongly agreed with the statement rising from 32% in 2007 to 54% in 2008

**FIGURE 12.** Change in level of interest in NCD attributed to the JWIVP

<table>
<thead>
<tr>
<th>Year</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
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</tbody>
</table>

Note: In 2006, this question was not asked.
FIGURE 13. Change in knowledge of NCD attributed to the JWIVP

Note: In 2006, this question was not asked.

FIGURE 14. Course contribution to capacity as NCD programme managers

Note: In 2006, this question was not asked.

FIGURE 15. Degree to which course met participants' expectations

Note: In 2006, this question was not asked.
Course evaluation, 2009

A completely different evaluation instrument was instituted by NIPH in 2009. The simplified questionnaire sought to obtain feedback from participants, the secretariat and course observers on 3 dimensions: course participation, facilitation and leadership, using a 5-point Lichert scale. Participants, members of the secretariat and course observers were also asked to rank their overall impression of the meeting.

The results of the 2009 evaluation are summarized in Figure 16. Attendees at the 2009 JWIVP, regardless of their role, tended to rank the meeting very highly overall, and also to rank participation, facilitation and leadership very favorably. Observers were slightly more likely to rank the meeting higher than either participants or secretariat members, while secretariat members were more likely to rank the meeting lower than the other categories of attendees. However, all attendees gave high marks for the course across the three dimensions specified, and the overall scores were uniformly high, signifying concordance across the respondent categories.

FIGURE 16. Summary of 2009 evaluation results

![Graph showing evaluation results](image)


In mid-2007, WHO commissioned an independent assessment of the JWIVP. The assessment was conducted by Dr Kazuyo Machiyama, then a Short-term Professional for the NCD programme at the Regional Office.

Ms Machiyama developed and pilot-tested a questionnaire based on Kirkpatrick’s evaluation model for training programmes, as adapted by Zinovieff for the WHO Fellowship Programme. This model includes 4 levels of assessment: levels 1 (Reaction) and 2 (Learning) comprise the formative evaluation component while levels 3 (Behaviour) and 4 (Results) make up the summative component.

The questionnaire was sent to participants of the JWIVP from 2005 to 2007 by fax or email. The response rate was 69%. A separate questionnaire was sent, with the participants’ permission, to their supervisors, to verify the participants’ work performance and any changes made at work as a result of their attendance at the JWIVP. The response rate from the participants’ supervisors was 32%. The results are summarized in a report
submitted to WHO in August 2007. The limitations of the evaluation exercise were enumerated in the report. The report, but not the actual survey database, was made available for desk review.

The results of this survey with regards to learning and relevance mirror the results obtained through the JWIVP evaluation, highlighted in the previous section, and will not be repeated here. The value added by Ms Machiyama's survey relates to the outcomes and impact attributed to the JWIVP. The available data and results are discussed below.

**Outcome Indicators**

*Changes in behaviour and work practices resulting from JWIVP participation*

Figure 17 highlights the degree of agreement by survey respondents to the four statements alluding to behavioural changes and work practices directly as a result of attendance at the JWIVP.

**FIGURE 17.** Self-reported personal and work-related change as a result of attendance at the JWIVP

![Bar chart showing changes in behaviour and work practices](chart.png)

Over 80% of the respondents reported making positive changes to their approaches to NCD work after attending the JWIVP. Ms Machiyama's report notes that:

- A quarter of respondents…had adopted an integrated approach in their work. Half noted they had changed their lifestyle and had advocated a healthy lifestyle to colleagues. The participants stated they had used evidence presented through the STEPwise approach. Others noted that more emphasis was put on prevention, advocacy, population approaches and collaboration with other sectors. Generally the participants seemed to become more actively involved in NCD work after their participation (at the JWIVP).
- Almost all…had applied knowledge and skills acquired in JWIVP in their workplace. They shared knowledge with colleagues in the workplace or as trainers in workshops. The stepwise approach was used for development and revision of national NCD strategies and programmes. A number of
respondents had applied their knowledge into STEPs and other surveillance (activities) in which they were involved.

- Seventy-three percent stated that they had implemented or contributed to country plans and projects.

- More than 90% noted that the personal lifestyle intervention during the JWIVP resulted in (their own) lifestyle modification. Generally, the respondents seemed more confident about their healthy behaviour and had been spreading the word to their family members and colleagues. Apparently, the personal intervention programme was significantly effective and helped the participants become role models in their communities.

These self-reported changes in personal and work-related behaviours were corroborated by the supervisors; over 90% agreed that they observed the positive changes in the programme participants, and believed that these changes could be attributed to attendance at the JWIVP.

Impact Indicators

Reported impact of participants in organizational and national progress in NCD

Machiyama’s survey queried JWIVP participants about their contribution to their organization and their country’s progress as a result of their attendance at the course. Nearly all (97%) of the respondents stated that they had made contributions that resulted in organizational and/or national progress in NCD. Because the information is self-reported, caution is required in interpreting the results.

Among the supervisors, 72% reported that they observed changes in their unit/organization as a result of their staff member’s participation at the JWIVP. All of the supervisors who responded to the survey indicated that they would willingly send another staff member to future iterations of the JWIVP.

Participants listed down specific activities they initiated or contributed to as a result of their JWIVP participation (Table 3).
### TABLE 3. Activities and achievements arising and or benefitting from JWIVP participants’ contribution to organizational/national progress in NCD

<table>
<thead>
<tr>
<th>Country</th>
<th>Year/s of JWIVP participation</th>
<th>Activities and achievements showcasing participant’s contribution to NCD work at the organizational and national level</th>
</tr>
</thead>
</table>
| Cambodia  | 2006/2007                     | - Members of Technical Working Group developing national NCD strategy  
- Diet and physical activity KAP survey being conducted  
- Diet and physical activity guidelines being developed  
- Involvement in alcohol control meetings  
- Diabetes management training  
- Model for diabetes care in provincial Cambodia created |
| China     | 2006                          | - National NCD action plan being developed  
- Community-based NCD intervention being conducted |
| Cook Islands | 2005                              | - Partnership with other NCD stakeholders being expanded |
| Fiji      | 2005–2007                     | - National and divisional NCD strategies and programme developed and implemented using integrated approaches  
- School-based NCD projects: Potiki Sports program, Avarua Health-promoting School pilot project, School Lunch and Healthy Food Policy monitoring program, School-based Obesity program  
- Fiji Save the Food project  
- Green prescription  
- Move for Health |
| Lao PDR   | 2007                          | - Regular NCD meetings set up within MOH  
- STEPS implementation |
| Malaysia  | 2005                          | - Media campaign to prevent alcohol-related harm  
- Intervention project to promote physical activity in MOH  
- Comprehensive diabetes management projects in provinces; facilitated making diabetes control a priority among district heads  
- Malaysia National Health and Morbidity Survey 2007  
- MyHESS System  
- Body weight management course |
| Micronesia| 2007                          | - Emphasis on population-based interventions rather than individual approaches for NCD  
- Chuuk STEPS Survey 2006 |
| Mongolia  | 2005–2007                     | - Finalized national NCD strategy 2005  
- Implemented STEPS in 2006, with report out by 2007  
- National strategy on diet and physical activity being developed  
- 5 NCD intervention projects implemented  
- National NCD risk factor surveillance being planned  
- Clinical treatment guidelines for patient diets submitted by MOH  
- Advocacy and networking with other stakeholders |
| Philippines| 2005–2007                     | - NCD national plan of action developed  
- NCD national coalition established; regional coalitions being developed  
- NCD programs disseminated via television  
- Chronic respiratory disease project, Guimaras, Iloilo  
- National Cancer Consciousness Campaign  
- Sentrong Sigla Phase III (Quality Assurance program)  
- Rainbow Tents  
- Training of front-line health workers in NCD |
| Samoa     | 2006                          | - Advocated for increase in NCD, Nutrition and Tobacco Control budgets  
- Worked with consultants to develop tobacco control policies, legislation and plan of action  
- Diabetes Guidelines for Samoa and Tokelau  
- Physical Activity program with Communities Strategic Planning  
- All awareness program on NCD prevention (SNAP) |
| Tonga     | 2005–2007                     | - Health Promotion Foundation established  
- Social marketing for NCD |
| Viet Nam  | 2005–2007                     | - NCD national plan of action developed  
- NCD surveillance conducted in several provinces  
- NCD programs implemented and NCD budget increased  
- Directly involved in designing NCD models/studies, making work plans, developing educational and training materials, organizing training courses on NCD prevention  
- Posbindu PTM program  
- National Diabetes Project  
- Tobacco Free Initiative |

**Note:** Specific programmes are italicized.
While it is not possible to directly attribute activities and achievements exclusively to participation at the JWIVP, it is clear that the JWIVP participants played essential roles in developing and implementing NCD policies and programmes within their own countries. Thus any capacity enhancement arising from attendance at the JWIVP would have had a beneficial impact on the participants' performance of their duties and on their influence on the development of effective national strategies for NCD prevention and control.

Participants at the 5th JWIVP, 3–5 August 2009, Saitama, Japan
Conclusions

Noncommunicable diseases are a critical health and development issue for the Western Pacific Region. A key component to realizing progress in NCD within the Region is sufficient capacity at the national level to implement effective strategies for NCD prevention and control. The JWIVP anticipated this and provided an effective regional mechanism to strengthen capacity and build leadership for NCD.

The course evolved and improved over the years, and served as a complementary mechanism linked to the achievement of the WHO global NCD goal, and eventually, with the objectives of the Regional Action Plan on NCD prevention and control through concrete applications of lessons and skills learned, with implementation of action plans expected upon return of the participants to their countries. The week-long course was comprised of an innovative mix of didactic (theoretical) and interactive sessions (group work), field visits (study tours) and experiential opportunities (self health promotion programme) that showcased new and emerging evidence in NCD prevention and control as well as creative approaches to NCD from Japan and other countries. Over time, the course content changed from a predominantly technical set of topic areas to a more practical mix that included advocacy, networking and health systems, indicative of the shift towards a more integrative model, consistent with the move from vertical towards horizontal approaches in NCD prevention and control. During the last year, progress assessment against the RAP, policy interventions and integrated approaches were emphasized, using a set of tools to guide systematic thinking in identifying gaps and setting priority areas for action.

Participant selection was effective, as overall, 76% of participants were national-level public health professionals, and 29% of all participants were senior-level officials. Senior-level national public health officers hold the greatest potential for influencing NCD policy and programmes within countries.

Two independent evaluation mechanisms---(1) the JWIVP evaluation survey conducted annually from 2006–2009 and (2) Ms Machiyama’s evaluation questionnaires in 2007---indicated high overall participant satisfaction with the programme. In general, participant feedback on the appropriateness and usefulness of each of the 4 educational approaches used was highly favorable, with positive feedback increasing over time. This indicates that while course delivery was good to begin with, further improvements occurred with each succeeding year. Majority of participants judged the mix of theory and practice to be appropriate for both years when this indicator was assessed.

All participants in both years attributed an increase in their interest and knowledge of NCD prevention and control to their attendance at the JWIVP. All participants also perceived the course to have contributed to increasing their capacity as NCD programme managers. In line with these findings, all participants also agreed that the JWIVP met their expectations, with the proportion of participants who strongly agreed with the statement rising from 32% in 2007 to 54% in 2008.
Over 80% of the respondents reported making positive changes both in their personal life and in their approaches to NCD work after attending the JWIVP. These self-reported changes in personal and work-related behaviours were corroborated by the supervisors; over 90% of supervisors agreed that they observed the positive changes in the programme participants, and believed that these changes could be attributed to attendance at the JWIVP.

Nearly all (97%) of the respondents stated that they had made contributions that resulted in organizational and/or national progress in NCD. Because the information is self-reported, caution is required in interpreting the results. However, corroboration is provided by the respondents’ supervisors, of which 72% reported that they observed changes in their unit/organization as a result of their staff members’ participation at the JWIVP. All of the supervisors who responded to the survey indicated that they would willingly send another staff member to future iterations of the JWIVP.

Suggestions made by participants to further strengthen the JWIVP in the future clustered around two thematic areas:

1. Greater involvement of representatives of other sectors, and addressing the relationship of public health to other sectors in the discussions – Participants clearly recognized the multi-sectoral nature of NCD work, and indicated that the course could be strengthened by broadening discussions to cover the role of other sectors and expanding the faculty to include individuals representing other sectors, such as trade and the private sector.

2. More time allotted to interactive sessions, particularly cross-country sharing of experiences – Numerous participants affirmed the value of learning from each other during interactive sessions, not just of success but also of failures and lessons learned, and expressed the desire to see more of these types of discussions in future versions of the JWIVP. Participants also recognized the value of maintaining relationships with other participants as an informal network for NCD support.

Clearly, the JWIVP fulfilled its function of facilitating capacity enhancement for NCD prevention and control among a key set of influential national and subnational programme managers.

Given the increasing burden of NCD in the Western Pacific, and in light of the recent endorsement of the Global and Regional NCD Plans of Action, the following recommendations are made:

“The Japan-WHO course will become a model of NCD prevention and control (capacity building) among Asian and Pacific Island Countries.”

Participant, 2nd JWIVP, 2006
Recommendations

- Consider ongoing and expanded support to sustain NCD regional capacity building, with an emphasis on promoting cost-effective, evidence-based, integrated approaches to NCD prevention and control, building on existing regional initiatives such as Healthy Settings, Healthy Cities and Healthy Islands, and consistent with the stated objectives and strategies outlined in the Global and Regional NCD Plans of Action.

- Explore how to utilize this regional mechanism to foster the development of a systematic strategy to monitor and assess Member States’ progress in achieving the goals and objectives of the Global and Regional NCD Plans of Action.

- Examine the utility of adapting this capacity building model for national and subnational NCD capacity enhancement activities, and implement suitably adapted versions to expand the NCD workforce within countries.
## Annexure – Participants of JWIVP 2005–2009

### 1st JWIVP, 4–9 April 2005, Saitama, Japan

<table>
<thead>
<tr>
<th>Country</th>
<th>Participant Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>Dr Kong Lingzhi</td>
</tr>
<tr>
<td>Philippines</td>
<td>Dr Myrna Cabotaje, Ms Prescilla Cuevas</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>Ms Karen Tairea</td>
</tr>
<tr>
<td>Samoa</td>
<td>Dr Satupaitea Viali</td>
</tr>
<tr>
<td>Fiji</td>
<td>Dr Teo Waganivalu</td>
</tr>
<tr>
<td>Tonga</td>
<td>Dr Vilami Puloka</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Dr Yasmin bt Sulaiman, Dr Azmi B. Ahmed</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Dr Vuong Anh Duong, Dr Duc Truong</td>
</tr>
<tr>
<td>Mongolia</td>
<td>Dr Gomdodorj Tsetsegdary, Shagdarusen Enkhabat</td>
</tr>
</tbody>
</table>

### 2nd JWIVP, 3–10 April 2006, Saitama, Japan

<table>
<thead>
<tr>
<th>Country</th>
<th>Participant Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Dr Khuon Eng Mony, Dr Prak Piseath Raingsey</td>
</tr>
<tr>
<td>Samoa</td>
<td>Ms Nancy Macdonald, Mr Andrew Peteru</td>
</tr>
<tr>
<td>China</td>
<td>Dr Wu Yanwei, Dr Li Guanglin</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Dr John Paulsen</td>
</tr>
<tr>
<td>Fiji</td>
<td>Sr Amelia Tikoudaadua Railala</td>
</tr>
<tr>
<td>Tonga</td>
<td>Dr Sione Talanoa Latu, Ms Naomi Pale Inia Fakauka</td>
</tr>
<tr>
<td>Micronesia, Federated States of</td>
<td>Mr Amato Elymore, Mr Andrew Peteru</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Dr Christopher Tariang</td>
</tr>
<tr>
<td>Mongolia</td>
<td>Dr Jigjidsuren Altantuya, Ms Bayandorj Tsogzolma</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Dr Ly Ngoc Kinh, Dr Duc Truong</td>
</tr>
<tr>
<td>Philippines</td>
<td>Dr John Juliard Go, Dr Jane Mari Cabulisan</td>
</tr>
</tbody>
</table>

### 3rd JWIVP, 10–17 April 2007, Saitama, Japan

<table>
<thead>
<tr>
<th>Country</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Dr Thac Varouen, Dr Tim Kosal</td>
</tr>
<tr>
<td>Mongolia</td>
<td>Dr Lkhagvasuren Oyunaa, Dr Khasag Altai, Dr Norov Bolormaa</td>
</tr>
<tr>
<td>China</td>
<td>Dr Li Xun, Ms Gong Weiwei</td>
</tr>
<tr>
<td>New Caledonia</td>
<td>Ms Karen Fukofuka</td>
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<tr>
<td>Fiji</td>
<td>Dr Salanieta Saketa</td>
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<td>Philippines</td>
<td>Dr Marlyn Convocar, Dr Francisa Cuevas</td>
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<tr>
<td>Lao PDR</td>
<td>Dr Chanphommavongpho, Dr Vang Chu</td>
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<tr>
<td>Samoa</td>
<td>Mrs Maatasesa Samuelu Matthes</td>
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<td>Malaysia</td>
<td>Dr Rozanim Kamarudin, Dr Rotina Sabu Bakar</td>
</tr>
<tr>
<td>Tonga</td>
<td>Mr Eva Mafi</td>
</tr>
<tr>
<td>Micronesia, Federated States of</td>
<td>Mr Carter Apaisam, Mr Kipier Lippwe</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Dr Le Van Kham, Dr Ha Van Thuc</td>
</tr>
</tbody>
</table>
### 4th JWIVP, 8–15 April 2008, Saitama, Japan

<table>
<thead>
<tr>
<th>Country</th>
<th>Participants</th>
</tr>
</thead>
</table>
| Cambodia       | Dr Chuun Loun  
Mr Va Luong Khun                                                            |
| Mongolia       | Dr Tseren-Ochir Khandarmaa  
Dr Dangaa Baigalma  
Dr Bazarsad Battsetseg                                                       |
| China          | Dr Zhang Qinqjun  
Dr Lei Zhenglong                                                             |
| Papua New Guinea | Dr Thomas Vinit                                                      |
| Fiji           | Sr Silina Rokodraewe Waqa                                                  |
| Philippines    | Dr Yolanda Oliveros  
Dr Tato Usman  
Dr Ma. Luisa Paran                                                             |
| Lao PDR        | Dr Bounpheng Sodouangdenh  
Dr Xaysana Sombandith                                                          |
| Viet Nam       | Dr Truong Le Van Ngoc  
Dr Chu Hing Thang  
Dr Tran Quoc Bao                                                                |
| Malaysia       | Dr Nora’l Binti Mohd Said  
Dr Feisul Idzwan Bin Mustapha                                                  |

### 5th JWIVP, 3–5 August 2009, Saitama, Japan

<table>
<thead>
<tr>
<th>Country</th>
<th>Participants</th>
</tr>
</thead>
</table>
| Cambodia       | Dr Prak Piseth Raingsey  
Dr Khuon Eng Mony                                                               |
| Mongolia       | Dr Dangaa Baigalma  
Dr Bolorchimeg Bold                                                             |
| China          | Dr Zhao Wenhua  
Dr Shi Xiaoming                                                                  |
| Papua New Guinea | Ms Vicky Wari                                      |
| Cook Islands   | Mrs Karen Tairea                                                               |
| Philippines    | Ms Frances Prescilla Cuevas  
Dr Francisca Cuevas                                                            |
| Fiji           | Dr Isimeli Naisoso Tukana                                                    |
| Samoa          | Mr Andrew Peteru                                                              |
| Lao PDR        | Dr Xaysana Sombandith                                                         |
| Solomon Islands | Ms Christina Qotso                                                           |
| Malaysia       | Dr Feisul Idzwan Mustapha                                                     |
| Tonga          | Mr Eva Mafi                                                                    |
| Micronesia, Federated States of | Ms Moria Shomour                                           |
| Viet Nam       | Dr Truong Le Van Ngoc  
Dr Le Thi Thu Hien                                                               |
References


ii WHO Western Pacific Regional Office. WHO Member States support action to cut deaths from noncommunicable diseases. Press release, Fifty-seventh session of the WHO Regional Committee for the Western Pacific, 19 September 2006, Auckland, New Zealand.


GEARING UP FOR SUCCESS

Mobilizing political support and strengthening programme capacity for NCD prevention and control
Introduction

The Western Pacific Regional Action Plan for Noncommunicable Diseases, endorsed by the Regional Committee during its fifty-ninth session in September 2008, lays out the strategic direction for action to address the public health burden from noncommunicable diseases (NCD) in the Region. It harmonizes the action areas from the Global Strategy for the Prevention and Control of Noncommunicable Diseases with the realities and priorities of the Western Pacific, and operationalizes the Global Strategy within the regional context.

Implementation of the Regional Action Plan critically hinges upon political support and strengthened programme capacity at the national level. These two key elements create the foundation for effective country and regional responses to the rapidly growing burden of NCD, and jointly determine the likelihood of achieving progress in preventing and controlling NCD.

The Participant's Workbook for the 5th NIPH-WHO International Workshop for NCD Prevention and Control was developed to assist NCD programme officers to systematically assess and analyse how to effectively garner political support for NCD prevention and control and augment current national capacity to implement the Regional Action Plan (RAP). The tools utilized in the workbook were derived from various quality-improvement training programmes, including the Prolead Health Promotion Leadership Training Programme of the WHO Regional Office for the Western Pacific, the Field Management Training Programme of the United States Centers for Disease Control and Prevention, and the WHO Western Pacific Regional Tobacco Free Initiative data application workshops. The original tools and exercises were modified to address the core objectives of the workshop. Some of the tools were previously tested in the 4th NIPH-WHO International Workshop for NCD Prevention and Control (2008).

The tools are also intended for countries to use at national and subnational levels, as part of a capacity-building process for NCD. WHO encourages Member States to translate and further adapt these exercises to best meet their needs as they establish and expand political and programme capacity to take definitive action against NCD.
Curriculum Outline

SESSION 1  Sharing journeys and setting expectations
SESSION 2  Timelines
SESSION 3  Mapping progress in relation to the Regional Action Plan
SESSION 4  Spidergrams
SESSION 5  Selecting priority action areas
SESSION 6  Identifying barriers to political support and programme capacity in priority action areas
SESSION 7  Fishbone barrier analysis
SESSION 8  Reverse fishbone and countermeasures
SESSION 9  Integrated approaches to NCD: SWOT analysis
SESSION 10 Advocacy for NCD: One-page briefer and briefing slides
SESSION 11 Measuring progress: Development of proposed indicators to benchmark success
### OBJECTIVES
To get to know each other better and to establish workshop expectations

### ACTIVITY 1
**Expectations**

**INSTRUCTIONS:** List three things that you expect to achieve in this workshop.

1. 
2. 
3. 

### ACTIVITY 2
**Where are you on your NCD journey?**

**INSTRUCTIONS:** Look at all the photographs that are displayed and select the one that best captures where you are on your NCD journey. How does this reflect your expectations from this workshop? Share your reflections with the group.

### KEY QUESTIONS
- Where am I on my NCD journey?
- What do I expect from the workshop?
Timelines

**OBJECTIVES**
To identify milestones in NCD work and to identify the factors that contributed to both high and low points in NCD prevention and control.

**INSTRUCTIONS**
1. Reflect on your work in NCD since your participation in the Saitama workshop. What was the highest point or best achievement? What was the lowest point?
2. Mark out the highest and lowest points along the timeline.
3. What factors prompted the best achievement? What factors contributed to the lowest point? Write these down on metacards.

**HIGHEST POINT**

2005 2006 2007 2008 2009

**LOWEST POINT**
Mapping progress in relation to the Regional Action Plan

OBJECTIVE : To assess progress in relation to the six objectives of the NCD Regional Action Plan

BACKGROUND :

The causation pathway for NCD

Common risk factors underlie NCD. An estimated 80% of premature heart disease, stroke and type 2 diabetes, and 40% of cancer, could be avoided through healthy diet, regular physical activity and avoidance of tobacco and alcohol use. Globalization and urbanization serve as conduits for the promotion of unhealthy lifestyles and environmental changes that make otherwise diverse communities within the Region susceptible to tobacco and alcohol use, unhealthy diets and physical inactivity. These common risk factors give rise to intermediate risk factors such as high blood pressure, elevated blood glucose, abnormal lipid profiles and obesity. In turn, the intermediate risk factors predispose individuals to the “fatal four” – cardiovascular disease, cancer, chronic respiratory disease and diabetes (Figure 1).

The objectives of the global and regional action plans

The causation pathway for chronic diseases provided the framework for elucidating key components of the Western Pacific Regional Action Plan (RAP), developed to operationalize the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. Consistent with the global plan, the RAP has six objectives that allude to six action areas:

<table>
<thead>
<tr>
<th>RAP objective</th>
<th>Action area</th>
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<tbody>
<tr>
<td>1. To raise the priority accorded to noncommunicable diseases in development</td>
<td>ADVOCACY</td>
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<td>work at global and national levels, and to integrate prevention and control</td>
<td></td>
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<td>of such diseases into policies across all government departments.</td>
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<td>2. To establish and strengthen national policies and plans for the prevention</td>
<td>NATIONAL NCD POLICIES AND PLANS</td>
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<td>and control of noncommunicable diseases.</td>
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<td>3. To promote interventions to reduce the main shared modifiable risk factors</td>
<td>POPULATION-BASED LIFESTYLE INTERVENTIONS</td>
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<td>for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity</td>
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<td>and harmful use of alcohol.</td>
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<td>4. To promote research for the prevention and control of noncommunicable</td>
<td>RESEARCH</td>
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<tr>
<td>diseases.</td>
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<td>5. To promote partnerships for the prevention and control of</td>
<td>PARTNERSHIPS</td>
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<td>noncommunicable diseases.</td>
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<td>6. To monitor noncommunicable diseases and their determinants and evaluate</td>
<td>MONITORING AND EVALUATION</td>
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<td>progress at the national, regional and global levels.</td>
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</table>

Two elements are essential for the successful attainment of these objectives and for effective implementation of interventions in the six action areas: political support and programme capacity. Without political support, it will be very difficult to raise the priority of NCD prevention and control and to leverage the diverse resources needed to achieve the objectives of the RAP. Without programme capacity, even with abundant resources, strategic action leading to measurable impacts on disease burden and health outcomes will not occur. Thus, it is important for national NCD programmes to gauge the level of political support and programme capacity existing in relation to each of the action areas above as a baseline for assessment of potential progress.
INSTRUCTIONS: Based on the RAP objectives, use the progress assessment grid to determine where your programme is in relation to political support and programme capacity for each of the six NCD action areas. Use circles with the corresponding number for each of the six action areas.
SESSION 4

Spidergrams

OBJECTIVE : To conduct a rapid assessment of the strength of political support and programme capacity to achieve the objectives in the six action areas of the NCD RAP.

INSTRUCTIONS :

Assess the level of political support – Using the red marker, place a square on the appropriate level along the scale from 0–4 to indicate the level of political support existing for each of the action areas in the NCD RAP.

**Political support scale:**

0 No political support, with no existing policies  
1 Very weak political support, with few policies evolving  
2 Minimal political support, with evolving policies and minimum engagement of multisectoral stakeholders and/or high-profile champions  
3 Growing political support, with evolving and/or established policies and good engagement of multisectoral stakeholders and/or high-profile champions  
4 Strong political support, with established policies and good engagement of multisectoral stakeholders and/or high-profile champions

Assess programme capacity – Using the blue marker, place a circle on the appropriate level along the scale from 0–4 to indicate the degree of programme capacity existing for each of the action areas in the NCD RAP.

**Programme capacity scale**

0 No programme capacity, with no programme objectives  
1 Very weak programme capacity, with evolving programme objectives  
2 Minimal programme capacity, with evolving programme objectives minimally implemented by a programme manager with insufficient human, material and financial resources  
3 Growing programme capacity, with developed programme objectives partially implemented by a programme team with sufficient material and financial resources
4 Strong programme capacity, with established programme objectives fully implemented by a programme unit/department with sufficient material and financial resources.
Reality check: In real life, the six action areas—the six “legs” of the spider—are all interconnected. Improvements in mobilizing political support and/or enhancing programme capacity in one action area have an impact on the other action areas.

Review your progress assessment grid and spidergrams

How does improvement in one leg contribute to improvement in the other legs and to overall progress?

Draw lines, circles and squares connecting to other circles and squares, to indicate where improvements in one leg affect progress in the other legs. (For example, strengthening programme capacity in research can justifiably lead to enhanced programme capacity for monitoring and research. Increasing political support for NCD advocacy can lead to increased national policies for NCD prevention and control.)

Where do you see the greatest benefit from improvements in political support and programme capacity?
Selecting priority action areas

**OBJECTIVE**: To identify priority action areas in the NCD RAP for improvement in the immediate future.

**INSTRUCTIONS**:
1. Reflect upon the spidergram and how the legs of the spider are interconnected.
2. Select three action areas where improvements in programme capacity and political support would produce the greatest benefit for overall progress.
3. Identify the internal and external stakeholders whose participation and engagement are needed for improvement in the action area.
4. Using the action selection matrix, select the one area of improvement that would have the greatest impact and has favourable conditions for immediate action.

   - High impact – significant change is expected if the area is improved
   - Favourable conditions – opportunities, timing and situation favour success

<table>
<thead>
<tr>
<th>3 PRIORITY RAP AREAS FOR ACTION</th>
<th>Reason for improvement</th>
<th>Internal stakeholders</th>
<th>External stakeholders</th>
<th>High impact? 0–5</th>
<th>Favourable conditions? 0–5</th>
<th>Total X/25</th>
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After completing your individual action selection matrix, your facilitator will lead you in a multi-voting exercise to determine the top three priority action areas for the entire group.
SESSION 6

Identifying barriers to political support and programme capacity in priority action areas

OBJECTIVE: To identify common barriers to mobilizing political support and strengthening programme capacity in the priority action areas.

INSTRUCTIONS:

1. On metacards, write down the barriers to strengthening programme capacity in the action area you are working on.
2. Put your responses on the wall.
3. Review and discuss the group’s output.
4. Similar responses may be grouped. Responses that refer to the same idea may be collapsed.
5. Repeat the exercise and brainstorm on barriers to strengthening political support.
6. Use the multi-voting grid to arrive at one barrier to mobilizing political support and one barrier to strengthening of programme capacity in the priority action area you are working on.
MULTI-VOTING GRID FOR PRIORITY BARRIERS TO STRENGTHENING PROGRAMME CAPACITY

Action area: _____________________________________________________________

Using a multi-voting system, select a few high-priority barriers that you want to address as a group. Count the number of barriers and vote for half the number. For example, if there are six barriers, on the first round vote three times (for three priority barriers). On the next round vote twice (for two priority barriers) and continue until you end up with one high-priority barrier.

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<tr>
<th>Barrier</th>
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<th>VOTE 2</th>
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</table>
MULTI-VOTING GRID FOR PRIORITY BARRIERS TO STRENGTHENING POLITICAL SUPPORT

Action area: _____________________________________________________________

Using a multi-voting system, select a few high-priority barriers that you want to address as a group. Count the number of barriers and vote for half the number. For example, if there are six barriers, on the first round vote three times (for three priority barriers). On the next round vote twice (for two priority barriers) and continue until you end up with one high-priority barrier.

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SESSION 7

Fishbone barrier analysis

OBJECTIVE : To identify the root causes of the priority barriers selected.

INSTRUCTIONS :
1. Do a fishbone analysis of underlying reasons for the barriers to strengthening:
   a. programme support; and,
   b. political support.
2. With each lateral fishbone, explore the root causes until you derive a root cause that you can change, modify, mitigate or improve. Draw a cloud around these actionable root causes.
3. Start on another lateral fishbone and proceed in the same manner.
4. Look at all the root causes with clouds. Review your work and see if there is a logical flow from the clouds to the fish head.
5. Identify at least three actionable root causes for each of the identified barriers to strengthening political support and programme capacity.
Action area:  _____________________________________________________________

The Ishikawa fishbone analysis for priority barriers to mobilizing political support
Action area: ________________________________________________________________

The Ishikawa fishbone analysis for priority barriers to strengthening programme capacity
OBJECTIVE: To delineate measures to counter the root causes of the barriers identified.

INSTRUCTIONS:

1. Brainstorm with your subgroup on countermeasures to address the root causes of the barriers you have selected.
   a. What are country-specific actions to address the barriers?
   b. What are regional actions to address the barriers?

2. Think collectively about practical steps that you can take to implement the countermeasures and complete the chart on the opposite page. Assess the effectiveness and feasibility of each step identified on a scale of 0–5. Multiply both parameters to get your overall score.

   - **E = Effectiveness** – the practical method will result in significant change toward overcoming the barrier
   - **F = Feasibility** – resources (material, human and time) are available and accessible for taking the action needed
   - **O = Overall score** – the product of the Effectiveness score and the Feasibility score, or \((E \times F)\) (Maximum overall score is 25.)

Reverse fishbone and countermeasures
The countermeasures matrix for priority barriers to mobilizing political support

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<th>BARRIER</th>
<th>CAUSES</th>
<th>COUNTER MEASURES</th>
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Part 3: Gearing Up for Success
Action area: _____________________________________________________________

The countermeasures matrix for priority barriers to strengthening programme capacity

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<th>BARRIER</th>
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**OBJECTIVE**: To assess how integrated approaches can maximize strengths and opportunities while minimizing weaknesses and threats to NCD prevention and control within your country context.

**INSTRUCTIONS**
1. Look at the countermeasures charts for the priority action area you are working on.
2. Review your high and low points in NCD prevention and control.
3. Recall the integrated approaches for NCD prevention and control.
4. Conduct a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis to come up with approaches that can be scaled up once the barriers to mobilizing political support and strengthening programme capacity in the selected priority area of work are overcome.
SESSION 10

Advocacy for NCDs: One-page briefer and briefing slides

OBJECTIVE: To become familiar with the principles and process of developing advocacy tools

INSTRUCTIONS:

1. Prepare a one-page briefing paper, or “briefer”, and four slides to summarize your recommendations for:
   a. Strengthening political support; and,
   b. Strengthening programme capacity for your group’s selected priority action area for NCD prevention and control.

2. Steps to preparing a one-page policy briefing paper:
   a. Frame the issue
   b. Highlight the consequences of inaction
   c. Summarize the overall approach and its benefits

3. Steps to preparing a four-point PowerPoint® presentation:
   a. Slide 1 – magnitude of problem
   b. Slide 2 – impact of problem on development in the country
   c. Slide 3 – consequences of inaction
   d. Slide 4 – urgent action points
SESSION 11

Measuring progress
Development of proposed indicators to benchmark success

OBJECTIVE: To identify potential indicators that could be used to benchmark progress in relation to the NCD RAP at both the national and regional levels.

INSTRUCTIONS:
1. Work in your sub-groups on your selected priority action area.
2. Divide the remaining three action areas so that each subgroup is working on two NCD RAP action areas each.
3. For each of your two action areas, identify as many as possible potential indicators that could be used to measure progress at the national level and as an aggregate at the regional level. Write out these proposed indicators on metacards, one indicator per card.
4. Post the metacards on the wall.
5. Working as a team, group together similar indicators to arrive at a final list.
6. Do multi-voting to determine the top three indicators per action area.
7. Present your work to the rest of the big group in plenary. Discuss the issues regarding the selection of feasible indicators to tangibly measure progress over time in relation to the NCD RAP. Remember that these indicators will need to apply to both national and regional assessments of progress.
8. As a big group, do multi-voting to select the best indicator for each action area. At the end of the session, there should be one proposed indicator for each action area.

Sub-group worksheet

<table>
<thead>
<tr>
<th>Action area</th>
<th>Proposed indicators</th>
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### Plenary worksheet

<table>
<thead>
<tr>
<th>Action area in NCD Regional Action Plan</th>
<th>Indicators proposed by subgroup</th>
<th>Selected priority indicator</th>
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<tbody>
<tr>
<td>ADVOCACY</td>
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<td>NATIONAL NCD POLICIES AND PLANS</td>
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<td>POPULATION-BASED LIFESTYLE INTERVENTIONS</td>
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<td>RESEARCH</td>
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