ASSESSING NATIONAL CAPACITY FOR THE PREVENTION AND CONTROL OF

NONCOMMUNICABLE DISEASES

Report of the 2015 country capacity survey in the Eastern Mediterranean Region

World Health Organization

Regional Office for the Eastern Mediterranean

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Foreword

It is a critical time in history to strengthen the capacity of countries and human resources to prevent and control noncommunicable diseases. Since the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, global efforts to scale up the fight against noncommunicable diseases have gained substantial momentum.

In Eastern Mediterranean Region, this dedication was pledged in solid commitments as translated by the regional framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, endorsed by the Member States at the 59th session of the WHO Regional Committee for the Eastern Mediterranean in 2012. The regional framework for action targets strategic interventions around four main areas: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and health care. It also incorporates a set of 10 progress indicators used to monitor the implementation of the United Nations Political Declaration.

Health information which is valid, timely and reliable is critical in health policy planning, development, monitoring and evaluation. Sound health information is the evidence that forms the basis of all decision-making, rational resource allocation and capacity-building. The WHO global noncommunicable diseases country capacity survey aims to provide countries with guidance, based on the 10 progress indicators, in the collection of such vital information through a structured evaluation of their national efforts to prevent and control noncommunicable diseases.

The 2015 country capacity survey marks the fifth WHO global country capacity survey; previous surveys were conducted in 2000, 2005, 2010 and 2013. It aims to further support countries by: informing progress made to date in noncommunicable disease prevention and control; identifying further gaps; highlighting lessons learnt; and recommending opportunities for improvement or potential replicability.

This regional report of the 2015 country capacity survey offers an overview of the current capacities of the countries of the Eastern Mediterranean Region to respond to noncommunicable diseases, particularly in the four key areas of governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care. The report shows that in spite of positive developments in several countries of the Region, the progress has been generally inadequate and uneven, and more work is needed. This is particularly true for: the setting of national targets; the development of multisectoral action plans; the strengthening of cancer registration; the periodic as well as routine assessment of noncommunicable disease risk factors; the effective implementation of the "best buys"; and the strengthening of existing regional health care systems' capacities to prevent and control noncommunicable diseases. Hence, it remains crucial to address these gaps, in order for countries of the Region to be able to fulfil the national commitments made in regard to the 2011 United Nations Political Declaration and the regional framework for action, as well as to successfully alleviate the major developmental challenges associated with the heavy burden of noncommunicable diseases.

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Executive summary

Introduction

Noncommunicable diseases are the leading cause of death worldwide. They are responsible for approximately 68% of global mortality each year, with cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases being the four main noncommunicable disease killers. It is estimated that annually, 16 million people die prematurely, that is, before the age of 70, as a result of noncommunicable diseases.

Most noncommunicable disease deaths (74%) occur in low- and middle-income countries, where this public health crisis is especially challenging due to the severe social and economic conditions already faced by these countries.

In the Eastern Mediterranean Region, about 60% of deaths are attributed to noncommunicable diseases. The Region also suffers from some of the highest rates of noncommunicable disease-related risk factors, such as: physical inactivity, tobacco, and high salt, sugar and fat intake. Despite this, with sound and committed national and regional as well as international efforts, the burden of noncommunicable diseases in the Region could be prevented and controlled.

WHO conducts periodic global country capacity surveys to assess the capacity of countries to prevent and control noncommunicable diseases. The most recent survey was conducted in 2015, and future surveys are planned for 2017 and 2020. These surveys are intended to help countries assess, monitor and evaluate their capacity to address noncommunicable diseases, particularly in regard to: governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care. The results of the 2010 country capacity survey informed the 2011 United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases that led to the landmark adoption of the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which committed countries to taking concrete actions to address the burden of noncommunicable diseases. In addition, WHO created the Global action plan for the prevention and control of noncommunicable diseases 2013–2020 that articulated six objectives and 25 outcome indicators that relate to the nine voluntary targets to be achieved by 2025. The 2014 United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases produced an outcome document with four time-bound commitments that countries should strive to achieve by 2016. To monitor these commitments, WHO created a set of 10 progress indicators (to be assessed by end of 2017) to report on progress at the next United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2018. The results of the 2015 country capacity survey will inform progress made in the Region based on these 10 progress indicators.

The 2015 country capacity survey was conducted online using a web-based application, where each country's noncommunicable disease focal point was provided with unique log-in credentials to access the questionnaire tool. The focal points were either personnel at ministries of health responsible for a unit or programme on noncommunicable diseases, or delegated members of staff of ministries of health or other national institutes or agencies. In order to ensure completeness of information, the instructions sent to focal points requested that they lead the completion of the questionnaire, involving relevant experts in the topic-specific sections of the questionnaire that they could not address themselves. The questionnaire included questions on infrastructure, partnerships and multisectoral collaboration; the existence of relevant policies, strategies and action plans; capacity for surveillance to address noncommunicable diseases and their risks at the national level; and capacity for noncommunicable disease prevention, early detection, treatment and care in their respective health systems. Data collection was carried out between May and September 2015, and data management, cleaning and analysis followed at the Regional Office for the Eastern Mediterranean jointly with headquarters.

With the exception of Djibouti, all of the countries in the Region (21 countries out of 22, 95%) responded to the survey. Significant revisions were made to the 2015 survey in terms of questionnaire content, design, administration, and validation processes.

This report presents the findings of the 2015 noncommunicable disease country capacity survey for countries of the Eastern Mediterranean Region. The current 2015 findings will be of great assistance in preparations for the third United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2018. This report primarily addresses regional performance in

terms of the implementation of the regional framework for action based on its four main areas of strategic intervention: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation, and health care. Below is a snapshot of the main findings observed concerning the achievements of countries based on the 10 progress indicators, and the performance of countries regarding the four main areas of strategic intervention of the regional framework for action.

Progress indicators

The calculation of the 10 progress indicators that report on progress made in the implementation of the regional framework for action of the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases is based on achievement of 18 sub-indicators. A median of 5.5 out of the 18 sub-indicators were fully achieved in the Region, ranging from the lowest achievement level of none of the indicators (Syrian Arab Republic), two indicators (Djibouti and Pakistan), to the highest achievement level of 15 (Islamic Republic of Iran). The hardest to achieve indicator for most of the countries of the Region was Sub-indicator 5d: Reduce affordability of tobacco products by increasing tobacco excise taxes, while the indicator most fully achieved by countries was Sub-indicator 6b: Comprehensive restrictions or bans on alcohol advertising and promotions.

Six countries (27%) fully achieved Indicator 1: Member State has set time-bound national targets and indicators based on WHO guidance; five countries (23%) fully achieved Indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis; eight countries (36%) fully achieved Indicator 3: Member State has a STEPS or comprehensive health examination survey every 5 years; and nine countries (41%) fully achieved Indicator 4: Member State has an operational multisectoral national policy/action plan that integrates the major noncommunicable diseases and their shared risk factors.

In regard to implementation of the four demand-reduction measures (MPOWER) of the WHO Framework Convention on Tobacco Control at the highest level of achievement, as required in Indicator 5, the two sub-indicators most fully achieved (six countries, 27%) were 5b: Create by law completely smoke-free environments in all indoor workplaces, public places and public transport; and 5d: Ban all forms of tobacco advertising, promotion and sponsorship. This was followed by 5c: Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns (three countries, 14%); and 5a: Reduce affordability of tobacco products by increasing tobacco excise taxes (two countries, 9%).

In regard to measures to reduce the harmful use of alcohol, 15 countries (68%) fully achieved Sub-indicator 6b: Member State has implemented, as appropriate according to national circumstances, comprehensive restrictions or bans on alcohol advertising and promotions; 13 countries (59%) fully achieved Sub-indicator 6a: Member State has implemented, as appropriate according to national ciscumstances, regulations over commercial and public availability of alcohol; and 12 countries (55%) fully achieved Sub-indicator 6c: Member State has implemented, as appropriate according to national ciscumstances, pricing policies such as excise tax increases on alcoholic beverages.

In regard to the implementation of the four measures to combat unhealthy diet, six countries (27%) fully achieved Sub-indicator 7a: Member State has adopted policies to reduce population salt/sodium consumption; seven countries (32%) fully achieved Sub-indicator 7b: Member State has adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply; 12 countries (55%) fully achieved Sub-indicator 7d: Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes; and 11 countries (50%) fully achieved Indicator 8: Member State has implemented at least one recent public awareness programme on diet and/or physical activity.

In regard to strengthening health systems to enable them to address noncommunicable diseases, nine countries (41%) fully achieved Indicator 9: Member State has evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary healthcare approach, recognized/approved by government or competent authorities; and eight countries (36%) fully achieved Indicator 10: Member State has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level.

Results

Governance

An integrated national noncommunicable disease policy/strategy or action plan was developed in the majority of the countries of the Region (17 of the 22 countries, 77%), but it was operational in only eight countries (38%). With respect to the content of the noncommunicable disease strategies, all four main noncommunicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) were included in most of the countries' strategies, as were the following risk factors: unhealthy diet, physical inactivity and tobacco. Harmful use of alcohol was only included in the strategies of six countries (27%). The vertical programmes addressing noncommunicable diseases most commonly included were for cancer, unhealthy diet and tobacco use (59–64%). Among Group 3 countries, only one country indicated the existence of vertical programmes addressing noncommunicable diseases.

A high percentage of countries – 91% – had one or more units, branches or departments responsible for noncommunicable diseases at their ministry of health. The most commonly funded noncommunicable disease-related activity was health care management and control (86%), followed by early detection and screening (73%), primary prevention, and capacity building (68% each). A clear gap exists between Group 1 and Group 3 countries in terms of funding for noncommunicable diseases and their associated risk factors, with the latter group having the least funding allocated.

The most common source for noncommunicable disease funding came from government revenues (86%), followed by health insurance (59%). Funding from international/national donors was more prevalent in Group 2 and Group 3 countries than those in Group 1.

Tobacco taxation was by far the most common (86%) fiscal intervention measure for health in the Region, followed by alcohol taxation (45%). Price subsidies for healthy food and taxation of sugar-sweetened beverages were enforced in only four countries (18%), while both the implementation of taxation on foods high in fat, sugar or salt content and tax incentives for promoting physical activity were not reported by any country.

Although most countries of the Region (68%) indicated the existence of a national multisectoral body that oversees noncommunicable diseases, only eight countries (36%) stated that this multisectoral body was operational, and none of these were in Group 3.

Prevention and reduction of risk factors

A majority (68%) of countries indicated that noncommunicable diseases were included in their national health plans, while, 45% indicated that noncommunicable diseases were included in their national development agenda. The majority (55%) of countries have developed a relevant set of national noncommunicable disease indicators.

Only four countries (18%) of the Region have implemented policies that regulate the marketing of foods and non-alcoholic beverages to children. Only seven countries (32%) have implemented national policies to limit saturated fatty acids and virtually eliminate industrially produced trans-fats, while six countries (27%) have national policies to reduce salt consumption. Group 3 countries lack any kind of national public awareness programmes on diet and physical activity; this is in strong contrast to countries in Groups 1 and 2.

Surveillance, monitoring and evaluation

Eighteen countries (82%) indicated that they have a department (exclusive/non-exclusive/shared) within their ministry of health responsible for the surveillance of noncommunicable diseases and their related risk factors. Five countries (23%) had a satisfactorily functioning system for generating reliable cause-specific mortality data on a routine basis. Population-based cancer registries were available in 82% of countries, with 64% having population-based cancer registries, and 41% having national coverage. Diabetes registries were less common, with only 41% of countries reporting the presence of these, while 27% of countries indicated recording facilities for diabetes-related complications. Afghanistan, Djibouti, Pakistan and Somalia lacked both cancer and diabetes registries.

Eight (36%) countries indicated they had implemented a STEPS survey or comprehensive health examination survey within the last 5 years: Egypt, Islamic Republic of Iran, Iraq, Kuwait, Palestine, Qatar, Saudi Arabia and United Arab Emirates.

In terms of data collection on noncommunicable disease risk factors (gathered in a STEPS survey), the regional average was 6.3 out of a total of 9 risk factors. Data collection on these risk factors decreased markedly in Group 3 countries in comparison to both Group 1 and Group 2 countries. Adolescent surveys shared similar data collection findings, with a regional average of 2.7

out of a total of five risk factors. Data collection on these risk factors also decreased markedly in Group 3 countries in comparison to both Group 1 and Group 2 countries. The risk factors on which the least data were collected were salt intake among adults (data were available in 32% of the surveys), and the harmful use of alcohol among adolescents (data were available in 18% of the surveys).

Health care

The regional availability of evidence-based national guidelines for the management of noncommunicable diseases was most common for diabetes (73%) and cardiovascular diseases (68%). The same was true for the availability of referral systems from primary care to tertiary care. In terms of the availability of the 13 basic technologies for early detection, diagnosis and monitoring of noncommunicable diseases, the average available number of basic technologies was 6.4/13 at public primary care facilities and 6.8/13 at private primary care facilities. Here too, there was a marked difference in availability between Group 1 and Group 3 countries, with the latter group having the lowest number of available basic technologies (3.2–3.5). As regards the availability of the 12 essential noncommunicable disease medicines at public sector primary care facilities, the regional average was 8.1 out of 12. Medicines reported to be least available were: oral morphine (found in 18% of countries), statins (found in 50% of countries) and steroid inhalers (found in 55% of countries).

Regarding cancer screening programmes, breast cancer screening was by far the most commonly available screening programme, accessible in 68% of countries. In contrast, less than 30% of countries indicated the availability of screening programmes for cancers of the cervix, colon and prostate. Screening programmes were notably absent in almost all Group 3 countries, with the exception of breast cancer screening in Yemen. About two-thirds of countries reported that early detection of cancers was integrated into primary health care services. Only two countries (9%) had a national ongoing HPV vaccination programme (Libya, United Arab Emirates).

The regional availability of specific procedures for treating noncommunicable diseases in publicly funded health systems varied from 55% for retinal photocoagulation and renal transplantation to 77% for coronary bypass or stenting and renal dialysis. Availability of such procedures was lowest among Group 3 countries. Moreover, availability of cancer diagnosis and treatment services in the public sector was relatively high among Group 1 and Group 2 countries (80–90%), but lower in Group 3 countries (50%). Only three countries (14%) of the Region reported having palliative care for patients with noncommunicable diseases in the public health system (Qatar, Saudi Arabia, Syrian Arab Republic).

When interpreting the findings of the regional country capacity survey, it is important to keep in mind its associated limitations, such as: the use of an intercountry survey to capture many complex health system-related measures; data are based on a system of self-reporting; and the relative expertise of the noncommunicable disease focal points completing the survey, coupled with their relative overall comprehension of the survey questions. Parallel to these limitations, many countries of the Region are experiencing major political instability, which is also hindering noncommunicable disease-related progress. In addition, there is a marked disparity in capacities between Group 3 countries and countries in Groups 1 and 2. However, despite these challenges, it can be concluded from the results of the survey that since 2011, notable progress can be observed in noncommunicable disease prevention and control in the Region.

Fig. 1.

The 10 progress monitoring indicators published by WHO in May 2015

World Health Organization

GETTING TO 2018: PROGRESS MONITOR ON NONCOMMUNICABLE DISEASES

PREPARING FOR THE THIRD UN HIGH-LEVEL MEETING ON NONCOMMUNICABLE DISEASES[1]

The WHO Director-General will use the following 10 progress indicators to report, by the end of 2017, to the United Nations General Assembly on the progress achieved in the implementation of the four time-bound commitments included in the 2014 UN Outcome Document on noncommunicable diseases:

Time-bound commitments	Indicators
BY 2015 — Consider setting national noncommunicable disease targets for 2025	1 Member State has set time-bound national targets and indicators based on WHO guidance 2 Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis 3 Member State has a STEPS survey or a comprehensive health examination survey every 5 years
BY 2015 — Consider developing national multisectoral policies and plans to achieve the national targets by 2025	4 Member State has an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors
BY 2016 — Reduce risk factors for noncommunicable diseases, building on guidance set out in the WHO Global Noncommunicable Disease Action Plan	5 Member State has implemented the following four demand-reduction measures of the WHO FCTC at the highest level of achievement: a. Reduce affordability of tobacco products by increasing tobacco excise taxes b. Create by law completely smoke-free environments in all indoor workplaces, public places and public transport c. Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns d. Ban all forms of tobacco advertising, promotion and sponsorship 6 Member State has implemented, as appropriate according to national circumstances, the following three measures to reduce the harmful use of alcohol as per the WHO Global Strategy to Reduce the Harmful Use of Alcohol: a. Regulations over commercial and public availability of alcohol b. Comprehensive restrictions or bans on alcohol advertising and promotions c. Pricing policies such as excise tax increases on alcoholic beverages 7 Member State has implemented the following four measures to reduce unhealthy diets: a. Adopted national policies to reduce population salt/sodium consumption b. Adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply c. WHO set of recommendations on marketing of foods and non-alcoholic beverages to children d. Legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes 8 Member State has implemented at least one recent national public awareness programme on diet and/or physical activity
BY 2016 — Strengthen health systems to address noncommunicable diseases through people-centred primary health care and universal health coverage, building on guidance set out in the WHO Global Noncommunicable Disease Action Plan	9 Member State has evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities 10 Member State has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level

Introduction

Noncommunicable diseases are the leading cause of death worldwide: they are responsible for approximately 38 million deaths each year, or 68% of annual global mortality. Cardiovascular diseases account for the majority of noncommunicable disease deaths (46.2%), followed by cancers (21.7%), chronic respiratory diseases (10.7%), and diabetes (4%). 16 million people are estimated to die prematurely, that is, before the age of 70, as a result of these four noncommunicable diseases. Most noncommunicable disease deaths (74%) occur in low- and middle-income countries, where socioeconomic development is impacted the most (*2*).

Approximately 60% of deaths in the Eastern Mediterranean Region are due to noncommunicable diseases. The Region has the second-highest age-standardized noncommunicable disease death rates of all WHO regions. It is also the Region with the highest rates of noncommunicable disease risk factors: physical inactivity, diabetes and obesity, high blood pressure, tobacco use, and high salt, sugar and fat intake. With national commitment and well-coordinated efforts, a huge proportion of noncommunicable diseases can be prevented and controlled. Best evidence points to the fact that focusing on prevention through the four main noncommunicable disease risk factors – tobacco use, physical inactivity, unhealthy diet and harmful use of alcohol – can substantially reduce the burden of noncommunicable diseases (*3*).

To assist in planning, monitoring and evaluating noncommunicable disease-related actions/interventions, WHO conducts periodic global country capacity surveys to assess the capacities of individual countries to prevent and control noncommunicable diseases. These surveys aim to assist countries to assess, monitor and evaluate their capacities, particularly in relation to: governance, prevention of risk factors, surveillance, monitoring and evaluation, and health care at the national level (that is, the four strategic interventions of the regional Framework for action to implement the 2011 United Nations Political Declaration on Noncommunicable Diseases (*3*)). The first survey was conducted in 2000, with subsequent surveys in 2000, 2005, 2010 and 2013.

The results of the 2010 noncommunicable disease country capacity survey were used to inform the first United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases that took place in New York in 2011. The outcome was the landmark adoption of the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which committed countries to taking action through setting national targets, developing national plans and implementing proven interventions to prevent, control and monitor noncommunicable diseases. Concurrently, WHO created the Global action plan for the prevention and control of noncommunicable diseases 2013–2020, which articulated six objectives and 25 process indicators that relate to the nine voluntary targets to be achieved by 2025 (*4,5*).

The second United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which took place in 2014, resulted in an outcome document that produced an updated regional framework for action with 10 progress indicators and four time-bound commitments that countries should aim to achieve by 2016 (*6,7*). These progress indicators will be used to report on progress during the third United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2018. The 2015 country capacity survey was revised accordingly, in order to include these 10 progress indicators in the reporting process. Two additional country capacity surveys are also being planned for 2017 and 2020. The results of the 2017 survey will be used to report on progress during the 2018 third United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

In recent years there has been a growing global recognition of the increasing burden of noncommunicable diseases and their associated negative consequences on social as well as economic development. This recognition is reflected in the commitments pledged by WHO Member States and other stakeholders, and the unprecedented emphasis placed on noncommunicable disease prevention and control by the Sustainable Development Goals of the 2015 United Nations General Assembly development agenda: "Transforming our world: the 2030 agenda for sustainable development," (*8*) in particular by

the 13 health targets in Sustainable Development Goal 3. Six of these targets[1] aim to curb the burden of noncommunicable diseases globally, as well as regionally and nationally.

This report presents the findings of the 2015 noncommunicable disease country capacity survey for the Eastern Mediterranean Region, which was carried out between May and September 2015 in 21 countries of the Region. This survey aims, as already indicated, to assist countries to assess, monitor and evaluate their capacities to address noncommunicable diseases in relation to the four time-bound commitments of the regional Framework for action to implement the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

Country classification

The WHO Eastern Mediterranean Region comprises 22 countries with an estimated total population of about 617 million people – approximately 8.6% of the world's population.

The countries of the Region are characterized by many differences, such as geographic area, population size, political system, climate, and cuisine, as well as levels of economic and social development. Several countries are currently experiencing or have experienced long-term or episodic political instability and threats to their security, which significantly impact their capacity for growth and development. To better take account of these socioeconomic disparities, the WHO Eastern Mediterranean Region country classification system was developed in 2012. In this system, the countries of the Region are divided into three groups[2] (Table 1).

Several countries in Group 2 are currently in conflict and crisis situations, which undoubtedly have had a serious impact on the three criteria for grouping. Nevertheless, for the purpose of the sub-analysis conducted in this report, these countries have been retained in Group 2.

1 Target 3.4: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being; target 3.5: Strengthen the prevention and treatment of … harmful use of alcohol; 3.8: Achieve universal health coverage; target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination; target 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate; target 3b: Support the research and development of vaccines and medicines for the … noncommunicable diseases that primarily affect developing countries.

2 The three groups were defined based on population health outcomes, health system performance and level of health expenditure: 1) countries in which socioeconomic development has progressed considerably over the last four decades, supported by high income; 2) countries, largely middle-income, which have developed an extensive public health service delivery infrastructure but that face resource constraints; 3) countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability, conflicts and other complex development challenges.

Table 1.

Population and World Bank country income group of countries of the Eastern Mediterranean Region, by country group

Country	Population in millions (2013)[a]	Country group	2015 World Bank country income group (*9*)
Bahrain	1.33	Group 1	High income
Kuwait	3.37	Group 1	High income
Oman	3.63	Group 1	High income
Qatar	2.17	Group 1	High income
Saudi Arabia	28.83	Group 1	High income
United Arab Emirates	9.35	Group 1	High income
Group 1 total	**48.68**		
Egypt	82.06	Group 2	Lower-middle income
Iran (Islamic Republic of)	77.45	Group 2	Upper-middle income
Iraq	33.77	Group 2	Upper-middle income
Jordan	7.27	Group 2	Upper-middle income
Lebanon	4.82	Group 2	Upper-middle income
Libya	6.20	Group 2	Upper-middle income
Morocco	33.01	Group 2	Lower-middle income
Palestine	4.42[b]	Group 2	Lower-middle income
Syrian Arab Republic	21.90	Group 2	Lower-middle income
Tunisia	11.00	Group 2	Upper-middle income
Group 2 total	**281.89**		
Afghanistan	30.55	Group 3	Low Income
Djibouti	0.87	Group 3	Lower-middle income
Pakistan	182.14	Group 3	Lower-middle income
Somalia	10.50	Group 3	Low income
Sudan	37.96	Group 3	Lower-middle income
Yemen	24.41	Group 3	Lower-middle income
Group 3 total	**286.44**		
Eastern Mediterranean Region total	**617.00**		

[a] Population figures taken from WHO Country Profiles (*10*) except for Palestine

[b] Palestinian Central Bureau of Statistics. State of Palestine (http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/gover_e.htm)

Methods

Overview

The 2015 country capacity survey was adapted from its 2013 predecessor, and included improvements made both to the questionnaire design and the validation process. A web-based application was used to host the questionnaire tool and for data collection. Twenty-one out of the 22 Eastern Mediterranean Region countries took part in the 2015 country capacity survey (95%) (Djibouti was unable to participate[3]). In comparison, the 2010 and 2015 surveys had a 100% regional response rate. Unique log-in details were provided for each country's assigned noncommunicable disease focal point. The focal points were either personnel at ministries of health responsible for a unit or programme on noncommunicable diseases, or delegated members of staff of ministries of health or other national ministries or institutes. To ensure completeness of information, the instructions sent to focal points requested that they lead the completion of the questionnaire, consulting with nationals experts responsible for topic-specific sections of the questionnaire as necessary. Data collection took place between May and September 2015.

WHO reviewed and validated country responses as far as possible. Where responses were left blank, the noncommunicable disease focal point was informed of non-completeness and requested to respond accordingly. Where it was established with the focal point that they did not know the response to an item on the questionnaire, after exhausting all means to acquire such information, the 'Don't know' response option was selected. Validation of the reported data included the use of many resources, such as: the International Agency for Research on Cancer GLOBOCAN online database for cancer-related data; the WHO Global InfoBase and internal survey tracking systems for WHO-supported surveys such as STEPS (adult risk-factor surveillance), the Global school-based health survey and the Global Youth Tobacco Survey; the WHO guidelines on nutrition labelling; country mortality data stored in the WHO Global Health Observatory; and national strategies, guidelines, and survey reports submitted online by the focal points along with the completed questionnaire.

Consistency of reported data was also cross-checked with the responses provided in the 2013 survey for any major outlier responses. In all cases, the focal points were contacted by the WHO survey team for final confirmation and modification of responses.

With regard to the "Don't know" response option in the questionnaire, instructions for respondents requested that when several "Don't knows" were ticked, another respondent with greater awareness of the information in question should complete that particular section of the questionnaire.

The questionnaire

The revision of the 2015 country capacity survey questionnaire was conducted at a technical meeting at WHO headquarters on 24–25 April 2015, which brought together all the designated focal points from all six WHO regional offices. The revisions to the questions focused on redesigning them in such a way that they would yield objective information rather than the personal opinions of respondents. They were also formulated to measure the 10 progress indicators developed by WHO in light of the outcome document of the 2014 second United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (*11*).

The 2015 noncommunicable diseases country capacity survey questionnaire is divided into four modules related to noncommunicable disease prevention and control.

***Module I**: Public health infrastructure, partnerships and multisectoral collaboration for noncommunicable diseases and their risk factors*. This module includes questions related to the presence of a unit or division in the ministry of health dedicated to noncommunicable diseases and risk factors, staff and funding. It also assesses the availability of fiscal interventions as incentives to influence health behaviour and/or to raise funds for health-related activities, and the existence of a formal multisectoral mechanism to coordinate noncommunicable disease-related activities in sectors outside health.

Module II: *Status of noncommunicable disease-relevant policies, strategies, and action plans*. This module includes questions relating to the presence of policies, strategies, or action plans. The questions differentiate between integrated policies/strategies/action plans that address several risk factors or diseases, and policies/strategies/action plans that address a specific disease or risk factor. Additional questions address the implementation of specific policies related to cost-effective interventions for noncommunicable diseases.

***Module III**: Health information systems, surveillance and surveys for noncommunicable diseases and their risk factors*. This module collects data on the availability of statistics and associated generating systems related to noncommunicable disease mortality, morbidity and risk factors. It also gathers information about cancer registration.

***Module IV:** Capacity for noncommunicable disease early detection, treatment and care within the health system*. This module assesses national health care system

3 Data on Djibouti was updated during the fourth WHO Eastern Mediterranean Region annual regional meeting to scale up implementation of the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases held in Cairo, Egypt on 26–28 April 2016.

capacity regarding noncommunicable disease early detection, treatment and care, with specific focus on the primary health care sector. The questions focus on: availability of guidelines or protocols to manage the major noncommunicable diseases; the availability of tests, procedures and equipment related to the diseases within the health care system; and the availability of palliative care services for noncommunicable diseases.

Responses to the questions in all four modules will enable reporting against the 10 progress indicators and the four time-bound commitments developed following the 2014 second United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases, as well as against the 25 Global monitoring framework indicators set out in the Global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Analysis

Data for each country response were extracted from the web-based application in Microsoft Excel format, with subsequent cleaning carried out to ensure consistency of responses within questions and their subsections. STATA v.11 software (Stata Corporation, 2009) was used for all analysis conducted. Group-level analysis was conducted using the regional country classification system.

For country-level analysis, the denominator used was always the total number of responding countries, either overall or within a particular sub-group. Percentages reported reflect the positive responses to a question, while non-positive responses (that is, "no", "don't know", missing response) were treated equally.

In order to highlight progress achieved (or the lack thereof), trend analysis was also carried out using data from the 2010 and 2013 country capacity survey assessments, which thus provided three points in time for analysis for most countries (those who responded to all three assessments).

Results

Overall status of the 10 progress indicators in the Eastern Mediterranean Region

The progress indicators most achieved by countries, as shown in Table 2, were: Progress indicator 6, Sub-indicators a: Member State has implemented, as appropriate according to national circumstances, regulations over commercial and public availability of alcohol (13 countries); b: Member State has implemented, as appropriate according to national circumstances, comprehensive restrictions or bans on alcohol advertising and promotions (15 countries); and c: Member State has implemented, as appropriate according to national circumstances, pricing policies such as excise tax increases on alcoholic beverages (12 countries); Progress indicator 7, Sub-indicator d: Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (12 countries); and Progress indicator 8: Member State has implemented at least one recent national public awareness programme on diet and/or physical activity (11 countries).

Table 2.

Overall summary of progress indicator achievement in the Eastern Mediterranean Region[4]

Progress indicator number	Progress indicator[a]	Number and percentage of countries achieving indicator	Countries achieving indicator
1	Member State has set time-bound national targets and indicators based on WHO guidance	6 countries (27%)	Bahrain, Islamic Republic of Iran, Iraq, Morocco, Saudi Arabia, United Arab Emirates
2	Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis	5 countries (22.7%)	Bahrain, Jordan, Kuwait, Palestine, Qatar
3	Member State has implemented a STEPS survey or a comprehensive health examination survey every 5 years	8 countries (36%)	Egypt, Islamic Republic of Iran, Iraq, Kuwait, Palestine, Qatar, Saudi Arabia, United Arab Emirates
4	Member State has an operational multisectoral national strategy/ action plan that integrates the major noncommunicable diseases and their shared risk factors	9 countries (41%)	Bahrain, Islamic Republic of Iran, Iraq, Lebanon, Morocco, Oman, Palestine, Saudi Arabia, United Arab Emirates
5a	Member State has implemented measures to reduce affordability of tobacco products by increasing tobacco excise taxes	2 countries (8.7%)	Jordan, Palestine
5b	Member State has implemented measures to create by law completely smoke-free environments in all indoor workplaces, public places and public transport	6 countries (27%)	Islamic Republic of Iran, Lebanon, Libya, Pakistan, Palestine, Saudi Arabia
5c	Member State has implemented measures to warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns	3 countries (13.6%)	Djibouti, Egypt, Islamic Republic of Iran
5d	Member State has implemented measures to ban all forms of tobacco advertising, promotion and sponsorship	6 countries (27%)	Bahrain, Djibouti, Islamic Republic of Iran, Libya, United Arab Emirates, Yemen

[a]For details of the definition of the 10 progress indicators and how they are calculated, see Reference 11 on page 97 of this report.

4 Last updated during the fourth WHO Eastern Mediterranean Region annual regional meeting to scale up implementation of the 2011 United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases held in Cairo, Egypt on 26–28 April 2016

Progress indicator number	Progress indicator[a]	Number and percentage of countries achieving indicator	Countries achieving indicator
6a	Member State has implemented regulations over commercial and public availability of alcohol	13 countries (59%)	Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Libya, Morocco, Oman, Saudi Arabia, Somalia, Sudan, Tunisia, United Arab Emirates, Yemen
6b	Member State has implemented comprehensive restrictions or bans on alcohol advertising and promotions	15 countries (68%)	Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Jordan, Libya, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Tunisia, United Arab Emirates, Yemen
6c	Member State has implemented pricing policies such as excise tax increases on alcoholic beverages	12 countries (55%)	Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Libya, Morocco, Oman, Saudi Arabia, Somalia, Sudan, United Arab Emirates, Yemen
7a	Member State has adapted national policies to reduce population salt/ sodium consumption	6 countries (27%)	Bahrain, Islamic Republic of Iran, Kuwait, Oman, Qatar, Saudi Arabia
7b	Member State has adapted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply	7 countries (31.8%)	Bahrain, Islamic Republic of Iran, Iraq, Kuwait, Qatar, Saudi Arabia, Tunisia
7c	Member State has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children	12 countries (55%)	Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Saudi Arabia, Tunisia, United Arab Emirates, Yemen
7d	Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes	12 countries (55%)	Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Saudi Arabia, Tunisia, United Arab Emirates, Yemen
8	Member State has implemented at least one recent national public awareness programme on diet and/or physical activity	11 countries (50%)	Bahrain, Islamic Republic of Republic, Iraq, Jordan, Kuwait, Morocco, Palestine, Qatar, Saudi Arabia, Tunisia, United Arab Emirates
9	Member State has evidence-based national guidelines/protocols/ standards for the management of major noncommunicable diseases through a primary health care approach, recognized/approved by government or competent authorities	9 countries (41%)	Bahrain, Islamic Republic of Iran, Kuwait, Lebanon, Palestine, Qatar, Saudi Arabia, Sudan, United Arab Emirates
10	Member State has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level	8 countries (36%)	Bahrain, Jordan, Kuwait, Oman, Palestine, Qatar, Saudi Arabia, United Arab Emirates

Overview of the 10 progress indicators by country, country group, and achievement status

Six countries (27%) fully implemented Progress indicator 1: Bahrain, Islamic Republic of Iran, Iraq, Morocco, Saudi Arabia, and United Arab Emirates. In Group 1, only Kuwait has not set its national time-bound targets and indicators, while half of Group 2 and 83% of Group 3 have not yet done so (Table 3).

Table 3.

Progress indicator 1: Member State has set time-bound national targets and indicators based on WHO guidance

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	.	.	✓
	Oman	.	✓	.
	Qatar	.	✓	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**50%**	**33%**	**17%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	✓	.
	Lebanon	.	.	✓
	Libya	.	.	✓
	Morocco	✓	.	.
	Palestine	.	.	✓
	Syrian Arab Republic	.	.	✓
	Tunisia	.	.	✓
	Group 2	**30%**	**20%**	**50%**
Group 3	Afghanistan	.	✓	.
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**17%**	**83%**
Eastern Mediterranean Region		**27%**	**23%**	**50%**

Only five countries (23%) have fully achieved a functioning system for generating reliable cause-specific mortality data on a routine basis: Bahrain, Jordan, Kuwait, Palestine and Qatar. Lebanon and Libya in Group 2, as well as all Group 3 countries, have not yet achieved such a system (Table 4).

Table 4.

Progress indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	.	✓	.
	Qatar	✓	.	.
	Saudi Arabia	.	✓	.
	United Arab Emirates	.	✓	.
	Group 1	**50%**	**50%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	.	✓	.
	Iraq	.	✓	.
	Jordan	✓	.	.
	Lebanon	.	.	✓
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	✓	.
	Tunisia	.	✓	.
	Group 2	**20%**	**60%**	**20%**
Group 3	Afghanistan	.	.	✓
	Djibouti	.	.	✓
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**23%**	**41%**	**36%**

Approximately one in four countries has not conducted a STEPS survey or comprehensive health examination survey in the past 5 years. Two-thirds of Group 1 countries have conducted a STEPs survey or its equivalent in the past 5 years, while only 40% of Group 2 countries have done so. In Group 3, only Pakistan and Sudan have partially achieved this indicator (Table 5).

Table 5.

Progress indicator 3: Member State has a STEPS survey or a comprehensive health examination survey every 5 years

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	.	✓	.
	Kuwait	✓	.	.
	Oman	.	✓	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**67%**	**33%**	**0%**
Group 2	Egypt	✓	.	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	.	✓	.
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	.	✓
	Tunisia	.	✓	.
	Group 2	**40%**	**50%**	**10%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	✓	.
	Somalia	.	.	✓
	Sudan	.	✓	.
	Yemen	.	.	✓
	Group 3	**0%**	**33%**	**67%**
Eastern Mediterranean Region		**5%**	**73%**	**23%**

Nine countries (41%) have developed an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their risk factors. Among Group 1 countries only Kuwait has not achieved this indicator, while in Group 2, Libya, Syrian Arab Republic and Tunisia have not done so. In Group 3, only Afghanistan has partially achieved this indicator (Table 6).

Table 6.

Progress indicator 4: Member State has an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	.	.	✓
	Oman	✓	.	.
	Qatar	.	✓	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**67%**	**17%**	**17%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	✓	.
	Lebanon	✓	.	.
	Libya	.	.	✓
	Morocco	✓	.	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	.	✓
	Tunisia	.	.	✓
	Group 2	**50%**	**20%**	**30%**
Group 3	Afghanistan	.	✓	.
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**17%**	**83%**
Eastern Mediterranean Region		**41%**	**18%**	**41%**

Only 12 countries (54%) have been able to fully or partially implement measures to reduce tobacco product affordability through excise tax increases. Jordan and Palestine were the only two countries to fully achieve this sub-indicator. Two-thirds of Group 1 countries have not achieved this indicator, compared to 40% and 33% of Groups 2 and 3 respectively (Table 7).

Table 7.

Progress indicator 5a: Member State has implemented measures to reduce affordability of tobacco products by increasing tobacco excise taxes

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	.	✓	.
	Kuwait	.	✓	.
	Oman	.	.	✓
	Qatar	.	.	✓
	Saudi Arabia	.	.	✓
	United Arab Emirates	.	.	✓
	Group 1	**0%**	**33%**	**67%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	.	.	✓
	Iraq	.	.	✓
	Jordan	✓	.	.
	Lebanon	.	✓	.
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	.	✓
	Tunisia	.	✓	.
	Group 2	**20%**	**40%**	**40%**
Group 3	Afghanistan	.	.	✓
	Djibouti	.	✓	.
	Pakistan	.	✓	.
	Somalia	.	.	✓
	Sudan	.	✓	.
	Yemen	.	✓	.
	Group 3	**0%**	**67%**	**33%**
Eastern Mediterranean Region		**9%**	**45%**	**45%**

Approximately two-thirds of countries have either fully or partially implemented measures to create completely smoke-free environments in all indoor workplaces, public places and public transport. With the exception of Kuwait and Saudi Arabia, most Group 1 countries (67%) were not able to enforce these measures, while 90% (9 countries) of Group 2 and 67% (4 countries) of Group 3 countries had either fully or partially implemented them. Pakistan was the only Group 3 country to fully implement such measures (Table 8).

Table 8.

Progress indicator 5b: Member State has implemented measures to create by law completely smoke-free environments in all indoor workplaces, public places and public transport

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	.	.	✓
	Kuwait	.	✓	.
	Oman	.	.	✓
	Qatar	.	.	✓
	Saudi Arabia	✓	.	.
	United Arab Emirates	.	.	✓
	Group 1	**17%**	**17%**	**67%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	.	✓	.
	Lebanon	✓	.	.
	Libya	✓	.	.
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	✓	.
	Tunisia	.	.	✓
	Group 2	**40%**	**50%**	**10%**
Group 3	Afghanistan	.	✓	.
	Djibouti	.	✓	.
	Pakistan	✓	.	.
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	✓	.
	Group 3	**17%**	**50%**	**33%**
Eastern Mediterranean Region		**27%**	**41%**	**32%**

Three countries – Egypt, Islamic Republic of Iran, and Djibouti – have fully implemented measures to warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns. All Group 1 countries were partially able to implement such measures, compared to about one-third of Group 2 and Group 3 countries. Half of the countries in Groups 2 and 3 were not able to achieve this sub-indicator (Table 9).

Table 9.

Progress indicator 5c: Member State has implemented measures to warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	.	✓	.
	Kuwait	.	✓	.
	Oman	.	✓	.
	Qatar	.	✓	.
	Saudi Arabia	.	✓	.
	United Arab Emirates	.	✓	.
	Group 1	**0%**	**100%**	**0%**
Group 2	Egypt	✓	.	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	.	.	✓
	Morocco	.	.	✓
	Palestine	.	.	✓
	Syrian Arab Republic	.	.	✓
	Tunisia	.	.	✓
	Group 2	**20%**	**30%**	**50%**
Group 3	Afghanistan	.	.	✓
	Djibouti	✓	.	.
	Pakistan	.	✓	.
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	✓	.
	Group 3	**17%**	**33%**	**50%**
Eastern Mediterranean Region		**14%**	**50%**	**36%**

Most countries (19 countries, 86%) have either fully or partially implemented measures to ban all forms of tobacco advertising, promotion and sponsorship (TAPS ban). However, the majority of these countries reported only partial implementation, and while Bahrain, Djibouti, Islamic Republic of Iran, Libya, United Arab Emirates and Yemen all reported full implementation, Oman and Saudi Arabia from Group 1 and Somalia from Group 3 reported that they had not been able to achieve this sub-indicator (Table 10).

Table 10.

Progress indicator 5d: Member State has implemented measures to ban all forms of tobacco advertising, promotion and sponsorship

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	.	✓	.
	Oman	.	.	✓
	Qatar	.	✓	.
	Saudi Arabia	.	.	✓
	United Arab Emirates	✓	.	.
	Group 1	**33%**	**33%**	**33%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	✓	.	.
	Morocco	.	✓	.
	Palestine	.	✓	.
	Syrian Arab Republic	.	✓	.
	Tunisia	.	✓	.
	Group 2	**20%**	**80%**	**0%**
Group 3	Afghanistan	.	✓	.
	Djibouti	✓	.	.
	Pakistan	.	✓	.
	Somalia	.	.	✓
	Sudan	.	✓	.
	Yemen	✓	.	.
	Group 3	**33%**	**50%**	**17%**
Eastern Mediterranean Region		**27%**	**59%**	**14%**

Thirteen countries (59%) have fully implemented regulations over commercial and public availability of alcohol, while three countries in Group 2 (Jordan, Lebanon and Syrian Arab Republic) and one country in Group 3 (Pakistan) have partially achieved this sub-indicator. No data were available on this sub-indicator for: Bahrain, Djibouti, Kuwait, Palestine and Qatar (Table 11).

Table 11.

Progress indicator 6a: Member State has implemented, as appropriate according to national circumstances, regulations over commercial and public availability of alcohol

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	na	na	na
	Kuwait	na	na	na
	Oman	✓	.	.
	Qatar	na	na	na
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**50%**	**0%**	**50%**
Group 2	Egypt	✓	.	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	✓	.	.
	Morocco	✓	.	.
	Palestine	na	na	na
	Syrian Arab Republic	.	✓	.
	Tunisia	✓	.	.
	Group 2	**60%**	**30%**	**10%**
Group 3	Afghanistan	✓	.	.
	Djibouti	na	na	na
	Pakistan	.	✓	.
	Somalia	✓	.	.
	Sudan	✓	.	.
	Yemen	✓	.	.
	Group 3	**67%**	**17%**	**17%**
Eastern Mediterranean Region		**59%**	**18%**	**23%**

Fifteen countries (68%) have fully implemented comprehensive restrictions or bans on alcohol advertising and promotions; 50% of Group 1, 70% of Group 2, and 83% of Group 3 reported full implementation. Lebanon and Syrian Arab Republic reported partial implementation, while no data were available for Bahrain, Djibouti, Kuwait, Palestine and Qatar (Table 12).

Table 12.

Progress indicator 6b: Member State has implemented, as appropriate according to national circumstances, comprehensive restrictions or bans on alcohol advertising and promotions

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	na	na	na
	Kuwait	na	na	na
	Oman	✓	.	.
	Qatar	na	na	na
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**50%**	**0%**	**50%**
Group 2	Egypt	✓	.	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	✓	.	.
	Lebanon	.	✓	.
	Libya	✓	.	.
	Morocco	✓	.	.
	Palestine	na	na	na
	Syrian Arab Republic	.	✓	.
	Tunisia	✓	.	.
	Group 2	**70%**	**20%**	**10%**
Group 3	Afghanistan	✓	.	.
	Djibouti	na	na	na
	Pakistan	✓	.	.
	Somalia	✓	.	.
	Sudan	✓	.	.
	Yemen	✓	.	.
	Group 3	**83%**	**0%**	**17%**
Eastern Mediterranean Region		**68%**	**9%**	**23%**

Twelve countries (55%) have fully implemented pricing policies such as excise tax increases on alcoholic beverages; full implementation was reported by 50% of Group 1, 50% of Group 2, and 67% of Group 3 countries. Jordan, Lebanon, Syrian Arab Republic and Tunisia from Group 2 and Pakistan from Group 3 reported partial implementation, while no data were available for Bahrain, Djibouti, Kuwait, Palestine and Qatar (Table 13).

Table 13.

Progress indicator 6c: Member State has implemented, as appropriate according to national circumstances, pricing policies such as excise tax increases on alcoholic beverages

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	na	na	na
	Kuwait	na	na	na
	Oman	✓	.	.
	Qatar	na	na	na
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**50%**	**0%**	**50%**
Group 2	Egypt	✓	.	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	✓	.	.
	Morocco	✓	.	.
	Palestine	na	na	na
	Syrian Arab Republic	.	✓	.
	Tunisia	.	✓	.
	Group 2	**50%**	**40%**	**10%**
Group 3	Afghanistan	✓	.	.
	Djibouti	na	na	na
	Pakistan	.	✓	.
	Somalia	✓	.	.
	Sudan	✓	.	.
	Yemen	✓	.	.
	Group 3	**67%**	**17%**	**17%**
Eastern Mediterranean Region		**55%**	**23%**	**23%**

All Group 1 countries with the exception of United Arab Emirates have fully adapted national policies to reduce population salt/sodium consumption; United Arab Emirates has partially adapted such policies. Among Group 2 countries, only Islamic Republic of Iran has fully adapted such policies, while none of the countries in Group 3 have fully achieved this sub-indicator (Table 14).

Table 14.

Progress indicator 7a: Member State has adopted national policies to reduce population salt/sodium consumption

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	✓	.	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	.	✓	.
	Group 1	**83%**	**17%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	.	✓	.
	Lebanon	.	✓	.
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	.	✓	.
	Syrian Arab Republic	.	.	✓
	Tunisia	.	✓	.
	Group 2	**10%**	**70%**	**20%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**27%**	**36%**	**36%**

Only seven countries (32%) have fully adapted national policies that limit fatty acids and virtually eliminate industrially produced trans-fats in the food supply, of which 67% were in Group 1 and 30% were in Group 2. None of the countries in Group 3 were able to fully achieve this sub-indicator (Table 15).

Table 15.

Progress indicator 7b: Member State has adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	.	✓	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	.	✓	.
	Group 1	**67%**	**33%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	✓	.	.
	Jordan	.	.	✓
	Lebanon	.	.	✓
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	.	.	✓
	Syrian Arab Republic	.	.	✓
	Tunisia	✓	.	.
	Group 2	**30%**	**20%**	**50%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**32%**	**18%**	**50%**

Only four countries (18%) – Bahrain, Saudi Arabia and Qatar from Group 1, and Islamic Republic of Iran from Group 2 – have fully implemented the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children. None of the countries from Group 3 have implemented these recommendations (Table 16).

Table 16.

Progress indicator 7c: Member State has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	.	.	✓
	Oman	.	✓	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	.	✓	.
	Group 1	**50%**	**33%**	**17%**
Group 2	Egypt	.	.	✓
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	.	✓
	Jordan	.	✓	.
	Lebanon	.	.	✓
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	.	✓	.
	Syrian Arab Republic	.	.	✓
	Tunisia	.	✓	.
	Group 2	**10%**	**40%**	**50%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**18%**	**27%**	**55%**

Twelve countries (55%) have fully implemented legislation or regulations fully implementing the International Code of Marketing of Breast-milk Substitutes. Djibouti, Libya and Somalia were the only countries not to achieve this sub-indicator (Table 17).

Table 17.

Progress indicator 7d: Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	✓	.	.
	Qatar	.	✓	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**83%**	**17%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	✓	.	.
	Lebanon	✓	.	.
	Libya	.	.	✓
	Morocco	✓	.	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	✓	.
	Tunisia	✓	.	.
	Group 2	**60%**	**30%**	**10%**
Group 3	Afghanistan	.	✓	.
	Djibouti	.	.	✓
	Pakistan	.	✓	.
	Somalia	.	.	✓
	Sudan	.	✓	.
	Yemen	✓	.	.
	Group 3	**17%**	**50%**	**33%**
Eastern Mediterranean Region		**55%**	**32%**	**14%**

Eleven countries (50%) – 100% of Group 1 and 60% of Group 2 – reported full implementation of Indicator 8 and were able to implement at least one recent national public awareness programme on diet and/or physical activity. None of the countries in Group 3 achieved this progress indicator. For those countries that reported full implementation, the content of the awareness programme was the same in Group 1 and Group 2 countries with the exception of Oman, whose awareness programme focused on diet only (Table 18).

Table 18.

Progress indicator 8: Member State has implemented at least one recent national public awareness programme on diet and/or physical activity

Group	Country	On diet		On physical activity		On diet and/or physical activity	Fully achieved	Partially achieved	Not achieved
		Yes	No	Yes	No				
Group 1	Bahrain	✓	.	✓	.	✓	✓	.	.
	Kuwait	✓	.	✓	.	✓	✓	.	.
	Oman	✓	.	.	✓	✓	.	✓	.
	Qatar	✓	.	✓	.	✓	✓	.	.
	Saudi Arabia	✓	.	✓	.	✓	✓	.	.
	United Arab Emirates	✓	.	✓	.	✓	✓	.	.
	Group 1	**100%**	**0%**	**83%**	**17%**	**100%**	**83%**	**17%**	**0%**
Group 2	Egypt	.	✓	.	✓	.	.	✓	.
	Iran (Islamic Republic of)	✓	.	✓	.	✓	✓	.	.
	Iraq	✓	.	✓	.	✓	✓	.	.
	Jordan	✓	.	✓	.	✓	✓	.	.
	Lebanon	.	✓	.	✓	.	.	✓	.
	Libya	.	✓	.	✓	.	.	.	✓
	Morocco	✓	.	✓	.	✓	✓	.	.
	Palestine	✓	.	✓	.	✓	✓	.	.
	Syrian Arab Republic	.	✓	.	✓	.	.	.	✓
	Tunisia	✓	.	✓	.	✓	✓	.	.
	Group 2	**60%**	**40%**	**60%**	**40%**	**60%**	**60%**	**20%**	**20%**
Group 3	Afghanistan	.	✓	.	✓	.	.	.	✓
	Djibouti	na	na	na	na	na	na	na	na
	Pakistan	na	na	na	na	na	na	na	na
	Somalia	.	✓	.	✓	.	.	.	✓
	Sudan	.	✓	.	✓	.	.	.	✓
	Yemen	.	✓	.	✓	.	.	.	✓
	Group 3	**0%**	**100%**	**0%**	**100%**	**0%**	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**55%**	**45%**	**50%**	**50%**	**55%**	**50%**	**14%**	**36%**

Nine countries (41%) reported full implementation of progress indicator 9: 83% of Group 1, 30% of Group 2, and only one country – Sudan – in Group 3 (Table 19).

Table 19.

Progress indicator 9: Member State has evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	.	✓	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**83%**	**17%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	✓	.
	Jordan	.	✓	.
	Lebanon	✓	.	.
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	.	✓
	Tunisia	na	na	na
	Group 2	**30%**	**40%**	**30%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	✓	.	.
	Yemen	.	.	✓
	Group 3	**17%**	**0%**	**83%**
Eastern Mediterranean Region		**41%**	**23%**	**36%**

Eight countries (36%) reported full provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level. Full implementation was reported by all countries in Group 1, and Jordan and Palestine from Group 2, while none of the countries in Group 3 fully achieved this indicator (Table 20).

Table 20.

Progress indicator 10: Member State has provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level

Group	Country	Fully achieved	Partially achieved	Not achieved
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	✓	.	.
	Qatar	✓	.	.
	Saudi Arabia	✓	.	.
	United Arab Emirates	✓	.	.
	Group 1	**100%**	**0%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	.	✓	.
	Iraq	.	✓	.
	Jordan	✓	.	.
	Lebanon	.	✓	.
	Libya	.	.	✓
	Morocco	.	✓	.
	Palestine	✓	.	.
	Syrian Arab Republic	.	.	✓
	Tunisia	na	na	na
	Group 2	**20%**	**50%**	**30%**
Group 3	Afghanistan	.	.	✓
	Djibouti	na	na	na
	Pakistan	.	.	✓
	Somalia	.	.	✓
	Sudan	.	.	✓
	Yemen	.	.	✓
	Group 3	**0%**	**0%**	**100%**
Eastern Mediterranean Region		**36%**	**23%**	**41%**

Eastern Mediterranean Region status of the strategic interventions of the regional Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases

Governance

All countries except Lebanon and Djibouti reported the existence of a unit/branch/department at the ministry of health responsible for noncommunicable diseases. The number of full-time staff in these noncommunicable disease units was reported to be highest in Group 1 countries and lowest in Group 3 countries (Table 21).

Table 21.

Countries with unit/branch/department at the ministry of health responsible for noncommunicable diseases

Group	Country	Existence of unit/branch/department at ministry of health responsible for noncommuniable diseases	Number of full-time staff
Group 1	Bahrain	✓	11 or more
	Kuwait	✓	2 to 5
	Oman	✓	11 or more
	Qatar	✓	11 or more
	Saudi Arabia	✓	11 or more
	United Arab Emirates	✓	11 or more
	Group 1	**100%**	
Group 2	Egypt	✓	2 to 5
	Iran (Islamic Republic of)	✓	11 or more
	Iraq	✓	6 to 10
	Jordan	✓	11 or more
	Lebanon	.	
	Libya	✓	11 or more
	Morocco	✓	11 or more
	Palestine	✓	2 to 5
	Syrian Arab Republic	✓	11 or more
	Tunisia	✓	2 to 5
	Group 2	**90%**	
Group 3	Afghanistan	✓	2 to 5
	Djibouti	na	na
	Pakistan	✓	2 to 5
	Somalia	✓	2 to 5
	Sudan	✓	6 to 10
	Yemen	✓	1
	Group 3	**83%**	
Eastern Mediterranean Region		**91%**	

Compared to the 2013 regional survey data, only Egypt and United Arab Emirates reported having established a new unit for noncommunicable diseases where none existed before. The changes observed for Lebanon in 2015 can be assumed to be correct, and the reported data for Lebanon in 2013 were likely due to a reporting error (Table 22).

Table 22.

Comparison of countries with a unit/branch/department at the ministry of health responsible for noncommunicable diseases

Group	Country	Existence of a unit/branch/department at ministry of health responsible for noncommunicable diseases		
		2015	**2013**	**2010**
Group 1	Bahrain	✓	✓	
	Kuwait	✓	✓	
	Oman	✓	✓	
	Qatar	✓	✓	
	Saudi Arabia	✓	✓	
	United Arab Emirates	✓	.	
	Group 1	**100%**	**83%**	**na**
Group 2	Egypt	✓	.	
	Iran (Islamic Republic of)	✓	✓	
	Iraq	✓	✓	
	Jordan	✓	✓	
	Lebanon	.	✓	
	Libya	✓	✓	
	Morocco	✓	✓	
	Palestine	✓	✓	
	Syrian Arab Republic	✓	✓	
	Tunisia	✓	✓	
	Group 2	**90%**	**90%**	**na**
Group 3	Afghanistan	✓	✓	
	Djibouti	na	✓	
	Pakistan	✓	✓	
	Somalia	✓	✓	
	Sudan	✓	✓	
	Yemen	✓	✓	
	Group 3	**83%**	**100%**	**na**
Eastern Mediterranean Region		**91%**	**91%**	**82%**

Of the seven noncommunicable disease and risk-factor-related activities/functions related to disease prevention, management and control, health care and treatment was reported to be the most commonly funded activity/function in the Region (86%). This was followed by early detection and screening (73%), and primary prevention and capacity-building (68% each). The least commonly funded activities/functions were surveillance, monitoring and evaluation (50%), and palliative care (55%). All countries in Group 1 reported having funding for all seven activities/functions, while Group 2 had an average of 5.2/7 funded activities/functions and Group 3 an average of only 1.3/7 funded activities/functions. Overall, countries had an average of 4.6/7 funded activities/functions (Table 23).

Table 23.

Funding for noncommunicable disease and risk factor-related activities and functions

Group	Country	Funding for noncommunicable disease and risk factor-related activities/functions							
		Primary prevention	Health promotion	Early detection/ screening	Health care and treatment	Surveillance, monitoring and evaluation	Capacity-building	Palliative care	Total areas funded (out of 7)
Group 1	Bahrain	✓	✓	✓	✓	✓	✓	✓	7
	Kuwait	✓	✓	✓	✓	✓	✓	✓	7
	Oman	✓	✓	✓	✓	✓	✓	✓	7
	Qatar	✓	✓	✓	✓	✓	✓	✓	7
	Saudi Arabia	✓	✓	✓	✓	✓	✓	✓	7
	United Arab Emirates	✓	✓	✓	✓	✓	✓	✓	7
	Group 1	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**7.0**
Group 2	Egypt	✓	.	✓	✓	.	✓	.	4
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	.	6
	Iraq	✓	✓	✓	✓	.	✓	.	5
	Jordan	✓	✓	✓	✓	.	✓	.	5
	Lebanon	.	.	✓	✓	✓	✓	✓	5
	Libya	.	.	.	✓	.	.	✓	2
	Morocco	✓	✓	✓	✓	✓	✓	✓	7
	Palestine	✓	✓	✓	✓	✓	✓	✓	7
	Syrian Arab Republic	✓	✓	.	✓	.	.	✓	4
	Tunisia	✓	✓	✓	✓	✓	✓	✓	7
	Group 2	**80%**	**70%**	**80%**	**100%**	**50%**	**80%**	**60%**	**5.2**
Group 3	Afghanistan	.	.	.	.	.	.	.	0
	Djibouti	na	na	na	na	na	na	na	0
	Pakistan	.	.	.	✓	.	.	.	1
	Somalia	.	.	.	.	.	.	.	0
	Sudan	✓	✓	✓	✓	.	✓	.	5
	Yemen	.	.	✓	✓	.	.	.	2
	Group 3	**17%**	**17%**	**33%**	**50%**	**0%**	**17%**	**0%**	**1.3**
Eastern Mediterranean Region		**68%**	**64%**	**73%**	**86%**	**50%**	**68%**	**55%**	**4.6**

The major source of funding in most countries was reported to come from general government revenues (86%), with health insurance the next largest source (59%). International/national donors played a larger role in noncommunicable disease funding for Group 2 and Group 3 countries than for those in Group 1. Only four countries had earmarked taxes funding for noncommunicable diseases and their risk factors: Islamic Republic of Iran, Oman, Palestine and Tunisia (Table 24).

Table 24.

Major sources of noncommunicable disease funding

Group	Country	Major sources of funding for noncommunicable diseases and their risk factors				
		General government revenues	Health insurance	International/ national donors	Earmarked taxes	Other
Group 1	Bahrain	✓	.	.	.	.
	Kuwait	✓	.	.	.	.
	Oman	✓	✓	✓	✓	✓
	Qatar	✓	✓	.	.	✓
	Saudi Arabia	✓	.	.	.	.
	United Arab Emirates	✓	✓	.	.	.
	Group 1	**100%**	**50%**	**17%**	**17%**	**33%**
Group 2	Egypt	✓	.	✓	.	.
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓
	Iraq	✓	.	✓	.	.
	Jordan	✓	✓	✓	.	.
	Lebanon	✓	✓	✓	.	.
	Libya	✓	✓	.	.	.
	Morocco	✓	✓	✓	.	.
	Palestine	✓	✓	✓	✓	.
	Syrian Arab Republic	✓	✓	✓	.	.
	Tunisia	✓	✓	✓	✓	.
	Group 2	**100%**	**80%**	**90%**	**30%**	**10%**
Group 3	Afghanistan	.	.	.	.	.
	Djibouti	na	na	na	na	na
	Pakistan	✓	✓	.	.	.
	Somalia	.	.	.	.	.
	Sudan	✓	✓	✓	.	.
	Yemen	✓	.	✓	.	.
	Group 3	**50%**	**33%**	**33%**	**0%**	**0%**
Eastern Mediterranean Region		**86%**	**59%**	**55%**	**18%**	**14%**

Taxation on tobacco was by far the most commonly reported fiscal intervention for health among the countries of the Region, with 86% of countries reporting the implementation of this type of intervention (with the exception of Afghanistan, Djibouti, and Somalia). The next most common type of fiscal intervention was alcohol taxation (reported by 45% of countries). Only two countries had price subsidies for healthy foods (Saudi Arabia and Tunisia), while only one country – Islamic Republic of Iran – had implemented taxation on sugar-sweetened beverages. Implementation of two fiscal interventions was not reported by any country: taxation on foods high in fat, sugar or salt, and tax incentives to promote physical activity (Table 25).

Table 25.

Fiscal interventions for health, by type

Group	Country	Fiscal interventions currently implemented							How these funds are used		
		Taxation on alcohol	Taxation on tobacco	Taxation on sugar-sweetened beverages	Taxation on foods high in fat, sugar or salt	Price subsidies for healthy foods	Taxation incentives to promote physical activity	Other	Towards general revenue	General funds for health and health services	To influence health behaviours
Group 1	Bahrain	✓	✓	.	.	.	.	.	✓	.	.
	Kuwait	.	✓	.	.	.	.	.	✓	.	.
	Oman	✓	✓	.	.	.	.	.	✓	.	.
	Qatar	.	✓	.	.	.	.	.	.	.	.
	Saudi Arabia	.	✓	.	.	✓	.	.	.	✓	.
	United Arab Emirates	✓	✓	.	.	.	.	.	✓	.	.
	Group 1	**50%**	**100%**	**0%**	**0%**	**17%**	**0%**	**0%**	**67%**	**17%**	**0%**
Group 2	Egypt	✓	✓	.	.	.	.	.	.	✓	.
	Iran (Islamic Republic of)	.	✓	✓	.	.	.	✓	✓	.	.
	Iraq	.	✓	.	.	.	.	.	.	.	.
	Jordan	✓	✓	.	.	.	.	.	✓	.	.
	Lebanon	✓	✓	.	.	.	.	.	✓	.	.
	Libya		✓	.	.	.	.	.	✓	.	.
	Morocco	✓	✓	.	.	.	.	.	✓	.	.
	Palestine	.	✓	.	.	.	.	✓	.	✓	.
	Syrian Arab Republic	✓	✓	.	.	.	.	.	✓	.	.
	Tunisia	✓	✓	.	.	✓	.	.	✓	.	.
	Group 2	**60%**	**100%**	**10%**	**0%**	**10%**	**0%**	**20%**	**70%**	**20%**	**0%**
Group 3	Afghanistan	.	.	.	.	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na	na	na	na	na
	Pakistan	✓	✓	.	.	.	.	.	✓	.	.
	Somalia	.	.	.	.	.	.	.	.	.	.
	Sudan	.	✓	.	.	.	.	.	.	.	.
	Yemen	.	✓	.	.	.	.	.	✓	.	.
	Group 3	**17%**	**50%**	**0%**	**0%**	**0%**	**0%**	**0%**	**33%**	**0%**	**0%**
Eastern Mediterranean Region		**45%**	**86%**	**5%**	**0%**	**9%**	**0%**	**9%**	**59%**	**14%**	**0%**

Funds generated from fiscal interventions for health were most commonly directed towards general revenue in countries of the Region, with 59% of countries using funds in this way. Only 14% of the countries directed their funds towards health and health-related services, and none of the countries directed their funds towards influencing health behaviours (Table 26).

Table 26.

Fiscal interventions for health, by use of funds

Group	Country	How these funds are used		
		Towards general revenue	General funds for health and health services	Towards influencing health behaviours
Group 1	Bahrain	✓	.	.
	Kuwait	✓	.	.
	Oman	✓	.	.
	Qatar	.	.	.
	Saudi Arabia	.	✓	.
	United Arab Emirates	✓	.	.
	Group 1	**67%**	**17%**	**0%**
Group 2	Egypt	.	✓	.
	Iran (Islamic Republic of)	✓	.	.
	Iraq	.	.	.
	Jordan	✓	.	.
	Lebanon	✓	.	.
	Libya	✓	.	.
	Morocco	✓	.	.
	Palestine	.	✓	.
	Syrian Arab Republic	✓	.	.
	Tunisia	✓	.	.
	Group 2	**70%**	**20%**	**0%**
Group 3	Afghanistan	.	.	.
	Djibouti	na	na	na
	Pakistan	✓	.	.
	Somalia	.	.	.
	Sudan	.	.	.
	Yemen	✓	.	.
	Group 3	**33%**	**0%**	**0%**
Eastern Mediterranean Region		**59%**	**14%**	**0%**

A large proportion of countries (68%) reported the existence of a national multisectoral body to oversee noncommunicable disease engagement, policy coherence and accountability in sectors beyond health; however, these bodies were operational in only about 50% of these countries. Existing but non-operational bodies were reported in seven countries: Iraq, Lebanon, Morocco, Tunisia, Sudan, United Arab Emirates and Yemen. Two-thirds of Group 1 countries had operational national multisectoral bodies, compared to 40% of Group 2 countries and none of the countries in Group 3 (Table 27).

Table 27.

National responsibility for noncommunicable diseases by presence and settings covered

Group	Country	National multi-sectoral body to oversee noncommunicable disease engagement, policy coherence and accountability of sectors beyond health		Settings covered		
		Present	Operational	Schools	Worksites	Cities
Group 1	Bahrain	✓	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓	✓
	Oman	✓	✓	✓	✓	✓
	Qatar	.	.	.	.	.
	Saudi Arabia	✓	✓	✓	✓	✓
	United Arab Emirates	✓	.	✓	✓	✓
	Group 1	**83%**	**67%**	**83%**	**83%**	**83%**
Group 2	Egypt	✓	✓	.	.	.
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓
	Iraq	✓	.	✓	✓	.
	Jordan	✓	✓	✓	✓	✓
	Lebanon	✓	.	✓	.	✓
	Libya	.	.	.	.	.
	Morocco	✓	.	✓	✓	✓
	Palestine	✓	✓	✓	✓	✓
	Syrian Arab Republic	.	.	.	.	.
	Tunisia	✓	.	✓	✓	✓
	Group 2	**80%**	**40%**	**70%**	**60%**	**60%**
Group 3	Afghanistan	.	.	.	.	.
	Djibouti	na	na	na	na	na
	Pakistan	.	.	.	.	.
	Somalia	.	.	.	.	.
	Sudan	✓	.	✓	✓	✓
	Yemen	✓	.	✓	✓	✓
	Group 3	**33%**	**0%**	**33%**	**33%**	**33%**
Eastern Mediterranean Region		**68%**	**36%**	**64%**	**59%**	**59%**

With regard to membership of noncommunicable disease multi-sectoral committees, national responsibility for noncommunicable disease prevention and control was extended beyond the ministries of health to include a number of other sectors/partners. In 68% of countries, responsibility was extended to other government ministries, while this responsibility included academia in 64% of countries, nongovernmental/community-based organizations/civil society in 59% of countries, and the private sector in 55% of countries. Partnership extending to United Nations agencies and other international institutions was only reported in 41% and 18% of countries respectively (Table 28).

Table 28.

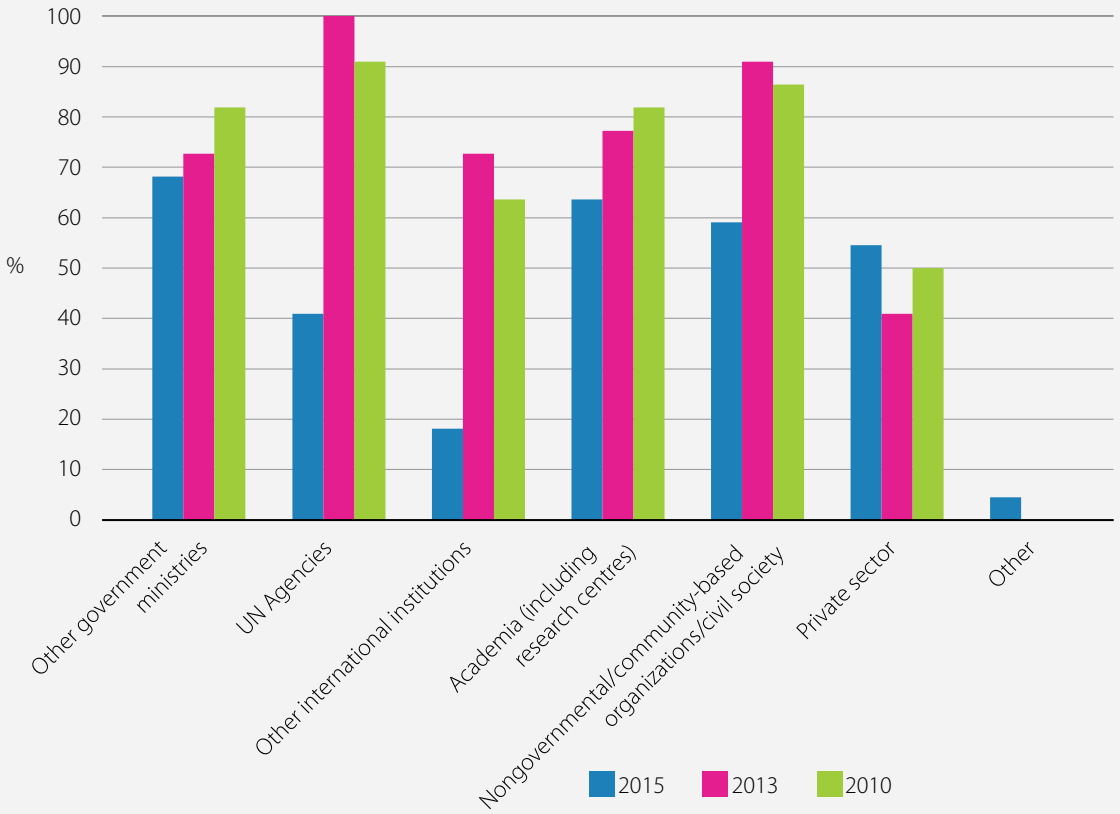
National responsibility for noncommunicable diseases, by sector

Group	Country	Sector						
		Other government ministries	United Nations agencies	Other international institutions	Academia (including research centres)	Nongovernmental/ community-based organizations/ civil society	Private sector	Other
Group 1	Bahrain	✓	.	.	✓	✓	✓	.
	Kuwait	✓	.	.	✓	✓	✓	.
	Oman	✓	✓	.	✓	✓	✓	.
	Qatar	.	.	.	.	.	.	.
	Saudi Arabia	✓	.	.	✓	✓	✓	.
	United Arab Emirates	✓	.	✓	✓	✓	✓	.
	Group 1	**83%**	**17%**	**17%**	**83%**	**83%**	**83%**	**0%**
Group 2	Egypt	✓	✓	.	✓	.	.	.
	Iran (Islamic Republic of)	✓	.	.	.	✓	.	✓
	Iraq	✓	.	.	✓	.	.	.
	Jordan	✓	✓	✓	✓	✓	✓	.
	Lebanon	✓	✓	.	✓	✓	✓	.
	Libya	.	.	.	.	.	.	.
	Morocco	✓	✓	.	✓	✓	✓	.
	Palestine	✓	✓	✓	✓	✓	✓	.
	Syrian Arab Republic	.	.	.	.	.	.	.
	Tunisia	✓	✓	✓	✓	✓	✓	.
	Group 2	**80%**	**60%**	**30%**	**70%**	**60%**	**50%**	**10%**
Group 3	Afghanistan	.	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.	.
	Sudan	✓	✓	.	✓	✓	✓	.
	Yemen	✓	✓	.	✓	✓	✓	.
	Group 3	**33%**	**33%**	**0%**	**33%**	**33%**	**33%**	**0%**
Eastern Mediterranean Region		**68%**	**41%**	**18%**	**64%**	**59%**	**55%**	**5%**

In a comparison of 2015 membership of national multisectoral bodies to oversee noncommunicable disease engagement, policy coherence and accountability of sectors beyond health with 2010 and 2013 data, it was observed that the number of partnerships and collaborations with United Nations agencies as well as other international institutions and nongovernmental/community-based organizations/civil society regarding national responsibility for noncommunicable disease prevention and control became more limited in 2015 (Fig. 2).

Fig. 2.

Comparison of national responsibility for noncommunicable diseases 2010–2015 by percentage distribution



A sizeable proportion of countries reported the inclusion of noncommunicable disease prevention and control in their national health plan (68%), while 45% of countries reported that noncommunicable disease prevention and control was also included in their national development agenda. While 12 countries (55%) reported having set national noncommunicable disease indicators, only six (27%) of these countries – Bahrain, Saudi Arabia, and United Arab Emirates from Group 1, and Islamic Republic of Iran, Iraq and Morocco from Group 2 – had made these targets time-bound (Table 29).

Table 29.

Country noncommunicable disease commitment and planning

Group	Country	Noncommunicable diseases included in national health plan	Noncommunicable diseases included in national development agenda	A set of national noncommunicable disease indicators	Time-bound national targets for national noncommunicable disease indicators
Group 1	Bahrain	✓	✓	✓	✓
	Kuwait	✓	✓	✓	.
	Oman	✓	.	.	.
	Qatar	✓	✓	✓	.
	Saudi Arabia	✓	✓	✓	✓
	United Arab Emirates	✓	✓	✓	.
	Group 1	**100%**	**83%**	**83%**	**33%**
Group 2	Egypt	✓	.	✓	.
	Iran (Islamic Republic of)	✓	✓	✓	✓
	Iraq	✓	.	✓	✓
	Jordan	✓	✓	✓	.
	Lebanon	.	.	.	.
	Libya	.	.	.	.
	Morocco	✓	✓	✓	✓
	Palestine	✓	✓	.	.
	Syrian Arab Republic	.	.	.	.
	Tunisia	✓	✓	✓	.
	Group 2	**70%**	**50%**	**60%**	**30%**
Group 3	Afghanistan	✓	.	.	.
	Djibouti	na	na	na	na
	Pakistan	.	.	.	.
	Somalia	.	.	.	.
	Sudan	✓	.	✓	.
	Yemen	.	.	.	.
	Group 3	**33%**	**0%**	**17%**	**0%**
Eastern Mediterranean Region		**68%**	**45%**	**55%**	**23%**

A substantial number of countries (77%) reported having an integrated national noncommunicable disease policy, strategy or action plan; exceptions were Djibouti, Libya, Pakistan, Syrian Arab Republic and Somalia. A large number of countries (73%) reported that their existing integrated national policy, strategy or action plan was multisectoral and multi-stakeholder. However, these policies, strategies or action plans were operational in only eight countries (36%): Bahrain, Qatar, Saudi Arabia and United Arab Emirates (Group 1), and Iraq, Jordan, Lebanon and Palestine (Group 2). None of the countries in Group 3 had an operational policy, strategy or action plan (Table 30).

Table 30.

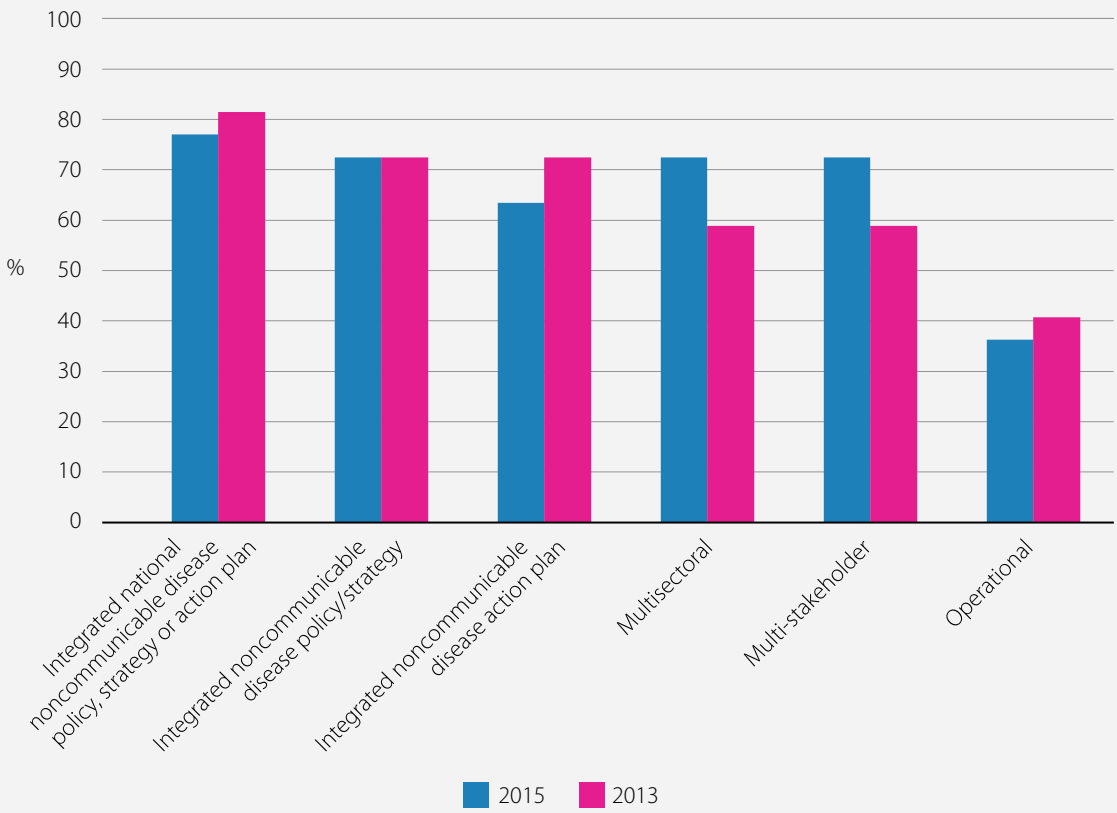
National noncommunicable disease approach and planning

Group	Country	Integrated national noncommunicable disease policy, strategy or action plan	Integrated noncommunicable disease policy/ strategy	Integrated noncommunicable disease action plan	Multisectoral	Multi-stakeholder	Operational
Group 1	Bahrain	✓	✓	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓	✓	.
	Oman	✓	✓	.	✓	✓	.
	Qatar	✓	✓	.	✓	✓	✓
	Saudi Arabia	✓	✓	✓	✓	✓	✓
	United Arab Emirates	✓	✓	✓	✓	✓	✓
	Group 1	**100%**	**100%**	**67%**	**100%**	**100%**	**67%**
Group 2	Egypt	✓	✓	✓	✓	✓	.
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	.
	Iraq	✓	✓	✓	✓	✓	✓
	Jordan	✓	✓	✓	✓	✓	✓
	Lebanon	✓	✓	✓	✓	✓	✓
	Libya	.	.	.	.	.	.
	Morocco	✓	✓	✓	✓	✓	.
	Palestine	✓	✓	✓	✓	✓	✓
	Syrian Arab Republic	.	.	.	.	.	.
	Tunisia	✓	✓	✓	✓	✓	.
	Group 2	**80%**	**80%**	**80%**	**80%**	**80%**	**40%**
Group 3	Afghanistan	✓	✓	.	✓	✓	.
	Djibouti	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.
	Sudan	✓	✓	✓	✓	✓	.
	Yemen	✓	.	✓	.	.	.
	Group 3	**50%**	**33%**	**33%**	**33%**	**33%**	**0%**
Eastern Mediterranean Region		**77%**	**73%**	**64%**	**73%**	**73%**	**36%**

In a comparison of the 2015 regional survey figures with those from the 2013 regional survey, despite some minor changes relating to the reporting of national approaches and noncommunicable disease planning between the two years, it was observed that the inclusion of multisectoral and multi-stakeholder approaches within the actions plans of countries increased from 59% to 76%. However, the percentage of countries with fully operational plans decreased from 41% in 2013 to 36% in 2015 (Fig. 3).

Fig. 3.

Percentage of countries with a national noncommunicable disease policy, strategy or action plan, by level of plan integration, approach and operational status, 2013–2015



A sizeable proportion of countries (77%) included the four main noncommunicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their related risk factors in their national integrated noncommunicable disease policy, strategy or action plan. However, harmful use of alcohol was only included in the integrated policy, strategy or action plan of six countries (27%). Out of a total of eight noncommunicable disease items, the regional average inclusion rate was 5.5, ranging between 7.3/8, 5.4/8 and 3.8/8 in Group 1, Group 2 and Group 3 countries respectively (Table 31).

Table 31.

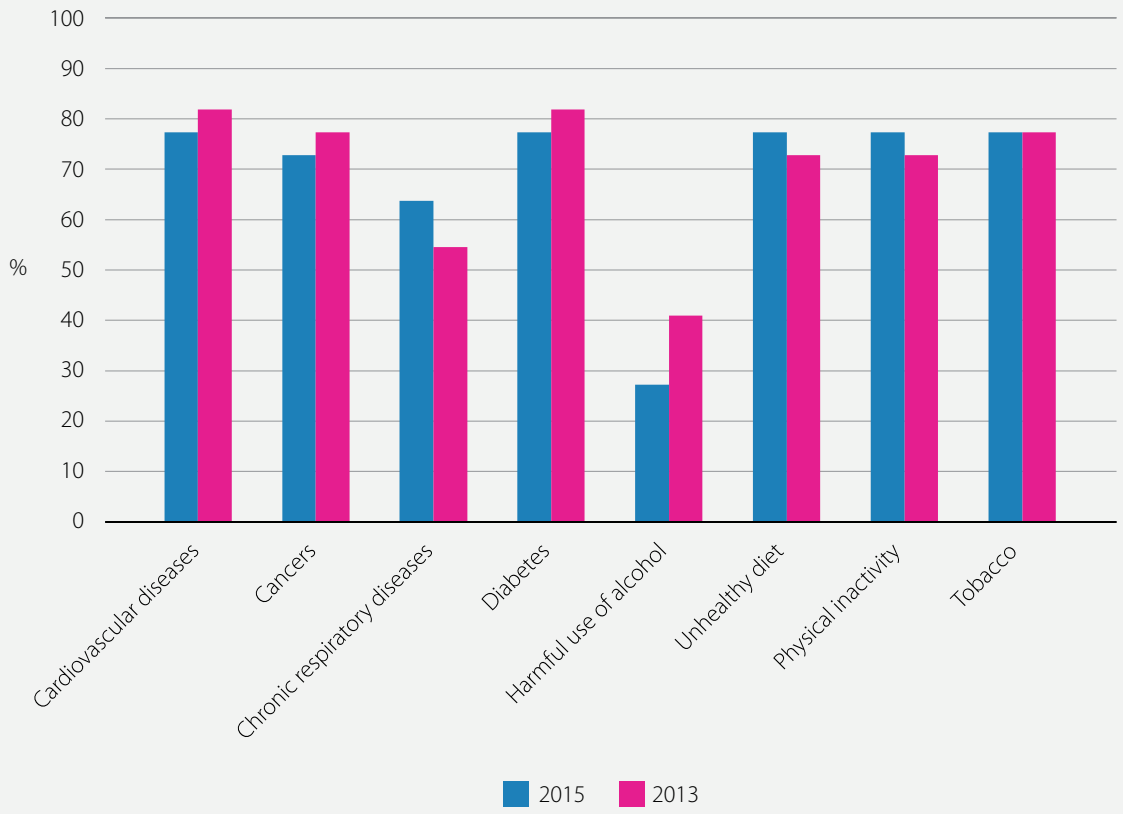
Inclusion of the four main noncommunicable diseases and their risk factors in national integrated policy/ strategy or action plans

Group	Country	Noncommunicable disease (combined early detection, treatment and care of)				Risk factor in integrated policy, strategy or action plan				Total number of items (out of 8)
		Cardiovascular diseases	Cancers	Chronic respiratory diseases	Diabetes	Harmful use of alcohol	Unhealthy diet	Physical inactivity	Tobacco	
Group 1	Bahrain	✓	✓	✓	✓	.	✓	✓	✓	7
	Kuwait	✓	✓	✓	✓	✓	✓	✓	✓	8
	Oman	✓	✓	✓	✓	✓	✓	✓	✓	8
	Qatar	✓	✓	✓	✓	.	✓	✓	✓	7
	Saudi Arabia	✓	✓	✓	✓	.	✓	✓	✓	7
	United Arab Emirates	✓	✓	✓	✓	.	✓	✓	✓	7
	Group 1	**100%**	**100%**	**100%**	**100%**	**33%**	**100%**	**100%**	**100%**	**7.3**
Group 2	Egypt	✓	✓	.	✓	.	✓	✓	✓	6
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	✓	✓	8
	Iraq	✓	✓	✓	✓	.	✓	✓	✓	7
	Jordan	✓	.	.	✓	.	✓	✓	✓	5
	Lebanon	✓	✓	✓	✓	.	✓	✓	✓	7
	Libya	.	.	.	.	.	.	.	.	0
	Morocco	✓	✓	.	✓	✓	✓	✓	✓	7
	Palestine	✓	✓	✓	✓	.	✓	✓	✓	7
	Syrian Arab Republic	.	.	.	.	.	.	.	.	0
	Tunisia	✓	✓	✓	✓	.	✓	✓	✓	7
	Group 2	**80%**	**70%**	**50%**	**80%**	**20%**	**80%**	**80%**	**80%**	**5.4**
Group 3	Afghanistan	✓	✓	✓	✓	✓	✓	✓	✓	8
	Djibouti	na	na	na	na	na	na	na	na	0
	Pakistan	.	.	.	.	.	.	.	.	0
	Somalia	.	.	.	.	.	.	.	.	0
	Sudan	✓	✓	✓	✓	✓	✓	✓	✓	8
	Yemen	✓	✓	✓	✓	.	✓	✓	✓	7
	Group 3	**50%**	**50%**	**50%**	**50%**	**33%**	**50%**	**50%**	**50%**	**3.8**
Eastern Mediterranean Region		**77%**	**73%**	**64%**	**77%**	**27%**	**77%**	**77%**	**77%**	**5.5**

In a comparison of the inclusion of the four main noncommunicable diseases and their four main risk factors in national integrated policies, strategies or action plans between 2013 and 2015, differences were minimal, except for the inclusion of harmful use of alcohol, which decreased from 41% in 2013 to 27% in 2015 (Figure 4).

Fig. 4.

Inclusion of the four main noncommunicable diseases and their risk factors in existing national noncommunicable disease integrated policies, strategies or action plans, 2013–2015



Prevention and reduction of risk factors

Cancer programmes were the most common vertical programmes addressing noncommunicable diseases, with 64% of countries reporting the existence of such programmes. The next most common vertical programmes were those addressing diabetes (present in 50% of countries) and cardiovascular diseases (present in 45% of countries). With regard to vertical programmes addressing noncommunicable disease risk factors, the risk factors most commonly addressed were unhealthy diet and tobacco use (both addressed in 59% of countries).

Only one country in Group 3 (Yemen) reported having a vertical programme addressing cancers, and another addressing tobacco use. Out of nine vertical programmes addressing the four main noncommunicable diseases and the four main risk factors, the average number of programmes was 7.3/9 for Group 1, 4.3/9 for Group 2, and 0.3/9 for Group 3. When asked to report the existence of other vertical programmes, four countries – Jordan, Lebanon, Morocco and Qatar – reported having mental health vertical programmes (Table 32).

Table 32.

Vertical programmes addressing noncommunicable diseases and their risk factors

Group	Country	Noncommunicable diseases addressed in vertical programme				Risk factors addressed in vertical programme					Total number of items (out of 9)
		Cardiovascular diseases	Cancers	Chronic respiratory diseases	Diabetes	Harmful use of alcohol	Overweight/ obesity	Unhealthy diet	Physical inactivity	Tobacco	
Group 1	Bahrain	✓	✓	.	✓	.	✓	✓	✓	✓	7
	Kuwait	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
	Oman	✓	✓	✓	✓	.	✓	✓	✓	✓	8
	Qatar	.	✓	.	✓	.	✓	✓	✓	✓	6
	Saudi Arabia	✓	✓	.	✓	.	✓	✓	✓	✓	7
	United Arab Emirates	✓	✓	.	✓	.	✓	✓	✓	✓	7
	Group 1	**83%**	**100%**	**33%**	**100%**	**17%**	**100%**	**100%**	**100%**	**100%**	**7.3**
Group 2	Egypt	.	✓	.	.	.	.	✓	.	✓	3
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
	Iraq	✓	✓	✓	✓	.	✓	✓	.	.	6
	Jordan	✓	✓	.	✓	.	✓	✓	✓	✓	7
	Lebanon	.	.	.	.	.	.	.	.	✓	1
	Libya	.	.	.	.	.	.	.	.	.	0
	Morocco	✓	✓	.	✓	✓	.	✓	.	✓	6
	Palestine	.	✓	.	.	.	✓	✓	.	.	3
	Syrian Arab Republic	.	.	.	.	.	.	.	.	.	0
	Tunisia	✓	✓	✓	✓	.	✓	✓	✓	✓	8
	Group 2	**60%**	**70%**	**30%**	**50%**	**20%**	**50%**	**70%**	**30%**	**60%**	**4.3**

Table 32. *(continued)*

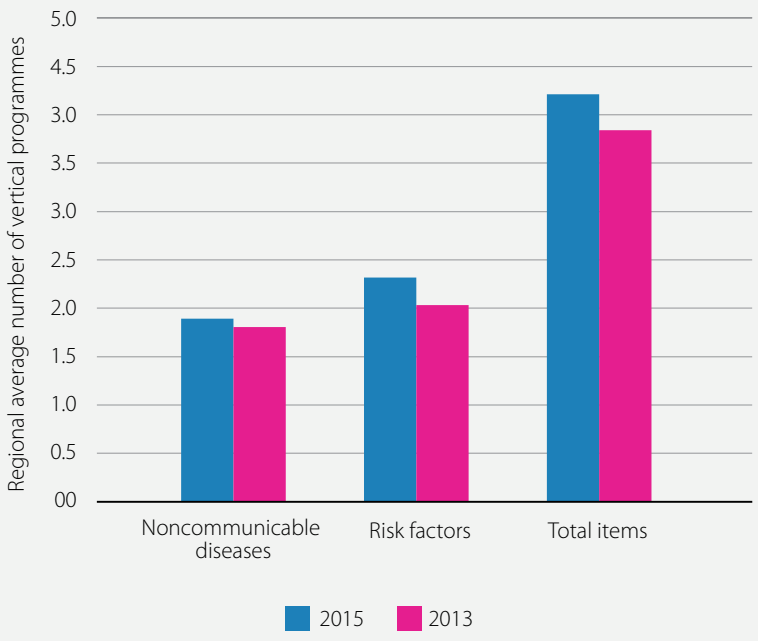
Vertical programmes addressing noncommunicable diseases and their risk factors

Group	Country	Noncommunicable diseases addressed in vertical programme				Risk factors addressed in vertical programme					Total number of items (out of 9)
		Cardiovascular diseases	Cancers	Chronic respiratory diseases	Diabetes	Harmful use of alcohol	Overweight/ obesity	Unhealthy diet	Physical inactivity	Tobacco	
Group 3	Afghanistan	.	.	.	.	.	.	.	.	.	0
	Djibouti	na	na	na	na	na	na	na	na	na	0
	Pakistan	.	.	.	.	.	.	.	.	.	0
	Somalia	.	.	.	.	.	.	.	.	.	0
	Sudan	.	.	.	.	.	.	.	.	.	0
	Yemen	.	✓	.	.	.	.	.	.	✓	2
Group 3		**0%**	**17%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**17%**	**0.3**
Eastern Mediterranean Region		**45%**	**64%**	**23%**	**50%**	**14%**	**50%**	**59%**	**41%**	**59%**	**4.0**

In a comparison of the results of the 2013 and 2015 regional surveys, the regional average number of vertical programmes addressing noncommunicable diseases and their risk factors increased from 3.9 in 2013 to 4.2 in 2015, reflecting minor improvement (Fig. 5).

Fig. 5.

Comparison of regional average number of vertical programmes addressing noncommunicable diseases and their risk factors



Only four countries in the Region (19%) – Bahrain, Islamic Republic of Iran, Qatar and United Arab Emirates – have implemented policies to reduce the impact of the marketing to children of foods and non-alcoholic beverages high in saturated fats, trans-fats, free sugars, or salt (Table 33).

Table 33.

Implementation of policies to reduce the impact of the marketing to children of foods and non-alcoholic beverages high in saturated fats, trans-fats, free sugars, or salt

Group	Country	Implementation of policies to reduce marketing of noncommunicable disease-related foods and non-alcoholic beverages to children	Policy characteristics		Authority responsible for policy enforcement and complaints				Policy addresses effects of cross-border marketing of foods and non-alcoholic beverages to children
			Voluntary/ self-regulating	Government legislation	Government	Food industry	Independent regulator	Other	
Group 1	Bahrain	✓	✓	.	✓	.	.	.	✓
	Kuwait	.	.	.	.	.	.	.	.
	Oman	.	.	.	.	.	.	.	.
	Qatar	✓	✓	.	✓	.	.	.	.
	Saudi Arabia	.	.	.	.	.	.	.	.
	United Arab Emirates	✓	✓	.	✓	.	.	.	✓
	Group 1	**50%**	**50%**	**0%**	**30%**	**0%**	**0%**	**0%**	**33%**
Group 2	Egypt	.	.	.	.	.	.	.	.
	Iran (Islamic Republic of)	✓	✓	.	✓	.	.	.	.
	Iraq	.	.	.	.	.	.	.	.
	Jordan	.	.	.	.	.	.	.	.
	Lebanon	.	.	.	.	.	.	.	.
	Libya	.	.	.	.	.	.	.	.
	Morocco	.	.	.	.	.	.	.	.
	Palestine	.	.	.	.	.	.	.	.
	Syrian Arab Republic	.	.	.	.	.	.	.	.
	Tunisia	.	.	.	.	.	.	.	.
	Group 2	**10%**	**10%**	**0%**	**10%**	**0%**	**0%**	**0%**	**0%**
Group 3	Afghanistan	.	.	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.	.	.
	Sudan	.	.	.	.	.	.	.	.
	Yemen	.	.	.	.	.	.	.	.
	Group 3	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**18%**	**18%**	**0%**	**18%**	**0%**	**0%**	**0%**	**9%**

Only five countries (23%) – Bahrain, Islamic Republic of Iran, Kuwait, Qatar and Tunisia – have implemented national policies to limit saturated fatty acids and virtually eliminate industrially produced trans-fats in the food supply. Ten countries (48%) have national policies to reduce salt consumption: all Group 1 countries, and Islamic Republic of Iran, Jordan, Palestine and Tunisia in Group 2 (Table 34).

Table 34.

Implementation of national policies to limit saturated fatty acids and virtually eliminate industrially produced trans-fats in the food supply, and reduce salt consumption

Group	Country	Policy to limit saturated fatty acids and virtually eliminate industrially produced trans-fats			Policy to reduce salt consumption		
		National policy	Voluntary/ self-regulating	Government legislation	National policy	Voluntary/ self-regulating	Government legislation
Group 1	Bahrain	✓	.	✓	✓	.	✓
	Kuwait	✓	.	✓	✓	.	.
	Oman	.	.	.	✓	✓	.
	Qatar	✓	.	✓	✓	✓	.
	Saudi Arabia	.	.	.	✓	.	✓
	United Arab Emirates	.	.	.	✓	.	✓
	Group 1	**50%**	**0%**	**50%**	**100%**	**33%**	**50%**
Group 2	Egypt	.	.	.	.	.	.
	Iran (Islamic Republic of)	✓	.	✓	✓	.	✓
	Iraq	.	.	.	.	.	.
	Jordan	.	.	.	✓	.	✓
	Lebanon	.	.	.	.	.	.
	Libya	.	.	.	.	.	.
	Morocco	.	.	.	.	.	.
	Palestine	.	.	.	✓	.	✓
	Syrian Arab Republic	.	.	.	.	.	.
	Tunisia	✓	✓	.	✓	✓	.
	Group 2	**20%**	**10%**	**10%**	**40%**	**10%**	**30%**
Group 3	Afghanistan	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.
	Sudan	.	.	.	.	.	.
	Yemen	.	.	.	.	.	.
	Group 3	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**23%**	**5%**	**18%**	**48%**	**14%**	**27%**

Five countries (83%) in Group 1 and five countries (50%) in Group 2 reported having national public awareness programmes on diet and/or physical activity, while all Group 3 countries lacked such programmes. The overall regional average achievement of this progress indicator was 45% (Table 35).

Table 35.

Implementation of national public awareness programmes on diet and physical activity within the past 5 years

Group	Country	Awareness programme on diet	Awareness programme on physical activity
Group 1	Bahrain	✓	✓
	Kuwait	.	✓
	Oman	✓	.
	Qatar	✓	✓
	Saudi Arabia	✓	✓
	United Arab Emirates	✓	✓
	Group 1	**83%**	**83%**
Group 2	Egypt	.	.
	Iran (Islamic Republic of)	✓	✓
	Iraq	✓	✓
	Jordan	.	✓
	Lebanon	.	.
	Libya	.	.
	Morocco	✓	✓
	Palestine	✓	.
	Syrian Arab Republic	.	.
	Tunisia	✓	✓
	Group 2	**50%**	**50%**
Group 3	Afghanistan	.	.
	Djibouti	na	na
	Pakistan	.	.
	Somalia	.	.
	Sudan	.	.
	Yemen	.	.
	Group 3	**0%**	**0%**
Eastern Mediterranean Region		**45%**	**45%**

Surveillance, monitoring and evaluation

Almost all countries reported the existence of either an exclusive or non-exclusive/shared unit within the ministry of health responsible for the surveillance of noncommunicable diseases and their risk factors. Exceptions were Afghanistan, Djibouti, Somalia and Yemen in Group 3 (Table 36).

Table 36.

Body responsible for surveillance of noncommunicable diseases and their risk factors

Group	Country	Within ministry of health			External agency	None
		Body exclusive to noncommunicable diseases	Body not exclusive to noncommunicable diseases	Shared		
Group 1	Bahrain	.	.	✓	.	.
	Kuwait	.	✓	.	.	.
	Oman	✓	.	.	.	.
	Qatar	.	.	✓	.	.
	Saudi Arabia	✓	.	.	.	.
	United Arab Emirates	.	.	✓	.	.
	Group 1	**33%**	**17%**	**50%**	**0%**	**0%**
Group 2	Egypt	.	✓	.	.	.
	Iran (Islamic Republic of)	✓	.	.	.	.
	Iraq	✓	.	.	.	.
	Jordan	✓	.	.	.	.
	Lebanon	.	✓	.	.	.
	Libya	.	✓	.	.	.
	Morocco	✓	.	.	.	.
	Palestine	.	✓	..	.	.
	Syrian Arab Republic	✓	.	.	.	.
	Tunisia	.	.	✓	.	.
	Group 2	**50%**	**40%**	**10%**	**0%**	**0%**
Group 3	Afghanistan	.	.	✓	.	.
	Djibouti	na	na	na	na	na
	Pakistan	✓	.	.	.	.
	Somalia	.	.	.	.	✓
	Sudan	.	✓	.	.	.
	Yemen	.	.	.	.	✓
	Group 3	**17%**	**17%**	**17%**	**0%**	**33%**
Eastern Mediterranean Region		**36%**	**27%**	**23%**	**0%**	**9%**

A sizeable proportion of countries (77%) reported having a functioning system for generating reliable cause-specific mortality data on a routine basis; this included all Group 1 countries, all Group 2 countries except Libya, and Sudan and Yemen in Group 3. Most existing civil/vital registration systems were reported to be national, and data can be disaggregated by age and gender (Table 37).

Table 37.

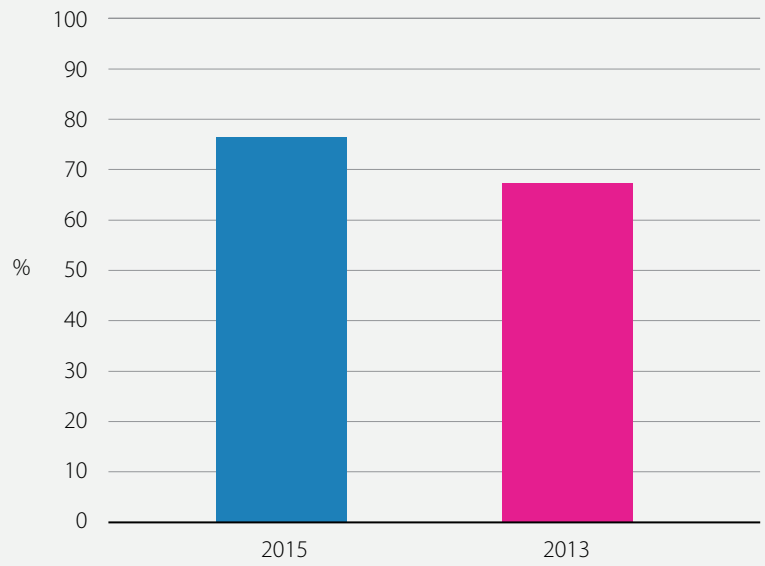
Availability and characteristics of mortality registration systems

Group	Country	Presence of system for routine collection of cause-specific mortality data	System type		Disaggregation characteristics		
			Civil/vital registration system	Sample registration system	Age	Gender	Other socioeconomic status factor
Group 1	Bahrain	✓	✓	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓	✓	✓
	Oman	✓	✓	.	✓	✓	✓
	Qatar	✓	✓	.	✓	✓	✓
	Saudi Arabia	✓	✓	.	✓	✓	✓
	UAE	✓	✓	.	✓	✓	✓
	Group 1	**100%**	**100%**	**33%**	**100%**	**100%**	**100%**
Group 2	Egypt	✓	✓	✓	✓	✓	.
	Iran (Islamic Republic of)	✓	✓	.	✓	✓	✓
	Iraq	✓	✓	.	✓	✓	.
	Jordan	✓	✓	.	✓	✓	.
	Lebanon	✓	✓	.	✓	✓	.
	Libya	.	.	.	.	.	.
	Morocco	✓	✓	.	✓	✓	.
	Palestine	✓	✓	.	✓	✓	✓
	Syrian Arab Republic	✓	✓	✓	✓	✓	✓
	Tunisia	✓	✓	.	✓	✓	✓
	Group 2	**90%**	**90%**	**20%**	**90%**	**90%**	**40%**
Group 3	Afghanistan	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.
	Sudan	✓	✓	.	✓	✓	.
	Yemen	✓	✓	.	✓	✓	✓
	Group 3	**33%**	**33%**	**0%**	**33%**	**33%**	**17%**
Eastern Mediterranean Region		**77%**	**77%**	**18%**	**77%**	**77%**	**50%**

A comparison of the data from the 2013 and 2015 regional surveys reveals that the availability of mortality registration systems increased in the Region from 68% in 2013 to 77% in 2015. New mortality reporting systems were established in Lebanon, Tunisia and Yemen. However, such systems are now no longer available in Libya and Djibouti (Fig. 6).

Fig. 6.

Availability of mortality registration systems



Population-based cancer registries were available in all Group 1 countries, 70% of Group 2 countries (exceptions were Iraq, Palestine and Syrian Arab Republic), and in Yemen in Group 3. Except for United Arab Emirates, all population-based cancer registries in Group 1 countries had national coverage, while the same was true for the population-based cancer registries of three Group 2 countries – Egypt, Jordan and Lebanon. For Yemen in Group 3, the population-based cancer registry coverage was subnational. Overall, regional cancer registry coverage was national in 41% of countries (Table 38).

Table 38.

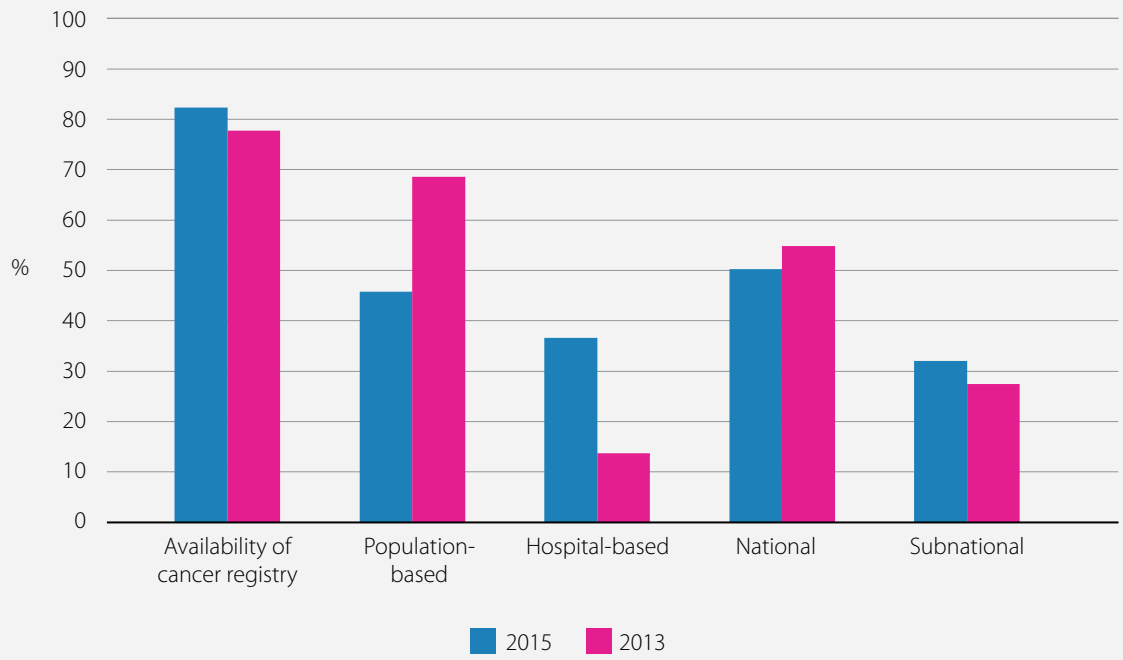
Availability and characteristics of cancer registries

Group	Country	Availability of cancer registry	Data collection method			Coverage	
			Population-based	Hospital-based	Other	National	Subnational
Group 1	Bahrain	✓	✓	.	.	✓	.
	Kuwait	✓	✓	.	.	✓	.
	Oman	✓	✓	.	.	✓	.
	Qatar	✓	✓	.	.	✓	.
	Saudi Arabia	✓	✓	.	.	✓	.
	United Arab Emirates	✓	✓	.	.	.	✓
	Group 1	**100%**	**100%**	**0%**	**0%**	**83%**	**17%**
Group 2	Egypt	✓	✓	.	.	✓	.
	Iran (Islamic Republic of)	✓	✓	.	.	.	✓
	Iraq	✓	.	✓	.	.	✓
	Jordan	✓	✓	.	.	✓	.
	Lebanon	✓	✓	.	.	✓	.
	Libya	✓	✓	.	.	.	✓
	Morocco	✓	✓	.	.	.	✓
	Palestine	✓	.	✓	.	.	✓
	Syrian Arab Republic	✓	.	✓	.	.	✓
	Tunisia	✓	✓	.	.	.	✓
	Group 2	**100%**	**70%**	**30%**	**0%**	**30%**	**70%**
Group 3	Afghanistan	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.
	Sudan	✓	.	✓	.	✓	✓
	Yemen	✓	✓	.	.	.	✓
	Group 3	**33%**	**17%**	**17%**	**0%**	**17%**	**33%**
Eastern Mediterranean Region		**82%**	**64%**	**18%**	**0%**	**41%**	**45%**

A comparison of the 2013 and 2015 regional survey data reveals that the overall availability of cancer registries increased from 77% in 2013 to 82% in 2015. However, the overall prevalence of population-based registries has dropped, and hospital-based cancer registration has increased (Fig. 7).

Fig. 7.

Comparison of availability and characteristics of cancer registries



Forty-one percent of countries reported having diabetes registries. This included all countries in Group 1 (with the exception of United Arab Emirates) and four countries (40%) in Group 2 (Islamic Republic of Iran, Iraq, Jordan and Palestine). 67% of Group 1 countries indicated that their diabetes registries record diabetes-related complications, compared to only 20% of Group 2 countries (Table 39).

Table 39.

Availability and characteristics of diabetes registries

Group	Country	Availability of diabetes registry	Data collection method			Coverage		Complications recorded
			Population-based	Hospital-based	Other	National	Subnational	
Group 1	Bahrain	✓	.	.	✓	✓	.	.
	Kuwait	✓	✓	.	.	✓	.	✓
	Oman	✓	.	.	✓	✓	.	✓
	Qatar	✓	.	✓	.	✓	.	✓
	Saudi Arabia	✓	.	.	✓	✓	.	✓
	United Arab Emirates	.	.	.	.	.	.	.
	Group 1	**83%**	**17%**	**17%**	**50%**	**83%**	**0%**	**67%**
Group 2	Egypt	.	.	.	.	.	.	.
	Iran (Islamic Republic of)	✓	✓	.	.	.	✓	✓
	Iraq	✓	.	.	✓	✓	.	.
	Jordan	✓	.	.	✓	.	✓	.
	Lebanon	.	.	.	.	.	.	.
	Libya	.	.	.	.	.	.	.
	Morocco	.	.	.	.	.	.	.
	Palestine	✓	.	.	✓	.	✓	✓
	Syrian Arab Republic	.	.	.	.	.	.	.
	Tunisia	.	.	.	.	.	.	.
	Group 2	**40%**	**10%**	**0%**	**30%**	**10%**	**30%**	**20%**
Group 3	Afghanistan	.	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.	.
	Somalia	.	.		.	.	.	.
	Sudan	.	.	.	.		.	.
	Yemen	.	.	.	.	..	.	.
	Group 3	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**41%**	**9%**	**5%**	**27%**	**27%**	**14%**	**27%**

Adult surveys (most commonly the WHO STEPwise approach to surveillance (STEPS)) collected data on an average of 7.8/9 and 7.9/9 of the noncommunicable disease risk factors in Group 1 and Group 2 countries respectively. For Group 3, the average number of risk factors collected was 2.2/9. The least commonly surveyed risk factor in countries of the Region was salt intake (32%), which was expected due to the fact that the salt module was only added to the STEPS survey in late 2013 (Table 40).

Table 40.

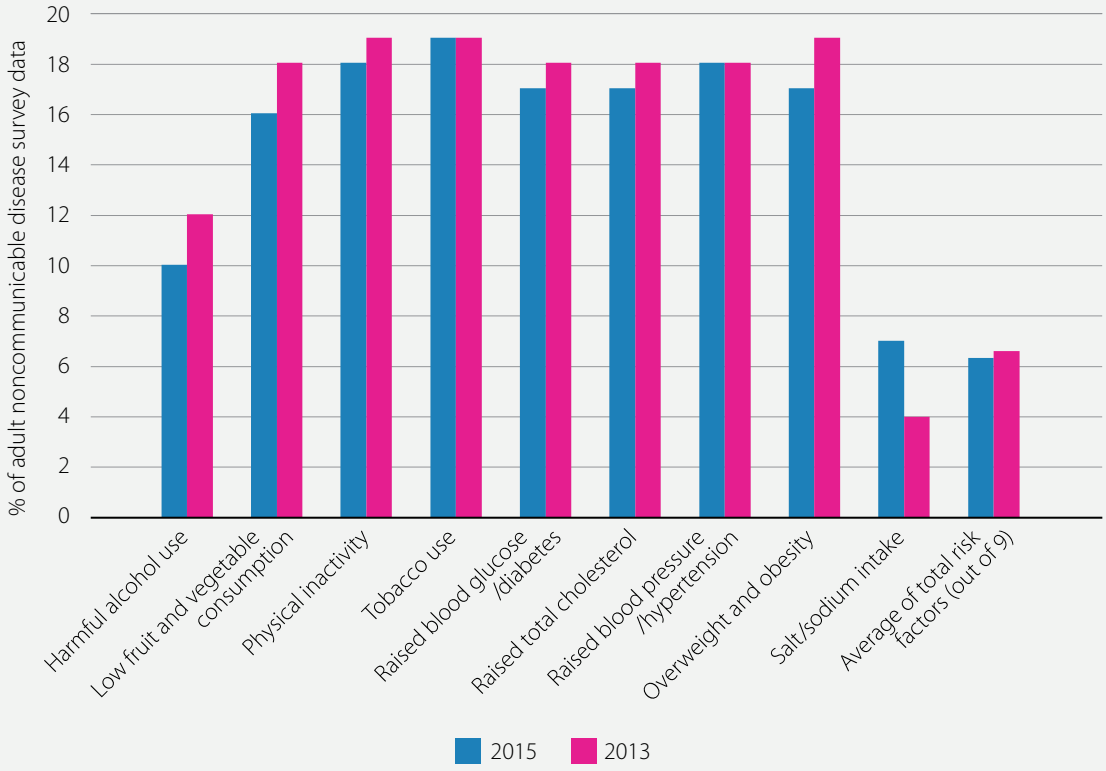
Surveys of noncommunicable disease risk factors among adults

Group	Country	Harmful alcohol use	Low fruit and vegetable consumption	Physical inactivity	Tobacco use	Raised blood glucose/ diabetes	Raised total cholesterol	Raised blood pressure/ hypertension	Overweight and obesity	Salt/sodium intake	Total number of risk factors (out of 9)
Group 1	Bahrain	.	✓	✓	✓	✓	✓	✓	✓	.	7
	Kuwait	✓	✓	✓	✓	✓	✓	✓	✓	.	8
	Oman	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
	Qatar	.	✓	✓	✓	✓	✓	✓	✓	✓	8
	Saudi Arabia	.	✓	✓	✓	✓	✓	✓	✓	✓	8
	United Arab Emirates	.	✓	✓	✓	✓	✓	✓	✓	.	7
	Group 1	**33%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**50%**	**7.8**
Group 2	Egypt	.	✓	✓	✓	✓	✓	✓	✓	.	7
	Iran (Islamic Republic of)	.	✓	✓	✓	✓	✓	✓	✓	.	7
	Iraq	✓	✓	✓	✓	✓	✓	✓	✓	.	8
	Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
	Lebanon	✓	.	✓	✓	✓	✓	✓	✓	✓	8
	Libya	✓	✓	✓	✓	✓	✓	✓	✓	.	8
	Morocco	.	✓	✓	✓	✓	✓	✓	✓	.	7
	Palestine	.	✓	✓	✓	✓	✓	✓	✓	✓	8
	Syrian Arab Republic	✓	✓	✓	✓	✓	✓	✓	✓	.	8
	Tunisia	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
	Group 2	**60%**	**90%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**40%**	**7.9**
Group 3	Afghanistan	.	.	.	.	.	.	.	.	.	0
	Djibouti	na	na	na	na	na	na	na	na	na	0
	Pakistan	.	.	✓	✓	.	.	✓	.	.	3
	Somalia	.	.	.	.	.	.	.	.	.	0
	Sudan	✓	✓	✓	✓	✓	✓	✓	✓	.	8
	Yemen	✓	.	.	✓	.	.	.	.	.	2
	Group 3	**33%**	**17%**	**33%**	**50%**	**17%**	**17%**	**33%**	**17%**	**0%**	**2.2**
Eastern Mediterranean Region		**45%**	**73%**	**82%**	**86%**	**77%**	**77%**	**82%**	**77%**	**32%**	**6.3**

In a comparison of the 2013 and 2015 regional survey results, there was no significant difference in the total number of risk factors collected in the STEPS surveys carried out by countries of the Region. The comparison also revealed that the average number of risk factors surveyed among adults decreased from 6.6/9 to 6.3/9 between 2013 and 2015 (Fig. 8).

Fig. 8.

Percentage comparison of noncommunicable disease surveys among adults collecting independent data on noncommunicable disease risk factors, 2013–2015.



In adolescent surveys of noncommunicable disease risk factors, the average number of risk factors on which data were collected was 3.8/5 and 3.4/5 in Group 1 and Group 2 countries respectively. For Group 3 countries where data were available, the average number of risk factors on which data were collected was 1. Overall, the most frequently surveyed risk factors were: tobacco use (in 82% of countries); physical inactivity (in 59% of countries); low fruit and vegetable consumption (in 59% of countries); and overweight and obesity (in 55% of countries). Four countries of the Region reported collection of data on the harmful use of alcohol in adolescent surveys: Kuwait in Group 1, and Lebanon, Syrian Arab Republic and Tunisia in Group 2 (Table 41).

Table 41.

Surveys of noncommunicable disease risk factors among adolescents

Group	Country	Harmful use of alcohol	Low fruit and vegetable consumption	Physical inactivity	Tobacco use	Overweight and obesity	Total number of risk factors surveyed (out of 5)
Group 1	Bahrain	.	✓	.	✓	.	2
	Kuwait	✓	✓	✓	✓	✓	5
	Oman	.	✓	✓	✓	✓	4
	Qatar	.	✓	✓	✓	✓	4
	Saudi Arabia	.	✓	✓	✓	✓	4
	United Arab Emirates	.	✓	✓	✓	✓	4
	Group 1	**17%**	**100%**	**83%**	**100%**	**83%**	**3.8**
Group 2	Egypt	.	.	.	.	.	0
	Iran (Islamic Republic of)	.	✓	✓	✓	✓	4
	Iraq	.	✓	✓	✓	✓	4
	Jordan	.	✓	✓	✓	✓	4
	Lebanon	✓	.	✓	✓	.	3
	Libya	.	✓	✓	✓	✓	4
	Morocco	.	.	.	✓	.	1
	Palestine	.	✓	✓	✓	✓	4
	Syrian Arab Republic	✓	✓	✓	✓	✓	5
	Tunisia	✓	✓	✓	✓	✓	5
	Group 2	**30%**	**70%**	**80%**	**90%**	**70%**	**3.4**
Group 3	Afghanistan	.	.	.	.	.	0
	Djibouti	na	na	na	na	na	0
	Pakistan	.	.	.	✓	.	1
	Somalia	.	.	.	.	.	0
	Sudan	.	.	.	✓	.	1
	Yemen	.	.	.	✓	.	1
	Group 3	**0%**	**0%**	**0%**	**50%**	**0%**	**0.5**
Eastern Mediterranean Region		**18%**	**59%**	**59%**	**82%**	**55%**	**2.7**

In a comparison of the results of the 2013 and 2015 regional surveys regarding the number of adolescent and adult surveys on noncommunicable disease risk factors carried out, the 2015 regional survey showed a slight increase in the total number of adult surveys, but a slight decrease in the total number of adolescent surveys (Table 42).

Table 42.

Comparison of frequency of adult and adolescent surveys on noncommunicable disease risk factors, 2013–2015

Risk factor	Number of surveys	
Adolescents	**2015**	**2013**
Harmful alcohol use	4	5
Low fruit and vegetable consumption	13	16
Physical inactivity	13	16
Tobacco use	18	16
Overweight and obesity	12	15
Total	**60**	**68**
Adults		
Harmful alcohol use	10	11
Low fruit and vegetable consumption	16	15
Physical inactivity	18	17
Tobacco use	19	19
Overweight and obesity	17	17
Total	**80**	**79**
Total adolescents and adults	**140**	**147**

Health care

In terms of the availability of evidence-based national guidelines/protocols/standards for the management and referral of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities, diabetes and cardiovascular diseases were the two diseases most commonly covered by national guidelines. Seventy-three per cent of countries had developed management guidelines for diabetes, while 68% of countries had management guidelines in place for cardiovascular diseases. The regional survey also revealed a similar pattern regarding the availability of guidelines for referral to secondary and tertiary care for the four main noncommunicable diseases (Table 43).

Table 43.

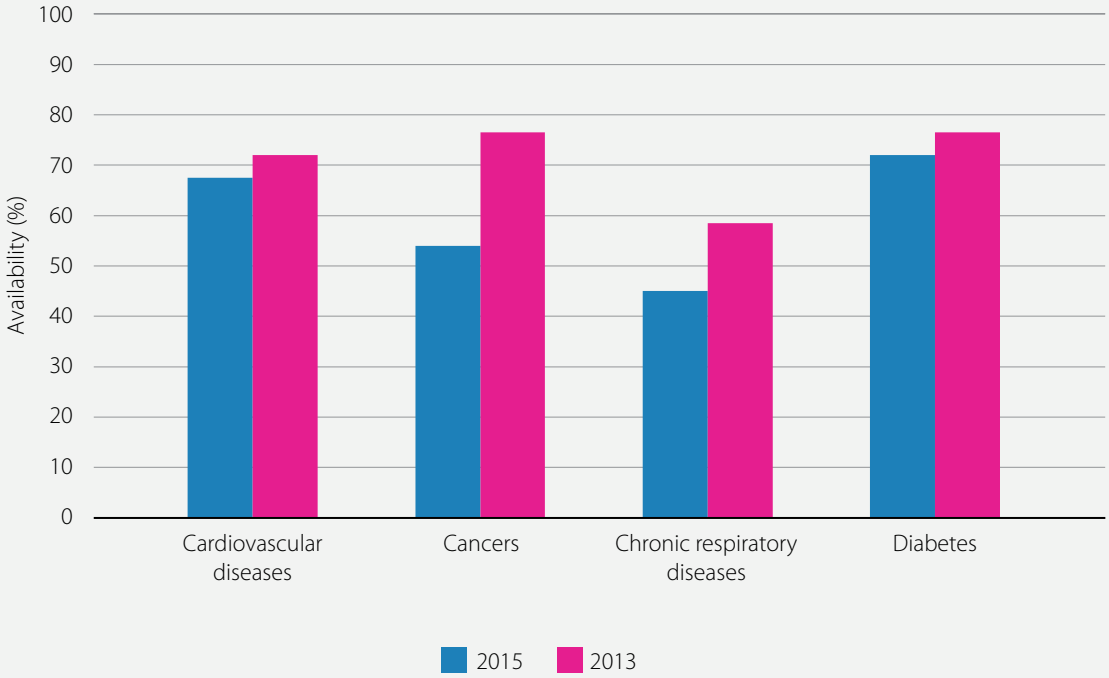
Availability of evidence-based national guidelines/protocols/standards for the management and referral of major noncommunicable diseases at the primary care level, recognized/approved by government or competent authorities

Group	Country	Management (diagnosis and treatment)				Referral (primary to secondary/tertiary)			
		Cardiovascular diseases	Cancers	Chronic respiratory diseases	Diabetes	Cardiovascular diseases	Cancers	Chronic respiratory diseases	Diabetes
Group 1	Bahrain	✓	✓	✓	✓	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓	✓	✓	✓	✓
	Oman	✓	.	✓	✓	✓	.	✓	✓
	Qatar	✓	✓	✓	✓	✓	✓	✓	✓
	Saudi Arabia	✓	✓	✓	✓	✓	✓	✓	✓
	United Arab Emirates	✓	✓	✓	✓	✓	✓	✓	✓
	Group 1	**100%**	**83%**	**100%**	**100%**	**100%**	**83%**	**100%**	**100%**
Group 2	Egypt	.	✓	.	✓	.	.	.	✓
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	.	.	✓
	Iraq	✓	✓	✓	✓	✓	✓	✓	✓
	Jordan	✓	✓	.	✓	✓	✓	.	✓
	Lebanon	✓	✓	✓	✓	✓	✓	✓	✓
	Libya	.	.	.	.	.	.	.	.
	Morocco	✓	✓	.	✓	✓	✓	.	✓
	Palestine	✓	.	.	✓	✓	.	.	✓
	Syrian Arab Republic	✓	.	.	✓	.	.	.	.
	Tunisia	✓	.	.	✓	.	.	.	.
	Group 2	**80%**	**60%**	**30%**	**90%**	**60%**	**40%**	**20%**	**70%**
Group 3	Afghanistan	.	.	.	.	.	.	.	.
	Djibouti	na	na	na	na	na	na	na	na
	Pakistan	.	.	.	.	.	.	.	.
	Somalia	.	.	.	.	.	.	.	.
	Sudan	✓	✓	✓	✓	.	.	.	.
	Yemen	.	.	.	.	.	.	.	.
	Group 3	**17%**	**17%**	**17%**	**17%**	**0%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**68%**	**55%**	**45%**	**73%**	**55%**	**41%**	**36%**	**59%**

In a comparison of the 2013 and 2015 regional surveys, there was a decrease in the average availability of evidence-based national guidelines/protocols/standards for the management of the four main noncommunicable diseases through a primary care approach, recognized/ approved by government or competent authorities (Fig. 9).

Fig. 9.

Overall trend comparison of availability of evidence-based national guidelines/protocols/ standards for the management of the four main noncommunicable diseases through a primary care approach, recognized/ approved by government or competent authorities, 2013–2015



Availability of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases at primary care facilities was highest in Group 1 countries (11/13 in the public sector, 9.7/13 in the private sector), followed by Group 2 countries (5.3/13 in the public sector, 7.3/13 in the private sector) and Group 3 countries (3.5/13 in the public sector, 3.2/13 in the private sector). The regional average availability was 6.4/13 at public sector facilities, and 6.8/13 at private sector facilities (Table 44).

Table 44.

Availability of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases at primary care facilities in the public/private health sectors

Group	Country	Public sector		Private sector	
		Number of basic technologies	%	Number of basic technologies	%
Group 1	Bahrain	13	100	13	100
	Kuwait	11	85	13	100
	Oman	10	77	10	77
	Qatar	12	92	0	0
	Saudi Arabia	10	77	11	85
	United Arab Emirates	10	77	11	85
	Group 1	**11.0**	**85**	**9.7**	**74**
Group 2	Egypt	5	38	0	0
	Iran (Islamic Republic of)	9	69	11	85
	Iraq	4	31	11	85
	Jordan	6	46	10	77
	Lebanon	6	46	9	69
	Libya	0	0	0	0
	Morocco	7	54	12	92
	Palestine	6	46	7	54
	Syrian Arab Republic	6	46	9	69
	Tunisia	4	31	4	31
	Group 2	**5.3**	**41**	**7.3**	**56**
Group 3	Afghanistan	3	23	3	23
	Djibouti	0	na	0	na
	Pakistan	3	23	1	8
	Somalia	7	54	11	85
	Sudan	4	31	0	0
	Yemen	4	31	4	31
	Group 3	**3.5**	**27**	**3.2**	**24**
Eastern Mediterranean Region		**6.4**	**49**	**6.8**	**52**

Breast cancer screening programmes were the most common national cancer screening programmes available in the Region; 68% of countries reported having this programme. Less than one third of countries in the Region reported having national cervix, colon or prostate cancer screening programmes. With the exception of breast cancer screening in Yemen, cancer screening programmes were not available in any of the countries in Group 3. National prostate cancer screening was available in only three countries in Group 1: Kuwait, Oman and United Arab Emirates. National cervical cancer screening programmes were available in three countries in Group 1 – Bahrain, Qatar and United Arab Emirates – and in Islamic Republic of Iran and Morocco in Group 2. National colon cancer screening programmes were available in all Group 1 countries except Bahrain, but in only one country – Islamic Republic of Iran – in Group 2 (Table 45).

Table 45.

National screening programmes for specific cancers, targeting the general population

Group	Country	Breast	Cervix	Colon	Prostate
Group 1	Bahrain	✓	✓	.	.
	Kuwait	✓	.	✓	✓
	Oman	✓	.	✓	✓
	Qatar	✓	✓	✓	.
	Saudi Arabia	✓	.	✓	.
	United Arab Emirates	✓	✓	✓	✓
	Group 1	**100%**	**50%**	**83%**	**50%**
Group 2	Egypt	✓	.	.	.
	Iran (Islamic Republic of)	✓	✓	✓	.
	Iraq	✓	.	.	.
	Jordan	✓	.	.	.
	Lebanon	✓	.	.	.
	Libya	.	.	.	.
	Morocco	✓	✓	.	.
	Palestine	✓	.	.	.
	Syrian Arab Republic	✓	.	.	.
	Tunisia	.	.	.	.
	Group 2	**80%**	**20%**	**10%**	**0%**
Group 3	Afghanistan	.	.	.	.
	Djibouti	na	na	na	na
	Pakistan	.	.	.	.
	Somalia	.	.	.	.
	Sudan	.	.	.	.
	Yemen	✓	.	.	.
	Group 3	**17%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**68%**	**23%**	**27%**	**14%**

A significant number of countries of the Region (64%) reported that early detection of breast cancer was integrated in primary health care services, but less than half of the countries had similar services for cancers of the cervix, colon, prostate and oral cavity. Having early detection of colon, prostate and oral cancers integrated at the primary care level was notably lacking in Group 2 and Group 3 countries (Table 46).

Table 46.

Primary health care service integration of early detection of cancers by means of rapid identification of the first symptoms

Group	Country	Breast	Cervix	Colon	Prostate	Oral
Group 1	Bahrain	✓	✓	✓	✓	.
	Kuwait	✓	✓	✓	✓	✓
	Oman	✓	.	✓	✓	.
	Qatar	✓	✓	✓	✓	✓
	Saudi Arabia	✓	.	✓	✓	.
	United Arab Emirates	✓	✓	✓	✓	✓
	Group 1	**100%**	**67%**	**100%**	**100%**	**50%**
Group 2	Egypt	✓	.	.	.	.
	Iran (Islamic Republic of)	.	.	.	.	.
	Iraq	✓	✓	.	.	.
	Jordan	✓	.	.	.	.
	Lebanon	✓	✓	.	.	.
	Libya	.	.	.	.	.
	Morocco	✓	✓	.	.	.
	Palestine	✓	.	.	.	.
	Syrian Arab Republic	✓	✓	✓	.	.
	Tunisia	.	.	.	.	.
	Group 2	**70%**	**40%**	**10%**	**0%**	**0%**
Group 3	Afghanistan	.	.	.	.	.
	Djibouti	na	na	na	na	na
	Pakistan	.	.	.	.	.
	Somalia	.	.	.	.	.
	Sudan	✓	✓	.	.	✓
	Yemen	.	.	.	.	.
	Group 3	**17%**	**17%**	**0%**	**0%**	**17%**
Eastern Mediterranean Region		**64%**	**41%**	**32%**	**27%**	**18%**

National HPV vaccination programmes were reported to be absent in almost all of the countries of the Region, with the exception of Libya and United Arab Emirates (Table 47).

Table 47.

Implementation of national HPV vaccination programmes

Group	Country	HPV vaccination programme
Group 1	Bahrain	.
	Kuwait	.
	Oman	.
	Qatar	.
	Saudi Arabia	.
	United Arab Emirates	✓
	Group 1	**17%**
Group 2	Egypt	.
	Iran (Islamic Republic of)	.
	Iraq	.
	Jordan	.
	Lebanon	.
	Libya	✓
	Morocco	.
	Palestine	.
	Syrian Arab Republic	.
	Tunisia	.
	Group 2	**10%**
Group 3	Afghanistan	.
	Djibouti	na
	Pakistan	.
	Somalia	.
	Sudan	.
	Yemen	.
	Group 3	**0%**
Eastern Mediterranean Region		**9%**

The regional average availability of the 12 essential noncommunicable disease medicines at the primary care facilities of the public health sector was 8.1/12. The medicines least available were oral morphine with 18% availability (available in four countries) and steroid inhaler with 55% availability (available in 12 countries). The availability of the 12 essential medicines at public health sector primary care level was highest in Group 1 countries: 11/12, followed by 8/12 in Group 2 countries and 5.3/12 in Group 3 countries (Table 48).

Table 48.

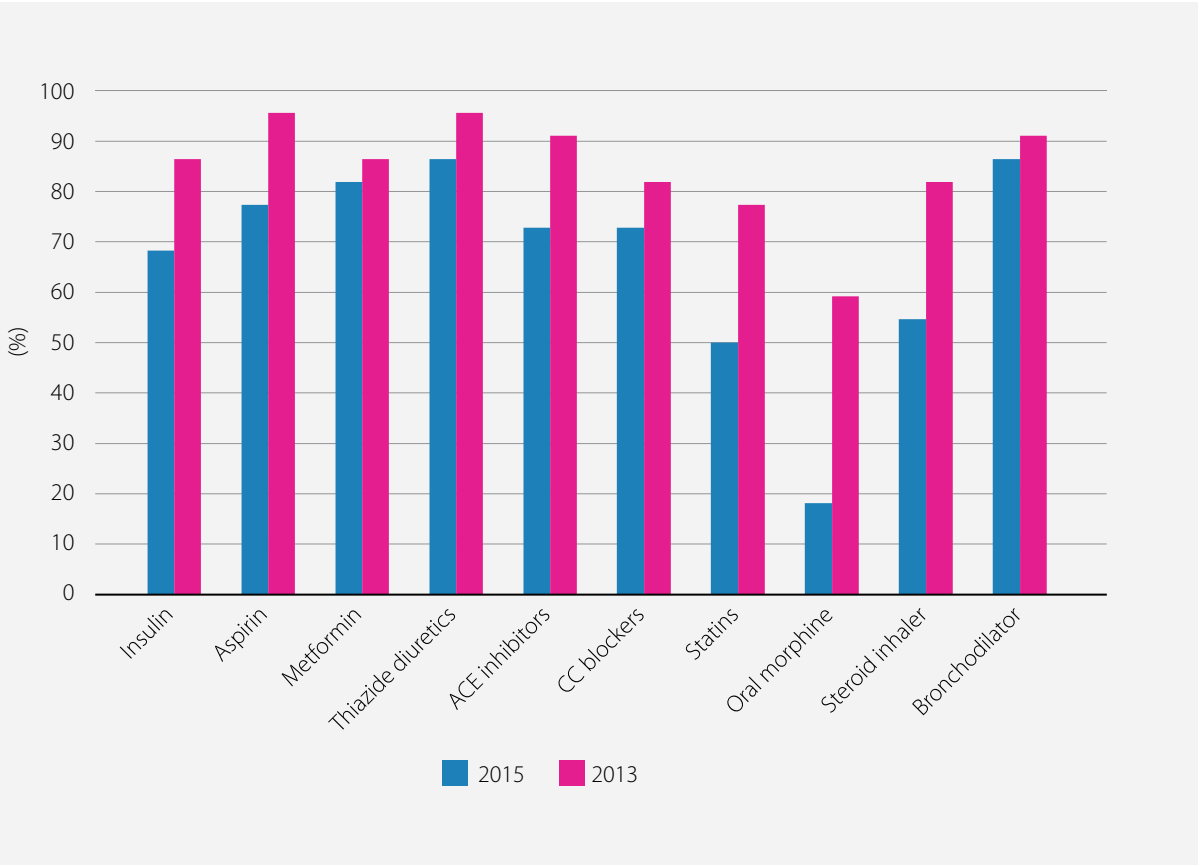
Availability of the 12 essential noncommunicable disease medicines at the primary care facilities of the public health sector

Group	Country	Insulin	Aspirin	Metformin	Thiazide diuretics	ACE inhibitors	CC blockers	Beta blockers	Statins	Oral morphine	Steroid inhaler	Bronchodilator	Sulphonylurea(s)	Total number of medicines available (out of 12)
Group 1	Bahrain	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
	Kuwait	✓	✓	✓	✓	✓	✓	✓	✓	.	.	✓	✓	10
	Oman	✓	✓	✓	✓	✓	✓	✓	✓	.	✓	✓	✓	11
	Qatar	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
	Saudi Arabia	✓	✓	✓	✓	.	.	✓	✓	.	✓	✓	✓	9
	United Arab Emirates	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
	Group 1	**100%**	**100%**	**100%**	**100%**	**83%**	**83%**	**100%**	**100%**	**50%**	**83%**	**100%**	**100%**	**11.0**
Group 2	Egypt	.	✓	✓	✓	✓	✓	✓	.	.	.	✓	✓	8
	Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	✓	✓	.	.	✓	.	9
	Iraq	.	✓	✓	✓	✓	✓	✓	.	.	✓	✓	✓	9
	Jordan	✓	✓	✓	✓	✓	✓	✓	✓	.	✓	✓	✓	11
	Lebanon	✓	✓	✓	✓	✓	✓	✓	.	.	✓	.	.	8
	Libya	.	.	.	.	.	.	.	.	.	.	.	.	0
	Morocco	✓	.	✓	✓	✓	✓	.	.	.	✓	✓	✓	8
	Palestine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
	Syrian Arab Republic	✓	✓	✓	✓	.	.	.	.	.	✓	✓	✓	7
	Tunisia	✓	✓	✓	✓	✓	✓	.	.	.	✓	✓	.	8
	Group 2	**70%**	**80%**	**90%**	**90%**	**80%**	**80%**	**60%**	**30%**	**10%**	**70%**	**80%**	**70%**	**8.0**
Group 3	Afghanistan	.	✓	.	✓	✓	.	.	✓	.	.	✓	.	5
	Djibouti	na	na	na	na	na	na	na	na	na	na	na	na	0
	Pakistan	.	.	✓	✓	✓	✓	✓	.	.	.	✓	✓	7
	Somalia	.	✓	✓	✓	.	✓	✓	.	.	.	✓	✓	7
	Sudan	✓	✓	✓	✓	✓	✓	✓	✓	.	.	✓	✓	10
	Yemen	✓	.	.	.	.	.	.	.	.	.	✓	✓	3
	Group 3	**33%**	**50%**	**50%**	**67%**	**50%**	**50%**	**50%**	**33%**	**0%**	**0%**	**83%**	**67%**	**5.3**
Eastern Mediterranean		**68%**	**77%**	**82%**	**86%**	**73%**	**73%**	**68%**	**50%**	**18%**	**55%**	**86%**	**73%**	**8.1**

With regard to the availability of the 10 essential noncommunicable disease medicines at primary care facilities of the public health sector whose availability data appears in both the 2013 and 2015 regional surveys, there has been a universal decrease in availability of these medicines in the period between the two surveys. Medicines whose availability decreased most sharply included: oral morphine (from 59% in 2013 to 18% in 2015); statins (from 77% in 2013 to 50% in 2015); and steroid inhaler (from 82% in 2013 to 55% in 2015) (Fig. 10).

Fig. 10.

Comparison of availability of the 10 essential noncommunicable disease medicines at primary care facilities of the public health sector (only medicines whose availability data appears in both the 2013 and 2015 regional surveys)



Availability of specific procedures for noncommunicable disease management in publicly funded health systems varied from 77% for both coronary bypass or stenting and renal dialysis, to 55% for retinal photocoagulation and renal transplantation. Availability of such procedures was lowest in Group 3 countries. In addition, renal transplantation was completely unavailable in Group 3 countries (Table 49).

Table 49.

Availability of specific procedures for treating noncommunicable diseases in publicly funded health systems

Group	Country	Retinal photocoagulation	Renal replacement therapy by dialysis	Renal replacement by transplantation	Coronary bypass or stenting	Thrombolytic therapy (streptokinase) for acute myocardial infarction
Group 1	Bahrain	✓	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓	✓
	Oman	✓	✓	✓	✓	✓
	Qatar	✓	✓	✓	✓	✓
	Saudi Arabia	.	✓	✓	✓	.
	United Arab Emirates	✓	✓	✓	✓	✓
	Group 1	**83%**	**100%**	**100%**	**100%**	**83%**
Group 2	Egypt	✓	✓	✓	✓	✓
	Iran (Islamic Republic of)	.	✓	.	✓	✓
	Iraq	✓	✓	✓	✓	✓
	Jordan	✓	✓	.	✓	✓
	Lebanon	.	✓	.	✓	✓
	Libya	.	.	.	.	.
	Morocco	✓	✓	✓	✓	✓
	Palestine	✓	✓	✓	✓	✓
	Syrian Arab Republic	.	✓	.	.	.
	Tunisia	✓	✓	.	✓	✓
	Group 2	**60%**	**90%**	**40%**	**80%**	**80%**
Group 3	Afghanistan	.	.	.	.	.
	Djibouti	na	na	na	na	na
	Pakistan	.	.	.	✓	✓
	Somalia	.	.	.	.	.
	Sudan	✓	✓	.	✓	✓
	Yemen	.	✓	.	✓	✓
	Group 3	**17%**	**33%**	**0%**	**50%**	**50%**
Eastern Mediterranean Region		**55%**	**77%**	**55%**	**77%**	**73%**

Availability of cancer diagnosis and treatment services in the public sector was relatively high in the Region, ranging between 77% and 82%. In countries in Groups 1 and 2, the availability of such services in the public sector ranged between 80% and100%, but dropped to 50% in Group 3 countries, while such services were completely absent in Afghanistan, Djibouti and Somalia (Table 50).

Table 50.

Availability of cancer diagnosis and treatment services in the public sector

Group	Country	Cancer centres or cancer departments at tertiary level	Pathology services (laboratories)	Cancer surgery	Subsidized chemotherapy
Group 1	Bahrain	✓	✓	✓	✓
	Kuwait	✓	✓	✓	✓
	Oman	✓	✓	✓	✓
	Qatar	✓	✓	✓	✓
	Saudi Arabia	✓	✓	.	✓
	United Arab Emirates	✓	✓	✓	✓
	Group 1	**100%**	**100%**	**83%**	**100%**
Group 2	Egypt	✓	✓	✓	✓
	Iran (Islamic Republic of)	.	✓	✓	.
	Iraq	✓	✓	✓	✓
	Jordan	✓	✓	✓	✓
	Lebanon	✓	✓	✓	✓
	Libya	✓	✓	✓	✓
	Morocco	✓	✓	✓	✓
	Palestine	✓	✓	✓	✓
	Syrian Arab Republic	✓	✓	✓	✓
	Tunisia	.	.	.	.
	Group 2	**80%**	**90%**	**90%**	**80%**
Group 3	Afghanistan	.	.	.	.
	Djibouti	na	na	na	na
	Pakistan	✓	✓	✓	✓
	Somalia	.	.	.	.
	Sudan	✓	✓	✓	✓
	Yemen	✓	✓	✓	✓
	Group 3	**50%**	**50%**	**50%**	**50%**
Eastern Mediterranean Region		**77%**	**82%**	**77%**	**77%**

Palliative care for patients with noncommunicable diseases was available in only three countries of the Region: Qatar and Saudi Arabia in Group 1, and Syrian Arab Republic in Group 2 (Table 51).

Table 51.

Availability of palliative care for patients with noncommunicable diseases in the public health system

Group	Country	In primary health care	In community or home-based care
Group 1	Bahrain	.	.
	Kuwait	.	.
	Oman	.	.
	Qatar	.	✓
	Saudi Arabia	✓	✓
	United Arab Emirates	.	.
	Group 1	**17%**	**33%**
Group 2	Egypt	.	.
	Iran (Islamic Republic of)	.	.
	Iraq	.	.
	Jordan	.	.
	Lebanon	.	.
	Libya	.	.
	Morocco	.	.
	Palestine	.	.
	Syrian Arab Republic	✓	✓
	Tunisia	.	.
	Group 2	**10%**	**10%**
Group 3	Afghanistan	.	.
	Djibouti	na	na
	Pakistan	.	.
	Somalia	.	.
	Sudan	.	.
	Yemen	.	.
	Group 3	**0%**	**0%**
Eastern Mediterranean Region		**9%**	**14%**

Discussion

The findings of the 2015 country capacity survey highlighted a number of opportunities and challenges relating to the capacities of countries in the Region to curb the burden and impact of noncommunicable diseases and their associated risk factors on health and wellbeing, as well as in regard to social and economic development.

In regard to achievement of the 10 progress indicators, those most fully achieved by countries were progress indicators 6, 7 and 8. The majority of countries fell short in their achievement of the progress indicators targeting: governance; surveillance, monitoring and evaluation; tobacco use; and health care.

Governance

Leadership and planning

A high level of commitment to addressing noncommunicable diseases was observed in many countries. Seventy-seven per cent of the countries indicated the development of an integrated noncommunicable disease policy, strategy or action plan; 68% had an established national multisectoral noncommunicable disease body; 91% had a dedicated noncommunicable disease department or unit within the ministry of health with one or more full-time member of staff; and 86% reported the availability of funding for noncommunicable diseases through various means (for example, taxation and health insurance).

However, the above-mentioned findings pertaining to governance reveal a somewhat incomplete picture due to the fact that many of the countries' national plans relating to noncommunicable diseases are not operational. An integrated noncommunicable disease policy/strategy/action plan was operational in only eight countries (36%).

Furthermore, in comparison with the findings of the 2013 survey, Syrian Arab Republic and Pakistan no longer have an integrated noncommunicable disease policy, strategy or action plan, while this remained lacking in Djibouti, Libya and Somalia. Hence, increased efforts to establish such approaches, particularly for countries in Groups 2 and 3, are both essential and urgent.

In comparison with the 2013 survey, a considerable decrease (to less than half the 2013 rate) was observed in terms of the direct involvement of United Nations agencies and other international institutions in national noncommunicable disease bodies. A substantial decrease was also observed regarding the involvement of nongovernmental organizations, community-based organizations and civil society.

Most of the noncommunicable disease policies/strategies/action plans incorporated all four of the major noncommunicable diseases and their shared risk factors; however, the harmful use of alcohol was incorporated in the national plans of only 27% of countries. While this finding suggests the low importance of and/or limited use of alcohol in the Region, it could also be due to reporting bias, given the social stigma associated with alcohol use in many countries of the Region.

Funding

General government revenues were the most common source of funding for noncommunicable diseases and their risk factors in most (86%) of the countries. This finding indicates that many countries are committed to investing in noncommunicable disease prevention and control. Lack of funding for noncommunicable diseases was most marked in Group 3 countries and in Afghanistan, Djibouti and Somalia in particular, mainly as a result of these countries' limited financial resources. Funding from international and national donors were the major sources of noncommunicable disease funding in almost all Group 2 countries as well as in Oman in Group 1 and Sudan and Yemen in Group 3, which is suggestive of the greater role in noncommunicable disease prevention and control these counterparts play in comparison to government in these countries.

Funding from earmarked taxes was reported in only four countries (18%). The most common fiscal interventions targeting noncommunicable diseases came from taxation on tobacco (86%), followed by taxation on alcohol (45%). Other fiscal interventions were almost completely or completely absent, in particular: funds from earmarked taxation on sugar-sweetened beverages and foods high in fat, sugar and salt; price subsidies for healthy foods; and taxation incentives to promote physical activity.

Furthermore, funds generated from fiscal interventions were mostly directed towards general government revenue as opposed to health and health services, which were budgeted for in only three countries (14%). In these three countries, revenues were only allocated for health management/care, and none were directed towards initiatives to influence health behaviours. These findings reveal the necessity on the part of governments in the Region to place more emphasis on the use of earmarked taxation in fiscal interventions. Governments should also consider increasing and diversifying both the type of fiscal interventions implemented and the use of funds raised from these fiscal interventions with regard to noncommunicable diseases.

Overall, funding for noncommunicable diseases and their risk factors was generally high and diverse in Group 1 and Group 2 countries. However, a wide gap was revealed in the availability of funding between countries in Groups 1 and 2 and those in Group 3; most noncommunicable disease activities or functions lacked funding in the

latter group. For countries in Groups 2 and 3, palliative care, as well as noncommunicable disease surveillance, monitoring and evaluation received the least funding. Broader funding efforts should be exerted in all Group 3 countries in order to prioritize noncommunicable disease prevention and control.

Funding is pivotal in noncommunicable disease prevention and control. A political will to enforce innovative funding mechanisms that can overcome financing barriers is therefore essential. Innovative financing mechanisms are defined as "non-traditional applications of Official Development Assistance (ODA), joint public-private mechanisms, and flows that support fundraising by tapping new resources or deliver financial solutions to development problems on the ground" (*12*). They are critical components in resource mobilization for global health, because they fill existing financial gaps in health-related targets.

Innovative funding has primarily been a common tool used in initiatives to combat communicable diseases. Examples include UNITAID's airline ticket levies to help stabilize costs and supply of medicines for HIV/AIDS, tuberculosis and malaria (*12*). Data show that initial investments in noncommunicable disease prevention and control are insignificant compared to the long-term costs and consequences of a lack of such interventions. Early investment in noncommunicable diseases has many merits in ensuring economic prosperity and social equality (*13*).

The lack of innovative funding strategies for the prevention and control of noncommunicable diseases in the Region can have a significant long-term negative impact on socioeconomic development. Focusing on the generation of innovative funding mechanisms for the prevention and control of noncommunicable diseases requires immediate attention by all countries of the Region, especially Group 1 countries, given the fact that they are equipped with better resources.

Implications

Based on the results pertaining to noncommunicable disease governance, it can be seen that many hurdles remain. Countries are guided by the regional Framework for action to implement the United Nations Political Declaration on Non-communicable Diseases (*3*), but while they know what work is required, the majority of countries still lack: time bound targets; integrated policies that address the four main noncommunicable diseases and the four risk factors; and multisectoral action plans. The Region requires a stronger leadership and a culture that cultivates noncommunicable disease champions, in order for countries to be able meet the time-bound commitments and their set voluntary targets. Stronger leadership can be forged through the decentralization of governance. Decentralization would allow more players to become accountable both locally and nationally, and could also decrease bureaucracy and support cohesive action to push forward the noncommunicable disease agenda. The Region is known for its centralized government which could impact local autonomy, financing and decision-making (*14*).

Furthermore, a wide gap in noncommunicable disease prevention and control leadership can be observed in Group 3 countries when compared to that in countries in Groups 1 and 2. Group 3 countries continue to struggle to implement measures to combat noncommunicable diseases and their risk factors because of the lack of support systems, or more precisely, a lack of funds. Nevertheless, the success observed in Group 2 countries can be seen to give hope to Group 3 countries, which can learn from the former, as the interest of international donors shifts to support Group 3 countries (*15*).

Prevention and reduction of risk factors

Vertical programmes

Vertical programmes on noncommunicable diseases and their risk factors were most common in Group 1 countries, followed by Group 2 countries (with the exception of Lebanon, Libya and Syrian Arab Republic), but were almost completely absent in Group 3 countries. The disease most addressed in these programmes was cancer (64%), while the disease least addressed was chronic respiratory disease (23%), and the risk factors least addressed were the harmful use of alcohol (14%) and physical inactivity (41%). Overall, there was a moderate increase in the regional average number of vertical programmes, up from 3.9 in 2013 to 4.2 in 2015. Despite these noticeable improvements in recent years, more targeted efforts are required to comprehensively integrate these vertical programmes, especially given the general low availability of such programmes in the Region.

Policy and implementation

Only four countries (18%) reported implementing policies to reduce the impact of the marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt to children. Only five countries (23%) reported implementing national policies to limit saturated fatty acids and to virtually eliminate industrially produced trans-fats. Forty-eight per cent of countries had policies to reduce salt consumption. Such policies were implemented in all Group 1 countries and almost half of Group 2 countries, but were completely absent in Group 3 countries. Forty-five per cent of countries had national public awareness programmes

on diet and/or physical activity (conducted in the five years preceding the survey). These were implemented in most of the countries in Group 1 and half of the countries in Group 2, but were also completely absent in Group 3 countries.

Implications

The prevailing gaps in targeting the prevention and control of noncommunicable disease risk factors can be associated with both funding and legislation barriers. Many countries require funding to conduct baseline studies and assessments to ensure the successful implementation of risk factor policies. Without available funds, it is difficult to implement such policies, and practically speaking, any efforts to target these risk factors may be futile, as countries will not be effectively equipped to monitor and evaluate associated potential changes in risk factor prevention and control.

Legislation is another key barrier to policy implementation. Without the support of the legislative system, policies cannot be effective due to a lack of enforcement. A success story where the law has supported such implementation can be seen in Pakistan, when the minister of health attempted to implement a policy banning tobacco advertisements. The tobacco industry contested the move, stating that the minister of health did not have the authority to implement such a ban. The tobacco industry was unsuccessful, however, as the Supreme Court ruled that the banning of advertisements was legal and enforceable (*16*). To support policies and their implementation, deeper analysis regarding the mechanisms that enforce and support policies is required.

Furthermore, the adequate engagement and cooperation of all stakeholders involved in noncommunicable disease prevention and control (government, industry, the private sector and civil society) is crucial for successful policy enforcement and implementation. The literature suggests that a gap exists between the burden of noncommunicable diseases and national policy responses in low- and middle-income countries. Urgent solutions to bridge this gap could include the joint development of multi-stakeholder policies to improve risk factor prevention and control (*17*).

Surveillance, monitoring and evaluation

Registration systems

Countries of the Region continue to acknowledge their need to build their capacities in the area of noncommunicable disease surveillance. A regional increase can be observed in the availability of mortality registration systems – up from 68% in 2013 to 77% in 2015 – as well as in the availability of population-based cancer registries – up from 77% in 2013 to 82% in 2015. However, major gaps in the availability of such registration systems persist in Group 3 countries; for example, mortality registration systems are unavailable in Afghanistan, Djibouti, Pakistan and Somalia. In many Group 2 countries, the coverage of such registration systems (whether mortality registration systems or cancer registries) is also predominantly subnational, with data not being generated on a regular basis and/or the direct causes of death not being recorded accurately in compliance with the WHO International Classification of Diseases, version 10 (ICD-10). All of these factors mean that only 23% of countries of the Region have achieved Progress indicator 2.

Furthermore, almost all Group 1 countries reported the availability of diabetes registries, while only 40% of countries in Group 2 reported having these facilities. This is congruent with the significant burden of diabetes in Region, which has the highest prevalence of type 2 diabetes globally (*18*).

Population surveys

Progress was also observed in the increased number of adult surveys on noncommunicable disease risk factors (that is, the STEPS survey), where all countries in Groups 1 and 2 have either conducted a STEPS survey in the last five years or have plans to conduct one in 2016. For Group 3 countries, this trend is significantly less pronounced, with only Sudan planning to implement a STEPS survey in 2016. This relative lack of implementation of adult surveys is primarily attributed to the limited financial resources available for the funding of such surveys in Group 3 countries.

Similarly, adolescent surveys of noncommunicable disease-related risk factors were also common in most Group 1 and Group 2 countries (with the exception of Egypt and Morocco), but were almost completely absent in Group 3 countries. Eighty-two per cent of countries reported conducting surveys on tobacco use, in contrast to only 18% reporting conducting surveys on the harmful use of alcohol. Furthermore, it is worth highlighting that since 2013, there has been a decrease in the number of adolescent noncommunicable disease-related risk factor surveys carried out, while, the number of adult surveys implemented has generally remained the same.

Implications

Irrespective of the availability of registration systems and routine noncommunicable disease risk factor surveys, all countries of the Region continue to face key challenges in noncommunicable disease surveillance. These

include: limited funding, especially in the presence of other pressing priorities (in particular, crisis and conflict situations); a lack of data sharing (including the lack of the legal frameworks that enforce it); limited human resources both in terms of numbers and capacity; a lack of accurate civil registration and vital statistics; a lack of accurate reporting of cause-specific mortality data; a lack of coordination among stakeholders; and fragmentation in data repositories.

The lack of data sharing in the Region is a substantial barrier to noncommunicable disease surveillance. Many countries that implemented the STEPS surveys do not have their results disseminated, or have not used the findings effectively for the purpose of lessons learnt. Information is essential in public health decision-making. The specific benefits of data sharing are widely accepted; these include: transparency and cooperation; reproducibility of results or research; cost-efficiency; acceleration of discovery; facilitation of innovation; and lifesaving through improved public health programmes (*17*). Barriers to data sharing involve technical but seemingly straightforward obstacles such as: data not being collected; data not being preserved properly; restrictions in data formatting which hinder their transferability; the lack of metadata and standards; and the unavailability of technical solutions to harmonize data. Other barriers relate to economics (that is, a lack of resources), motivation (that is, a lack of incentives), politics (that is, a lack of trust and nationally approved guidelines), legal frameworks (that is, a lack of ownership, copyright issues, and protection of privacy), and ethics (that is, a lack of reciprocity and confidentiality) [*17*]. With the growing global commitment to combating noncommunicable diseases, it is now more important than ever to overcome such challenges. This can be achieved through thoughtful country lobbying, or the implementation of a systematic framework or global operational guidelines for noncommunicable disease surveillance.

The lack of adequate human resources (in numbers and/or skills) is an equally important challenge for noncommunicable disease surveillance in the Region. Capacity-building of skilled workers coupled with their retention for the future is of vital importance, as is the development of continuous learning/training programmes to regularly empower the technical skill sets of staff (*19*).

Health care

Primary care

Cardiovascular diseases and diabetes were the two diseases most commonly covered by evidence-based national guidelines/protocols/standards for the management and referral of noncommunicable diseases at the primary care level in the Region. Cancers and chronic respiratory diseases were considerably less widely covered, and only 41% of countries indicated having national guidelines that target all four main noncommunicable diseases.

There was a marked difference in the availability of these guidelines in the three country groups; high availability was reported in Group 1 countries, while moderate availability was reported by Group 2 countries, and guidelines were almost non-existent in Group 3 countries. Compared with the 2013 survey data, guideline availability (especially for cancers and chronic respiratory diseases) has decreased generally, and particularly so in Group 2 countries. These findings could be attributed to reporting bias, and/or could be associated with ongoing conflict and crisis situations (for example, in Syrian Arab Republic and Yemen).

About half of the 13 basic technologies at the primary care level for the early detection, diagnosis and monitoring of noncommunicable diseases were available in countries of the Region, with almost no difference in availability between the public and private sectors (49% and 52% respectively). Availability of these technologies also differed across the three country groups; availability was highest in Group 1 countries (10/13), followed by Group 2 countries (6/13) and lowest in Group 3 countries (3/13). In general, the highest availability of the 13 basic technologies occurred in the public sector in Group 1 countries and in the private sector in Group 2 countries.

Cancer diagnosis and management

National screening programmes for breast cancer were available in almost all Group 1 and Group 2 countries, but were absent in most Group 3 countries. Eighty-three per cent of Group 1 countries reported the availability of national screening programmes for colon cancer and 50% reported availability of programmes for cervical and prostate cancers. However, screening programmes for cancers of the cervix, colon and prostate were almost completely absent (0–20% availability) in Group 2 and Group 3 countries.

A similar pattern can also be observed regarding the early detection of cancer at the primary care level: countries in Groups 2 and 3 do not have such capacities. It is noteworthy that the availability of services for the early detection of cancer at the primary care level was generally lower compared to the availability of national cancer screening programmes. This finding contradicts with the WHO recommendations to promote early detection of cancers of the breast, colon, and prostate (*20*). Moreover, the availability of national programmes for HPV vaccinations was reported in only two countries, which is consistent with the low prevalence of cervical cancer in the majority of countries.

The availability of cancer management and treatment services in the public sector was generally high in all countries of the Region. More than three-fourths of countries reported the availability of tertiary level services, pathology services, cancer surgery and subsidized chemotherapy. However, such services were completely absent in Afghanistan, Djibouti, Tunisia and Somalia.

Noncommunicable disease treatment and essential medicines

Specific procedures for treating noncommunicable diseases in publically funded health systems were available in most Group 1 and Group 2 countries (with the exception of Libya and Syrian Arab Republic), but were absent in most Group 3 countries. Procedures least available included retinal photocoagulation and renal transplantation (both only available in 55% of countries). Renal dialysis was not available in Afghanistan, Djibouti, Libya, Pakistan and Somalia.

Availability of the 12 essential noncommunicable disease medicines at public primary care facilities was generally high in most countries, with the exception of Afghanistan, Djibouti, Libya and Yemen. The three medicines least available in the Region were: oral morphine, statins, and steroid inhaler (18%, 50% and 55% respectively).

It should also be noted that in a comparison of the 2013 and 2015 data, the overall availability of essential medicines in the Region can be seen to have decreased, particularly in the case of oral morphine, statins and steroid inhaler. Countries most impacted by this decrease included Libya, Syrian Arab Republic and Yemen, and to a lesser extent Egypt, Iraq and Somalia. This situation could be attributed to conflict and crisis situations in these countries (*21*).

Increased efforts at the regional level are also required to improve the availability of palliative care for patients with noncommunicable diseases in the public sector, which was generally extremely low in the Region.

Implications

The above results reflect specific challenges relating to the performance and capacities of the existing primary health care systems in the Region, as well as current conflict and crisis situations in the Region which are impacting more than 50% of countries (*21*).

Existing primary health care systems in the Region are currently facing a number of performance and capacity-related challenges: staff shortages; the low status or priority given to primary health care in health systems; staff competency-building; and a lack of functional referral systems at both the secondary and tertiary levels (*22*).

The implementation of an adequately functioning health care system and a STEPwise approach (that integrates health information systems and patient-centred health service delivery models) is required and is generally universally accessible. A shift towards strengthening primary health care is needed to deliver the services required for noncommunicable disease prevention and control. The application of the WHO charts for the assessment of cardiovascular risk, coupled with universal access to affordable and good-quality noncommunicable disease medicines, is essential for all countries of the Region (*22*).

Conflict-related impacts have direct effects on the management and control of noncommunicable diseases in the Region. As mentioned above, more than half of the countries in the Region are currently in conflict and crisis situations (*21*). In addition, those countries not in crisis are nevertheless also often affected by crisis situations in neighbouring countries. This has resulted in priorities in the Region shifting away from noncommunicable diseases to other more pressing health concerns. Consequently, this has led to a decrease in the availability of noncommunicable disease services, including medicines (as the survey results show), and has also caused setbacks in the further development of services. Moving forward, countries in conflict and crisis situations in the Region require special focus, in order to improve the management of the major noncommunicable diseases in the context of such situations. Governments, United Nations agencies and international organizations have not been sufficiently dynamic in their response to the continuously changing environments of conflict (*23*). Present practices for health care in conflict settings are largely based on humanitarian relief models that are becoming increasingly inadequate in the face of the complexities of current conflicts. Current conflicts present daunting challenges due to the fact that they are intrastate, fought by irregular armed groups, and fuelled by economic opportunism and ethnic rivalry. In addition, this type of violence is taking place concurrently with both increased urbanization and an increasingly ageing society that tends to be at higher risk from noncommunicable diseases (*23*).

Survey strengths and limitations

The strengths of the 2015 survey included an enhanced questionnaire, and the fact that the survey became web administrated. It also required validation of responses through corresponding documents uploaded by respondents. In addition, several questions were retained from previous versions of the questionnaire, which allowed for temporal comparisons. The response rate of countries to the questionnaire was high, with only Djibouti not responding. Information gathering by

the noncommunicable disease focal points assigned to complete the survey was carried out in close consultation with national focal points whose expertise corresponded to specific sections of the questionnaire.

The survey limitations mainly related to reporting bias. The robust validation process used to assess responses in the survey was, however, not able to adequately reflect respondents' comprehensive understanding of specific measures or needs. Additionally, language and/or technical barriers (that is, unfamiliar wording or terms) could have impacted reporting.

Keeping these limitations in mind, considerable efforts were exerted to minimize the imperfections of the survey. The data management validation process was extensive, and it can be concluded that the results of the survey constitute a sound overview of noncommunicable disease-related capacities, resources and challenges in the Region.

Conclusion

Countries of the Region showed a high level of commitment to addressing the burden of noncommunicable diseases, and governments in the Region are contributing to efforts in this regard. However, more action is required to encourage all countries of the Region to set their time-bound national targets and implement operational integrated policies/strategies/action plans. Fiscal interventions for health are underutilized in the Region (with the exception of tobacco taxation), as is the earmarking of taxes for health, health-related services and health behaviour-related activities/campaigns.

In the past few years, there has been a marked increase in the number of national policies to reduce population salt/sodium consumption adopted by countries of the Region. This is indicative of the prioritization of this policy by many countries of the Region, and represents an important opportunity regarding the potential for the implementation of similar policies, such as the banning of the marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt to children, and the virtual elimination of industrially produced trans-fats in the food supply.

In terms of noncommunicable disease surveillance, the availability of mortality and cancer registries has slightly increased since 2013. A similar pattern can be observed for surveys on noncommunicable diseases and their risk factors (STEPS surveys) among adults. However, the quality and representativeness of data generated remains problematic in many countries of the Region.

Primary health care services continue to be challenged by the limited availability of national guidelines/protocols/standards for noncommunicable disease management, and basic technologies for the early detection, diagnosis and monitoring of the diseases. This is further compounded by a decrease in the availability of essential medicines at the public primary care level. Primary health care integration of services for the early detection of cancers is also lacking. Urgent efforts are required to address these gaps, particularly in countries facing ongoing conflict and crisis situations.

It is also of crucial importance to highlight and reflect upon the existing inequities impacting access to health services. In general, Group 2 countries have a weaker capacity to address noncommunicable diseases than Group 1 countries, while Group 3 countries have the weakest capacities in the Region to implement the 10 progress indicators. Group 3 countries and countries in recent or ongoing conflict and crisis situations have the lowest availability (or rather, in, many cases, the greatest absence) of resources, infrastructure, and services for noncommunicable disease prevention and control in all areas of strategic intervention. For example, based on the survey results, Libya, Syrian Arab Republic and Yemen demonstrated a steep decline during the course of only two years in terms of their capacities to counter noncommunicable diseases.

Recommendations and the way forward

Based on the findings of this survey, the following specific recommendations are proposed for the different stakeholders involved in the prevention and control of noncommunicable diseases.

1. Existing integrated noncommunicable disease policies/strategies/action plans should be enforced and implemented.
2. Fiscal interventions should be introduced, in particular those which impose taxation on sugar-sweetened beverages and foods high in fat/sugar/salt, incentivize the consumption of healthy foods, and promote physical activity.
3. Earmarking taxes for health should be considered, and earmarked funds dedicated for noncommunicable disease management and control.
4. Greater investment should be made in palliative care and in noncommunicable disease surveillance, monitoring and evaluation.
5. The burden of harmful use of alcohol should be assessed in countries where the consumption of alcohol is reported.
6. Policies should be implemented that aim to: reduce the impact of the marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt to children; virtually eliminate industrially produced trans-fats from the food supply; and reduce population salt/sodium consumption.
7. More focus should be placed on addressing chronic respiratory diseases and physical inactivity, and such efforts should be adequately linked and integrated with existing programmes for the prevention and control of noncommunicable diseases.
8. Greater pressure needs to be exerted by local expert groups/syndicates to encourage the development and implementation of national guidelines/protocols/standards for noncommunicable disease management at the primary care level that target all of the four main noncommunicable diseases in most of the countries of the Region.
9. The low availability of essential medicines and basic technologies should be addressed, particularly in countries currently in conflict or crisis situations.
10. Capacities for the early detection of cancer should be improved at the primary care level.

From a broader governance perspective, countries need to scale up action in the following key areas**.**

- **Stronger leadership and planning**. Inaction is more indicative of a lack of leadership than anything else with regard to noncommunicable disease prevention and control. The 2011 United Nations Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases represents solid proof that with a strong political will and commitment, change is possible. Countries of the Region should renew their commitments and identify noncommunicable disease champions that will aggressively push the agenda forward. A sense of urgency must be created.

- **Multisectoral efforts**. Noncommunicable disease prevention and control requires the involvement of multiple stakeholders. Efforts to improve stewardship and advocacy among members of government, the private sector, civil society and industry (if collectively and harmoniously working together) will improve progress. Lack of coordination among sectors is costly and ineffective. Working together will yield more powerful results.

- **Innovative solutions**. Innovations in both financing and policy processes are required. Implementing inclusive, integrated approaches coupled with innovative financing mechanisms gathers the various noncommunicable diseases under one strategy as well as supporting new developments at country level (*24*).

- I**ntegrated noncommunicable disease surveillance systems**. Sound decision-making in noncommunicable disease prevention and control requires up-to-date and reliable information. Integrating sustainable noncommunicable disease surveillance systems (that focus on the three pillars of outcome, risk factors and national system response) into national health information systems allows for continuous monitoring and evaluation of countries' progress; based on the evidence provided by such systems, countries can effectively enforce planning.

- **A focus on primary health care**. Currently, noncommunicable disease management is characterized by several caveats, as it is unable to adequately address the needs of people with noncommunicable diseases, particularly those in countries in conflict and crisis situations. Defining the role of service delivery for primary health care, in particular for countries in conflict and crisis situations, will result in improved availability of medicines, technologies and services.

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Annexes

Annex 1. Questionnaire

2015

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

MODULES:

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

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

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

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

Purpose

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

Process

- The survey is intended to assess national level capacity and response to NCDs. If responsibility for health is decentralized to sub-national levels, it can also be applied at sub-national levels.
- A focal point or survey coordinator will need to be identified to coordinate and ensure survey completion. However, in order to provide a complete response, a group of respondents with expertise in the topics covered in the modules will be needed. Please use the table provided to indicate the names and titles of all of those who have completed the survey and which sections they have completed.
- Please note that while there is space to indicate "Don't Know" for most questions, there should be very few of these. If someone is filling in numerous "Don't Knows", another person who is more aware of this information should be found to complete this section.
- In order to validate responses, documentation will be requested for affirmative responses throughout the questionnaire. Please make every effort to provide electronic copies of the requested documentation. If you are unable to provide electronic copies through the provided links, please ask your regional focal point for an alternative means to submit documentation.

Information on those who completed the survey

Who is the focal point for completion of this survey?

Name: .....

Position: .....

Contact Information: .....

Sections completed: .....

Name and contact information of others completing survey	Sections completed

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 2

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

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

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

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

If at least one Yes to above questions:

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

- ◯ General government revenues
- ◯ Health insurance
- ◯ International / National Donors
- ◯ Earmarked taxes on alcohol, tobacco, etc.
- ◯ Other (specify) .....
- ◯ Don't Know

3) Is your country implementing any of the following fiscal interventions?

taxation on alcohol	◯ Yes	◯ No	◯ Don't Know
taxation on tobacco (excise and non-excise taxes)	◯ Yes	◯ No	◯ Don't Know
taxation on sugar sweetened beverages	◯ Yes	◯ No	◯ Don't Know
taxation on foods high in fat, sugar or salt	◯ Yes	◯ No	◯ Don't Know
price subsidies for healthy foods	◯ Yes	◯ No	◯ Don't Know
taxation incentives to promote physical activity	◯ Yes	◯ No	◯ Don't Know
others (specify)	◯ Yes	◯ No	◯ Don't Know

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

3a) **How are these funds primarily used?**

- ◯ Towards general revenue
- ◯ General funds for health and health services
- ◯ For influencing health behaviours
- ◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to MODULE II

4a) **Indicate its stage:**

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

4b) Which of the following are members?

(Check all that apply)

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

4c) What settings are covered by the commission, agency or mechanism?

Schools	◯ Yes	◯ No	◯ Don't Know
Worksites	◯ Yes	◯ No	◯ Don't Know
Cities	◯ Yes	◯ No	◯ Don't Know

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

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

1a) Are NCDs included in your national health plan?

◯ Yes ◯ No ◯ Don't Know

1b) Are NCDs included in your national development agenda?

◯ Yes ◯ No ◯ Don't Know

2) Are there a set of national NCD indicators?

◯ Yes ◯ No ◯ Don't Know

If Yes:

2a) Are there a set of time-bound national targets for these indicators?

◯ Yes ◯ No ◯ Don't Know

II a: INTEGRATED POLICIES, STRATEGIES, AND ACTION PLANS

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 4

If yes:

Is it a policy/strategy?	◯ Yes	◯ No	◯ Don't Know
Is it an action plan?	◯ Yes	◯ No	◯ Don't Know
Is it multisectoral?	◯ Yes	◯ No	◯ Don't Know
Is it multi-stakeholder?	◯ Yes	◯ No	◯ Don't Know

Please provide the following information about the <u>policy, strategy or action plan:</u>

3a) Title: .....

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

Harmful use of alcohol	◯ Yes	◯ No	◯ Don't Know
Unhealthy diet	◯ Yes	◯ No	◯ Don't Know
Physical inactivity	◯ Yes	◯ No	◯ Don't Know
Tobacco	◯ Yes	◯ No	◯ Don't Know

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

Cancer	◯ Yes	◯ No	◯ Don't Know
Cardiovascular diseases	◯ Yes	◯ No	◯ Don't Know
Chronic respiratory diseases	◯ Yes	◯ No	◯ Don't Know
Diabetes	◯ Yes	◯ No	◯ Don't Know

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

◯ Yes ◯ No ◯ Don't Know

3e) Indicate its stage:

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

If Operational:

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

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

II b: POLICIES, STRATEGIES, ACTION PLANS FOR MAJOR DISEASES

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 5

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

4a) Write the title .....

4b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes for all cancers or cancer in general
◯ Yes but only for specific cancers (specify: .....)
◯ No
◯ Don't Know

IF NO: Go to Question 6

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

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

5a) Write the title .....

5b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 7

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

6a) Write the title .....

6b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 8

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

7a) Write the title .....

7b) Indicate its stage:

◯ Operational

◯ Under development

◯ Not in effect

◯ Don't know

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 9

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

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

Please specify which NCD: .....

8a) Write the title .....

8b) Indicate its stage:

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

If Operational:

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

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

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 10

If yes:

Is it a policy/strategy?	◯ Yes	◯ No	◯ Don't Know
Is it an action plan?	◯ Yes	◯ No	◯ Don't Know

9a) Write the title .....

9b) Indicate its stage:

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

If Operational:

9b-i) What was the first year of implementation? .....

9b-ii) What year will it expire? .....

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 11

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

10a) Write the title .....

10b) Indicate its stage:

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

If Operational:

10b-i) What was the first year of implementation? .....

10b-ii) What year will it expire? .....

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 12

If yes:

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

Is it an action plan? ◯ Yes ◯ No ◯ Don't Know

11a) Write the title .....

11b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 13

If yes:

Is it a policy/strategy?	◯ Yes	◯ No	◯ Don't Know
Is it an action plan?	◯ Yes	◯ No	◯ Don't Know

12a) Write the title .....

12b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 14

If yes:

Is it a policy/strategy?	◯ Yes	◯ No	◯ Don't Know
Is it an action plan?	◯ Yes	◯ No	◯ Don't Know

13a) Write the title .....

13b) Indicate its stage:

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

If Operational:

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

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 15

If Yes:

14a) Indicate its stage:

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 16

If yes:

15a) Are the policies:

◯ Voluntary/self-regulating
◯ Government legislation
◯ Don't know

15b) Who is responsible for overseeing enforcement and complaints?

◯ Government
◯ Food Industry
◯ Independent regulator
◯ Other, please specify:

15c) Do they include steps taken to address the effects of cross-border marketing of food and non-alcoholic beverages on children?

◯ Yes ◯ No ◯ Don't Know

15c-i) If yes, please provide details: .....

16) Is your country implementing the International Code of Marketing of Breast-Milk Substitutes through adoption of national laws?

◯ Yes ◯ No ◯ Don't Know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 18

17a) If yes, are the policies:

◯ Voluntary/self-regulating

◯ Government legislation

◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 19

18a) Are these targeted at:

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

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

◯ Voluntary/self-regulating

◯ Government legislation

◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 20

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

.....

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 21

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

.....

21) Does your country have nutrition labelling regulation, in line with international standards, in particular the Codex Alimentarius, for pre-packaged foods?

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to MODULE III

If yes:

21a) Does the regulation have norms in place for front-of package labelling that allow for quick and easy identification of energy-dense nutrient-poor products and sugar-sweetened beverages which take into consideration Codex norms?

◯ Yes ◯ No ◯ Don't Know

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

The questions in this module assess surveillance relating to the mortality, morbidity and risk factor reporting systems of each country and whether NCD mortality, morbidity and risk factor data were included in their national health reporting systems. Responses to these questions enable reporting against NCD Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

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

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

III a: DATA INCLUDED IN THE NATIONAL HEALTH INFORMATION SYSTEM

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 3

IF YES:

2a) Is there a civil/vital registration system?

◯ Yes ◯ No ◯ Don't Know

2b) Is there a sample registration system?

◯ Yes ◯ No ◯ Don't Know

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

.....

2d) Can the data collected be disaggregated by:

Age	◯ Yes	◯ No	◯ Don't Know
Gender	◯ Yes	◯ No	◯ Don't Know
Other sociodemographic factor	◯ Yes	◯ No	◯ Don't Know

3) Does your country have a cancer registry?

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 4

IF YES:

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

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

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

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

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

.....

4) Does your country have a diabetes registry?

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 5

IF YES:

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

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

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

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

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

◯ Yes ◯ No ◯ Don't Know

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

.....

III b: RISK FACTOR SURVEILLANCE

	5a) Harmful alcohol use	5b) Low fruit and vegetable consumption	5c) Physical inactivity	5d) Tobacco use
5) Have surveys of risk factors (may be a single RF or multiple) been conducted in your country for any of the following: **(Please fill in all columns, start in the first row, going left to right, and then continue left to right across the second row.)**	◯ Yes ◯ No ◯ Don't know **IF NO:** **Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** ◯ Yes ◯ No ◯ Don't know **IF YES:** i-1) Was it: ◯ National ◯ Subnational ◯ Don't know i-2) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know i-3) When was the last survey conducted? (give year) ..... **ii) Was there a survey on adults?** ◯ Yes ◯ No ◯ Don't know **IF YES:** ii-1) Was it: ◯ National ◯ Subnational ◯ Don't know	◯ Yes ◯ No ◯ Don't know **IF NO:** **Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** ◯ Yes ◯ No ◯ Don't know **IF YES:** i-1) Was it: ◯ National ◯ Subnational ◯ Don't know i-2) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know i-3) When was the last survey conducted? (give year) ..... **ii) Was there a survey on adults?** ◯ Yes ◯ No ◯ Don't know **IF YES:** ii-1) Was it: ◯ National ◯ Subnational ◯ Don't know	◯ Yes ◯ No ◯ Don't know **IF NO:** **Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** ◯ Yes ◯ No ◯ Don't know **IF YES:** i-1) Was it: ◯ Measured ◯ Self-reported ◯ Don't know i-2) Was it: ◯ National ◯ Subnational ◯ Don't know i-3) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know i-4) When was the last survey conducted? (give year) ..... **ii) Was there a survey on adults?** ◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know **IF NO:** **Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** ◯ Yes ◯ No ◯ Don't know **IF YES:** i-1) Was it: ◯ National ◯ Subnational ◯ Don't know i-2) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know i-3) When was the last survey conducted? (give year) ..... **ii) Was there a survey on adults?** ◯ Yes ◯ No ◯ Don't know **IF YES:** ii-1) Was it: ◯ National ◯ Subnational ◯ Don't know

	5a) Harmful alcohol use	5b) Low fruit and vegetable consumption	5c) Physical inactivity	5d) Tobacco use
	ii-2) How often is the survey conducted? ○ Ad hoc ○ Every 1 to 2 years ○ Every 3 to 5 years ○ Other ○ Don't know ii-3) When was the last survey conducted? (give year)	ii-2) How often is the survey conducted? ○ Ad hoc ○ Every 1 to 2 years ○ Every 3 to 5 years ○ Other ○ Don't know ii-3) When was the last survey conducted? (give year)	**IF YES:** ii-1) Was it: ○ Measured ○ Self-reported ○ Don't know ii-2) Did it assess physical activity for work/in the household, for transport and during leisure time? ○ Yes ○ No ○ Don't know ii-3) Was it: ○ National ○ Subnational ○ Don't know ii-4) How often is the survey conducted? ○ Ad hoc ○ Every 1 to 2 years ○ Every 3 to 5 years ○ Other ○ Don't know ii-5) When was the last survey conducted? (give year)	**ii) Was there a survey on adults?** ○ Yes ○ No ○ Don't know **IF YES:** ii-1) Was it: ○ National ○ Subnational ○ Don't know ii-2) How often is the survey conducted? ○ Ad hoc ○ Every 1 to 2 years ○ Every 3 to 5 years ○ Other ○ Don't know ii-3) When was the last survey conducted? (give year) ....

5e) Raised blood glucose/ diabetes	5f) Raised total cholesterol	5g) Raised blood pressure/ Hypertension	5h) Overweight and obesity	5i) Salt / Sodium intake
○ Yes ○ No ○ Don't know **IF NO: Go to next column.** **IF YES:** i) Was it: ○ Measured ○ Self-reported ○ Don't know ii) Was it: ○ National ○ Subnational ○ Don't know	○ Yes ○ No ○ Don't know **IF NO: Go to next column.** **IF YES:** i) Was it: ○ Measured ○ Self-reported ○ Don't know ii) Was it: ○ National ○ Subnational ○ Don't know	○ Yes ○ No ○ Don't know **IF NO: Go to next column.** **IF YES:** i) Was it: ○ Measured ○ Self-reported ○ Don't know ii) Was it: ○ National ○ Subnational ○ Don't know	○ Yes ○ No ○ Don't know **IF NO: Go to next column.** **IF YES:** **i) Was there a survey on adolescents?** ○ Yes ○ No ○ Don't know **IF YES:** i-1) Was it: ○ Measured ○ Self-reported ○ Don't know	○ Yes ○ No ○ Don't know **IF NO: Go to MODULE IV.** **IF YES:** i) Was it: ○ Measured by 24-hr urine collection ○ Measured by 12-hr urine collection ○ Measured by spot urine collection ○ Measured by combination of methods ○ Self-reported ○ Don't know

5e) Raised blood glucose/ diabetes	5f) Raised total cholesterol	5g) Raised blood pressure/ Hypertension	5h) Overweight and obesity	5i) Salt / Sodium intake
iii) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know iv) When was the last survey conducted? (give year)	iii) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know iv) When was the last survey conducted? (give year)	iii) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know iv) When was the last survey conducted? (give year)	i-2) Was it: ◯ National ◯ Subnational ◯ Don't know i-3) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know i-4) When was the last survey conducted? (give year) .... **ii) Was there a survey on adults?** ◯ Yes ◯ No ◯ Don't know **IF YES:** ii-1) Was it: ◯ Measured ◯ Self-reported ◯ Don't know ii-2) Was it: ◯ National ◯ Subnational ◯ Don't know ii-3) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know ii-4) When was the last survey conducted? (give year)	ii) Was it: ◯ National ◯ Subnational ◯ Don't know iii) How often is the survey conducted? ◯ Ad hoc ◯ Every 1 to 2 years ◯ Every 3 to 5 years ◯ Other ◯ Don't know iv) When was the last survey conducted? (give year) ....

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

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

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

	Cardiovascular Disease	Diabetes	Cancer	Chronic Respiratory Disease
1a) Are they available?	◯ Yes ◯ No ◯ Don't Know	◯ Yes ◯ No ◯ Don't Know	◯ Yes (specify cancer types) ◯ No ◯ Don't Know	◯ Yes ◯ No ◯ Don't Know
1b) Are they being implemented?	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know
1c) When were they last updated?				

2) For each of the major NCDs, please indicate the availability of standard criteria for the referral of patients from primary care level to a higher level of care (secondary/tertiary). Where standard criteria are available, please indicate their implementation status.

	Cardiovascular Disease	Diabetes	Cancer	Chronic Respiratory Disease
2a) Are they available?	◯ Yes ◯ No ◯ Don't Know	◯ Yes ◯ No ◯ Don't Know	◯ Yes ◯ No ◯ Don't Know	◯ Yes ◯ No ◯ Don't Know
2b) Are they being implemented?	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know	◯ Yes, fully ◯ yes, partially ◯ No ◯ Don't Know

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

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

	Availability in the primary care facilities of the public health sector (1, 2, or 3)	Availability in the primary care facilities of the private health sector (1, 2, or 3)
Overweight and obesity 3a) Measuring of weight 3b) Measuring of height	....	....
Diabetes mellitus 3c) Blood glucose measurement 3d) Oral glucose tolerance test 3e) HbA1c test 3f) Dilated fundus examination 3g) Foot vibration perception by tuning fork 3h) Foot vascular status by Doppler 3i) Urine strips for glucose and ketone measurement	....	....
Cardiovascular disease 3j) Blood pressure measurement 3k) Total cholesterol measurement 3l) Urine strips for albumin assay	....	....
Asthma and COPD 3m) Peak flow measurement spirometry	.....	.....

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

Cancers	Screening method (indicate only one, the most widely used)	Population targeted by the program	Type of program	Screening coverage
Breast ◯ Yes ◯ No ◯ Don't know If NO: Go to next row	◯ Clinical breast exam ◯ Mammography screening ◯ Don't know	Women aged ..... to ..... Other, specify:..... ◯ Don't know	◯ Organised population-based screening ◯ Opportunistic screening ◯ Don't Know	◯ Less than 10% ◯ 10% to 50% ◯ more than 50% but less than 70% ◯ 70% or more ◯ Don't know
Cervix ◯ Yes ◯ No ◯ Don't know If NO: Go to next row	◯ Visual inspection ◯ PAP smear ◯ HPV test ◯ Don't know	Women aged ..... to ..... Other, specify:..... ◯ Don't know	◯ Organised population-based screening ◯ Opportunistic screening ◯ Don't Know	◯ Less than 10% ◯ 10% to 50% ◯ more than 50% but less than 70% ◯ 70% or more ◯ Don't know
Colon ◯ Yes ◯ No ◯ Don't know If NO: Go to next row	◯ Faecal test ◯ Colonoscopy ◯ Don't know	People aged ..... to ..... Other, specify:..... ◯ Don't know	◯ Organised population-based screening ◯ Opportunistic screening ◯ Don't Know	◯ Less than 10% ◯ 10% to 50% ◯ more than 50% but less than 70% ◯ 70% or more ◯ Don't know
Prostate ◯ Yes ◯ No ◯ Don't know If NO: Go to question 5	◯ PSA ◯ Prostate palpation ◯ Don't know	Men aged ..... to ..... Other, specify:..... ◯ Don't know	◯ Organised population-based screening ◯ Opportunistic screening ◯ Don't Know	◯ Less than 10% ◯ 10% to 50% ◯ more than 50% but less than 70% ◯ 70% or more ◯ Don't know

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

	Breast	Cervix	Colon	Prostate	Oral
Program/guidelines to strengthen early detection of first symptoms at primary health care level	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know
Clearly defined referral system from primary care to secondary and tertiary care	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know	◯ Yes ◯ No ◯ Don't know

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

◯ Yes ◯ No ◯ Don't know

If NO: Go to Question 7.

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

6a) Who is targeted by the programme?

◯ Girls aged _____ to _____

◯ Other (specify: _____)

◯ Don't know

6b) What year did the programme begin? _____

6c) What is the immunization coverage of the programme?

◯ Less than 10%

◯ 10% to 50%

◯ more than 50% but less than 70%

◯ 70% or more

◯ Don't know

7) Describe the availability* of the medicines below in the primary care facilities of the public health sector, where: Generally available=1; Generally not available = 2, Don't know = 3.

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

Generic drug name	Availability*
7a) Insulin	
7b) Aspirin (100 mg)	
7c) Metformin	
7d) Thiazide Diuretics	
7e) ACE Inhibitors	
7f) CC Blockers	
7g) Statins	
7h) Oral morphine	
7i) Steroid inhaler	
7j) Bronchodilator	
7k) Sulphonylurea(s)	

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

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

Procedure name	Availability
8a) Retinal photocoagulation	
8b) Renal replacement therapy by dialysis	
8c) Renal replacement by transplantation	
8d) Coronary bypass or stenting	
8e) Thrombolytic therapy (streptokinase) for acute myocardial infarction	

9) Indicate the number of treatment centres which offer radiotherapy (centres with external beam therapy equipment like linear accelerators or cobalt 60 machines):

Number of public centres ..... ◯ Don't know

Number of private centres ..... ◯ Don't know

10) Detail the cancer diagnosis and treatment services in the public sector:

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

Service	Availability*
Cancer centres or cancer departments at tertiary level	◯ Generally available and affordable for the majority of patients ◯ Generally not available or affordable for the majority of patients ◯ Don't know
Pathology services (laboratories)	◯ Generally available and affordable for the majority of patients ◯ Generally not available or affordable for the majority of patients ◯ Don't know
Cancer surgery	◯ Generally available and affordable for the majority of patients ◯ Generally not available or affordable for the majority of patients ◯ Don't know
Subsidized chemotherapy	◯ Generally available and affordable for the majority of patients ◯ Generally not available or affordable for the majority of patients ◯ Don't know

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

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

Number of public laboratories: ..... ◯ Don't know

Number of private laboratories: ..... ◯ Don't know

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

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

12a) In primary health care:

- ◯ Generally available
- ◯ Generally not available
- ◯ Don't know

12b) In community or home-based care:

- ◯ Generally available
- ◯ Generally not available
- ◯ Don't know

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

- ◯ none
- ◯ less than 25%
- ◯ 25% to 50%
- ◯ more than 50%
- ◯ Don't know

If more than none:

13a) Which CVD risk scoring chart is used?

- ◯ WHO/ISH risk prediction charts
- ◯ Others (specify .....)
- ◯ Don't know

14) What percentage of public sector health facilities have provision for care of acute stroke and rehabilitation?

- ◯ none
- ◯ less than 25%
- ◯ 25% to 50%
- ◯ more than 50%
- ◯ Don't know

15) What percentage of public sector health facilities have provision for secondary prevention of rheumatic fever and rheumatic heart disease?

- ◯ none
- ◯ less than 25%
- ◯ 25% to 50%
- ◯ more than 50%
- ◯ Don't know

Annex 2. Glossary of terms used in the survey

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

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

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

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

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

Cardiovascular disease: A group of disorders of the heart and blood vessels that includes coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease,

congenital heart disease, deep vein thrombosis and pulmonary embolism.

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

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

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

Collaboration: A recognized relationship between different groups with a defined purpose.

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

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

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

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

Early detection/screening: Measures preformed in order to identify individuals who have early stages of disease (with apparent symptoms in the case or early detection and without in the case of screening).

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

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

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

Full immunization coverage: The proportion of people in the population targeted by the program who actually received the full dose(s) of vaccine.

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

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

Health behaviour: Any activity undertaken by an individual, regardless of actual or perceived *health status*, for the purpose of promoting, protecting or maintaining

health, whether or not such behaviour is objectively effective towards that end.

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

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

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

Healthy diet: A healthy diet throughout the life-course helps prevent malnutrition in all its forms as well as a range of noncommunicable diseases (NCDs) and conditions. The exact make-up of a healthy, balanced diet will vary depending on the individual needs (e.g. age, gender, lifestyle, degree of physical activity). For adults a healthy diet contains fruits, vegetables, legumes, nuts and whole grains and should be limited in free sugars, salt, total fat, saturated fats and free of industrial trans-fats.

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

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

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

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

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

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

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

Multi-stakeholder: Involving stakeholders from across the public sector, civil society, NGOs and the private sector.

National Cancer Screening Program: A government-endorsed program where screening is offered. NGO-led programs or national recommendations to go for screening at your own cost, do not qualify as national screening program.

National focal point, unit/department:

I. ***National focal point***: the person responsible for prevention and control of chronic diseases in a ministry of health or national institute.

II. ***Unit or department****:* a unit or department with responsibility for NCD disease prevention and control in a ministry of health or national institute.

National health reporting system, survey and surveillance:

I. ***National health reporting system*****:** The process by which a ministry of health produces annual health reports that summarize data on e.g national health human resources, population demographics, health expenditures, health indicators such as mortality and morbidity. Includes the process of collecting data from various health information sources e.g. disease registries, hospital admission or discharge data.

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

III. ***Surveillance*****:** The systematic collection of data (through survey or registration) on risk factors, chronic diseases and their determinants for continuous analysis, interpretation and feed-back.

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

National policy, strategy, action plan:

I. ***Policy*****:** A specific official decision or set of decisions designed to carry out a course of action endorsed by a political body, including a set of goals, priorities and main directions for attaining these goals. The policy document may include a strategy to give effect to the policy.

II. ***Strategy*****:** a long term plan designed to achieve a particular goal.

III. ***Action plan*:** A scheme of course of action, which may correspond to a policy or strategy, with defined activities indicating who does what (type of activities and people responsible for implementation), when (time frame), how and with what resources to accomplish an objective.

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

NGO: Non-governmental organization.

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

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

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

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

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

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

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

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

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

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

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

Public health sector: Publicly funded health care sector.

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

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

Risk factors associated with noncommunicable diseases The four main risk factors for NCDs are tobacco use, harmful use of alcohol, unhealthy diet and low levels of physical activity.

Sample registration system: A method and procedure for estimating vital statistics in national and regional populations by intensively registering and verifying vital events in population samples. For instance, in India more than 4,000 rural and 2,000 urban sample units, with a total of more than 6 million persons, i.e., less than 1% of the total national population, are included in a sample registration system that provides a reasonably reliable picture of the national pattern of vital events at a cost that is feasible and reasonable.

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

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

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

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

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

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

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

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

This regional report provides the results of the 2015 noncommunicable disease country capacity survey in the Eastern Mediterranean Region. It offers an overview of the current capacities of the countries of the Region to prevent and control noncommunicable diseases, particularly in regard to the four key areas of: governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care. The report aims to inform the work of decision-makers in ministries of health and other sectors related to health, noncommunicable disease managers, physicians, clinicians, researchers, the media, and others.

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