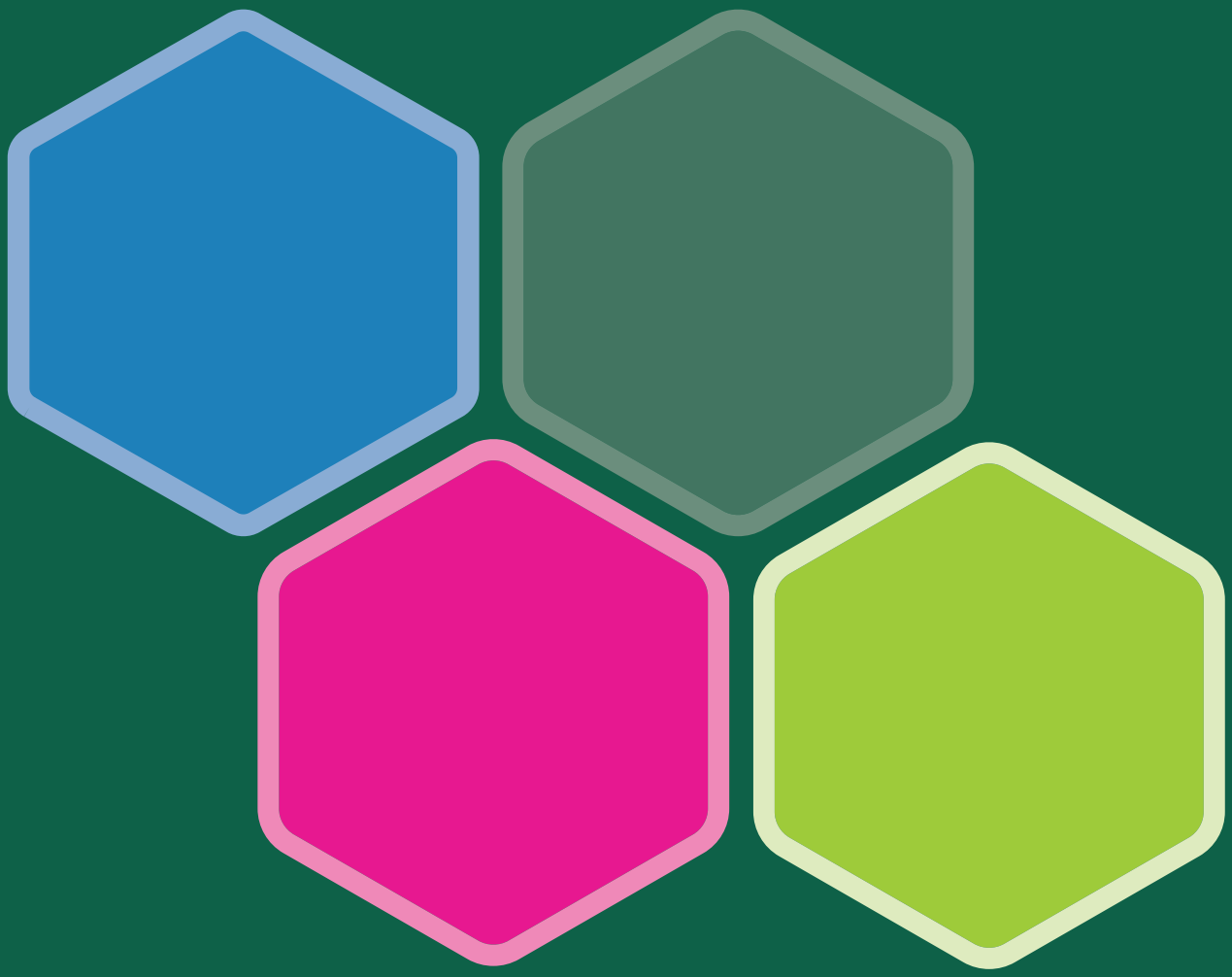
ASSESSING NATIONAL CAPACITY FOR THE
PREVENTION AND CONTROL OF

NONCOMMUNICABLE DISEASES



2017

Report of the 2017 country capacity survey in the
Eastern Mediterranean Region

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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Contents

Foreword

"Promote health, keep the world safe, serve the vulnerable." That is the mission of the World Health Organization (WHO), as summarized in the Organization's thirteenth General Programme of Work (GPW 13), 2019-2023. Adopted by the World Health Assembly in April 2018, GPW 13 is a 5-year strategic plan designed to help countries meet the health targets of the Sustainable Development Goals by 2030. It is centered on the "triple billion" targets: 1 billion more people benefitting from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being. To make a measurable difference in the lives of billions, it is critical for WHO to work with multiple stakeholders and on multiple fronts, including stepping up action to strengthen the capacity of countries and enhance human resources to prevent and control noncommunicable diseases.

Noncommunicable diseases – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – are the world's biggest killers and a leading cause of death in the Eastern Mediterranean Region. Every year, 2.5 million people in the Region die from these four diseases alone, and yet many of these deaths could be prevented through simple lifestyle-related changes and cost-effective interventions implemented by national governments. Following the United Nations High-level Political Declaration on NCDs in 2018, the scope of the NCD agenda has broadened to a "5 by 5" matrix that includes mental health disorders and other mental health conditions as a fifth disease group, and air pollution as a fifth risk factor.

To respond to the epidemic of noncommunicable diseases, countries must continue to conduct periodic assessments to monitor progress and achievements in expanding capacities. In this regard, WHO works with countries to conduct periodic assessment of national capacity for the prevention and control of noncommunicable diseases through the use of a global survey to all countries known as the Country Capacity Survey. The Survey 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 on the 2017 Country Capacity Survey marks the sixth WHO global Country Capacity Survey and 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: 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, progress has generally been inadequate and uneven, and more work is needed. This is particularly true when it comes to setting national targets, developing multisectoral action plans, strengthening cancer registration, periodic as well as routine assessment of noncommunicable disease risk factors, effective implementation of "best buys", and strengthening existing regional health care systems' capacities to prevent and control noncommunicable diseases.

All are critical components of WHO's work and the regional framework for action, which is a road map for countries in the Region to implement the 2011 United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases. This framework was endorsed in October 2012 by the WHO Regional Committee for the Eastern Mediterranean. It provides strategic interventions and indicators to assess country progress in the four areas highlighted above: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and health care. Implementation of the regional framework will contribute to progress on the attainment of the Sustainable Development Goal health targets to be attained in 2030, which include a one-third reduction in premature death from noncommunicable diseases by 2030.

Despite improvements in some countries and areas of work, challenges hampering national progress persist. Examples include: chronic emergencies, which increase needs while simultaneously compromising the capacity of health and social care systems to meet those needs; lack of political capacity and action; difficulties in priority setting; and the absence of robust accountability mechanisms at national level. Moreover, the strong impact of economic, commercial and market factors associated with the tobacco and food industries further impedes public health interventions. Fiscal measures to support healthy life-style choices are examples of public health interventions facing strong resistance due to industry interference.

To turn the tide of noncommunicable diseases, specific data is required for the development of effective strategies for the prevention and control of noncommunicable diseases. Good quality, reliable,

standardized and sustainable data help countries set their priorities and develop targeted interventions to reverse the noncommunicable diseases epidemic. Surveillance is thus a fundamental tool in WHO's work to prevent and control noncommunicable diseases.

It therefore remains crucial to address the gaps identified in this report, in order for countries of the Region to be able to deliver on the national commitments made in regard to the 2011 United Nations Political Declaration and the regional framework for action, as well as to successfully address the major developmental challenges linked with the escalating burden of noncommunicable diseases.

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Acknowledgments

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Hebe Gouda, WHO headquarters led the web-based data collection and oversaw the validation of results, and Melanie Cowan, WHO headquarters, performed all the data management and statistical analysis needed for the preparation of the survey results.

WHO gratefully acknowledges the support of regional noncommunicable disease focal points in conducting the survey at country level.

Executive summary

Introduction

Premature death from noncommunicable diseases continues to be one of the major development challenges in the 21st century. Wordwide, noncommunicable diseases kill 15 million peoplebetween the ages of 30 and 70 each year, and leave no country untouched.

The four main noncommunicable diseases are cardiovascular diseases, cancers, diabetes and chronic respiratory diseases. The burden of these diseases is rising disproportionately among lower income countries and populations. In 2015, 30.7 million deaths, or over three quarters of all noncommunicable disease deaths worldwide, occurred in low- and middle-income countries, with about 48% of deaths occurring before the age of 70.

The leading causes of noncommunicable disease deaths in 2015 were cardiovascular diseases (17.7 million deaths, or 45% of all noncommunicable disease deaths), cancers (8.8 million deaths, or 22% of all noncommunicable disease deaths), and respiratory diseases, including asthma and chronic obstructive pulmonary disease (3.9 million deaths, or 10% of all noncommunicable disease deaths). Diabetes caused another 1.6 million deaths, or 4% of all noncommunicable disease deaths.

More than 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. Only the WHO African Region has a higher premature mortality rate from these diseases.

Most of these premature deaths from noncommunicable diseases are largely preventable by enabling health systems to respond more effectively and equitably to the health care needs of people with noncommunicable diseases, and influencing public policies in sectors outside health that tackle the shared risk factors of tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

WHO conducts periodic assessment of national capacity for noncommunicable disease prevention and control through the use of a global survey in all Member States known as the non-communicable disease country capacity survey. In 2000, WHO carried out the first noncommunicable disease country capacity survey in the Eastern Mediterranean Region to gather detailed information on the progress of countries in addressing and responding to noncommunicable diseases. Subsequent surveys were carried out in 2005, 2010, 2013, 2015 and 2017. This comes in response to the increasing focus of the global public health community in recent years on ways to combat the burden of noncommunicable diseases. The 2011 United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, in addressing the results of the 2010 global country capacity survey, 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. The Political Declaration required countries to take concrete action to respond to noncommunicable diseases at national level. During this period, WHO also produced the Global action plan for the prevention and control of noncommunicable diseases 2013–2020, which included six objectives and 25 outcome indicators related to nine voluntary targets which should be achieved by 2025. A second United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2014 led to an outcome document which articulated four time-bound commitments that countries needed to achieve. In response, WHO created an updated regional framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases. This framework included ten progress indicators against which countries can measure their progress in relation to the four time-bound commitments outlined in the Outcome Document. The survey tool used in the 2017 regional country capacity survey is based on this framework, making use of the ten progress indicators in assessing the capacities of countries in regard to the following four areas of intervention of the regional framework for action: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and health care.

Objectives

This report presents the findings of the 2017 noncommunicable disease country capacity survey for the Eastern Mediterranean Region, which was carried out in 2017 in 22 countries of the Region with a 100% response rate.

In highlighting the limitations and challenges regarding national capacity for nonncommunicable disease prevention and control in the Region, the report aims to provide data which can be used to monitor progress made in relation to the objectives and recommendations of the Global action plan 2013–2020 and the four time-bound commitments and 10 progress indicators of the regional Framework for action. Comparisons will be made with results of the 2013 and 2015 surveys where appropriate.

Furthermore, these 2017 findings were 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.

Methods

The survey tool used in the 2017 noncommunicable disease country capacity survey was a modified version of the tool used in 2015 noncommunicable disease country capacity survey, with 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. 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. Data collection took place in 2017.

WHO reviewed and validated country responses by reviewing the relevant supporting documents submitted online by the noncommunicable disease focal point. Validation of the reported data included the use of many other 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 WHO Global school-based student health survey and the WHO Global youth tobacco survey; the WHO guidelines on nutrition labelling; and country mortality data stored in the WHO Global Health Observatory. Consistency of reported data was also cross-checked with the responses provided in the 2015 survey for any major outlier responses. Where discrepancies were noted between the country response and the documents provided for validation, a clarification request was returned to the country to allow them to verify information and update their response.

The 2017 noncommunicable disease country capacity survey questionnaire has a set of standardized questions that allows for the comparison of country capacities and responses. The survey is divided into four modules, assessing four key aspects of noncommunicable disease prevention and control.

1. Public health infrastructure, partnerships and multisectoral collaboration for noncommunicable diseases and their risk factors
2. Status of noncommunicable disease-relevant policies, strategies and action plans
3. Health information systems, monitoring, surveillance and surveys for noncommunicable diseases and their risk factors
4. Capacity for noncommunicable disease early detection, treatment and care within the health system

Responses to the questions in all four modules enable reporting against the four time-bound commitments and 10 progress monitoring indicators of the 2015 updated regional framework for action, as well as against the 25 Global monitoring framework outcome indicators set out in the Global action plan 2013–2020.

Details of the progress monitoring indicators, including detailed definitions, specifications, data sources and assessment criteria are included in Appendix 1 in the *WHO Noncommunicable Diseases Progress Monitor 2017*.

Results

The ten progress monitoring indicators

The calculation of the achievement level of the ten progress indicators that report on progress made in the implementation 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 is based on the achievement of 19 sub-indicators.

In the 2017 noncommunicable disease country capacity survey, a median of eight out of the 19 sub-indicators were fully achieved in the Region. The poorest achievement was reported for Indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis, while indicators and sub-indicators that were fully achieved were as follows: Indicator 1: Member State has set time-bound national targets based on WHO guidance; Sub-indicator 6b: Member State has implemented, as appropriate according to national circumstances, bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media); Sub-indicator 7 b: Member State has adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply;

and Indicator 8: Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change.

More than half of the countries (12/22) have fully achieved Indicator 1: Member State has set time-bound national targets and indicators based on WHO guidance; none of the countries have fully achieved Indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis; three countries (13.6%) have fully achieved Indicator 3: Member State has a STEPS survey or a comprehensive health examination survey every 5 years; and eight countries (36.4%) have fully achieved Indicator 4: Member State has an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors.

In regard to implementation of the demand-reduction measures (MPOWER) of the WHO Framework Convention on Tobacco Control at the highest level of achievement, as required in Indicator 5, the sub-indicator most fully achieved (nine countries, 40.9%) was 5d: Member State has enacted and enforced comprehensive bans on tobacco advertising, promotion and sponsorship. This was followed by Sub-indicator 5b: Member State has eliminated exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport (six countries, 27.3%). However, the sub-indicator least achieved was 5a: Member State has reduced affordability of tobacco products by increasing excise taxes and prices on tobacco products; only Jordan and Palestine have fully achieved this sub-indicator (9.1%).

For measures to reduce the harmful use of alcohol, 12 countries (54.5%) have fully achieved Sub-indicator 6b: Member State has implemented, as appropriate according to national circumstances, bans or comprehensive restrictions on alcohol advertising and promotions; 11 countries (50%) have fully achieved Sub-indicator 6a: Member State has implemented, as appropriate according to national circumstances, restrictions on the physical availability of retailed alcohol (via reduced hours of sale); and nine countries (40.9%) have fully achieved Sub-indicator 6c: Member State has implemented, as appropriate according to national circumstances, excise tax increases on alcoholic beverages.

With respect to the implementation of the four measures to reduce unhealthy diet, eight countries (36.4%) have fully achieved Sub-indicator 7a: Member State has adopted national policies to reduce population salt/sodium consumption; twelve countries (54.5%) have 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; seven countries (31.8%) have fully achieved Sub-indicator 7c: Member State has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children; and six countries (27.3%) have fully achieved Sub-indicator 7d: Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes. Twelve countries (54.5%) have fully achieved Indicator 8: Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change.

Finally, regarding strengthening health systems to enable them to address noncommunicable diseases, nine countries (40.9%) have 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 nine countries (40.9%) have 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.

Governance

A high percentage of countries (90.9%) 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 treatment (90.9%), followed by early detection and screening and capacity building (81.8% each). The least funded noncommunicable disease -related activity was research (50%). A clear gap exists between Group 1, Group 2 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 in the government budget for noncommunicable disease and risk factor activities/functions. Regarding the funding of the eight areas of work pertaining to noncommunicable disease prevention and control as undertaken by noncommunicable disease national structures, the average number of areas funded was highest in Group 1 countries (7.8) compared to Group 2 (6) and Group 3 countries (3.5).

The most common source of noncommunicable disease funding was government revenues (81.8%), followed by health insurance (41%). Government revenues were the main source of funding in all Group 1 countries, in 90% of Group 2 countries, and in 50% of Group 3 countries.

Tobacco taxation was the most common (95.5%) fiscal intervention measure currently implemented in the

Region, followed by alcohol taxation (40.9%). Taxation of sugar-sweetened beverages was enforced in only six countries (27.3%), while both the implementation of taxation on unhealthy foods and tax incentives for promoting physical activity were not reported by any country in the Region.

More than half of the countries of the Region (12 countries, 54.5%) indicated the existence of a national multisectoral body that oversees noncommunicable diseases, while only nine countries (40.9%) stated that this multisectoral body was operational, and none of these countries were in Group 3.

A majority (81.8%) of countries indicated that noncommunicable diseases were included in their national health plans, while 72.7% indicated that noncommunicable diseases were included in their national development agenda. Thirteen countries (59.1%) had time-bound national targets for noncommunicable diseases based on the nine global targets.

An operational multisectoral national policy, strategy or action plan that integrates the major noncommunicable diseases and their shared risk factors was developed by the majority of the countries of the Region (18 of the 22 countries, 81.8 %), but it was operational in only 12 countries (59.1%). Sixteen countries (77.3%) reported that the policy was multisectoral, while 14 countries (68.2%) reported that it was multi-stakeholder.

With respect to the content of national noncommunicable disease policies, strategies or action plans, all four main noncommunicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) were included in most of the countries' policies, strategies or action plans, as were the following risk factors: unhealthy diet, physical inactivity and tobacco. The noncommunicable diseases most commonly included in national noncommunicable disease policies, strategies or action plans were cardiovascular diseases (17 countries, 77.3%), diabetes (17 countries, 77.3%), and cancers (16 countries, 72.7%). Unhealthy diet, physical activity and tobacco were included in the national policies, strategies or action plans of 18 countries (81.8%), while harmful use of alcohol was only included in the policies, strategies or action plans of six countries (27.3%).

Prevention and reduction of risk factors

With regard to vertical programmes addressing noncommunicable disease risk factors, the risk factors most commonly addressed were tobacco use (15 countries, 68.2%) followed by unhealthy diet and overweight/obesity (both addressed in 12 countries (54.5%)). Nearly one in five of the countries of the Region (22.7%) has addressed alcohol use through vertical programmes; the majority of those countries (four out of the five countries) were in Group 2.

Seven countries of the Region (31.8%) have implemented policies to reduce the impact of the marketing of foods and non-alcoholic beverages high in saturated fatty acids, trans fatty acids, free sugars, or salt to children, while only one of these countries (Saudi Arabia) has taken steps to address the effects of cross-border marketing of food and non-alcoholic beverages on children.

More than half of the countries of the Region (54.5%) have implemented national policies that limit the intake of saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply, and 14 countries (63.6%) have national policies to reduce salt consumption. Generally, the implementation of these policies was more common in Group 1 countries compared to Groups 2 and 3. For example, 100% of Group 1 (six countries), 50% of Group 2 (five countries) and only 16.7% of Group 3 (one country) reported that their countries have implemented national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply.

Furthermore, more than half of the countries of the Region (54.5%) have implemented national public awareness programmes on diet and physical activity; however, there was a wide gap in implementation between countries in Groups 1 and 2, and Group 3. Group 3 countries lacked any kind of national public awareness programmes on physical activity compared to countries in Groups 1 and 2: all five Group 1 countries (100%) and six countries in Group 2 (60%) have fully implemented such programmes.

Surveillance, monitoring and evaluation

Twenty countries (90.9%) 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. All Group 1 and Group 2 countries 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 compared to 66.6% of countries in Group 3.

Sixteen countries (72.7%) reported having a system for collecting mortality data by cause of death on a routine basis, and 15 of those reported that it was a civil registration system.

Cancer registries were available in 19 countries (86.4%), and these were population-based registries in 15 countries (68.2%). In addition, cancer registries had

national coverage in only 50% of the countries of the Region.

Diabetes registries were less common, with only nine countries (40.9%) reporting the presence of diabetes registries, while an even lower proportion (four countries, 22.7%) indicated that diabetes-related complications were recorded.

Fifteen countries (68.2%) reported the availability of a patient information system. This includes all Group 1 countries (with the exception of Saudi Arabia), eight out of the 10 countries in Group 2 (with the exception of Libya and Syrian Arab Republic), and only Afghanistan and Djibouti in Group 3. Electronic medical records were available in all countries which reported the availability of a patient information system, with the exception of Afghanistan, Iraq, Kuwait, and Morocco.

Regarding data collection on noncommunicable disease risk factors in adults, the regional average number of surveys carried out was 7.2 out of a total of nine risk factors. Data collection on these risk factors was significantly lower in Group 3 countries, with an average of only 4.2 surveys being conducted compared to an average number of 8 and 8.5 surveys being conducted in Group 1 and Group 2 countries respectively). Nearly 60% of all countries reported that they have implemented surveys on the harmful use of alcohol, and 95.5% of countries reported that they have implemented surveys on tobacco use. For other risk factors, 86.4% of countries reported that they have implemented surveys on low fruit and vegetable consumption, physical inactivity, overweight and obesity, raised blood glucose/diabetes, and raised blood pressure/hypertension. Furthermore, 81.8% of countries have implemented surveys on raised total cholesterol, and 50% of countries reported that they have implemented surveys on salt/sodium intake.

The regional average number of risk factors addressed by adolescent noncommunicable disease risk factor surveys was four out of a total of five risk factors. Data collection on these risk factors was lower in Group 3 countries in comparison to both Group 1 and Group 2 countries. For example, none of the countries in Group 3 conducted surveys on the use of alcohol in adolescents, compared to 50% of Group 1 countries and 40% of Group 2 countries.

Health care

The regional availability of evidence-based national guidelines for the management of noncommunicable diseases was most common for diabetes (81.8%) and cancers (68%). In addition, guidelines included referral criteria for diabetes in 68% of countries and for cardiovascular diseases in 59% of countries.

In terms of the availability of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases, the regional average available number of basic technologies was 7.7/13 at public primary care facilities and 9.2/13 at private primary care facilities.

There were marked differences in the availability of the 13 basic technologies at public primary care facilities between Group 1, Group 2, and Group 3 countries; the latter group had the lowest number of available basic technologies (5/13) compared to countries in Groups 1 and 2, which had 11.7/13 and 7/13 basic technologies respectively).

Breast cancer screening programmes were reported to be available in the majority of the countries of the Region (77.3%). However, less than half of the countries reported the availability of screening programmes for cervical cancer (40.9%), while 27.3% reported the availability of screening programmes for colon cancer and only 4.5% (Kuwait) reported the availability of screening programmes for prostate cancer. Screening programme availability was higher in Group 1 and Group 2 countries than in Group 3 countries. For example, breast cancer screening was available in 100% of Group 1 countries, 90% of Group 2 countries and only 33.3% of Group 3 countries. A significant number of countries of the Region (68.2%) reported that early detection of breast cancer was integrated in primary health care services, but less than half of the countries reported such integration for cancers of the cervix, colon and prostate. Only two countries (9%) had a national ongoing HPV vaccination programmes (Libya and United Arab Emirates).

As regards the availability of the 14 essential noncommunicable disease medicines at public sector primary care facilities, the regional average number of available medicines was 9.2 out of 14. The availability of medicines differed across the 3 country groups; availability was highest in Group 1 countries, where the average number of medicines was 12.5, while countries in Group 2 had an average of 10.7 medicines and availability in Group 3 countries dropped sharply to an average of only 3.3 medicines.

Medicines reported to be most available in the Region were metformin (available in 86.4% of countries), and thiazide diuretics and aspirin (both available in 81.8% of countries); those reported to be least available were oral morphine (available in only 4.5% of countries) and nicotine replacement therapy (available in 22.7% of countries).

The regional availability of specific procedures for treating noncommunicable diseases in publicly funded health systems varied from 54.5% for renal transplantation to 81.8% for renal dialysis. Availability of such procedures was lowest among Group 3 countries. Only three countries (13.6%) of the Region reported having palliative care for patients with noncommunicable diseases either in primary health care or in community/home-based care (Bahrain,

Tunisia and Yemen). Seventeen countries (77.3%) reported the provision of care for acute stroke, while fourteen countries (63.3%) reported the availability of rehabilitation services for stroke patients in the public health system. The majority of these countries were in Groups 1 and 2. Only one country in Group 1 (Bahrain) reported the availability of a register of patients who have had rheumatic fever and rheumatic heart disease.

Conclusions

It can be concluded from the results of the 2017 regional country capacity survey that notable regional progress has been made in noncommunicable disease prevention and control since 2015; a median of eight out of the 19 Indicators were fully achieved in the Region. This progress varies across the four key areas of intervention related to noncommunicable disease prevention and control (governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care). In addition, there is a marked disparity in capacities between Group 3 countries and countries in Groups 1 and 2. However, several limitations should be noted while interpreting the findings of this regional country capacity survey. These include the major political instability many countries of the region are experiencing, the broad scope and complexity of the data collected, which extend beyond the health care sector and require collaboration between focal points and local colleagues to complete the questionnaire, and the fact that the data are self-reported and rely on the relative knowledge and expertise of the noncommunicable disease focal points completing the survey.

Introduction

The burden of noncommunicable diseases

Noncommunicable diseases, which include cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, and their key risk factors – tobacco, the harmful use of alcohol, unhealthy diet and physical inactivity – remain the leading causes of death worldwide. Of the 56.4 million global deaths in 2015, 39.5 million, or 70%, were due to noncommunicable diseases. In 2015, over three quarters of all noncommunicable disease deaths (30.7 million) occurred in low- and middle-income countries, with about 48% of deaths occurring before the age of 70 *(1)*.

The leading causes of global noncommunicable disease deaths in 2015 were cardiovascular diseases (17.7 million deaths, or 45% of all noncommunicable disease deaths), cancers (8.8 million deaths, or 22% of all noncommunicable disease deaths), and respiratory diseases, including asthma and chronic obstructive pulmonary disease (3.9 million deaths). Diabetes caused another 1.6 million deaths *(2)*.

More than 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 after the African Region *(3)*.

Besides being a health burden, noncommunicable diseases constitute a major threat to the social and economic development of countries. The developing world is experiencing an epidemiological transition in regard to the noncommunicable disease burden, due to the engagement of developing states in industrialization and urbanization with the consequent globalization of lifestyles, nutritional transition and population ageing. Wide disparities exist between developed and developing countries regarding the achievement of all noncommunicable disease progress monitoring indicators, with wealthier countries witnessing the beginning of a regression in both the noncommunicable disease epidemic and the prevalence of premature death from noncommunicable diseases *(1)*.

Most of these premature deaths from noncommunicable diseases are largely preventable by enabling health systems to respond more effectively and equitably to the health care needs of people with noncommunicable diseases, and influencing public policies in sectors outside health that tackle the shared risk factors of tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol *(1)*.

Noncommunicable disease mortality in the Eastern Mediterranean Region

The contribution of noncommunicable diseases to total mortality in the Eastern Mediterranean Region

Noncommunicable diseases accounted for 62% of all deaths occurring in the Region in 2015, with an increase of 5% as compared to data from 2012, which estimated that 57% of total mortality was due to noncommunicable diseases. The 2015 data revealed that cardiovascular diseases alone accounted for almost half of noncommunicable disease deaths (32%) while cancers and chronic respiratory diseases were responsible for 10% and 4% of all noncommunicable disease deaths respectively (Fig. 1).

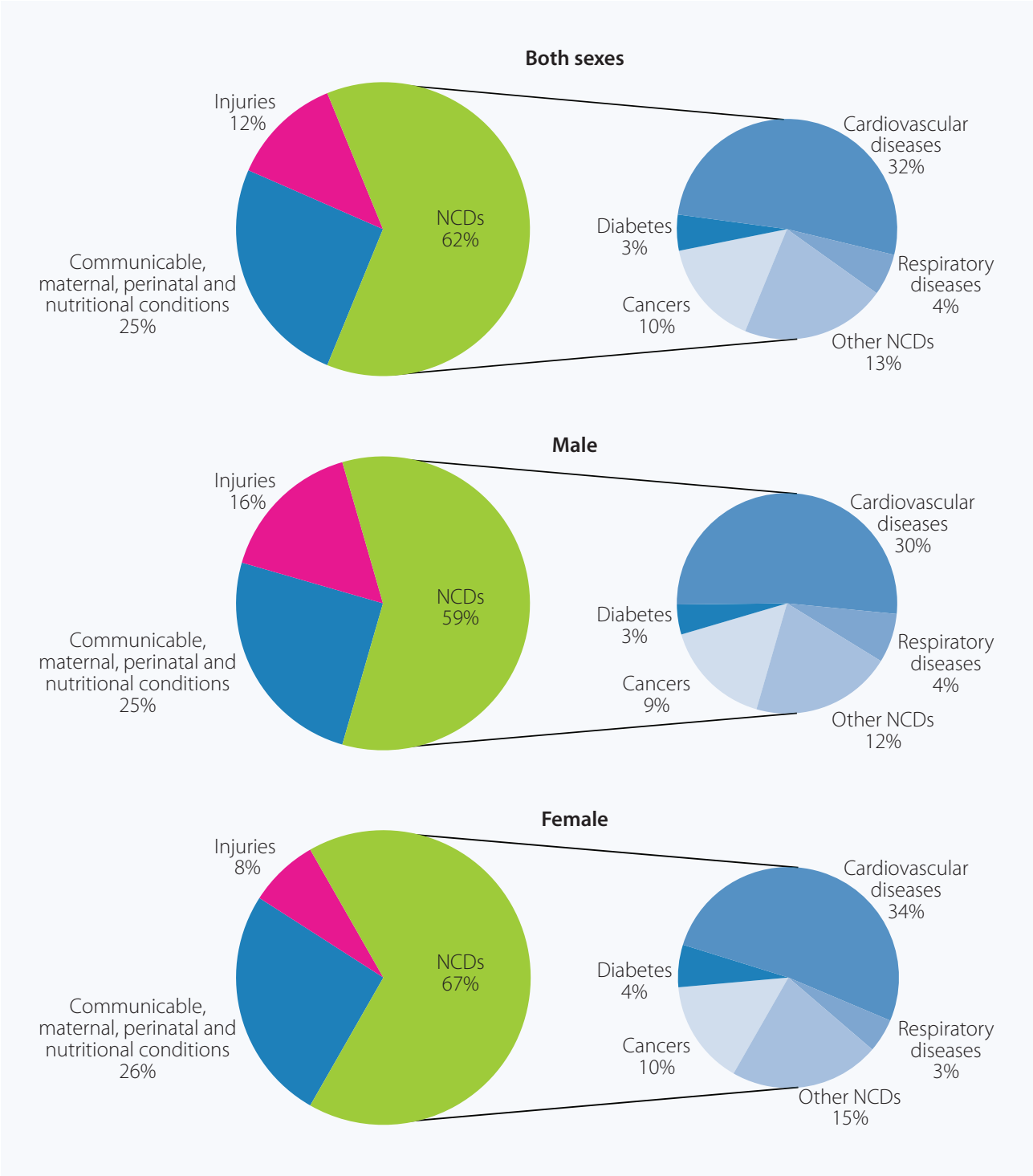
When countries of the Region were taken individually, data produced in 2015 showed that noncommunicable diseases were the leading cause of death in most of the countries of the region. The contribution of noncommunicable diseases to total crude mortality varied between 22% in Somalia and 89% in Lebanon (Table 1).

As Figures 2, 3 and 4 show, the noncommunicable disease proportionate mortality rate was lowest in Group 3 countries, followed by Group 1 and Group 2. The noncommunicable disease proportionate mortality rate reaches more than 80% in Lebanon, Bahrain, Tunisia, Egypt and Islamic Republic of Iran.

The Eastern Mediterranean Region is currently bearing one of the heaviest noncommunicable disease burdens in the world; according to the Global Health Observatory,

Fig. 1.

Total deaths in the Eastern Mediterranean Region by sex (2015)



Source: WHO, Global Health Observatory Data Repository 2015

Table 1.

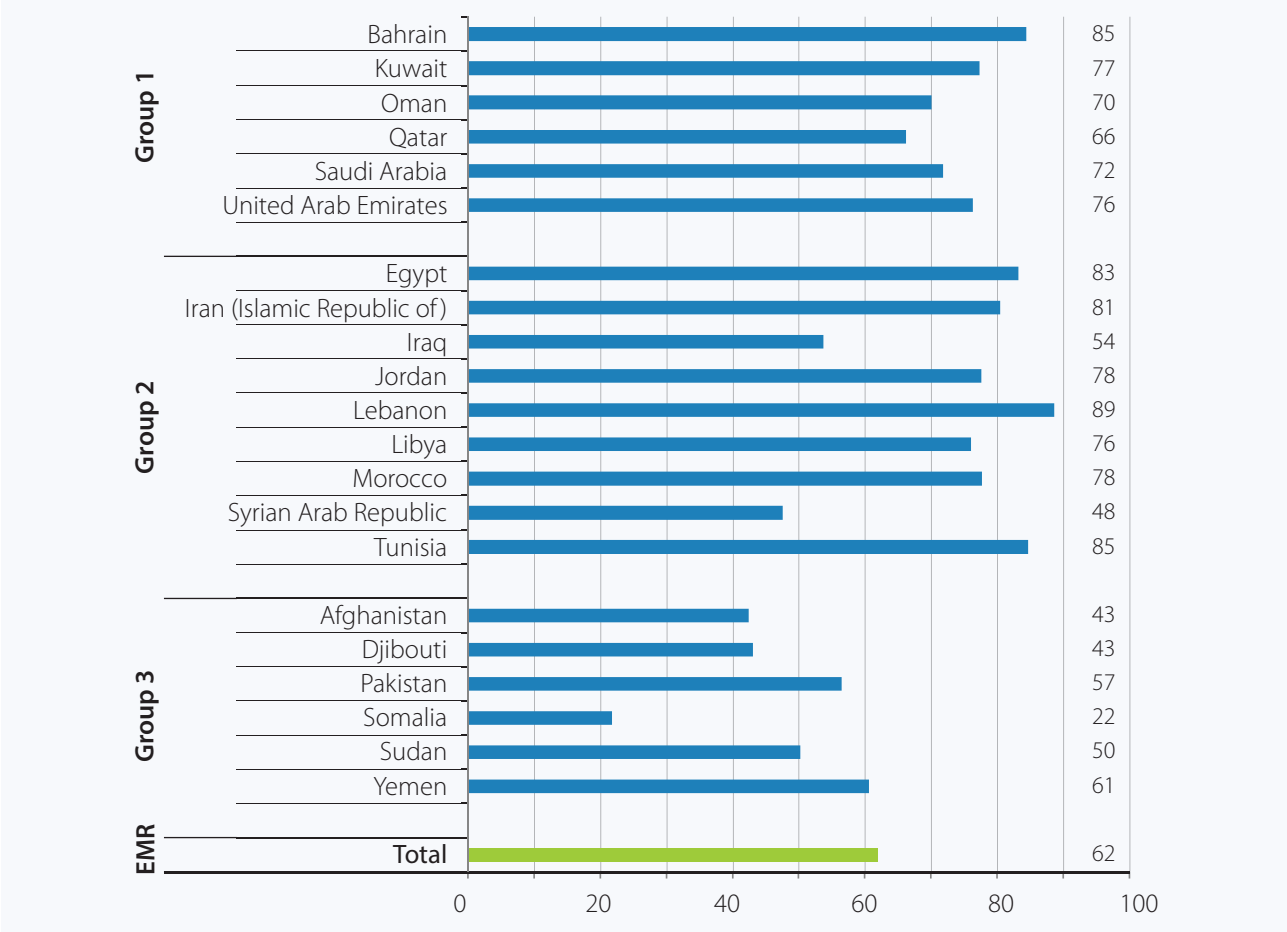
Noncommunicable disease proportionate mortality rate by country, 2015

Group	Country	Noncommunicable disease proportionate mortality rate by country
Group 1	Bahrain	84.5
	Kuwait	77.4
	Oman	70.1
	Qatar	66.3
	Saudi Arabia	71.9
	United Arab Emirates	76.4
	Total	**74.4**
Group 1	Egypt	83.3
	Iran (Islamic Republic of)	80.5
	Iraq	53.8
	Jordan	77.7
	Lebanon	88.7
	Libyan Arab Jamahiriya	76.1
	Morocco	77.8
	Syrian Arab Republic	47.6
	Tunisia	84.7
	Palestine	data unavailable
	Total	**74.5**
Group 1	Afghanistan	42.5
	Djibouti	43.1
	Pakistan	56.5
	Somalia	21.8
	Sudan	50.3
	Yemen	60.7
	Total	**45.8**
Eastern Mediterranean Region		**62.4**

Source: WHO, Global Health Observatory Data Repository 2015

Fig. 2.

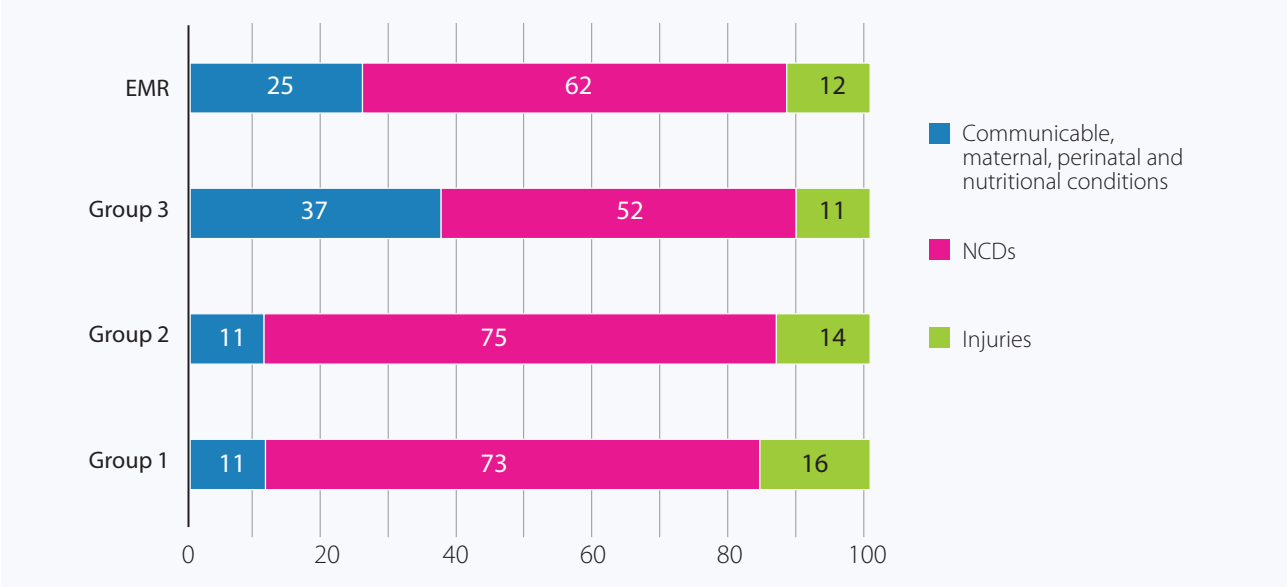
Noncommunicable disease proportionate mortality rate by country group in the Eastern Mediterranean Region, 2015



Source: WHO, Global Health Observatory Data Repository 2015

Fig. 3.

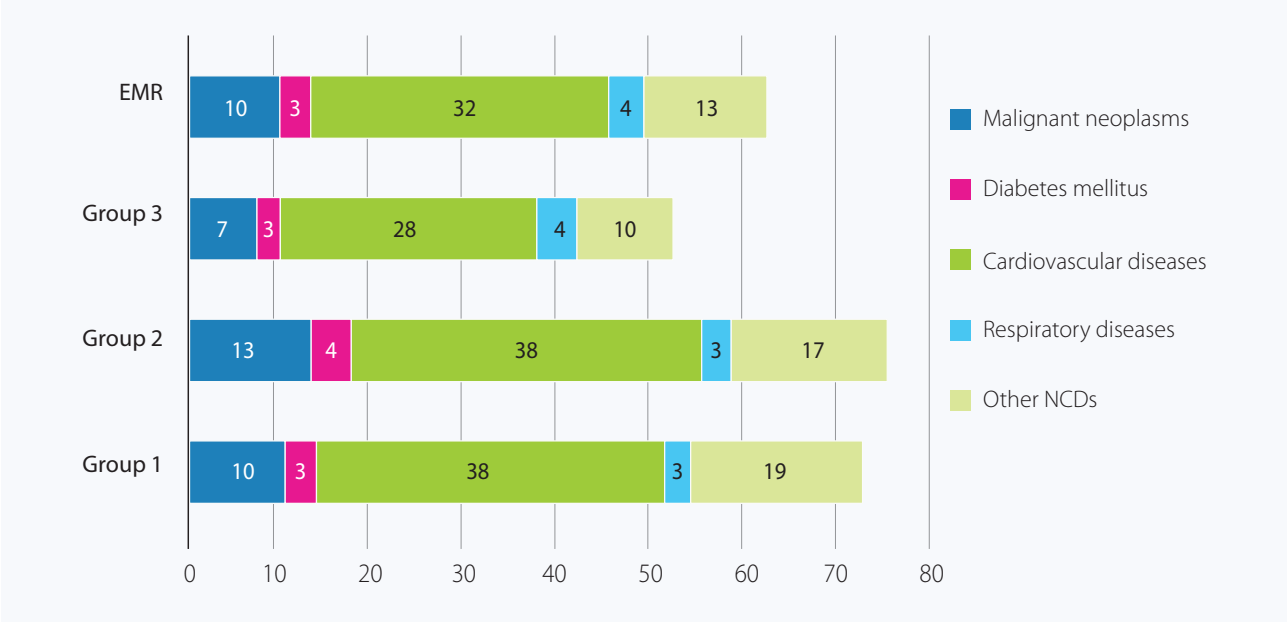
Proportionate mortality rates of noncommunicable diseases, communicable diseases, and injuries by country group in the Eastern Mediterranean Region, 2015



Source: WHO, Global Health Observatory Data Repository 2015

Fig. 4.

Proportionate mortality rates of the different noncommunicable diseases in the Eastern Mediterranean Region by country group, 2015

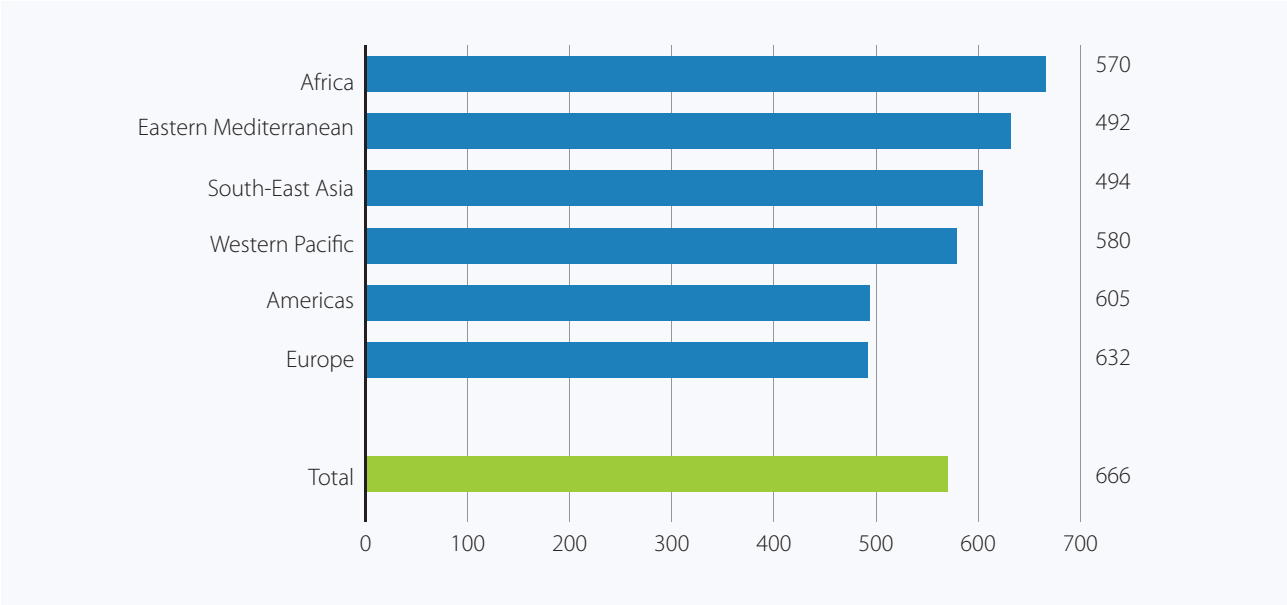


Source: WHO, Global Health Observatory Data Repository 2015

in 2015, the Region had the second-highest age-standardized noncommunicable disease death rates of all WHO regions. Only the WHO African Region has a higher premature mortality rate from these diseases *(2)* (Fig. 5, Table 2).

Fig. 5.

Age-standardized noncommunicable disease mortality rate per 100 000 population by WHO region in 2015



Source: WHO, Global Health Observatory Data Repository 2015

Table 2.

Age-standardized noncommunicable disease mortality rate per 100 000 population by WHO region in 2010 and 2015

WHO region	Year	Mean age-standardized noncommunicable disease mortality rate per 100 000 population	Number of countries
African	2010	680.4	47
	2015	665.9	47
Americas	2010	519.7	33
	2015	494.3	33
Eastern Mediterranean	2010	650.7	21
	2015	632.1	21
European	2010	543.1	50
	2015	492.0	50
South-East Asia	2010	638.6	11
	2015	604.8	11
Western Pacific	2010	611.4	21
	2015	579.5	21
Total	**2010**	**600.1**	**183**
	2015	**570.0**	**183**

Source: WHO, Global Health Observatory Data Repository 2015

However, it should be noted that that the age-standardized noncommunicable disease mortality rate per 100 000 population revealed a high mortality rate in Group 3 countries, particularly in Afghanistan and Yemen, with levels reaching around 900 deaths per 100 000 population. This shows that the death toll due to noncommunicable diseases disproportionately affects the countries of the Region, with less developed countries suffering more from the burden of noncommunicable diseases than their more developed counterparts (Figs. 6–8).

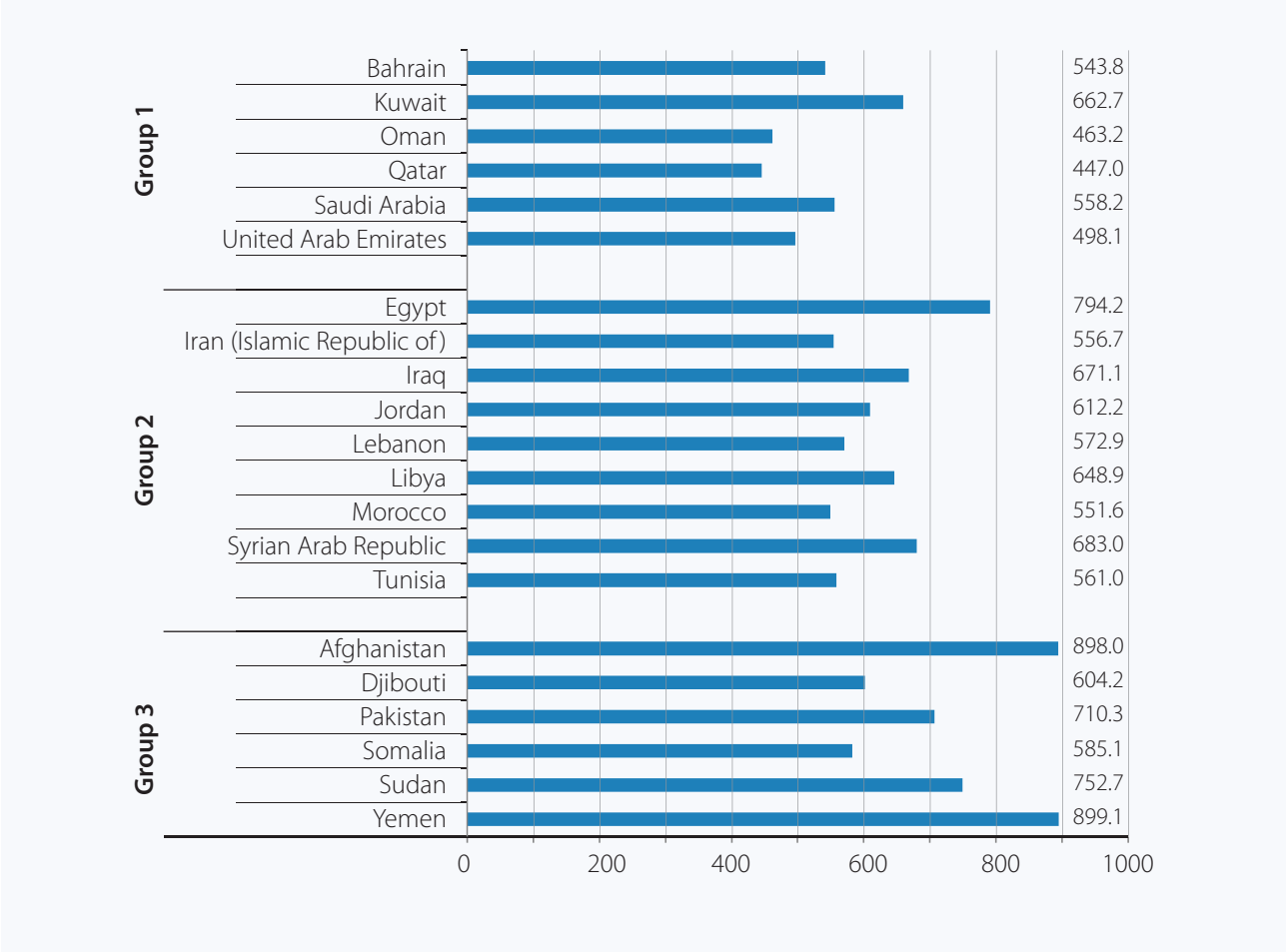
WHO's leadership and coordination role in noncommunicable disease prevention and control

Noncommunicable diseases have become an increasingly important priority for the global public health community and national leaders in recent years. Notably, the 2030 Agenda for Sustainable Development Goals, adopted at the United Nations Summit on Sustainable Development in September 2015, recognized the critical public health importance of addressing noncommunicable diseases and included a goal to reduce, by one third, premature mortality from noncommunicable diseases, along with targets to address risk factors such as alcohol and tobacco, in order to achieve the overarching goal of universal health coverage by 2030. This was the result of two High-level Meetings of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2011 and 2014, which reaffirmed WHO's leadership and coordination role in promoting and monitoring global action to reduce the burden of noncommunicable diseases *(4)*. Most recently, the scope of the NCDs agenda has broadened. The High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2018 issued a Political Declaration adopting a "5 by 5" matrix which includes mental health disorders and other mental health conditions as a fifth disease group, and air pollution as a fifth risk factor.

The 2011 United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, in addressing the results of the 2010 global country capacity survey, 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. The Political Declaration required countries to take concrete action to respond to noncommunicable diseases at national level. Following the 2011 Political

Fig. 6.

Age-standardized noncommunicable disease mortality rate per 100 000 population in the Eastern Mediterranean Region by country group (both sexes), 2015



Source: WHO, Global Health Observatory Data Repository 2015

declaration, WHO developed the Global monitoring framework for noncommunicable diseases, with nine voluntary targets to be achieved by 2025, and 25 progress indicators related to these targets which countries could use in their development of strategies to combat noncommunicable disease mortality, address noncommunicable disease risk factors, and strengthen national health system response.

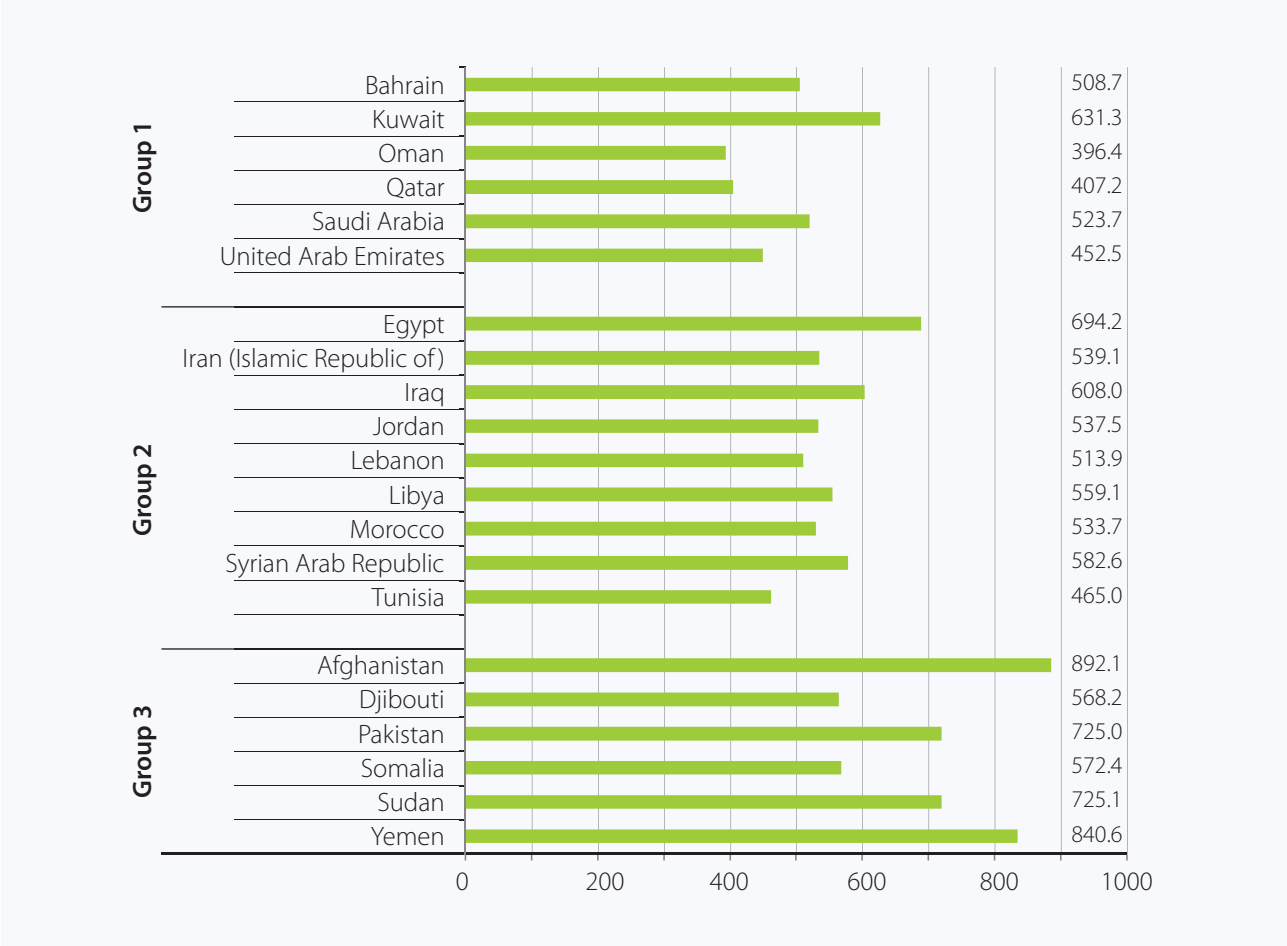
In 2013, the 66th World Health Assembly adopted the Global monitoring framework through the endorsement of the WHO Global action plan for the prevention and control of noncommunicable diseases 2013–2020 (resolution WHA66.10, 2013), which articulated six objectives and the 25 progress indicators that relate to the nine voluntary targets to be achieved by 2025 from the global monitoring framework. The plan provided a menu of recommended policy options and cost-effective interventions to contribute to the achievement of the voluntary targets. Countries were urged to develop their own national targets for 2025 based on the nine global targets, while taking into account their own circumstances and needs *(1)* .

The second United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2014 led to an outcome document which articulated four national time-bound commitments that countries needed to achieve.

In response to the 2014 Outcome Document, in May 2015 WHO published a Technical Note on how WHO will report in 2017 to the United Nations General Assembly on the progress achieved in the implementation of commitments included in the 2011 UN Political Declaration and 2014 UN Outcome Document on Noncommunicable Diseases. The Technical Note outlined a set of 10

Fig. 7.

Age-standardized noncommunicable disease mortality rate per 100 000 population in the Eastern Mediterranean Region by country group (females), 2015



Source: WHO, Global Health Observatory Data Repository 2015

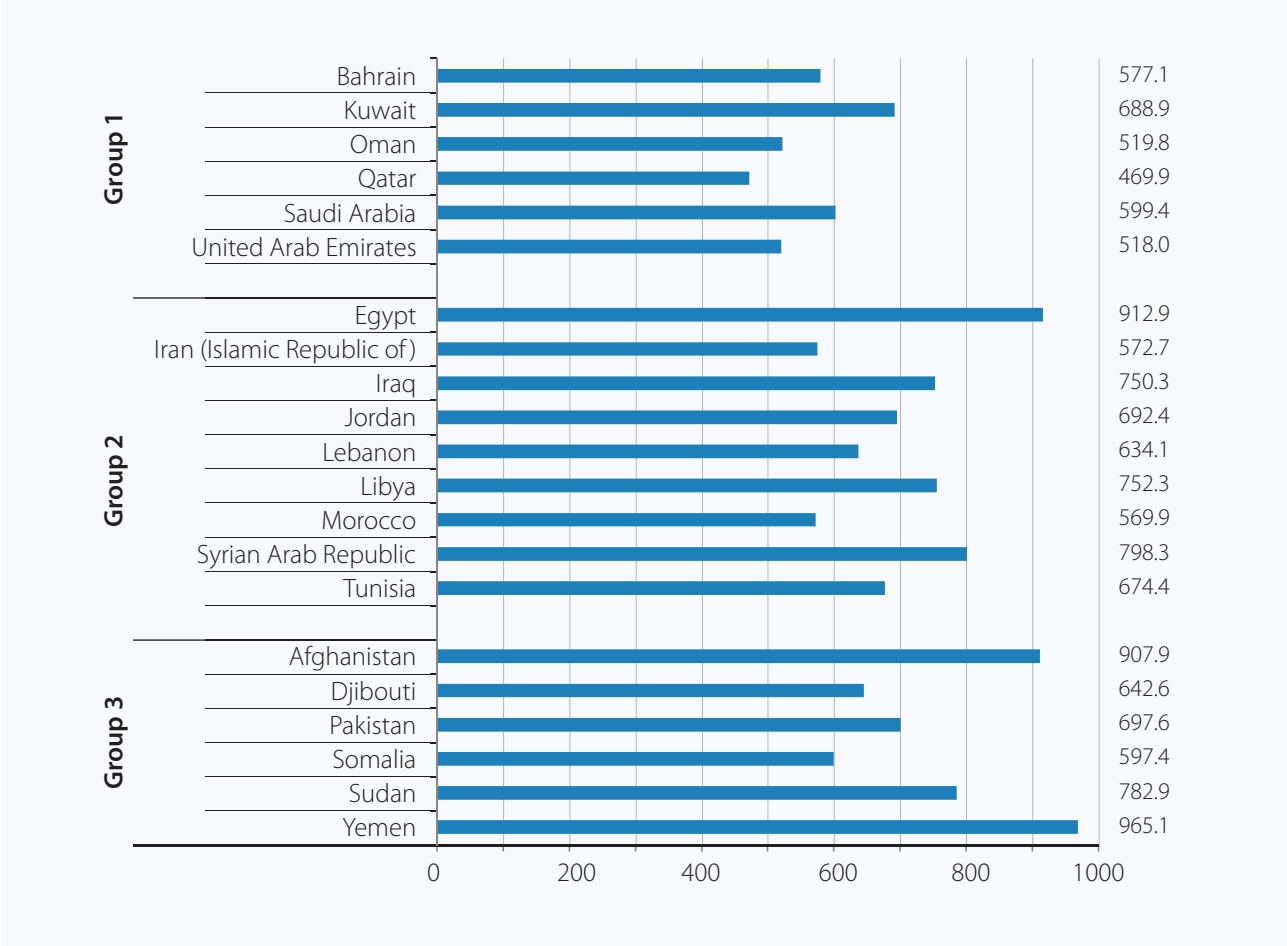
progress monitoring indicators intended to show the progress achieved in countries in the implementation of the four national time-bound commitments included in the 2014 Outcome Document (5). This then led to the creation of an updated regional framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, which made use of the 10 progress indicators in assessing the capacities of countries to combat noncommunicable diseases in regard to the following four areas of intervention: governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and health care. The Technical Note was updated in September 2017 to ensure consistency with the revised set of WHO "best-buys" and other recommended interventions for the prevention and control of noncommunicable diseases which were endorsed by the World Health Assembly in May 2017.

The noncommunicable disease country capacity curvey

To respond to the increasing burden of noncommunicable diseases wordwide, WHO conducts periodic assessment of national capacity for noncommunicable disease prevention and control through the use of a global survey in all Member States known as the noncommunicable disease country capacity curvey. In 2000, WHO conducted the first noncommunicable disease country capacity survey in the Eastern Mediterranean Region to gather detailed information on the progress of countries in addressing and responding to noncommunicable diseases. The survey tool used in the assessment has evolved and expanded over time. In particular, it assists countries in assessing the four areas of intervention of the regional Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases (governance; prevention and reduction of risk factors; surveillance, monitoring and evaluation; and

Fig. 8.

Age-standardized noncommunicable disease mortality rate per 100 000 population in the Eastern Mediterranean Region by country group (males), 2015



Source: WHO, Global Health Observatory Data Repository 2015

health care), through the use of the Framework's 10 progress indicators against which countries can measure their progress in relation to these four areas. The survey was repeated in 2005, 2010, 2013, 2015 and 2017.

Objectives

This report presents the findings of the 2017 noncommunicable disease country capacity survey for the Eastern Mediterranean Region, which was carried out in 2017 in 22 countries of the Region with 100% response rate.

In highlighting the limitations and challenges regarding national capacity for nonncommunicable disease prevention and control in the Region, the report aims to provide data which can be used to monitor progress made in relation to the objectives and recommendations of the Global action plan 2013–2020 and the four time-bound commitments and 10 progress indicators of the regional Framework for action. Comparisons will be made with results of the 2013 and 2015 surveys where appropriate.

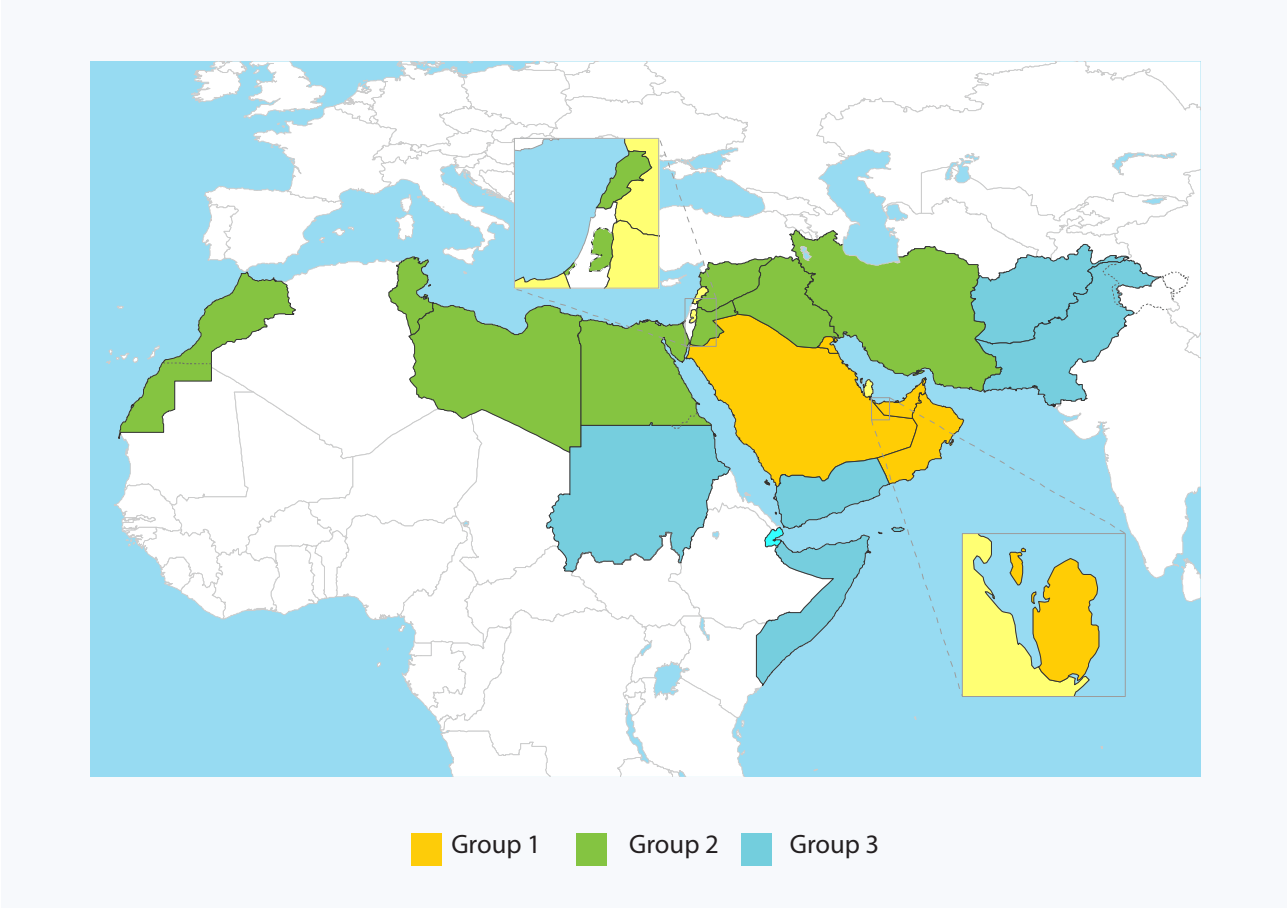
Furthermore, the 2017 findings were of great assistance for the third United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2018, at which the General Assembly reviewed progress in noncommunicable disease prevention and control and forged a consensus on the road ahead for the period 2018–2030.

Country classification

The WHO Eastern Mediterranean Region comprises 22 countries with an estimated total population of about 655.83 million people (Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen) (Figure 9).

Fig. 9.

Map of the 22 countries of the WHO Eastern Mediterranean Region, showing the three country groups



There is great diversity among the countries of the Region in terms of geographic area, climate, cuisine, demography, and political system, and many disparities exist between them with regard to levels of socioeconomic development. In addition, 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 (Table 4).

Table 3.

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

Country	Population in millions (2015)[a]	Country group	2017 World Bank country income group[b]
Bahrain	1.37	Group 1	High-income
Kuwait	3.94	Group 1	High-income
Oman	4.20	Group 1	High-income
Qatar	2.48	Group 1	High-income
Saudi Arabia	31.56	Group 1	High-income
United Arab Emirates	9.15	Group 1	High-income
Group 1 total	**52.70**		
Egypt	93.78	Group 2	Lower middle-income
Iran (Islamic Republic of)	79.36	Group 2	Upper middle-income
Iraq	36.12	Group 2	Upper middle-income
Jordan	9.16	Group 2	Upper middle-income
Lebanon	5.85	Group 2	Upper middle-income
Libya	6.24	Group 2	Upper middle-income
Morocco	34.80	Group 2	Lower middle-income
Palestine	4.68[c]	Group 2	Lower middle-income
Syrian Arab Republic	18.74	Group 2	Lower middle-income
Tunisia	11.27	Group 2	Upper middle-income
Group 2 total	**299.99**		
Afghanistan	33.74	Group 3	Low-income
Djibouti	0.93	Group 3	Lower middle-income
Pakistan	189.00	Group 3	Lower middle-income
Somalia	13.91	Group 3	Low-income
Sudan	38.65	Group 3	Lower middle-income
Yemen	26.92	Group 3	Lower middle-income
Group 3 total	**303.14**		
Eastern Mediterranean Region total	**655.83**		

[a] Population figures taken from WHO Country Profiles except for Palestine

[b] See: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

Methods

Overview

The survey tool used in 2017 country capacity survey was a modified version of the tool used in its 2015 predecessor, with 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. 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. Data collection took place in 2017.

WHO reviewed and validated country responses by reviewing the relevant supporting documents submitted online by the noncommunicable disease focal point. Validation of the reported data included the use of many other 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 WHO Global school-based student health survey and the WHO Global youth tobacco survey; the WHO guidelines on nutrition labelling; and country mortality data stored in the WHO Global Health Observatory. Consistency of reported data was also cross-checked with the responses provided in the 2015 survey for any major outlier responses. Where discrepancies were noted between the country response and the documents provided for validation, a clarification request was returned to the country for their consideration and an updating of their response

The questionnaire

The 2017 country capacity survey questionnaire has a set of standardized questions that allows comparisons of country capacities and responses. The survey is divided into four modules, assessing four key aspects of noncommunicable disease prevention and control.

***Module I**: Public health infrastructure, partnerships and multi-stakeholder 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 their risk factors, and staffing 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 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 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 WHO Global monitoring framework indicators set out in the Global action plan for the prevention and control of noncommunicable diseases 2013–2020 *(6)*.

The assessment of Progress indicators 1, 3, 4, 7a, 7b, 7c, 8, 9 and 10 was based on country responses to the 2017 country capacity survey. Progress indicators 7a, 7b and 7c were additionally reviewed against responses obtained by WHO in the *2nd Global Nutrition Policy Review* and supporting documentation contained in the WHO Global database on the Implementation of Nutrition Action (GINA).

The assessment of Progress indicator 2 (Country has a functioning system for generating reliable cause-specific mortality data on a routine basis) was based on data collected by WHO and stored in the WHO mortality database through a routine annual call for data.

The assessment of Progress indicator 5 was based on data collected from countries in 2016 for the production of the WHO Report on the Global Tobacco Epidemic. The

WHO assessment was shared with national authorities for review and approval.

The achievement status of Progress indicator 6 was based on the responses of country focal points, officially nominated by the ministry of health, to WHO's 2016 Global Survey on Alcohol and Health. Responses were reviewed and validated by WHO, and subsequently endorsed by countries.

The achievement status of Progress indicator 7d was based on the analysis by WHO, the United Nations Children's Fund (UNICEF), and the International Baby Food Action Network (IBFAN)/ICDC of copies of all national legislation and regulations on the International Code of Marketing of Breast-milk Substitutes for the production of the report on Marketing of breast-milk substitutes: National implementation of the international code Status Report 2016.

Details of the progress monitoring indicators, including detailed definitions, specifications, data sources and assessment criteria are included in Appendix 1 in the WHO *Noncommunicable Dieases Progress Monitor, 2017(3)*.

Analysis

Data for each country response were extracted from the web-based application in Microsoft Excel format, with subsequent data cleaning carried out to ensure consistency of the survey responses. SPSS 21 software was used for all analysis conducted.

Percentages reported in thefindings reflect the positive responses to a question, while non-positive responses ("No", "Don't know", "Not applicable", and missing answers) were treated equally as negative answers.

Country 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 country sub-group.

Whenever possible, trends in national noncommunicable disease capacity were derived from comparing the results of the 2017 survey with those of the capacity surveys conducted in 2015 and 2013.

Results

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

The 10 progress indicators were evaluated in all 22 countries of the Region in 2017. The achievement status of countries regarding the 10 progress indicators are presented in Tables 4–23 and Figures 10 and 11.

Overall, there was an increase in the number of countries of the Region which have fully achieved the 10 progress indicators, except in regard to Progress indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis. This indicator was fully achieved by one country in 2015 (Kuwait), but was not fully achieved by any of the countries in 2017.

There was a notable increase in the number of countries which have achieved Progess indicator 1: Member State has set time-bound national targets based on WHO guidance. Twelve countries (54.5%) achieved this indicator in 2017 compared to only three countries (13.6%) in 2015. These 12 countries are: Bahrain, Egypt, Iraq, Islamic Republic of Iran, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, and United Arab Emirates.

Fourteen countries (63.6%) have partially achieved Progress indicator 2: Bahrain, Egypt, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates, and Palestine.

With regard to Progress indicator 3: Member State has a STEPS survey or a comprehensive health examination survey every 5 years, only three countries – Iran, Saudi Arabia and Sudan (31.6%) – have fully achieved this indicator, while an additional 15 countries (68.2%) have partially done so.

Regarding Progress indicator 4: Member State has an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors, more than one third of countries (8/22: Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Kuwait, Qatar, Saudi Arabia, and United Arab Emirates) had an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors in 2017. This represents a remarkable increase in the number of the countries fully achieving this indicator compared to 2015, when only one country – Palestine – fully did so.

Regarding the five demand-reduction measures of the WHO FCTC (Progress Sub-indicators 5a–e), less than half of the countries have fully achieved these sub-indicators. Only 9% of the countries (Jordan and Palestine) have fully achieved Sub-indicator 5a: Member State has reduced affordability by increasing excise taxes and prices on tobacco products; nearly one third (Afghanistan, Islamic Republic of Iran, Lebanon, Libya, Pakistan and Palestine) have fully achieved Sub-indicator 5b: Member State has eliminated exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport; 13.6% (Djibouti, Egypt, and Islamic Republic of Iran) have fully achieved Sub-indicator 5c: Member State has implemented plain/standardized packaging and/or large graphic health warnings on all tobacco packages; 40.9% (Afghanistan, Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya, Qatar, United Arab Emirates and Yemen) have fully achieved Sub- indicator 5d: Member State has enacted and enforced comprehensive bans on tobacco advertising, promotion and sponsorship; and 13.6% (Jordan, Morocco and Pakistan) have fully achieved sub-indicator 5e: Member State has implemented effective mass media campaigns that educate the public about the harms of tobacco use and second-hand smoke.

Nearly half of the countries have implemented measures to reduce the harmful use of alcohol as per the WHO Global Strategy to Reduce the Harmful Use of Alcohol (Progress sub-indicators 6a–c). Half of the countries (50%; Afghanistan, Egypt, Iraq, Islamic Republic of Iran, Libya, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, and Yemen) have fully achieved Sub-indicator 6a: Member State has implemented, as appropriate according to national circumstances, restrictions on the physical availability of retailed alcohol (via reduced hours of sale); 54.5% (Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Libya, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, and Yemen) have fully achieved Sub-indicator 6b: Member State has implemented, as appropriate according to national circumstances, bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media); and 40.9% (Afghanistan, Djibouti, Islamic Republic of Iran, Libya, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, and Yemen) have fully achieved Sub- indicator 6c: Member State has implemented, as appropriate according to national circumstances, excise tax increases on alcoholic beverages.

Regarding the four measures to reduce unhealthy diets (Progress Sub-indicators 7a–d), 36.4% of countries (Islamic Republic of Iran, Jordan, Morocco, Oman, Palestine, Saudi Arabia, Tunisia, and United Arab Emirates) have fully achieved Sub- indicator 7a: Member State has adopted national policies to reduce population salt/sodium consumption; 54.5% (Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Tunisia and United Arab Emirates) have 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; 31.8% (Afghanistan, Bahrain, Islamic Republic of Iran, Jordan, Qatar, Saudi

Arabia and United Arab Emirates) have fully achieved Sub-indicator 7c: Member State has implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children; and 27.3% (Afghanistan, Bahrain, Kuwait, Lebanon, Pakistan, and Yemen) have fully achieved Sub-indicator 7d: Member State has implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes.

More than half of the countries 54.5% (Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia, Tunisia, and United Arab Emirates) have fully achieved Progress indicator 8: Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change.

Iraq, Islamic Republic of Iran, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Sudan and United Arab Emirates (40.9% of countries) have fully achieved 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.

Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Saudi Arabia, and United Arab Emirates (40.9% of countries) have fully achieved 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.

Table 4.

Overall summary of progress indicator achievement in the Eastern Mediterranean Region (22 countries)

Progress indicator number	Progress indicator[a]	Number and percentage of countries partially achieving indicator		Countries partially achieving indicator	Number and percentage of countries fully achieving indicator		Countries fully achieving indicator
1	Member State has set time-bound national targets based on WHO guidance	1	4.5	Jordan	12	54.5	Bahrain, Egypt, Iraq, Islamic Republic of Iran, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, United Arab Emirates
2	Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis	14	63.6	Bahrain, Egypt, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates	0	0.0	
3	Member State has a STEPS survey or a comprehensive health examination survey every 5 years	15	68.2	Afghanistan, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Tunisia, United Arab Emirates	3	13.6	Islamic Republc of Iran, Saudi Arabia, Sudan
4	Member State has an operational multisectoral national strategy/ action plan that integrates the major noncommunicable diseases and their shared risk factors	5	22.7	Egypt, Jordan, Lebanon, Morocco, Palestine	8	36.4	Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Kuwait, Qatar, Saudi Arabia, United Arab Emirates
5	**Member State has implemented the following four demand-reduction measures of the WHO Framework Convention on Tobacco Control at the highest level of achievement**:						
	a. Reduce affordability by increasing excise taxes and prices on tobacco products	8	36.4	Egypt, Iraq, Morocco, Pakistan, Sudan, Syrian Arab Republic Tunisia, Yemen	2	9.1	Jordan, Palestine
	b. Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport	10	45.5	Djibouti, Egypt, Iraq, Jordan, Kuwait, Morocco, Saudi Arabia, Syrian Arab Republic, United Arab Emirates, Yemen	6	27.3	Afghanistan, Islamic Republic of Iran, Lebanon, Libya, Pakistan, Palestine

Table 4.

Overall summary of progress indicator achievement in the Eastern Mediterranean Region (22 countries) *(continued)*

Progress indicator number	Progress indicator[a]	Number and percentage of countries partially achieving indicator		Countries partially achieving indicator	Number and percentage of countries fully achieving indicator		Countries fully achieving indicator
	c. Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages	13	59.1	Afghanistan, Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Tunisia, United Arab Emirates, Yemen	3	13.6	Djibouti, Egypt, Islamic Republic of Iran
	d. Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship	12	54.5	Egypt, Iraq, Jordan Lebanon, Morocco, Oman, Pakistan, Palestine, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia	9	40.9	Afghanistan, Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya, Qatar, United Arab Emirates, Yemen
	e. Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke	6	27.3	Bahrain, Iraq, Islamic Republic of Iran, Saudi Arabia, Tunisia, United Arab Emirates	3	13.6	Jordan, Morocco, Pakistan
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. Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)	6	27.3	Djibouti, Jordan, Lebanon, Morocco, Pakistan, Palestine	11	50.0	Afghanistan, Egypt, Iraq, Islamic Republic of Iran, Libya, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Yemen
	b. Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)	2	9.1	Iraq, Syrian Arab Republic	12	54.5	Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Libya, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Yemen
	c. Increase excise taxes on alcoholic beverages	6	27.3	Egypt, Iraq, Jordan, Lebanon, Oman, Pakistan	9	40.9	Afghanistan, Djibouti, Islamic Republic of Iran, Libya, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Yemen
7	Member State has implemented the following four measures to reduce unhealthy diets:						
	a. Adopt national policies to reduce population salt/sodium consumption	6	27.3	Afghanistan, Bahrain, Egypt, Iraq, Kuwait, Qatar	8	36.4	Islamic Republic of Iran, Jordan, Morocco, Oman, Palestine, Saudi Arabia, Tunisia, United Arab Emirates

Table 4.

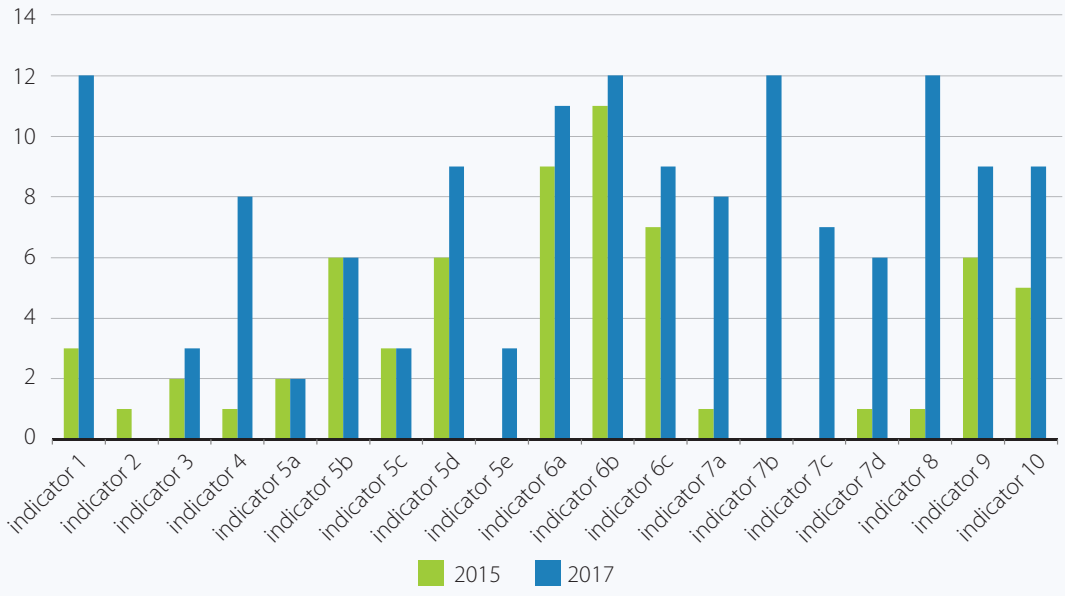
Overall summary of progress indicator achievement in the Eastern Mediterranean Region (22 countries) *(continued)*

Progress indicator number	Progress indicator[a]	Number and percentage of countries partially achieving indicator		Countries partially achieving indicator	Number and percentage of countries fully achieving indicator		Countries fully achieving indicator
	b. Adopt national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply	0	0.0		12	54.5	Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates
	c. WHO set of recommendations on marketing of foods and non-alcoholic beverages to children	0	0.0		7	31.8	Afghanistan, Bahrain, Islamic Republic of Iran, Jordan, Qatar, Saudi Arabia, United Arab Emirates
	d. Legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes	12	54.5	Djibouti, Egypt, Iraq, Islamic Republic of Iran, Jordan, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates	6	27.3	Afghanistan, Bahrain, Kuwait, Lebanon, Pakistan, Yemen
8	Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change	0	0.0		12	54.5	Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, 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 care approach, recognized/ approved by government or competent authorities	7	31.8	Egypt, Jordan, Morocco, Pakistan, Palestine, Syrian Arab Republic, Tunisia	9	40.9	Iraq, Islamic Republic of Iran, Kuwait, Lebanon, Oman, 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	1	4.5	Syrian Arab Republic	9	40.9	Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Saudi Arabia, United Arab Emirates

[a] For details of the definition of the 10 progress indicators and how they are calculated, see Reference ***(2017 NCD Progress Monitor)*** on page [TBC] of this report.

Fig. 10.

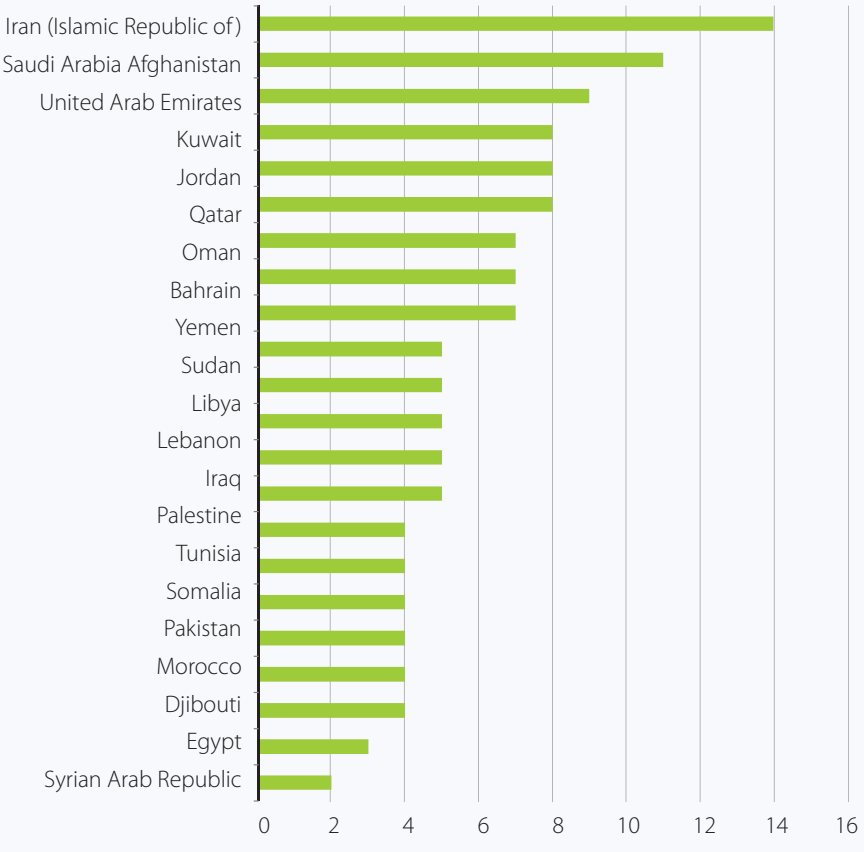
Comparison of the number of countries fully achieving the ten progress indicators[a] in 2015 and 2017



[a] Sub-indicators 7b and c were introduced in the 2017 country capacity survey

Fig. 11.

Number of progress indicators/sub-indicators fully achieved in 2017 by country



Overview of the achievement status of the ten progress indicators by country and country group

Progress indicator 1

Overall, 54.5% of countries have fully achieved the setting of time-bound national targets based on WHO guidance, while 4.5% have partially done so. Twelve countries have fully achieved this indicator: Bahrain, Egypt, Iraq, Islamic Republic of Iran, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, and United Arab Emirates. There was a notable difference in the achievement status of Progress indicator 1 between the three country groups: 100% of Group 1 countries have fully this indicator, while 50% of Group 2 countries and only 16.7% of Group 3 countries have fully done so (Table 5).

Table 5.

Progress indicator 1: achievement by country and country group

Member State has set time-bound national targets based on WHO guidance		Indicator 1		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			✓
	Kuwait			✓
	Oman			✓
	Qatar			✓
	Saudi Arabia			✓
	United Arab Emirates			✓
	Total	**0%**	**0%**	**100%**
Group 2	Egypt			✓
	Iran (Islamic Republic of)			✓
	Iraq			✓
	Jordan		✓	
	Lebanon	✓		
	Libya	✓		
	Morocco			✓
	Syrian Arab Republic	✓		
	Tunisia	✓		
	Palestine			✓
	Total	**40%**	**10%**	**50%**
Group 3	Afghanistan	✓		
	Djibouti	✓		
	Pakistan	✓		
	Somalia	✓		
	Sudan			✓
	Yemen	✓		
	Total	**83.3%**	**0%**	**16.7%**
	Eastern Mediterranean Region	**40.9%**	**4.5%**	**54.5%**

Progress indicator 2

Overall, none of the countries have fully achieved a functioning system for generating reliable cause-specific mortality data on a routine basis, while 63.6% have partially done so. Fourteen countries have partially achieved this indicator: Bahrain, Egypt, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, and United Arab Emirates. There was a notable difference in the achievement status of Progress indicator 2 between the three country groups: 100% of Group 1 countries have partially achieved this indicator, while 80% of Group 2 countries and0% of Group 3 countries have partially done so (Table 6).

Table 6.

Progress indicator 2: achievement by country and country group

Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis		Indicator 2		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain		✓	
	Kuwait		✓	
	Oman		✓	
	Qatar		✓	
	Saudi Arabia		✓	
	United Arab Emirates		✓	
	Total	**0%**	**100%**	**0%**
Group 2	Egypt		✓	
	Iran (Islamic Republic of)		✓	
	Iraq		✓	
	Jordan		✓	
	Lebanon	✓		
	Libya	✓		
	Morocco		✓	
	Syrian Arab Republic		✓	
	Tunisia		✓	
	Palestine		✓	
	Total	**20%**	**80%**	**0%**
Group 3	Afghanistan	✓		
	Djibouti	✓		
	Pakistan	✓		
	Somalia	✓		
	Sudan	✓		
	Yemen	✓		
	Total	**100%**	**0%**	**0%**
	Eastern Mediterranean Region	**36.4%**	**63.6%**	**0%**

Progress indicator 3

Overall, 13.6% of countries have fully conducted a STEPS survey or a comprehensive health examination survey every 5 years, while 68.2% of countries have partially done so. Three countries have fully achieved this indicator:Saudi Arabia, Islamic Republic of Iran, and Sudan. There was a notable difference in the achievement status of Progress indicator 3 between the three country groups: 83.3% of Group 1 countries have partially achieved the indicator, while 80% of Group 2 countries and 33.3% of Group 3 countries have partially done so (Table 7).

Table 7.

Progress indicator 3: achievement by country and country group

Member State has a STEPS survey or a comprehensive health examination survey every 5 years		Indicator 3		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain		✓	
	Kuwait		✓	
	Oman		✓	
	Qatar		✓	
	Saudi Arabia			✓
	United Arab Emirates		✓	
	Total	**0%**	**83.3%**	**16.7**
Group 2	Egypt		✓	
	Iran (Islamic Republic of)			✓
	Iraq		✓	
	Jordan		✓	
	Lebanon		✓	
	Libya		✓	
	Morocco		✓	
	Syrian Arab Republic	✓		
	Tunisia		✓	
	Palestine		✓	
	Total	**10%**	**80%**	**10%**
Group 3	Afghanistan		✓	
	Djibouti	✓		
	Pakistan		✓	
	Somalia	✓		
	Sudan			✓
	Yemen	✓		
	Total	**50%**	**33.3%**	**16.7%**
	Eastern Mediterranean Region	**18.2%**	**68.2%**	**13.6%**

Progress indicator 4

Overall, 36.4% of countries have fully achieved an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their risk factors, while 22.7% of countries have partially done so.

- Eight countries have fully achieved this indicator: Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Kuwait, Qatar, Saudi Arabia, and United Arab Emirates.
- There was a notable difference in the achievement status of Progress indicator 4 between the three country groups: 83.3% of Group 1 countries have fully achieved the indicator, while 20% of Group 2 countries and 16.7% of Group 3 countries have fully done so (Table 8).

Table 8.

Progress sub-indicator 4: achievement by country and country group

Member State has an operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors		Indicator 4		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			✓
	Kuwait			✓
	Oman	✓		
	Qatar			✓
	Saudi Arabia			✓
	United Arab Emirates			✓
	Total	**16.7%**	**0%**	**83.3%**
Group 2	Egypt		✓	
	Iran (Islamic Republic of)			✓
	Iraq			✓
	Jordan		✓	
	Lebanon		✓	
	Libya	✓		
	Morocco		✓	
	Syrian Arab Republic	✓		
	Tunisia	✓		
	Palestine		✓	
	Total	**30%**	**50%**	**20%**
Group 3	Afghanistan			✓
	Djibouti	✓		
	Pakistan	✓		
	Somalia	✓		
	Sudan	✓		
	Yemen	✓		
	Total	**83.3%**	**0%**	**16.7%**
	Eastern Mediterranean Region	**40.9%**	**22.7%**	**36.4%**

Progress sub-indicator 5a

Overall, 9.1% of countries have fully reduced affordability of tobacco products by increasing excise taxes and prices on such products, while 36.4% have partially done so. Two countries have fully achieved this sub-indicator: Jordan and Tunisia, while one of the countries in Groups 1 and 3 has fully done so (Table 9).

Table 9.

Progress sub-indicator 5a: achievement by country and country group

Member State has implemented the following demand-reduction measure of the WHO Framework Convention on Tobacco Control at the highest level of achievement: a. Reduce affordability by increasing excise taxes and prices on tobacco products		Sub-indicator 5a		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	✓		
	Kuwait	✓		
	Oman	✓		
	Qatar	✓		
	Saudi Arabia	✓		
	United Arab Emirates	✓		
	Total	**100%**	**0%**	**0%**
Group 2	Egypt		✓	
	Iran (Islamic Republic of)	✓		
	Iraq		✓	
	Jordan			✓
	Lebanon	✓		
	Libya	✓		
	Morocco		✓	
	Syrian Arab Republic		✓	
	Tunisia		✓	✓
	Palestine			
	Total	**30%**	**50%**	**20%**
Group 3	Afghanistan	✓		
	Djibouti	✓		
	Pakistan		✓	
	Somalia	✓		
	Sudan		✓	
	Yemen		✓	
	Total	**50%**	**50%**	**0%**
	Eastern Mediterranean Region	**54.5%**	**36.4%**	**9.1%**

Progress sub-indicator 5b

Overall, 27.3% of countries have fully eliminated exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport, while 45.5% have partially done so. Six countries that have fully achieved this sub-indicator: Afghanistan, Islamic Republic of Iran, Lebanon, Libya, Pakistan and Palestine. None of the countries in Group 1 have fully achieved this sub-indicator, while only two countries in Group 3 (Afghanistan and Pakistan) and four countries in Group 2 (Islamic Republic of Iran, Lebanon, Libya, and Palestine) have fully done so (Table 10).

Table 10.

Progress Monitor Indicator 5b: achievement by country and country group

Member State has implemented the following demand-reduction measure of the WHO Framework Convention on Tobacco Control at the highest level of achievement: b. Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport		Sub-indicator 5b		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	1		
	Kuwait		1	
	Oman	1		
	Qatar	1		
	Saudi Arabia		1	
	United Arab Emirates		1	
	Total	**50%**	**50%**	**0%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan		1	
	Lebanon			1
	Libya			1
	Morocco		1	
	Syrian Arab Republic		1	
	Tunisia	1		
	Palestine			1
	Total	**10%**	**50%**	**40%**
Group 3	Afghanistan			1
	Djibouti		1	
	Pakistan			1
	Somalia	1		
	Sudan	1		
	Yemen		1	
	Total	**33.3%**	**33.3%**	**33.3%**
	Eastern Mediterranean Region	**27.3%**	**45.5%**	**27.3%**

Progress Monitor sub-indicator 5c

Overall, 13.6% of countries have fully implemented plain/standardized packaging and/or large graphic health warnings on all tobacco packages, while 59.1% have partially done so. Three countries have fully achieved this sub-indicator: Egypt, Islamic Republic of Iran, and Djibouti. None of the countries in Group 1 have fully achieved this sub-indicator, while only 2 countries in Group 2 (Egypt and Islamic Republic of Iran) and 1 country in Group 3 (Djibouti) have fully done so (Table 11).

Table 11.

Progress sub-indicator 5c: achievement by country and country group

Member State has implemented the following demand-reduction measure of the WHO Framework Convention on Tobacco Control at the highest level of achievement: c. Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages		Sub-indicator 5c		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain		1	
	Kuwait		1	
	Oman		1	
	Qatar		1	
	Saudi Arabia		1	
	United Arab Emirates		1	
	Total	**0%**	**100%**	**0%**
Group 2	Egypt			1
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan		1	
	Lebanon		1	
	Libya	1		
	Morocco	1		
	Syrian Arab Republic	1		
	Tunisia		1	
	Palestine	1		
	Total	**40%**	**40%**	**20%**
Group 3	Afghanistan		1	
	Djibouti			1
	Pakistan		1	
	Somalia	1		
	Sudan	1		
	Yemen		1	
	Total	**33.3%**	**50%**	**16.7%**
	Eastern Mediterranean Region	**27.3%**	**59.1%**	**13.6%**

Progress sub-indicator 5d

Overall, 40.9% of countries have fully enacted and enforced comprehensive bans on tobacco advertising, promotion and sponsorship, while 54.5% have partially done so. Nine countries have fully achieved this sub-indicator: Afghanistan, Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya, Qatar, United Arab Emirates, and Yemen.

- Nearly two thirds (66.7%) of countries in Group 1 have fully achieved this sub-indicator, while only two countries in Group 2 (Libya and Iran) and half of the countries in Group 3 (Afghanistan, Djibouti, and Yemen) have fully done so (Table 12).

Table 12.

Progress sub-indicator 5d: achievement by country and country group

Member State has implemented the following demand-reduction measure of the WHO Framework Convention on Tobacco Control at the highest level of achievement: d. Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship		Sub-indicator 5d		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			1
	Kuwait			1
	Oman		1	
	Qatar			1
	Saudi Arabia		1	
	United Arab Emirates			1
	Total	**0%**	**33.3%**	**66.7%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan		1	
	Lebanon		1	
	Libya			1
	Morocco		1	
	Syrian Arab Republic		1	
	Tunisia		1	
	Palestine		1	
	Total	**0%**	**80%**	**20%**
Group 3	Afghanistan			1
	Djibouti			1
	Pakistan		1	
	Somalia	1		
	Sudan		1	
	Yemen			1
	Total	**16.7%**	**33.3%**	**50%**
	Eastern Mediterranean Region	**4.5%**	**54.5%**	**40.9%**

Progress sub-indicator 5e

Overall, 13.6% of countries have fully implemented effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke, while 27.3% have partially done so.

Three countries have fully achieved this sub-indicator: Jordan, Morocco, and Pakistan. None of the countries in Group 1 have fully achieved this sub-indicator, while only 2 countries in Group 2 (Jordan and Morocco) and one country in Group 3 (Pakistan) have fully done so (Table 13).

Table 13.

Progress sub-indicator 5e: achievement by country and country group

Member State has implemented the following demand-reduction measure of the WHO Framework Convention on Tobacco Control at the highest level of achievement: e. Implement effective mass media campaigns that educate the public about the harms of smoking/ tobacco use and second-hand smoke		Sub-indicator 5e		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain		1	
	Kuwait	1		
	Oman	1		
	Qatar	NR		
	Saudi Arabia		1	
	United Arab Emirates		1	
	Total	**50%**	**50%**	**0%**
Group 2	Egypt	1		
	Iran (Islamic Republic of)		1	
	Iraq		1	
	Jordan			1
	Lebanon	1		
	Libya	1		
	Morocco			1
	Syrian Arab Republic	1		
	Tunisia		1	
	Palestine	1		
	Total	**50%**	**30%**	**20%**
Group 3	Afghanistan	1		
	Djibouti	NR		
	Pakistan			1
	Somalia	1		
	Sudan	1		
	Yemen	1		
	Total	**83.3%**	**0%**	**16.7%**
	Eastern Mediterranean Region	**59.1%**	**27.3%**	**13.6%**

NR = Not reported

Progress sub-indicator 6a

Overall, 50% of countries have fully enacted and enforced restrictions on the physical availability of retailed alcohol (via reduced hours of sale), while 27.3% have partially done so. Eleven countries have fully achieved this sub-indicator: Afghanistan, Egypt, Iraq, Islamic Republic of Iran, Libya, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, and Yemen. Only 2 countries in Group 1 (Oman and Saudi Arabia) have fully achieved this sub-indicator, while two thirds of Group 3 and half of Group 2 countries have fully done so (Table 14).

Table 14.

Progress sub-indicator 6a: achievement by country and country group

Member State has implemented, as appropriate according to national circumstances, the following measure to reduce the harmful use of alcohol as per the WHO Global Strategy to Reduce the Harmful Use of Alcohol: a. Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)		Sub-indicator 6a		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	1		
	Kuwait	1		
	Oman			1
	Qatar	1		
	Saudi Arabia			1
	United Arab Emirates	1		
	Total	**66.7%**	**0%**	**33.3%**
Group 2	Egypt			1
	Iran (Islamic Republic of)			1
	Iraq			1
	Jordan		1	
	Lebanon		1	
	Libya			1
	Morocco		1	
	Syrian Arab Republic			1
	Tunisia	1		
	Palestine		1	
	Total	**10.0%**	**40.0%**	**50.0%**
Group 3	Afghanistan			1
	Djibouti		1	
	Pakistan		1	
	Somalia			1
	Sudan			1
	Yemen			1
	Total	**0%**	**33.3%**	**66.7%**
	Eastern Mediterranean Region	**22.7%**	**27.3%**	**50.0%**

Progress indicator 6b

Overall, 54.5% of countries have fully enacted and enforced bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media), while 9.1% have partially done so. Twelve countries have fully achieved this sub-indicator: Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Libya, Oman, Pakistan, Saudi Arabia, Somalia, Sudan and Yemen. Only two countries in Group 1 (Oman and Qatar) have fully achieved this sub-indicator, while four countries in Group 2 (Egypt, Islamic Republic of Iran, Jordan, and Libya) and all countries in Group 3 have fully done so (Table 15).

Table 15.

Progress sub-indicator 6b: achievement by country and country group

Member State has implemented, as appropriate according to national circumstances, the following measure to reduce the harmful use of alcohol as per the WHO Global Strategy to Reduce the Harmful Use of Alcohol: b. Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)		Sub-indicator 6b		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	NR		
	Kuwait	NR		
	Oman			1
	Qatar	NR		
	Saudi Arabia			1
	United Arab Emirates	NR		
	Total	**66.7%**	**0%**	**33.3%**
Group 2	Egypt			1
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan			1
	Lebanon	1		
	Libya			1
	Morocco	1		
	Syrian Arab Republic		1	
	Tunisia	NR		
	Palestine	1		
	Total	**40%**	**20%**	**40%**
Group 3	Afghanistan			1
	Djibouti			1
	Pakistan			1
	Somalia			1
	Sudan			1
	Yemen			1
	Total	**0%**	**0%**	**100%**
	Eastern Mediterranean Region	**36.4%**	**9.1%**	**54.5%**

NR = Not reported

Progress sub-indicator 6c

Overall, 40.9% of countries have fully increased excise taxes on alcoholic beverages, while 27.3% have partially done so. Nine countries that have fully achieved this sub-indicator: Afghanistan, Djibouti, Islamic Republic of Iran, Libya, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, and Yemen. Only one country (Saudi Arabia) in Group 1, and three countries in Group 2 (Islamic Republic of Iran, Libya, and Morocco) have fully achieved this sub-indicator, while all countries except Pakistan in Group 3 fully done so (Table 16).

Table 16.

Progress sub-indicator 6c: achievement by country and country group

Member State has implemented, as appropriate according to national circumstances, the following measure to reduce the harmful use of alcohol as per the WHO Global Strategy to Reduce the Harmful Use of Alcohol: c. Increase excise taxes on alcoholic beverages		Sub-indicator 6c		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	NR		
	Kuwait	NR		
	Oman		1	
	Qatar	NR		
	Saudi Arabia			1
	United Arab Emirates	NR		
	Total	**66.7 %**	**16.7%**	**16.7%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan		1	
	Lebanon		1	
	Libya			1
	Morocco	1		
	Syrian Arab Republic			1
	Tunisia	NR		
	Palestine	1		
	Total	**30%**	**40%**	**30%**
Group 3	Afghanistan			1
	Djibouti			1
	Pakistan		1	
	Somalia			1
	Sudan			1
	Yemen			1
	Total	**0%**	**16.7%**	**83.3%**
	Eastern Mediterranean Region	**31.8%**	**27.3%**	**40.9%**

NR = Not reported

Progress sub-indicator 7a

Overall, 36.4% of countries have fully adopted national policies to reduce population salt/sodium consumption, while 27.3% have partially done so.

Eight countries have fully achieved this sub-indicator: Islamic Republic of Iran, Jordan, Morocco, Oman, Palestine, Saudi Arabia, Tunisia, and United Arab Emirates. Half of the countries in Group 1 (Oman, Saudi Arabia, and United Arab Emirates) and Group 2 (Islamic Republic of Iran, Jordan, Morocco, Palestine, and Tunisia) have fully achieved this sub-indicator, while none of the countries in Group 3 have fully done so (Table 17).

Table 17.

Progress sub-indicator 7a: achievement by country and country group

Member State has implemented the following measure to reduce unhealthy diets: a. Adopt national policies to reduce population salt/ sodium consumption		Sub-indicator 7a		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain		1	
	Kuwait		1	
	Oman			1
	Qatar		1	
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**0%**	**50%**	**50%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)			1
	Iraq		1	
	Jordan			1
	Lebanon	1		
	Libya	1		
	Morocco			1
	Syrian Arab Republic	1		
	Tunisia			1
	Palestine			1
	Total	**30%**	**20%**	**50%**
Group 3	Afghanistan		1	
	Djibouti	1		
	Pakistan	1		
	Somalia	1		
	Sudan	1		
	Yemen	1		
	Total	**83.3%**	**16.7%**	**0%**
	Eastern Mediterranean Region	**36.4%**	**27.3%**	**36.4%**

Progress sub-indicator 7b

Overall, 54.5% of countries have fully adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply, while none of the countries has done so. Twelve countries that have fully achieved this indicator: Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Tunisia, and United Arab Emirates.

- There was a notable difference in the achievement status of Sub-indicator 7b between the three country groups: 100% of Group 1 countries have fully achieved this sub-indicator, while only 50% of Group 2 countries and 16.7% of Group 3 countries fully done so (Table 18).

Table 18.

Progress sub-indicator 7b: achievement by country and country group

Member State has implemented the following measure to reduce unhealthy diets: b. Adopt national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply		Sub-indicator 7b		
	Country	Not Achieved	Partially achieved	Fully Achieved
Group 1	Bahrain			1
	Kuwait			1
	Oman			1
	Qatar			1
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**0%**	**0%**	**100%**
Group 2	Egypt	1		
	Iran (Islamic Republic of)			1
	Iraq			1
	Jordan			1
	Lebanon	1		
	Libya	1		
	Morocco			1
	Syrian Arab Republic	1		
	Tunisia			1
	Palestine	1		
	Total	**50%**	**0%**	**50%**
Group 3	Afghanistan			1
	Djibouti	1		
	Pakistan	1		
	Somalia	1		
	Sudan	1		
	Yemen	1		
	Total	**83.3%**	**0%**	**16.7%**
	Eastern Mediterranean Region	**45.5%**	**0%**	**54.5%**

Progress sub-indicator 7c

Overall, 31.8% of countries have fully implemented the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children, while none of the countries has partially done so. Seven countries have fully achieved this sub-indicator: Afghanistan, Bahrain, Islamic Republic of Iran, Jordan, Qatar, Saudi Arabia, and United Arab Emirates. There was a notable difference in the achievement status of Sub-indicator 7c between the three country groups: 66.7% of Group 1 countries have fully achieved this sub-indicator, while only20% of Group 2 countries and 16.7% of Group 3 countries have fully done so (Table 19).

Table 19.

Progress Monitor Indicator 7c: achievement by country and country group

Member State has implemented the following measure to reduce unhealthy diets: c. WHO set of recommendations on marketing of foods and non-alcoholic beverages to children		Sub-indicator 7c		
	Country	Not Achieved	Partially achieved	Fully Achieved
Group 1	Bahrain			1
	Kuwait	1		
	Oman	1		
	Qatar			1
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**33.3%**	**0%**	**66.7%**
Group 2	Egypt	1		
	Iran (Islamic Republic of)			1
	Iraq	1		
	Jordan			1
	Lebanon	1		
	Libya	1		
	Morocco	1		
	Syrian Arab Republic	1		
	Tunisia	1		
	Palestine	1		
	Total	**80%**	**0%**	**20%**
Group 3	Afghanistan			1
	Djibouti	1		
	Pakistan	1		
	Somalia	1		
	Sudan	1		
	Yemen	NR		
	Total	**83.3%**	**0%**	**16.7%**
	Eastern Mediterranean Region	**68.2%**	**0%**	**31.8%**

NR = Not reported

Progress sub-indicator 7d

Overall, 27.3% of countries have fully implemented legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes, while 54.5% of countries have partially done so. Six countries have fully achieved this sub-indicator: Afghanistan, Bahrain, Kuwait, Lebanon, Pakistan and Yemen. Only one country in Group 2 (Lebanon) and 2 countries in Group 1 (Bahrain and Kuwait) have fully achieved this sub-indicator, while half of Group 3 countries (Afghanistan, Pakistan, and Yemen) have fully done so (Table 20).

Table 20.

Progress sub-indicator 7d: achievement by country and country group

Member State has implemented the following measure to reduce unhealthy diets: d. Legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes		Sub-indicator 7d		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			1
	Kuwait			1
	Oman		1	
	Qatar		1	
	Saudi Arabia		1	
	United Arab Emirates		1	
	Total	**0%**	**66.7%**	**33.3%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)		1	
	Iraq		1	
	Jordan		1	
	Lebanon			1
	Libya	1		
	Morocco	1		
	Syrian Arab Republic		1	
	Tunisia		1	
	Palestine	NR		
	Total	**30%**	**60%**	**10%**
Group 3	Afghanistan			1
	Djibouti		1	
	Pakistan			1
	Somalia	1		
	Sudan		1	
	Yemen			1
	Total	**16.7%**	**33.3%**	**50%**
	Eastern Mediterranean Region	**18.2%**	**54.5%**	**27.3%**

NR = Not reported

Progress indicator 8

Overall, 54.5% of countries have fully implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change, while none of the countries has partially done so. Twelve countries have fully achieved this indicator: Bahrain, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia, Tunisia, and United Arab Emirates. There was a notable difference in the achievement status of this indicator between the three country groups: 100% of Group 1 countries have fully achieved this indicator, while 60% of Group 2 and 0% of Group 3 countries have fully done so (Table 21).

Table 21.

Progress indicator 8: achievement by country and country group

Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change, during the last five years		Indicator 8		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			1
	Kuwait			1
	Oman			1
	Qatar			1
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**0%**	**0%**	**100%**
Group 2	Egypt	1		
	Iran (Islamic Republic of)			1
	Iraq			1
	Jordan			1
	Lebanon			1
	Libya	1		
	Morocco			1
	Syrian Arab Republic	1		
	Tunisia			1
	Palestine	1		
	Total	**40%**	**0%**	**60%**
Group 3	Afghanistan	NR		
	Djibouti	1		
	Pakistan	1		
	Somalia	1		
	Sudan	1		
	Yemen	1		
	Total	**100%**	**0%**	**0%**
	Eastern Mediterranean Region	**45.5%**	**0%**	**54.5%**

NR = Not reported

Progress indicator 9

Overall, 40.9% of countries have fully implemented 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, while 31.8% of countries have partially done so. Nine countries have fully achieved this indicator: Iraq, Islamic Republic of Iran, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Sudan, and United Arab Emirates. There was a notable difference in the achievement status of this indicator between the three country groups: 83.3% of Group 1 countries have fully achieved this indicator, while only 30.0% of Group 2 countries and 16.7% of Group 3 countries have fully done so (Table 22).

Table 22.

Progress indicator 9: achievement by country and country group

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		Indicator 9		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain	NR		
	Kuwait			1
	Oman			1
	Qatar			1
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**16.7%**	**0%**	**83.3%**
Group 2	Egypt		1	
	Iran (Islamic Republic of)			1
	Iraq			1
	Jordan		1	
	Lebanon			1
	Libya	NR		
	Morocco		1	
	Syrian Arab Republic		1	
	Tunisia		1	
	Palestine		1	
	Total	**10%**	**60%**	**30%**
Group 3	Afghanistan	1		
	Djibouti	1		
	Pakistan		1	
	Somalia	1		
	Sudan			1
	Yemen	1		
	Total	**66.7%**	**16.7%**	**16.7%**
	Eastern Mediterranean Region	**27.3%**	**31.8%**	**40.9%**

NR = Not reported

Progress indicator 10

Overall, 40.9% of countries has 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, while 4.5% of countries have partial provision of such therapy and counselling. Nine countries have fully achieved this indicator: Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Saudi Arabia, and United Arab Emirates. There was a notable difference in the achievement status of this indicator in the three country groups: 83.3% of Group 1 countries have fully achieved this indicator, while only 40.0% of Group 2 countries and 0% of Group 3 countries have fully done so (Table 23).

Table 23.

Progress indicator 10: achievement by country and country group

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		Indicator 10		
	Country	Not achieved	Partially achieved	Fully achieved
Group 1	Bahrain			1
	Kuwait			1
	Oman			1
	Qatar	1		
	Saudi Arabia			1
	United Arab Emirates			1
	Total	**16.7%**	**0%**	**83.3%**
Group 2	Egypt	1		
	Iran (Islamic Republic of)			1
	Iraq	1		
	Jordan			1
	Lebanon			1
	Libya	1		
	Morocco	1		
	Syrian Arab Republic		1	
	Tunisia	1		
	Palestine			1
	Total	**50%**	**10%**	**40%**
Group 3	Afghanistan	1		
	Djibouti	1		
	Pakistan	1		
	Somalia	1		
	Sudan	1		
	Yemen	1		
	Total	**100%**	**0%**	**0%**
	Eastern Mediterranean Region	**54.5%**	**4.5%**	**40.9%**

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 Yemen (20 out of 22 countries, 90.9%) reported the existence of a unit/branch/department at the ministry of health responsible for noncommunicable diseases, while 21 countries (95.5%) reported the presence of at least one full-time technical/professional member of staff in these noncommunicable disease units (Yemen reported the presence of one full-time technical/professional member of staff responsible for noncommunicable diseases despite the absence of a unit). When the information about the presence and the responsibilities of a noncommunicable disease unit/branch department at the ministry of health or its equivalent was examined by country group, the differences between country groups were not significant, and the countries of the Region performed similarly with regard to the availability of a noncommunicable disease unit/branch/department and responsibilities allocated to it. The number of full-time members of staff in these units was highest in Group 1 and Group 2 countries compared to Group 3 countries (Table 24). The proportion of countries that reported the existence of a unit/branch/department at the ministry of health responsible for noncommunicable diseases has remained stagnant at 91% since 2013 (Fig. 12).

Table 24.

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

		Unit/branch/department present	Number of full-time technical/ professional members of staff in the noncommunicable disease unit
Group 1	Bahrain	1	6–10
	Kuwait	1	2–5
	Oman	1	11 or more
	Qatar	1	11 or more
	Saudi Arabia	1	11 or more
	United Arab Emirates	1	11 or more
	Total	**100%**	
Group 2	Egypt	1	2–5
	Iran (Islamic Republic of)	1	11 or more
	Iraq	1	11 or more
	Jordan	1	11 or more
	Lebanon		
	Libya	1	11 or more
	Morocco	1	11 or more
	Syrian Arab Republic	1	2–5
	Tunisia	1	2–5
	Palestine	1	2–5
	Total	**90%**	

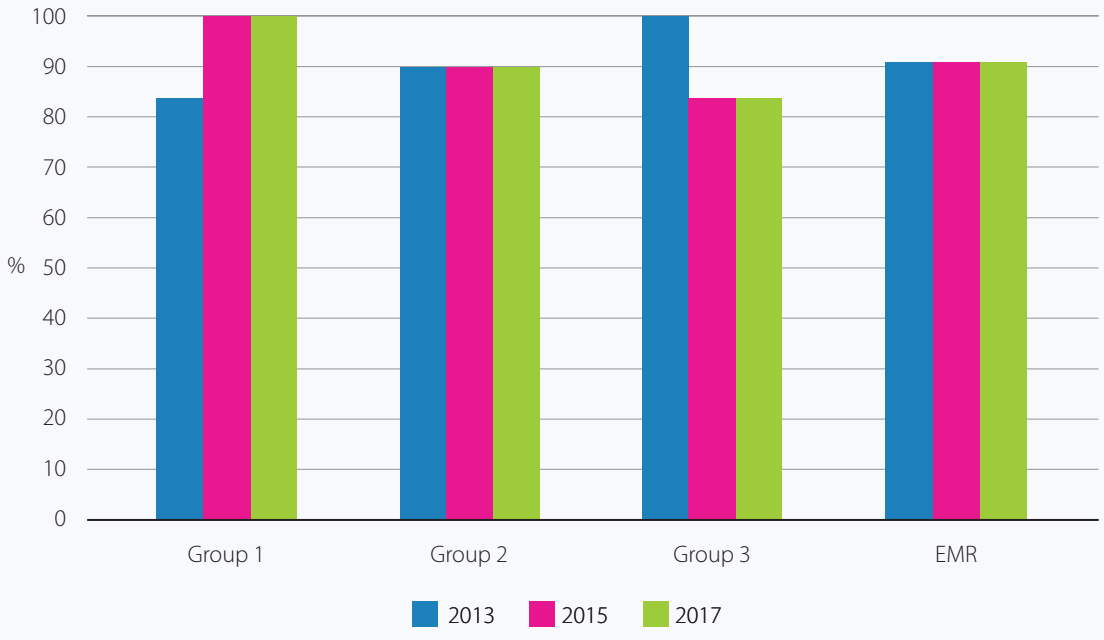
Table 24.

Countries with a unit/branch/department at the ministry of health responsible for noncommunicable diseases *(continued)*

		Unit/branch/department present	Number of full-time technical/ professional members of staff in the noncommunicable disease unit
Group 3	Afghanistan	1	2–5
	Djibouti	1	1
	Pakistan	1	6–10
	Somalia	1	2–5
	Sudan	1	2–5
	Yemen		1
	Total	**83.3%**	
	Eastern Mediterranean Region	**90.9%**	**95.5%**

Fig. 12

Noncommunicble disease capacity at noncommunicable disease unit/branch/department at the ministry of health or equivalent by country group in 2013, 2015, and 2017



To report on the functionality of noncommunicable disease units, the country capacity survey assessed the funding of eight areas of work pertaining to noncommunicable disease prevention and control as undertaken by the noncommunicable disease national structure. The most commonly funded area was health care and treatment (91% of all countries), followed by early detection/screening and surveillance, monitoring and evaluation (both funded in 81.8% of all countries). The least commonly funded areas were research and palliative care; only half of countries and 54.5% of countries reported government fund allocation for research and palliative care respectively. The average number of funded areas was highest in Group 1 countries (7.8/8) compared to Group 2 (6/8) and Group 3 countries (3.5/8). Overall, countries had an average of 5.8/8 funded areas (Table 25).

Table 25.

Funding allocated in the government budget for noncommunicable disease and risk factor-related activities/ functions

		Primary prevention	Health promotion	Early detection/ screening	Healthcare/ treatment	Surveillance, monitoring and evaluation	Capacity building	Palliative care	Research	Total areas funded out of 8 areas
Group 1	Bahrain	1	1	1	1	1	1	1		7
	Kuwait	1	1	1	1	1	1	1	1	8
	Oman	1	1	1	1	1	1	1	1	8
	Qatar	1	1	1	1	1	1	1	1	8
	Saudi Arabia	1	1	1	1	1	1	1	1	8
	United Arab Emirates	1	1	1	1	1	1	1	1	8
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**83.3%**	**7.8***
Group 2	Egypt	1	1	1	1		1			5
	Iran (Islamic Republic of)	1	1	1	1	1	1		1	7
	Iraq	1	1	1	1	1	1		1	7
	Jordan	1	1	1	1	1	1			6
	Lebanon	1	1	1	1	1	1			6
	Libya			1	1					2
	Morocco	1	1	1	1	1	1	1	1	8
	Syrian Arab Republic			1	1		1	1		4
	Tunisia	1	1	1	1	1	1	1	1	8
	Palestine	1	1	1	1	1	1	1		7
	Total	**80%**	**80%**	**100%**	**100%**	**70%**	**90%**	**40%**	**40%**	**6***
Group 3	Afghanistan									0
	Djibouti	1	1	1	1	1	1	1	1	8
	Pakistan	1	1	1	1		1		1	6
	Somalia									0
	Sudan	1	1		1	1	1	1		6
	Yemen				1					1
	Total	**50%**	**50%**	**33%**	**67%**	**33%**	**50%**	**33%**	**33%**	**3.5***
Eastern Mediterranean Region		**77.3%**	**77.3%**	**81.8%**	**90.9%**	**68.2%**	**81.8%**	**54.5%**	**50%**	**5.8***

* Average number

The majority of countries (81.8%) reported that government revenues were the largest source of regular funding for activities related to noncommunicable diseases and their risk factors. There were notable differences between the three country groups with respect extent to which government revenues contributed as a source of funding for noncommunicable diseases and their risk factors: all Group 1 countries, 90% of Group 2 and only half of Group 3 countries reported that government revenues were the largest source of regular funding in this regard. Other nongovernmental parties and sources contributing to the funding of action pertaining to noncommunicable diseases and their risk factors in the Region include health insurance and national donors (representing the second-largest sources of regional funding, with 41% of countries reporting both of these as sources of funding). In Group 3, after government revenues, health insurance and international donors were reported to be the next largest sources of funding, withhalf the countries in this group reporting both of these as sources of funding (Table 26).

Table 26.

Major sources of regular funding for noncommunicable diseases and their risk factors

		Governmental revenues	Health insurance	International Donors	National Donors	Earmarked taxes on alcohol, tobacco	Other
		Largest source	Next largest	Others			
Group 1	Bahrain	1					
	Kuwait	1					
	Oman	1	1		1		1
	Qatar	1		1		1	1
	Saudi Arabia	1					
	United Arab Emirates	1	1		1		
	Total	**100%**	**33.3%**	**16.7%**	**33.3%**	**16.7%**	**33.3%**
Group 2	Egypt	1			1		
	Iran (Islamic Republic of)	1	1			1	
	Iraq	1					
	Jordan	1	1	1	1	1	1
	Lebanon	1			1		
	Libya	1	1				
	Morocco						
	Syrian Arab Republic	1		1	1	1	
	Tunisia	1	1	1	1		
	Palestine	1				1	
	Total	**90%**	**40%**	**30%**	**50%**	**40%**	**10%**
Group 3	Afghanistan						
	Djibouti	1	1	1			
	Pakistan	1	1	1	1	1	1
	Somalia						
	Sudan	1	1	1	1		
	Yemen						
	Total	**50%**	**50%**	**50%**	**33.3%**	**16.7%**	**16.7%**
Eastern Mediterranean Region		**81.8%**	**41%**	**31.8%**	**41%**	**27.3%**	**18.2%**

Taxation on tobacco was the most commonly reported fiscal intervention for health among the countries of the Region, with 95.5% of countries reporting the implementation of this type of fiscal interventions (all countries except Somalia). The next most common type of fiscal intervention was alcohol taxation (reported by 40.9% of countries). Six countries implemented taxation on sugar-sweetened beverages (Djibouti, Iraq, Islamic Republic of Iran, Morocco, Saudi Arabia, and Tunisia). This represents a substantial improvement compared to the results reported in the 2015 country capacity survey – only Iran had implemented taxation on sugar-sweetened beverages in 2015. Only two countries had price subsidies for healthy foods (Tunisia and Sudan), and none of the countries reported the implementation of taxation on unhealthy foods or taxation incentives to promote physical activity as fiscal interventions for health. Only two countries in Group 2 (Islamic Republic of Iran and Morocco) reported that these funds are earmarked for health promotion or health service provision (Table 27).

Table 27.

Fiscal interventions for health, by source

		Tax on alcohol	Tax on tobacco	Tax on SSB	Tax on unhealthy food	Subsidies for health food	Tax to promote Physical Activity	Other	Earmarked for health promotion or health service provision
Group 1	Bahrain		1						
	Kuwait		1						
	Oman	1	1						
	Qatar		1						
	Saudi Arabia		1	1					
	United Arab Emirates		1						
	Total	**16.7%**	**100%**	**16.7%**	**0%**	**0%**	**0%**	**0%**	**0%**
Group 2	Egypt	1	1						
	Iran (Islamic Republic of)		1	1					1
	Iraq	1	1	1					
	Jordan	1	1						
	Lebanon	1	1						
	Libya		1						
	Morocco	1	1	1					1
	Syrian Arab Republic		1						
	Tunisia	1	1	1		1			
	Palestine		1						
	Total	**60%**	**100%**	**40%**	**0%**	**10%**	**0%**	**0%**	**20%**
Group 3	Afghanistan		1						
	Djibouti	1	1	1					
	Pakistan	1	1						
	Somalia								
	Sudan		1			1			
	Yemen		1						
	Total	**33.3%**	**83.3%**	**16.7%**	**0%**	**16.7%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**40.9%**	**95.5%**	**27.3%**	**0%**	**9%**	**0%**	**0%**	**9.1%**

The importance of multisectoral collaboration in noncommunicable disease prevention and control has been highlighted since 2000, and was particularly stressed upon in the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (*7*). More than half of the countries (54.5%) reported the existence of a national multisectoral body to oversee noncommunicable disease engagement, policy coherence and accountability in sectors beyond health; these bodies were operational in 40.9% of countries and excluded the tobacco industry from participating in the national multisectoral commission in 36.4% of countries. Operational bodies were reported in 100%, 30% and 0% of Group 1, Group 2 and Group 3 countries respectively. Morocco, Palestine, and Sudan reported the presence of non-operational bodies (Table 28). Compared to the results of the 2015 country capacity survey, despite a reduction in the number of countries reporting the existence of a national multisectoral body to oversee noncommunicable disease engagement, policy coherence and accountability in sectors beyond health from 15 countries in 2015 to 12 countries in 2017, the number of countries reporting that these bodies were operational has increased since 2015 (Fig. 13).

Table 28.

Presence of a national multisectoral commission, agency or mechanism to oversee noncommunicable disease engagement, policy coherence and accountability of sectors beyond health, and tobacco industry involvement

		Present	Operational	Tobacco industry excluded from participating in the national multisectoral commission
Group 1	Bahrain	1	1	1
	Kuwait	1	1	
	Oman	1	1	
	Qatar	1	1	1
	Saudi Arabia	1	1	1
	United Arab Emirates	1	1	1
	Total	**100%**	**100%**	**66.7%**
Group 2	Egypt			
	Iran (Islamic Republic of)	1	1	
	Iraq	1	1	
	Jordan	1	1	1
	Lebanon			
	Libya			
	Morocco	1		1
	Syrian Arab Republic			
	Tunisia			1
	Palestine	1		
	Total	**50%**	**30%**	**30%**
Group 3	Afghanistan			
	Djibouti			
	Pakistan			
	Somalia			
	Sudan	1		1
	Yemen			
	Total	**16.7%**	**0%**	**16.7%**
Eastern Mediterranean Region		**54.5%**	**40.9%**	**36.4%**

Fig. 13.

Comparison of availability of a national multisectoral commission, agency or mechanism to oversee noncommunicable disease engagement, policy coherence and accountability of sectors beyond health 2015–2017

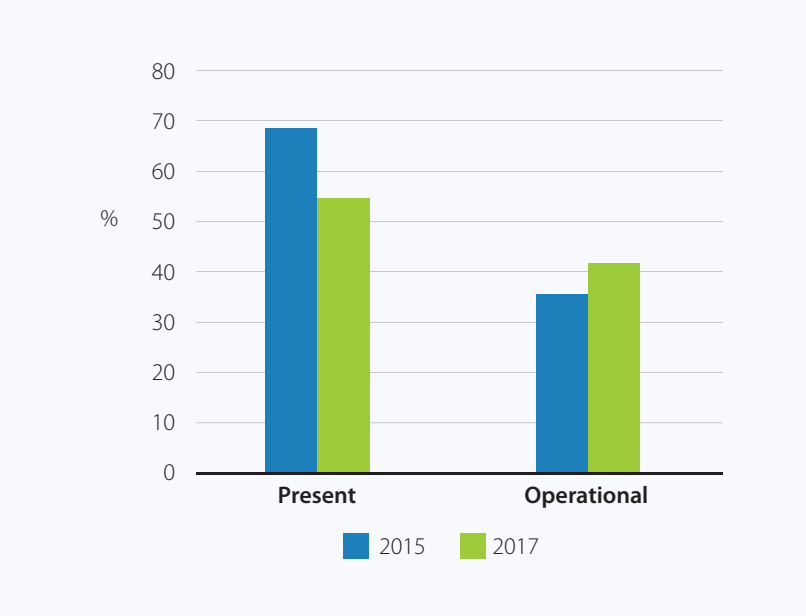
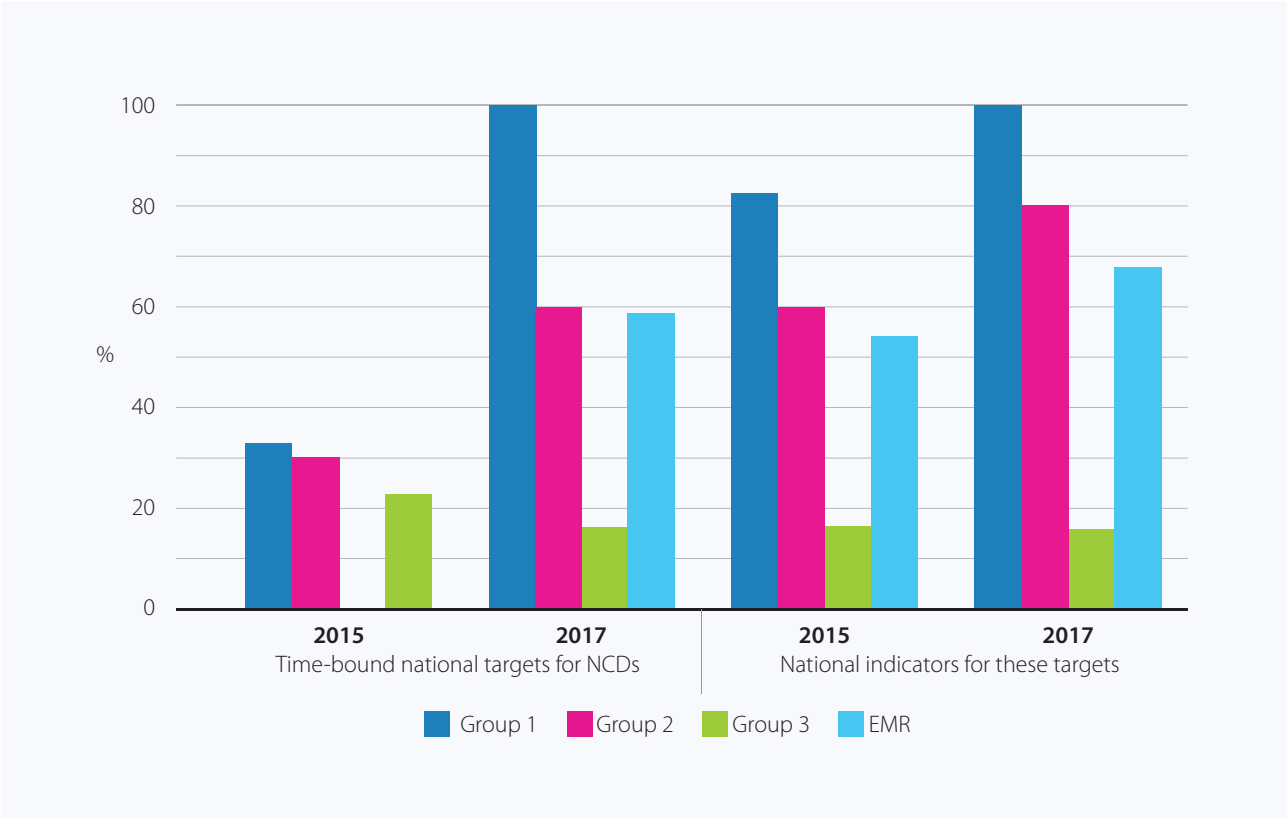


Fig. 14.

Comparision of the Percentage of countries with time-bound national targets for noncommunicable diseases and national indicators for these targets based on the WHO Global monitoring framework, 2015–2017



The majority of countries reported the inclusion of noncommunicable disease prevention and control in their national health plan (81.8%), and a slightly lower proportion (72.7%) reported that noncommunicable disease prevention and control was also included in their national development agenda. More than half of the countries reported the presence of time-bound national targets for noncommunicable diseases based on the nine global targets of the WHO Global monitoring framework and national indicators for these targets based on the Global monitoring framework; 100% of Group 1 countries reported the presence of time-bound national targets for noncommunicable diseases based on the nine global targets from the Global monitoring framework compared to 60 % in Group 2 (Egypt, Iraq, Islamic Republic of Iran, Jordan, Morocco, and Palestine), while only 16.7% of Group 3 countries (Sudan) did so (Table 29). There was notable improvement in the number of countries reporting that noncommunicable diseases are included in their current national health plan in 2017 (81.8%) compared to 2015 (68%). Furthermore, there was improvement in the extent of the existence of time-bound national targets for noncommunicable diseases based on the nine global targets of the Global monitoring framework and national indicators for these targets based on the Global monitoring framework in 2017 compared to 2015 in all country groups (Fig. 14).

Table 29.

Country noncommunicable disease commitment and planning

		Noncommunicable diseases included in current national health plan	Noncommunicable diseases included in national development agenda	Time-bound national targets for noncommunicable diseases based on the nine global targets of the WHO Global monitoring framework	National indicators based on the WHO Global monitoring framework
Group 1	Bahrain	1	1	1	1
	Kuwait	1	1	1	1
	Oman	1	1	1	1
	Qatar	1	1	1	1
	Saudi Arabia	1	1	1	1
	United Arab Emirates	1	1	1	1
	Total	**100%**	**100%**	**100%**	**100%**
Group 2	Egypt	1	1	1	1
	Iran (Islamic Republic of)	1	1	1	1
	Iraq	1	1	1	1
	Jordan	1	1	1	1
	Lebanon				1
	Libya				
	Morocco	1	1	1	1
	Syrian Arab Republic				
	Tunisia	1			1
	Palestine	1		1	1
	Total	**70%**	**50%**	**60%**	**80%**
Group 3	Afghanistan	1	1		
	Djibouti	1	1		
	Pakistan	1	1		
	Somalia	1	1		
	Sudan	1	1	1	1
	Yemen				
	Total	**83.3%**	**83.3%**	**16.7%**	**16.7%**
Eastern Mediterranean Region		**81.8%**	**72.7%**	**59.1%**	**68.2%**

A substantial number of countries (81.8%, 18 countries) reported having an integrated national noncommunicable disease policy, strategy or action plan; exceptions were Djibouti, Pakistan, Somalia, and Syrian Arab Republic.

A sizeable proportion of countries (77.3%) reported that the existing integrated national noncommunicable disease policy, strategy or action plan was multisectoral, and 68.2% of countries reported that it was multi-stakeholder.

Out of the 18 countries reporting the presence of an integrated national noncommunicable disease policy, strategy or action plan, 12 countries reported that the policy, strategy or action plan was operational (exceptions were Libya, Morocco, Oman, Tunisia, Sudan, and Yemen) (Table 30).

Table 30.

National noncommunicable disease approach and planning

		National noncommunicable disease policy, strategy or action plan which integrates several noncommunicable diseases and their risk factors					
		Present	Operational	A policy/ strategy	An action plan	Multisectoral	Multi-stakeholder
Group 1	Bahrain	1	1	1	1	1	1
	Kuwait	1	1	1	1	1	1
	Oman	1		1	1	1	1
	Qatar	1	1	1	1	1	1
	Saudi Arabia	1	1	1	1	1	1
	United Arab Emirates	1	1	1	1	1	1
	Total	**100%**	**83.3%**	**100%**	**100%**	**100%**	**100%**
Group 2	Egypt	1	1	1	1	1	1
	Iran (Islamic Republic of)	1	1	1	1	1	1
	Iraq	1	1	1	1	1	1
	Jordan	1	1	1	1	1	1
	Lebanon	1	1	1	1	1	1
	Libya	1		1			
	Morocco	1		1		1	
	Syrian Arab Republic						
	Tunisia	1		1		1	1
	Palestine	1	1	1	1	1	1
	Total	**90%**	**60%**	**90%**	**60%**	**80%**	**70%**
Group 3	Afghanistan	1	1	1		1	1
	Djibouti						
	Pakistan						
	Somalia						
	Sudan	1		1	1	1	1
	Yemen	1			1	1	
	Total	**50%**	**16.7%**	**33.3%**	**33.3%**	**50%**	**33.3%**
Eastern Mediterranean Region		**81.8%**	**54.5%**	**77.3%**	**63.6%**	**77.3%**	**68.2%**

* = National noncommunicable disease policy, strategy or action plan is under development

A sizeable proportion of countries included the four main noncommunicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) in their national integrated policies, strategies or action plans; coverage of these noncommunicable diseases ranged between 63.6% and 77.3% in countries of the Region. The majority of countries (81.8%) reported the inclusion of unhealthy diet, physical Inactivity and tobacco in their national integrated noncommunicable disease policy, strategy or action plans. However, harmful use of alcohol was only included in the integrated policy, strategy or action plan of six countries (27.3%) As such, this inclusion rate has remained almost unchanged since 2015; the country capacity survey for that year also reported that this risk factor was only addressed by six countries (27%).

When the information for the eight noncommunicable disease and risk factor items was stratified by country group, Group 1 had the best collective performance in terms of integrating noncommunicable diseases and their risk factors in national policies/strategies/action plans, with a country average inclusion rate of 7.2/8 items, while this rate dropped to 5.8/8 in Group 2 and to only 3.8/8 in Group 3. In general, noncommunicable disease risk factors were slightly better addressed in integrated policies/strategies/action plans than noncommunicable diseases. The regional average inclusion rate reported in the 2017 country capacity survey was very close to that reported in the 2015 survey – 5.6/8 in 2017 compared to 5.5/8 in 2015 (Table 31).

Table 31.

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

		National noncommunicable disease policy, strategy or action plan addresses one or more of the following major noncommunicable diseases and their risk factors									
		Harmful use of alcohol	Unhealthy diet	Physical inactivity	Tobacco	Cancers	Cardiovascular diseases	Chronic respiratory diseases	Diabetes	Sum of the 8 items	Palliative care*
Group 1	Bahrain		1	1	1	1	1	1	1	7	1
	Kuwait	1	1	1	1	1	1	1	1	8	1
	Oman		1	1	1	1	1	1	1	7	
	Qatar		1	1	1	1	1	1	1	7	1
	Saudi Arabia		1	1	1	1	1	1	1	7	1
	United Arab Emirates		1	1	1	1	1	1	1	7	1
	Total	**16.7%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**7.2**	**83.3%**
Group 2	Egypt		1	1	1	1	1	1	1	7	
	Iran (Islamic Republic of)	1	1	1	1	1	1	1	1	8	1
	Iraq		1	1	1	1	1	1	1	7	
	Jordan		1	1	1	1	1		1	6	1
	Lebanon		1	1	1	1	1	1	1	7	1
	Libya		1	1	1					3	
	Morocco	1	1	1	1	1	1		1	7	1
	Syrian Arab Republic									0	
	Tunisia	1	1	1	1	1	1	1	1	8	1
	Palestine		1	1	1		1		1	5	1
	Total	**30%**	**90%**	**90%**	**90%**	**70%**	**80%**	**50%**	**80%**	**5.8**	**60%**

Table 31.

Inclusion of the four main noncommunicable diseases and their risk factors in national integrated policies, strategies or action plans *(continued)*

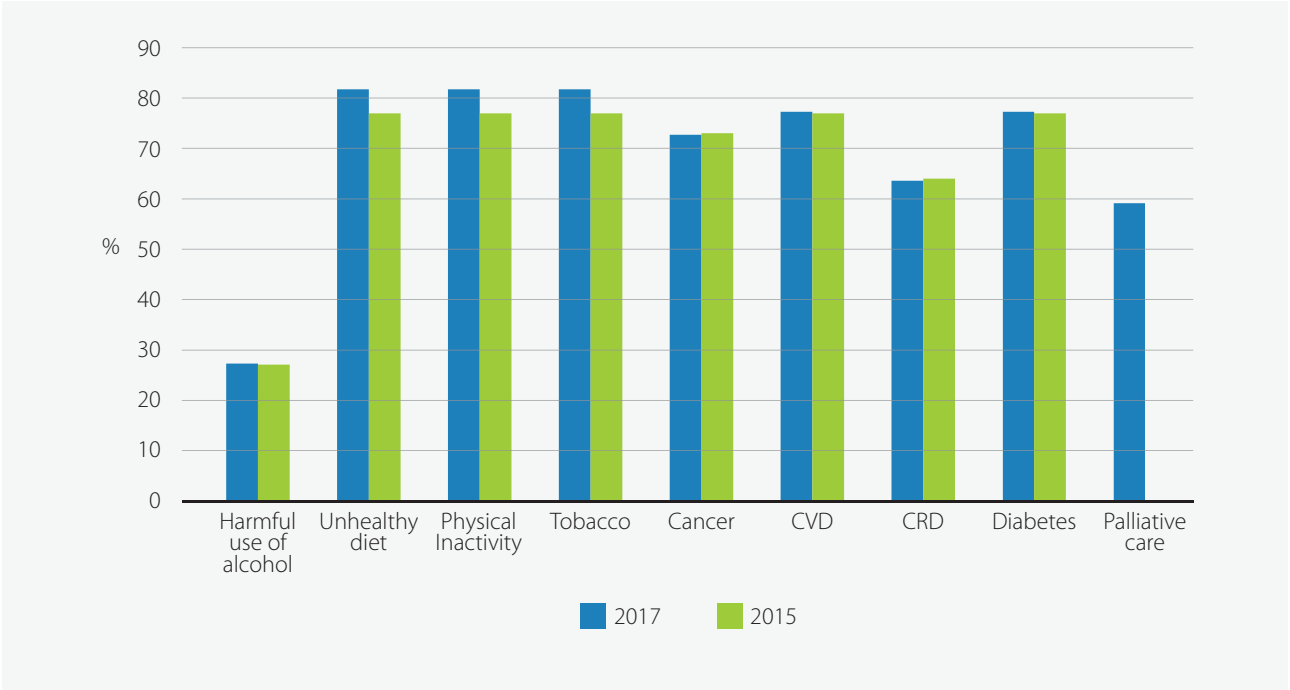
		National noncommunicable disease policy, strategy or action plan addresses one or more of the following major noncommunicable diseases and their risk factors									
		Harmful use of alcohol	Unhealthy diet	Physical inactivity	Tobacco	Cancers	Cardiovascular diseases	Chronic respiratory diseases	Diabetes	Sum of the 8 items	Palliative care*
Group 3	Afghanistan	1	1	1	1	1	1	1	1	8	
	Djibouti									0	
	Pakistan									0	
	Somalia									0	
	Sudan	1	1	1	1	1	1	1	1	8	1
	Yemen		1	1	1	1	1	1	1	7	1
	Total	**33.3%**	**50%**	**50%**	**50%**	**50%**	**50%**	**50%**	**50%**	**3.8**	**33.3%**
Eastern Mediterranean Region		**27.3%**	**81.8%**	**81.8%**	**81.8%**	**72.7%**	**77.3%**	**63.6%**	**77.3%**	**5.6**	**59.1%**

* Added in the 2017 country capacity survey

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 2015 and 2017, differences were minimal (Figure 15).

Fig. 15.

Inclusion of the four main noncommunicable diseases and their risk factors in national noncommunicable disease integrated policies, strategies or action plans, 2015–2017



Prevention and reduction of risk factors

The suboptimal performance of the Region in terms of operational integrated policies, strategies or action plans that combine the four major noncommunicable diseases and their risk factors may be due to the fact that many countries have developed and made operational several vertical programmes addressing one group of diseases or one noncommuncable disease-related risk factor at a time. Cancer programmes were the most common vertical programmes addressing noncommunicable diseases, with 63.6% of countries reporting the existence of such programmes. The next most common vertical programmes were those addressing diabetes (present in 45.5% of countries) and cardiovascular diseases (present in 36.4% of countries). However, only 18.2% of countries reported the presence of a vertical programme addressing chronic respiratory diseases. The availability of vertical programmes addressing noncommunicable diseases varied between the different country groups; Group 3 countries were the least likely to report the existence of such vertical programmes compared to Group 1 and Group 2 countries. The regional average number of main noncommunicable diseases addressed by vertical programmes was 1.6/4 in 2017, which is slightly lower than the regional average reported in the 2015 country capacity survey (1.9) (Table 32). The average numberof vertical programmes addressing the four major noncommunicable diseases was higher in Group 1 countries (2.8) compared to Group 2 (1.8) and Group 3 (0.17) countries (Figure 16).

Table 32.

Vertical programmes addressing noncommunicable diseases

		Cardiovascular diseases	Cancers	Diabetes	Chronic respiratory diseases	Total number of main noncommunicable diseases addressed (out of 4)	Oral health	Other noncommunicable diseases
Group 1	Bahrain	1	1	1		3		
	Kuwait		1			1		
	Oman	1	1	1	1	4	1	1
	Qatar		1	1		2	1	1
	Saudi Arabia	1	1	1	1	4		1
	United Arab Emirates	1	1	1		3	1	1
	Total	**66.7%**	**100%**	**83.3%**	**33.3%**	**2.8***	**50%**	**66.7%**
Group 2	Egypt		1			1		
	Iran (Islamic Republic of)	1	1	1	1	4	1	1
	Iraq	1	1	1	1	4		1
	Jordan	1	1	1		3	1	1
	Lebanon					0		1
	Libya					0	1	1
	Morocco	1	1	1		3	1	1
	Syrian Arab Republic					0		
	Tunisia		1	1		2	1	1
	Palestine		1			1		
	Total	**40%**	**70%**	**50%**	**20%**	**1.8***	**50%**	**70%**

Table 32.

Vertical programmes addressing noncommunicable diseases *(continued)*

		Cardiovascular diseases	Cancers	Diabetes	Chronic respiratory diseases	Total number of main noncommunicable diseases addressed (out of 4)	Oral health	Other noncommunicable diseases
Group 3	Afghanistan					0		
	Djibouti					0		1
	Pakistan					0		
	Somalia					0		
	Sudan		1			1		
	Yemen					0		
	Total	**0%**	**16.7%**	**0%**	**0%**	**0.17***	**0%**	**16.7%**
Eastern Mediterranean Region		**36.4%**	**63.6%**	**45.5%**	**18.2%**	**1.6***	**36.4%**	**54.5%**

* = Average number

With regard to vertical programmes addressing noncommunicable disease risk factors, the risk factors most commonly addressed were tobacco use (68.2%), followed by unhealthy diet and overweight/Obesity (both addressed in 54.5% of countries). Nearly one in five countries (22.7%) addressed the harmful use of alcohol through vertical programmes; the majority of those countries (4 out of the 5 countries) were in Group 2. Only one country in Group 1 (Kuwait) reported the existence of a vertical programme addressing the harmful use of alcohol (Table 30). The regional average number of vertical programmes addressing the five major noncommunicable disease-related risk factors () was 2.5/5, with the highest average achieved by Group 1 (4.2/5) and the lowest average achieved by Group 3 (0.8/5) (Table 33, Figure 16). Furthermore, the regional average number of vertical programmes addressing the five risk factors was higher in 2017 compared to the results of the 2015 and 2013 country capacity surveys (Figure 16). A comparison of the proportion of countries reporting the presence of vertical programmes addressing the major noncommunicable diseases and their related risk factors in 2015 and 2017 is shown in Figure 17.

Table 33.

Vertical programmes addressing major noncommunicable disease-related risk factors

		Harmful use of alcohol	Overweight/ obesity	Physical inactivity	Tobacco use	Unhealthy diet	Total number of risk factors addressed (out of 5)
Group 1	Bahrain		1	1	1	1	**4**
	Kuwait	1	1	1	1	1	**5**
	Oman		1	1	1	1	**4**
	Qatar		1	1	1	1	**4**
	Saudi Arabia		1	1	1	1	**4**
	United Arab Emirates		1	1	1	1	**4**
	Total	**16.7%**	**100.%**	**100.%**	**100.%**	**100.%**	**4.2***
Group 2	Egypt				1		**1**
	Iran (Islamic Republic of)	1	1	1	1	1	**5**
	Iraq	1	1	1	1	1	**5**
	Jordan		1	1	1	1	**4**
	Lebanon	1			1		**2**
	Libya						**0**
	Morocco	1					**1**
	Syrian Arab Republic						**0**
	Tunisia		1	1	1	1	**4**
	Palestine		1			1	**2**
	Total	**40%**	**50%**	**40%**	**60%**	**50%**	**2.4***
Group 3	Afghanistan		1			1	**2**
	Djibouti						**0**
	Pakistan				1		**1**
	Somalia						**0**
	Sudan				1		**1**
	Yemen				1		**1**
	Total	**0%**	**16.7%**	**0%**	**50%**	**16.7%**	**0.8***
Eastern Mediterranean Region		**22.7%**	**54.5%**	**45.5%**	**68.2%**	**54.5%**	**2.5***

* = Average number

Fig. 16.

Comparison of the regional average number of vertical programmes addressing noncommunicable diseases and their major risk factors, 2013, 2015, and 2017

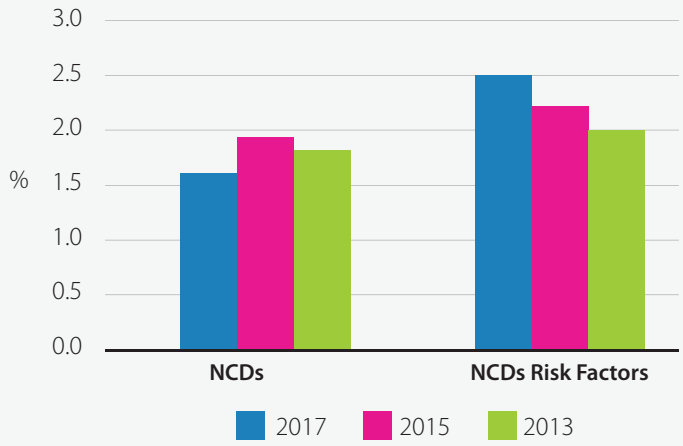
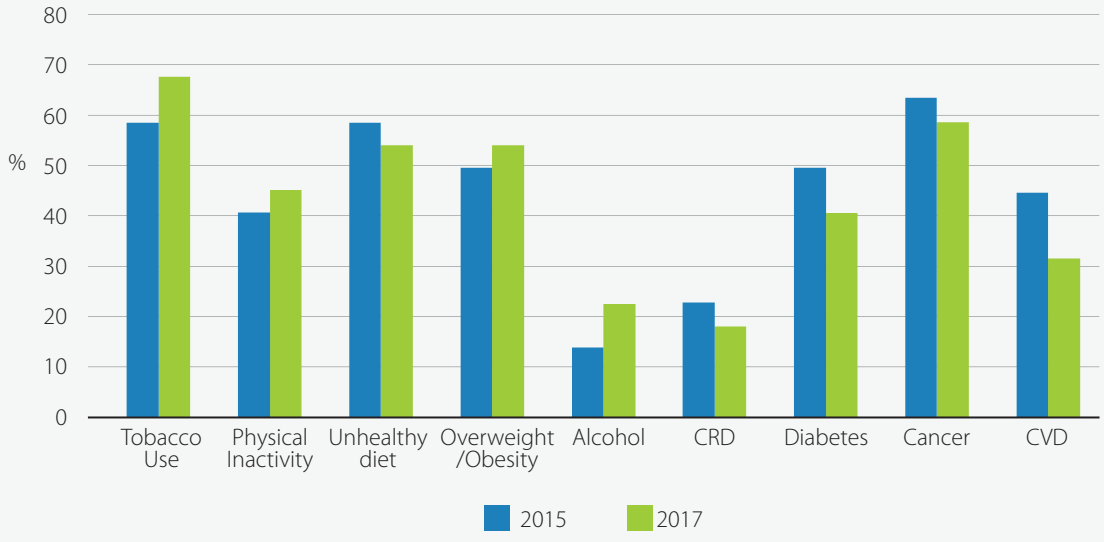


Fig.17.

Comparison of the percentage of countries with vertical programmes addressing the major noncommunicable diseases and their related risk factors, 2015–2017



Nearly one third of countries (31.8%) – Afghanistan, Bahrain, Islamic Republic of Iran, Jordan, Qatar, Saudi Arabia, and United Arab Emirates – reported the presence of policies to reduce the impact of the marketing to children of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt, and the same countries reported that these policies were in the form of government legislation. However, only Saudi Arabia has taken steps to address the effects of cross-border marketing of food and non-alcoholic beverages on children (Table 34).

Table 34.

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

		Present	Policy the form of government legislation	Government responsible for overseeing enforcement	Steps taken to address the effects of cross-border marketing of food and non-alcoholic beverages on children
Group 1	Bahrain	1	1	1	
	Kuwait				
	Oman				
	Qatar	1	1	1	
	Saudi Arabia	1	1		1
	United Arab Emirates	1	1	1	
	Total	**66.7%**	**66.7%**	**50%**	**16.7%**
Group 2	Egypt				
	Iran (Islamic Republic of)	1	1	1	
	Iraq				
	Jordan	1	1	1	
	Lebanon				
	Libya				
	Morocco				
	Syrian Arab Republic				
	Tunisia				
	Palestine				
	Total	**20%**	**20%**	**20%**	
Group 3	Afghanistan	1	1	1	
	Djibouti				
	Pakistan				
	Somalia				
	Sudan				
	Yemen				
	Total	**16.7%**	**16.7%**	**16.7%**	
Eastern Mediterranean Region		**31.8%**	**31.8%**	**27.3%**	**4.5%**

More than half of the countries in the Region (54.5%, 12 countries) reported the presence of national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply. Nine out of those 12 countries reported that these national policies were in the form of government legislation, while and the remaining 3 countries (Morocco, Tunisia, and United Arab Emirates) reported that these policies were voluntary/self- regulating (Table 35).

Table 35.

Implementation of national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply

		Present	Policy in the form of government legislation	Policy is voluntary/self-regulating
Group 1	Bahrain	1	1	
	Kuwait	1	1	
	Oman	1	1	
	Qatar	1	1	
	Saudi Arabia	1	1	
	United Arab Emirates	1		1
	Total	**100%**	**83.3%**	**16.7%**
Group 2	Egypt			
	Iran (Islamic Republic of)	1	1	
	Iraq	1	1	
	Jordan	1	1	
	Lebanon			
	Libya			
	Morocco	1		1
	Syrian Arab Republic			
	Tunisia	1		1
	Palestine			
	Total	**50%**	**30%**	**20%**
Group 3	Afghanistan	1	1	
	Djibouti			
	Pakistan			
	Somalia			
	Sudan			
	Yemen			
	Total	**16.7%**	**16.7%**	**0%**
Eastern Mediterranean Region		**54.5%**	**40.9%**	**13.6%**

Fourteen countries (63.6%) reported the presence of national policies to reduce population salt consumption. Eleven of these countries reported that these policies were in the form government legislation, while only three countries (Morocco, Tunisia, and United Arab Emirates) reported that these policies were voluntary/ self-regulating. There were notable differences in the extent of the presence of these policies between the three country groups; the presence of policies was reported by 100% of Group 1 countries, 70% of Group 2 countries and by only 16.7% (Afghanistan) of Group 3 countries (Table 36).

Table 36.

Implementation of national policies to reduce population salt consumption

		Policies to reduce population salt consumption						
		Present	Product reformulation	Regulation of salt content of food	Public awareness programme	Nutrition labelling	Government legislation	Voluntary/ self-regulating
Group 1	Bahrain	1	1	1		1	1	
	Kuwait	1		1	1		1	
	Oman	1	1	1	1	1	1	
	Qatar	1	1	1	1		1	
	Saudi Arabia	1	1	1	1	1	1	
	United Arab Emirates	1	1	1	1	1		1
	Total	**100%**	**83.3%**	**100%**	**83.3%**	**66.6%**	**83.3%**	**16.7%**
Group 2	Egypt	1		1			1	
	Iran (Islamic Republic of)	1	1	1	1	1	1	
	Iraq	1		1	1		1	
	Jordan	1		1	1	1	1	
	Lebanon							
	Libya							
	Morocco	1	1		1	1		1
	Syrian Arab Republic							
	Tunisia	1	1		1	1		1
	Palestine	1	1	1	1	1	1	
	Total	**70%**	**40%**	**50%**	**60%**	**50%**	**50%**	**20%**
Group 3	Afghanistan	1	1	1	1		1	
	Djibouti							
	Pakistan							
	Somalia							
	Sudan							
	Yemen							
	Total	**16.7%**	**16.7%**	**16.7%**	**16.7%**	**0%**	**16.7%**	**0%**
Eastern Mediterranean Region		**63.6%**	**45.5%**	**54.5%**	**54.5%**	**40.9%**	**50%**	**13.6%**

More than half of the countries reported the implementation of national public awareness campaigns on diet and physical activity in the past 5 years, with 54.5% of countries implementing both types of campaign. None of Group 3 countries reported the implementation of campaigns on physical activity, and only Afghanistan reported the implementation of campaigns on diet in the past 5 years (Table 37).

Table 37.

Implementation of national public awareness campaigns on diet and physical activity in the past 5 years

		Awareness campaign on diet	Awareness campaign on physical activity
Group 1	Bahrain	1	1
	Kuwait		1
	Oman		1
	Qatar	1	1
	Saudi Arabia	1	1
	United Arab Emirates	1	1
	Total	**66.7%**	**100%**
Group 2	Egypt	1	
	Iran (Islamic Republic of)	1	1
	Iraq	1	1
	Jordan	1	1
	Lebanon	1	1
	Libya		
	Morocco	1	1
	Syrian Arab Republic		
	Tunisia	1	1
	Palestine		
	Total	**70%**	**60%**
Group 3	Afghanistan	1	
	Djibouti		
	Pakistan		
	Somalia		
	Sudan		
	Yemen		
	Total	**16.7%**	**0%**
Eastern Mediterranean Region		**54.5%**	**54.5%**

Surveillance, monitoring and evaluation

Public health monitoring or surveillance activities comprise the regular collection of health information in terms of health indicators, the routine analysis of indicators over time, according to place and between population groups, and the sharing of available scientific knowledge, as well as the regular dissemination of results *(5)*. Noncommunicable disease surveillance constitutes one of the fundamental tools that public health initiatives can use to tackle the noncommunicable disease epidemic.

Regarding national surveillance structures, 20 countries (90.9%) 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. Only Somalia and Yemen in Group 3 reported the lack of any form of national surveillance structure (Table 38).

Table 38.

Body responsibility for surveillance of noncommunicable diseases and their risk factors

		Body exclusive to noncommunicable diseases	Body not exclusive to noncommunicable diseases	Responsibility shared across ministry of health
Group 1	Bahrain	1		
	Kuwait		1	
	Oman			1
	Qatar		1	
	Saudi Arabia	1		
	United Arab Emirates		1	
	Total	**33.3%**	**50%**	**16.7%**
Group 2	Egypt			1
	Iran (Islamic Republic of)	1		
	Iraq	1		
	Jordan	1		
	Lebanon			1
	Libya			1
	Morocco	1		
	Syrian Arab Republic	1		
	Tunisia			1
	Palestine		1	
	Total	**50%**	**10%**	**40%**
Group 3	Afghanistan			1
	Djibouti		1	
	Pakistan			1
	Somalia			
	Sudan			1
	Yemen			
	Total	**0%**	**16.7%**	**50%**
Eastern Mediterranean Region		**31.8%**	**22.7%**	**36.4%**

* No form of national surveillance structure present

With regard to mortality registration, 16 out of the 22 countries (72.7%) reported having a system for collecting cause-specific mortality data on a routine basis. Similar to the results reported in the 2015 country capacity survey, these included all Group 1 countries, all Group 2 countries except Libya, and only Sudan in Group 3. More than two thirds of countries (68.2%) reported having a civil/vital registration system. The most common disaggregation characteristics were age and gender, with (72.7% of countries reporting both types of disaggregation characteristics (Table 39).

Table 39.

Availability and characteristics of mortality registration systems

		A system for collecting cause-specific mortality data on a routine basis	System type		Disaggregation characteristics		
			Civil/ vital registration	Sample registration	Age	Gender	Other socio-demographic factor
Group 1	Bahrain	1	1		1	1	
	Kuwait	1	1	1	1	1	1
	Oman	1	1	1	1	1	1
	Qatar	1	1	1	1	1	1
	Saudi Arabia	1		1	1	1	1
	United Arab Emirates	1	1	1	1	1	1
	Total	**100%**	**83.3%**	**83.3%**	**100%**	**100%**	**83.3%**
Group 2	Egypt	1	1		1	1	1
	Iran (Islamic Republic of)	1	1		1	1	1
	Iraq	1	1		1	1	
	Jordan	1	1		1	1	1
	Lebanon	1	1		1	1	
	Libya						
	Morocco	1	1		1	1	
	Syrian Arab Republic	1	1	1	1	1	
	Tunisia	1	1		1	1	1
	Palestine	1	1		1	1	1
	Total	**90%**	**90%**	**10%**	**90%**	**90%**	**50%**
Group 3	Afghanistan						
	Djibouti						
	Pakistan						
	Somalia						
	Sudan	1	1		1	1	
	Yemen						
	Total	**16.7%**	**16.7%**	**0%**	**16.7%**	**16.7%**	**0%**
Eastern Mediterranean Region		**72.7%**	**68.2%**	**27.3%**	**72.7%**	**72.7%**	**45.5%**

The majority of countries reported the availability of a cancer registry (86.4%). In 68.2% of countries this was a population-based cancer registry, while in 9.1% of countries this was a hospital-based registry. Cancer registries was available in all Group 1 and Group 2 countries. However, only half of Group 3 countries (Pakistan, Sudan, and Yemen) reported the availability of a cancer registry. Regarding cancer registry coverage, half of the countries reported that the coverage was national: all Group 1 countries, 40% of Group 2 countries (Egypt, Islamic Republic of Iran, Jordan, and Lebanon), and only Sudan in Group 3 (Table 40). There was notable improvement in the proportion of countries reporting the availability of cancer registries in 2017 compared to the results of the 2015 and 2013 country capacity surveys – 86%, 82% and 77% of countries respectively (Figure 18). However, national cancer registry coverage has remained stable since 2015, with only half of the countries reporting that coverage was national in both 2015 and 2017.

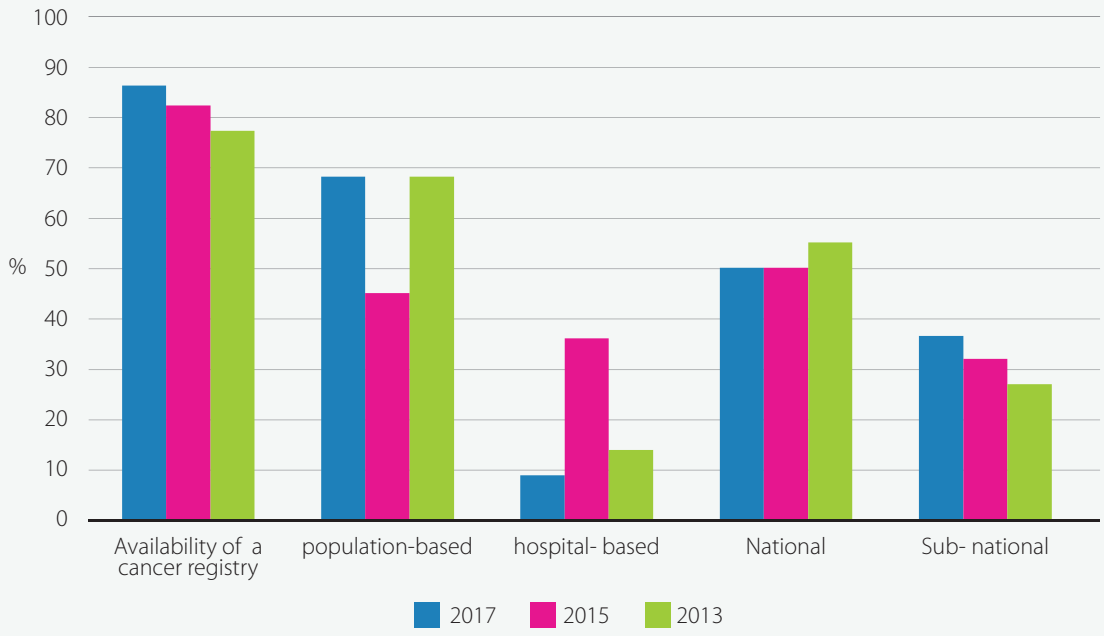
Table 40.

Availability and characteristics of cancer registries

		Availability of cancer registry	Data collection method			Coverage	
			Population-based	Hospital-based	Other/ don't know	National	Subnational
Group 1	Bahrain	1	1			1	
	Kuwait	1	1			1	
	Oman	1	1			1	
	Qatar	1	1			1	
	Saudi Arabia	1	1			1	
	United Arab Emirates	1	1			1	
	Total	**100%**	**100%**			**100%**	**0%**
Group 2	Egypt	1	1			1	
	Iran (Islamic Republic of)	1	1			1	
	Iraq	1	1				1
	Jordan	1	1			1	
	Lebanon	1	1			1	
	Libya	1			1		1
	Morocco	1	1				1
	Syrian Arab Republic	1		1			1
	Tunisia	1	1				1
	Palestine	1		1			1
	Total	**100%**	**70%**	**20%**	**10%**	**40%**	**60%**
Group 3	Afghanistan						
	Djibouti						
	Pakistan	1			1		1
	Somalia						
	Sudan	1	1			1	
	Yemen	1	1				1
	Total	**50%**	**33.3%**	**0%**	**16.7%**	**16.7%**	**33.3%**
Eastern Mediterranean Region		**86.4%**	**68.2%**	**9.1%**	**9.1%**	**50%**	**36.45**

Fig. 18.

Comparison of regional availability and characteristics of cancer registries, 2013, 2015, and 2017.



Nine countries (40.9%) reported the availability of diabetes registries. This included 66.7% of countries in Group 1 (all except Bahrain and Kuwait) and four countries (40%) in Group 2 (Islamic Republic of Iran, Iraq, Libya, and Palestine). Only Pakistan in Group 3 reported the availability of diabetes registries. The registries were hospital-based in four countries (18.2%), while other methods of data collection – clinic-based, primary health care centre-based, private sector-based or at-risk population-based – were used in five countries (22.7%). Out of the nine countries reporting the availability of diabetes registries, three countries (Islamic Republic of Iran, Jordan and Saudi Arabia) reported that registry coverage was national, while the remaining six countries (Iraq, Libya, Oman, Pakistan, Palestine, Qatar, and United Arab Emirates) reported subnational coverage (Table 41). The overall regional availability of diabetes registries reported in the 2017 country capacity survey was practically the same as that reported in the 2015 survey; 41% of countries reported the availability of registries in 2015 compared to 40.9% in 2017. However, changes in availability within country groups during this period can be observed; availability in Group 1 countries has decreased from 83% of countries in 2015 to 66.7% in 2017, while availability in Group 3 has increased from 0% of countries in 2015 to 16.7% of countries (Pakistan) in 2017 (Figure 19).

Table 41.

Availability and characteristics of diabetes registries

		Availability of diabetes registry	Data collection method		Coverage		Diabetes complications recorded
			Hospital-based	Other[a]	National	Subnational	
Group 1	Bahrain						
	Kuwait						
	Oman	1	1			1	1
	Qatar	1	1			1	1
	Saudi Arabia	1		1	1		1
	United Arab Emirates	1	1			1	
	Total	**66.7%**	**50%**	**16.7%**	**16.7%**	**50%**	**50%**
Group 2	Egypt						
	Iran (Islamic Republic of)	1		1	1		
	Iraq	1		1	1		
	Jordan						
	Lebanon						
	Libya	1	1			1	
	Morocco						
	Syrian Arab Republic						
	Tunisia						
	Palestine	1		1		1	1
	Total	**40%**	**10%**	**30%**	**30%**	**20%**	**20%**
Group 3	Afghanistan						
	Djibouti						
	Pakistan	1		1		1	
	Somalia						
	Sudan						
	Yemen						
	Total	**16.7%**	**0%**	**16.7%**	**0%**	**16.7%**	**0%**
Eastern Mediterranean Region		**40.9%**	**18.2%**	**22.7%**	**18.2%**	**27.3%**	**22.7%**

[a]Primary health care centre-based, the private sector-based, at-risk population-based

Fig. 19.

Comparison of regional availability of mortality registration systems and cancer and diabetes registries, 2015–2017

Fifteen countries (68.2%) reported the availability of a patient information system: all countries in Group 1 except Saudi Arabia, eight out of the 10 countries in Group 2 (all except Libya and Syrian Arab Republic), and only Afghanistan and Djibouti in Group 3. Electronic medical records were available in all countries reporting the availability of a patient information system except Afghanistan, Iraq, Kuwait, and Morocco. Eight out of these 15 countries reported that patient information system coverage was national. Only four countries (18.2%) – Djibouti, Morocco, Saudi Arabia, and United Arab Emirates – have conducted surveys of facilities to assess noncommunicable disease service availability and readiness (Table 42).

Table 42.

Availability and characteristics of patient information systems*

		Patient information system		Coverage		Service availability and readiness	Coverage	
		Present	Availability of electronic medical records	National	Subnational	Survey conducted	National	Subnational
Group 1	Bahrain	1	1	1			1	
	Kuwait	1		1				
	Oman	1	1		1			
	Qatar	1	1		1			
	Saudi Arabia					1		
	United Arab Emirates	1	1	1		1		1
	Total	**83.3%**	**66.7%**	**50%**	**33.3%**	**33.3%**	**16.7%**	**16.7%**
Group 2	Egypt	1	1		1			
	Iran (Islamic Republic of)	1	1	1				
	Iraq	1			1			
	Jordan	1	1	1				
	Lebanon	1	1		1			
	Libya							
	Morocco	1		1		1	1	
	Syrian Arab Republic							
	Tunisia	1	1		1			
	Palestine	1	1		1			
	Total	**80%**	**60%**	**30%**	**50%**	**10%**	**10%**	**0%**
Group 3	Afghanistan	1		1				
	Djibouti	1	1	1		1	1	
	Pakistan							
	Somalia							
	Sudan							
	Yemen							
	Total	**33.3%**	**16.7%**	**33.3%**	**0%**	**16.7%**	**16.7%**	**0%**
Eastern Mediterranean Region		**68.2%**	**50%**	**36.4%**	**31.8%**	**18.2%**	**13.6%**	**9.1%**

* New information added in the 2017 country capacity survey

Adult surveys (most commonly the WHO STEPwise approach to surveillance (STEPS)) gathered data on an average of 8/9 and 8.5/9 of the noncommunicable disease risk factors in Group 1 and Group 2 countries respectively. For Group 3, the average number of risk factors surveyed was 4.2/9. The most commonly surveyed risk factor in countries of the Region was tobacco use (95.5%). This was followed by risk factor surveys for low fruit and vegetable consumption, physical inactivity, overweight and obesity, and raised blood glucose/diabetes (86.4% of countries surveyed each of these risk factors). The least commonly surveyed risk factor was salt intake (50%); this was an improvement on the extent to which this risk factor was surveyed in 2015 (when at 32% it was also the least commonly surveyed risk factor), and, as in 2015, was expected due to the fact that the salt module was only added to the STEPS survey in late 2013 (Table 43). Comparing the results of the 2017 country capacity survey with that of 2015, there was a notable increase in the number of countries reporting the implementation of noncommunicable disease risk factor surveys among adults (Figures 20, 22).

Table 43.

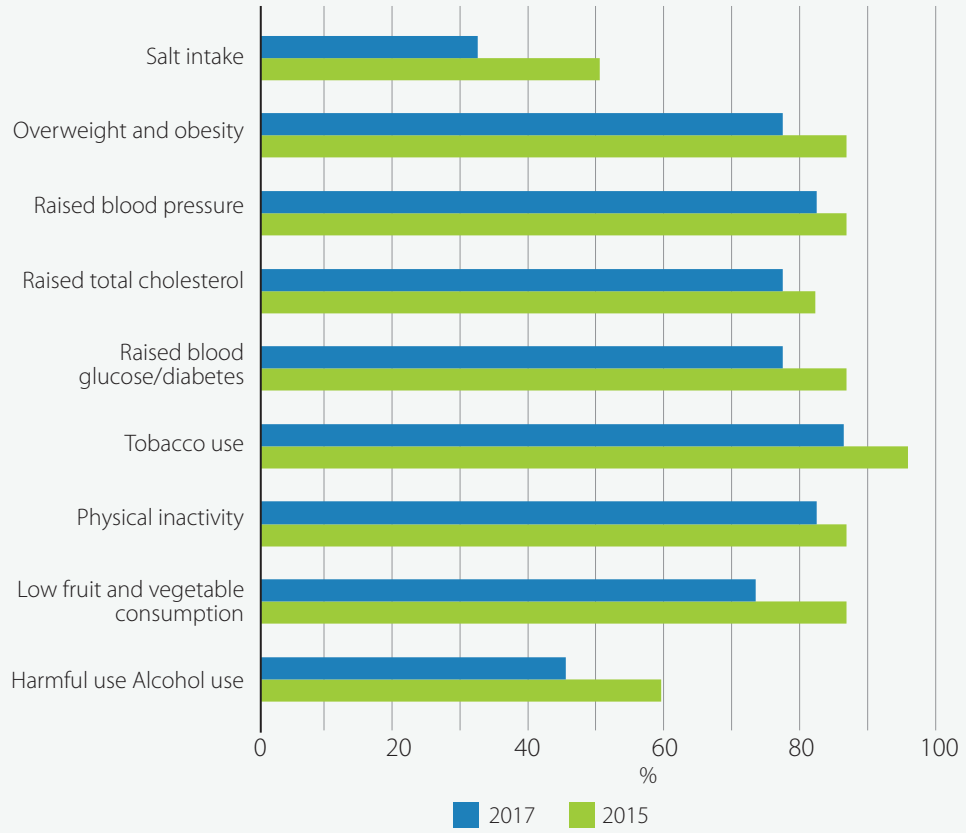
Surveys of noncommunicable disease risk factors among adults

		Harmful use of alcohol	Low fruit and vegetable consumption	Physical inactivity	Tobacco use	Overweight and obesity	Raised blood glucose/ diabetes	Raised total cholesterol	Raised blood pressure	Salt intake	Total number of risk factors (out of 9)
Group 1	Bahrain		1	1	1	1	1	1	1		7
	Kuwait	1	1	1	1	1	1	1	1		8
	Oman	1	1	1	1	1	1	1	1	1	9
	Qatar		1	1	1	1	1	1	1	1	8
	Saudi Arabia		1	1	1	1	1	1	1	1	8
	United Arab Emirates	1	1	1	1	1	1	1	1		8
	Total	**50%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**50%**	**8***
Group 2	Egypt	1	1	1	1	1	1	1	1		8
	Iran (Islamic Republic of)	1	1	1	1	1	1	1	1	1	9
	Iraq	1	1	1	1	1	1	1	1	1	9
	Jordan	1	1	1	1	1	1	1	1		8
	Lebanon	1	1	1	1	1	1	1	1	1	9
	Libya	1	1	1	1	1	1	1	1		8
	Morocco	1	1	1	1	1	1	1	1	1	9
	Syrian Arab Republic	1	1	1	1	1	1	1	1		8
	Tunisia	1	1	1	1	1	1	1	1	1	9
	Palestine		1	1	1	1	1	1	1	1	8
	Total	**90%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**60%**	**8.5***
Group 3	Afghanistan		1	1	1	1	1		1		6
	Djibouti				1					1	2
	Pakistan		1	1	1	1	1	1	1		7
	Somalia										0
	Sudan	1	1	1	1	1	1	1	1	1	9
	Yemen				1						1
	Total	**16.7%**	**50%**	**50%**	**83.3%**	**50%**	**50%**	**33.3%**	**50%**	**33.3%**	**4.2***
Eastern Mediterranean Region		**59.1%**	**86.4%**	**86.4%**	**95.5%**	**86.4%**	**86.4%**	**81.8%**	**86.4%**	**50%**	**7.2***

* Average number

Fig. 20.

Percentage comparison of noncommunicable disease surveys among adults collecting independent data on noncommunicable disease risk factors, 2015–2017



In adolescent surveys of noncommunicable disease risk factors, the average number of risk factors on which data were collected was 4/5, 4.2/5, and 3.5/5 in Group 1, Group 2, and Group 3 countries respectively. Surveys on adolescent tobacco use were conducted by all countries (100%). Overall, the most frequently surveyed risk factors were: physical inactivity (in 90.9% of countries); and low fruit and vegetable consumption and overweight and obesity (both in 86.4% of countries). Seven countries of the Region reported collection of data on the harmful use of alcohol in adolescent surveys: Kuwait, Qatar and United Arab Emirates in Group 1, and Lebanon, Morocco, Syrian Arab Republic and Tunisia in Group 2 (Table 44). Comparing the results of the 2017 country capacity survey with that of 2015, there was a notable increase in the number of countries reporting the implementation of noncommunicable disease risk factor surveys among adolescents in 2017 (Figures 21, 22).

Table 44.

Surveys of noncommunicable disease risk factors among adolescents

		Harmful use of alcohol	Low fruit and vegetable consumption*	Physical inactivity	Tobacco use	Overweight and obesity	Total number of risk factors (out of 5)
Group 1	Bahrain		1	1	1	1	4
	Kuwait	1	1	1	1	1	5
	Oman		1	1	1	1	4
	Qatar	1	1	1	1	1	5
	Saudi Arabia				1		1
	United Arab Emirates	1	1	1	1	1	5
	Total	**50%**	**83.3%**	**83.3%**	**100%**	**83.3%**	**4****
Group 2	Egypt		1	1	1	1	4
	Iran (Islamic Republic of)		1	1	1	1	4
	Iraq			1	1	1	3
	Jordan		1	1	1	1	4
	Lebanon	1	1	1	1	1	5
	Libya		1	1	1	1	4
	Morocco	1	1	1	1	1	5
	Syrian Arab Republic	1	1	1	1		4
	Tunisia	1	1	1	1	1	5
	Palestine		1	1	1	1	4
	Total	**40%**	**90%**	**100%**	**100%**	**90%**	**4.2****
Group 3	Afghanistan		1	1	1	1	4
	Djibouti		1	1	1	1	4
	Pakistan		1	1	1	1	4
	Somalia				1		1
	Sudan		1	1	1	1	4
	Yemen		1	1	1	1	4
	Total	**0%**	**83.3%**	**83.3%**	**100%**	**83.3%**	**3.5****
Eastern Mediterranean Region		**31.8%**	**86.4%**	**90.9%**	**100%**	**86.4%**	**4**

*Low fruit and vegetable consumption = less than the five servings of fruit and vegetables per day recommended by WHO.

**Average number.

Fig. 21.

Percentage comparison of adolescent noncommunicable disease risk factor surveys implemented in the Eastern Mediterranean Region, by risk factor, 2015–2017

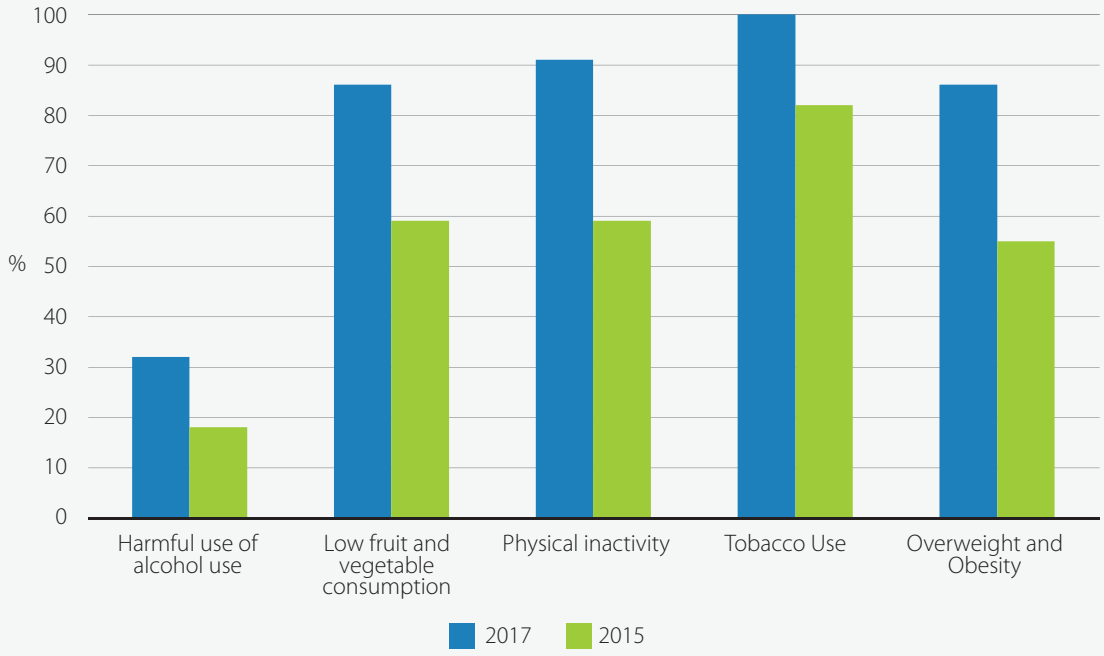
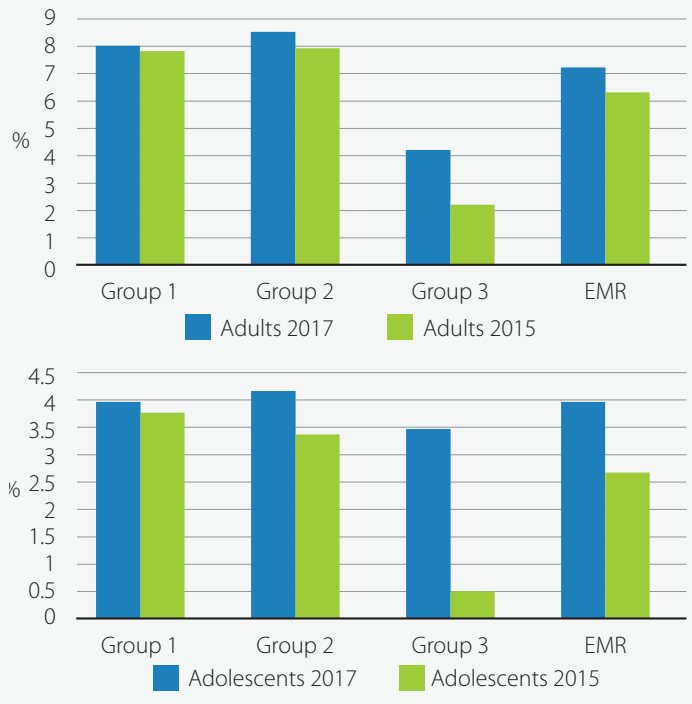


Fig.22.

Comparison of the average number of adult and adolescent noncommunicable disease risk factors surveyed, by country group, 2015 and 2017 (Total number of risk factors surveyed = 9 for adults and 5 for adolescents)



In a comparison of the results of the 2013, 2015 and 2017 regional surveys regarding the number of adolescent and adult surveys on noncommunicable disease risk factors carried out, the 2017 regional survey showed a notable increase in the total number of both adolescent and adult surveys (Table 45).

Table 45.

Comparison of frequency of adult and adolescent surveys on noncommunicable disease risk factors, by risk factor, 2013, 2015, and 2017

	Number of surveys		
Risk factor	**2017**	**2015**	**2013**
	Adolescents		
Harmful use of alcohol	7	4	5
Low fruit and vegetable consumption	19	13	16
Physical inactivity	20	13	16
Tobacco use	22	18	16
Overweight and obesity	19	12	15
Total number of surveys	**87**	**60**	**68**
	Adults		
Harmful use of alcohol	13	10	11
Low fruit and vegetable consumption	19	16	15
Physical inactivity	19	18	17
Tobacco use	21	19	19
Overweight and obesity	19	17	17
Raised blood glucose/diabetes	19	17	
Raised total cholesterol	18	17	
Raised blood pressure	19	18	
Salt intake	11	7	
Total number of surveys	**158**	**139**	**79**

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, cancers and cardiovascular diseases were the diseases most commonly covered by national guidelines; 81.8% of countries had developed management guidelines for diabetes, while 68.2% and 63.6% of countries had guidelines for cancers and cardiovascular diseases respectively. Guidelines for chronic respiratory diseases were only available in half of the countries of the Region. A similar pattern was noted regarding both the utilization of the guidelines in at least 50% of health facilities and the availability of guidelines for referral to secondary and tertiary care for the four main noncommunicable diseases (Table 46).

Table 46.

Availability of evidence-based national guidelines/protocols/standards for the management (diagnosis and treatment) of the four major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities

	Country	Noncommunicable diseases for which guidelines are available				Guidelines utilized in at least 50% of health facilities				Guidelines include referral criteria			
		Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases	Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases	Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases
Group 1	Bahrain		1		1		1		1		1		1
	Kuwait	1	1	1	1	1	1	1	1	1	1	1	1
	Oman	1	1	1	1	1	1	1	1	1	1	1	1
	Qatar	1	1	1	1	1	1	1	1	1	1	1	1
	Saudi Arabia	1	1	1	1	1	1			1	1	1	1
	United Arab Emirates	1	1	1	1	1	1	1	1	1	1	1	1
	Total	**83.3%**	**100%**	**83.3%**	**100%**	**83.3%**	**100%**	**66.6%**	**83.3%**	**83.3%**	**100%**	**83.3%**	**100%**
Group 2	Egypt	1	1	1							1	1	
	Iran (Islamic Republic of)	1	1	1	1	1	1	1		1	1	1	1
	Iraq	1	1	1	1	1	1	1	1	1	1		1
	Jordan	1	1	1		1	1	1		1	1		
	Lebanon	1	1	1	1	1	1	1	1	1	1	1	1
	Libya		1										
	Morocco	1	1	1		1	1	1		1	1	1	
	Syrian Arab Republic		1	1			1	1					
	Tunisia		1	1			1	1					
	Palestine	1	1			1	1			1	1		
	Total	**70%**	**100%**	**80%**	**30%**	**60%**	**80%**	**70%**	**20%**	**60%**	**70%**	**40%**	**30%**

Table 46.

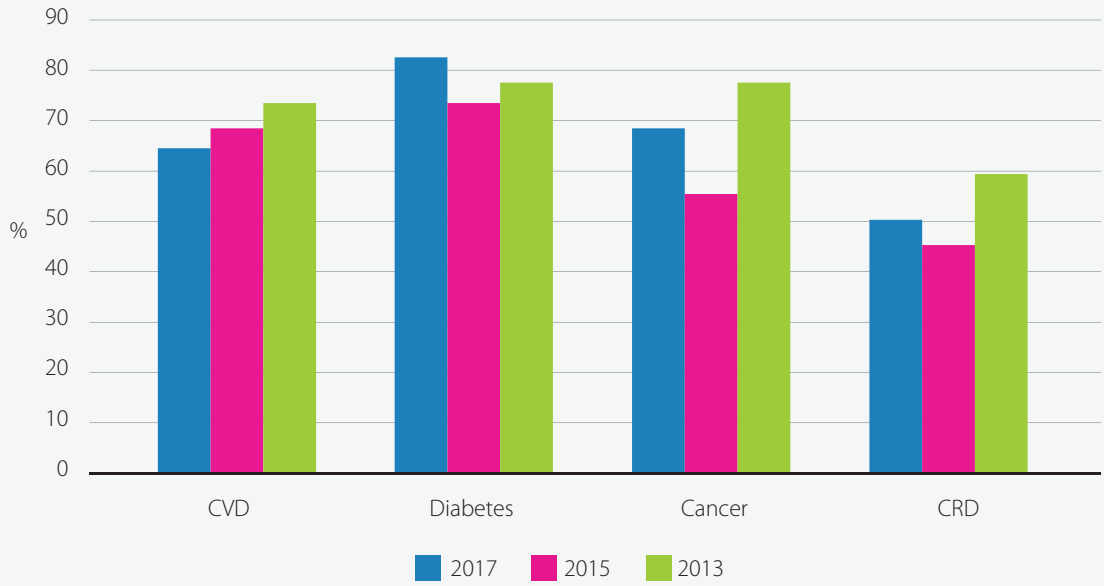
Availability of evidence-based national guidelines/protocols/standards for the management (diagnosis and treatment) of the four major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities *(continued)*

	Country	Noncommunicable diseases for which guidelines are available				Guidelines utilized in at least 50% of health facilities				Guidelines include referral criteria			
		Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases	Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases	Cardiovascular diseases	Diabetes	Cancers	Chronic respiratory diseases
Group 3	Afghanistan												
	Djibouti			1								1	
	Pakistan	1	1		1	1	1		1	1	1		1
	Somalia												
	Sudan	1	1	1	1	1	1	1	1	1	1	1	1
	Yemen												
	Total	**33.3%**	**33.3%**	**33.3%**	**33.3%**	**33.3%**	**33.3%**	**16.7%**	**33.3%**	**33.3%**	**33.3%**	**33.3%**	**33.3%**
Eastern Mediterranean Region		**63.6%**	**81.8%**	**68.2%**	**50%**	**61.9%**	**72.7%**	**54.5%**	**40.9%**	**59%**	**68.2%**	**50%**	**50%**

The 2017 country capacity survey results revealed a slight improvement in the number of countries reporting the 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, compared to the results of the 2015 survey, with the exception of the availability of cardiovascular disease guidelines. Overall, the results of the three most recent surveys revealed that guideline availability in both 2017 and 2015 was lower than in 2013 (Figure 23).

Fig. 23.

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, 2013–2017



More than half of the countries (59.4%) reported the availability of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases at primary care facilities of the public sector. However, a larger proportion (71%) reported the availability of the 13 basic technologies at primary care facilities of the private sector. The number of available technologies was highest in Group 1 countries (11.7/13 in the public sector and 11.5/13 in the private sector), followed by Group 2 (7/13 in the public sector and 8.7/13 in the private sector), and lastly by Group 3 (5/13 in the public sector and 7.8/13 in the private sector). In a comparision of the 2017 and 2015 country capacity survey results, the regional average number of available technologies was higher in 2017 compared to 2015 in both the public and private sectors (6.4 in the public sector and 6.8 in the private sector in 2015 compared to 7.7 in the public sector and 9.2 in the private sector in 2017) (Table 46).

Table 46.

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

Country		Public sector		Private sector	
		Number of basic technologies	%	Number of basic technologies	%
Group 1	Bahrain	13	100	13	100
	Kuwait	11	84.6	13	100
	Oman	12	92.3	12	92.3
	Qatar	13	100	10	76.9
	Saudi Arabia	9	69.2	10	76.9
	United Arab Emirates	12	92.3	11	84.6
	Total	**11.7***	**89.7**	**11.5***	**88.5**
Group 2	Egypt	7	53.8	0	0
	Iran (Islamic Republic of)	8	61.5	9	69.2
	Iraq	6	46.2	12	92.3
	Jordan	11	84.6	12	92.3
	Lebanon	9	69.2	13	100
	Libya	6	46.2	12	92.3
	Morocco	8	61.5	7	53.8
	Syrian Arab Republic	7	53.8	13	100
	Tunisia	2	15.4	2	15.4
	Palestine	6	46.2	7	53.8
	Total	**7***	**53.8**	**8.7***	**66.9**
Group 3	Afghanistan	5	38.5	7	53.8
	Djibouti	7	53.8	9	69.2
	Pakistan	4	30.8	13	100
	Somalia	6	46.2	8	61.5
	Sudan	4	30.8	6	46.2
	Yemen	5	38.5	4	30.8
	Total	**5***	**38.5**	**7.8***	**60.3**
Eastern Mediterranean Region		**7.7***	**59.4**	**9.2***	**71**

* = Average number

Breast cancer screening programmes were reported to be available in the majority of countries (77.3%). However, less than half of the countries reported the availability of screening programmes for cervical cancer (40.9%), 27.3% reported the availability of screening programmes for colon cancer, and only 4.5% (Kuwait) reported the availability of screening programmes for prostate cancer. For all screened cancers, the largest proportion of countries offering screening programmes was in Group 1, followed by Group 2 and lastly by Group 3. Initial screening methods were reported to be mammography for breast cancer (in 40.9% countries) and PAP smear for cervical cancer (in 27.3% countries). Screening programmes for breast and cervical cancers were reported to be organized population-based in 40.9% and 27.3% of countries respectively (Tables 47 and 48). Compared to the results of the 2015 country capacity survey, the proportion of countries reporting the availability of screening programmes for breast and cervical cancers has increased in 2017, with 68% and 77% of countries offering screening programmes for breast cancer in 2015 and 2017 respectively, and 23% and 40.9% of countries offering screening programmes for cervical cancer in 2015 and 2017 respectively.

Table 47.

Availability of national screening programmes for breast cancer

Country		National breast cancer screening programme available	Initial screening method		Type of programme	
			Clinical breast exam	Mammography	Opportunistic	Organized population-based
Group 1	Bahrain	1		1		1
	Kuwait	1	1		1	
	Oman	1	1			1
	Qatar	1		1		1
	Saudi Arabia	1		1	1	
	United Arab Emirates	1		1		1
	Total	**100%**	**33.3%**	**66.7%**	**33.3%**	**66.7%**
Group 2	Egypt	1		1	1	
	Iran (Islamic Republic of)	1	1			1
	Iraq	1	1			1
	Jordan	1		1	1	
	Lebanon	1		1		1
	Libya					
	Morocco	1	1			1
	Syrian Arab Republic	1		1	1	
	Tunisia	1	1		1	
	Palestine	1	1		1	
	Total	**90%**	**50%**	**40%**	**50%**	**40%**
Group 3	Afghanistan					
	Djibouti	1		1		1
	Pakistan	1				
	Somalia					
	Sudan					
	Yemen					
	Total	**33.3%**	**0%**	**16.7%**	**0%**	**16.7%**
Eastern Mediterranean Region		**77.3%**	**31.8%**	**40.9%**	**31.8%**	**40.9%**

Table 48.

Availability of national screening programmes for cancers of the cervix, colon and prostate

	Country	National screening programme for cervical cancer available	Initial screening method			Type of programme		National screening programme avaialable	
			HPV test	PAP smear	Visual inspection	Opportunistic	Organized population-based	Colon cancer	Prostate cancer
Group 1	Bahrain	1		1			1		
	Kuwait							1	1
	Oman							1	
	Qatar	1		1		1		1	
	Saudi Arabia								
	United Arab Emirates	1		1			1	1	
	Total	**50%**	**0%**	**50%**	**0%**	**16.7%**	**33.3%**	**66.7%**	**16.7%**
Group 2	Egypt								
	Iran (Islamic Republic of)	1	1				1	1	
	Iraq	1			1	1			
	Jordan								
	Lebanon								
	Libya								
	Morocco	1			1		1		
	Syrian Arab Republic	1		1			1		
	Tunisia	1		1		1		1	
	Palestine								
	Total	**50%**	**10%**	**20%**	**20%**	**20%**	**30%**	**20%**	**0%**
Group 3	Afghanistan								
	Djibouti	1		1			1		
	Pakistan								
	Somalia								
	Sudan								
	Yemen								
	Total	**16.7%**	**0%**	**16.7%**	**0%**	**0%**	**16.7%**	**0%**	**0%**
Eastern Mediterranean Region		**40.9%**	**4.5%**	**27.3%**	**9.1%**	**13.6%**	**27.3%**	**27.3%**	**4.5%**

A significant number of countries of the Region (68.2%) reported that early detection of breast cancer was integrated in primary health care services, but less than half of the countries reported such integration for cancers of the cervix, colon and prostate. In a comparison of the 2015 and 2017 country capacity survey findings, the availability of primary health care service integration of early detection of colon cancer has risen in Group 2 countries from 10% in 2015 to 30% in 2017, but fallen sharply in Group 1 countries over the same period from 100% in 2015 to 50%. The integration of early detection of breast, cervix, colon and prostate cancers at the primary care level was notably completely unavailable in Group 3 countries (Table 49).

Table 49.

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

		Early detection of the following cancers by means of rapid identification of the first symptoms is integrated into primary health care services			
	Country	Breast	Cervix	Colon	Prostate
Group 1	Bahrain	1	1		
	Kuwait	1	1	1	1
	Oman	1			
	Qatar	1	1	1	
	Saudi Arabia	1			
	United Arab Emirates	1	1	1	
	Total	**100%**	**66.7%**	**50%**	**16.7%**
Group 2	Egypt	1			
	Iran (Islamic Republic of)	1	1	1	
	Iraq	1	1		
	Jordan	1			
	Lebanon	1	1	1	
	Libya	1			
	Morocco	1	1		
	Syrian Arab Republic	1	1		
	Tunisia	1	1	1	
	Palestine				
	Total	**90%**	**60%**	**30%**	**0%**
Group 3	Afghanistan				
	Djibouti				
	Pakistan				
	Somalia				
	Sudan				
	Yemen				
	Total	**0%**	**0%**	**0%**	**0%**
Eastern Mediterranean Region		**68.2%**	**45.5%**	**27.3%**	**4.5%**

The results of the 2017 country capacity survey were almost identical to those of the 2015 survey; in 2017, 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 50).

Table 50.

Implementation of national HPV vaccination programmes

	Country	Implementation of national HPV vaccination programme
Group 1	Bahrain	
	Kuwait	
	Oman	
	Qatar	
	Saudi Arabia	
	United Arab Emirates	1
	Total	**16.7%**
Group 2	Egypt	
	Iran (Islamic Republic of)	
	Iraq	
	Jordan	
	Lebanon	
	Libya	1
	Morocco	
	Syrian Arab Republic	
	Tunisia	
	Palestine	
	Total	**10%**
Group 3	Afghanistan	
	Djibouti	
	Pakistan	
	Somalia	
	Sudan	
	Yemen	
	Total	**0%**
	Eastern Mediterranean Region	**9.1%**

The regional average availability of the 14 essential noncommunicable disease medicines at the primary care facilities of the public health sector was 9.2/14. The medicines least available were oral morphine with 9% availability (available only in Syria and Tunisia) and steroid inhaler with 59% availability (available in 13 countries). The availability of the 14 essential medicines at the public sector primary care level was highest in Group 1 countries: 12.5/14, followed by 10.7/14 in Group 2 countries and 3.3/14 in Group 3 countries (Table 51).

A comparison of the regional average availability of essential noncommunicable disease medicines at the primary care facilities of the public health sector in 2013, 2015 and 2017 are shown in Figure 24. (It should be noted in this context that there were ten essential noncommunicable disease medicines in 2013, 12 in 2015, and 14 in 2017.)

With regard to the availability of the ten essential noncommunicable disease medicines at primary care facilities of the public health sector whose availability data appears in the 2013, 2015, and 2017 regional surveys, there was a universal decrease in availability of these medicines (except for metformin) in the period between 2013 and 2017. Medicines whose availability has decreased most sharply include: oral morphine (from 59% in 2013 to 4.5% in 2017); steroid inhaler (from 82% in 2013 to 59% in 2017); and statins (from 77% in 2013 to 59% in 2017). However, the availability of some these medicines has relatively increased in the period between 2015 and 2017. These include insulin (from 68% in 2015 to 73% in 2017); metformin (from 82% in 2015 to 86% in 2017); ACE inhibitors (from 73% in 2015 to 77% in 2017); Beta Blockers (from 68% in 2015 to 77% in 2017); statins (from 50% in 2015 to 59% in 2017); and steroid inhalers (from 55% in 2015 to 59% in 2017).

Table 51.

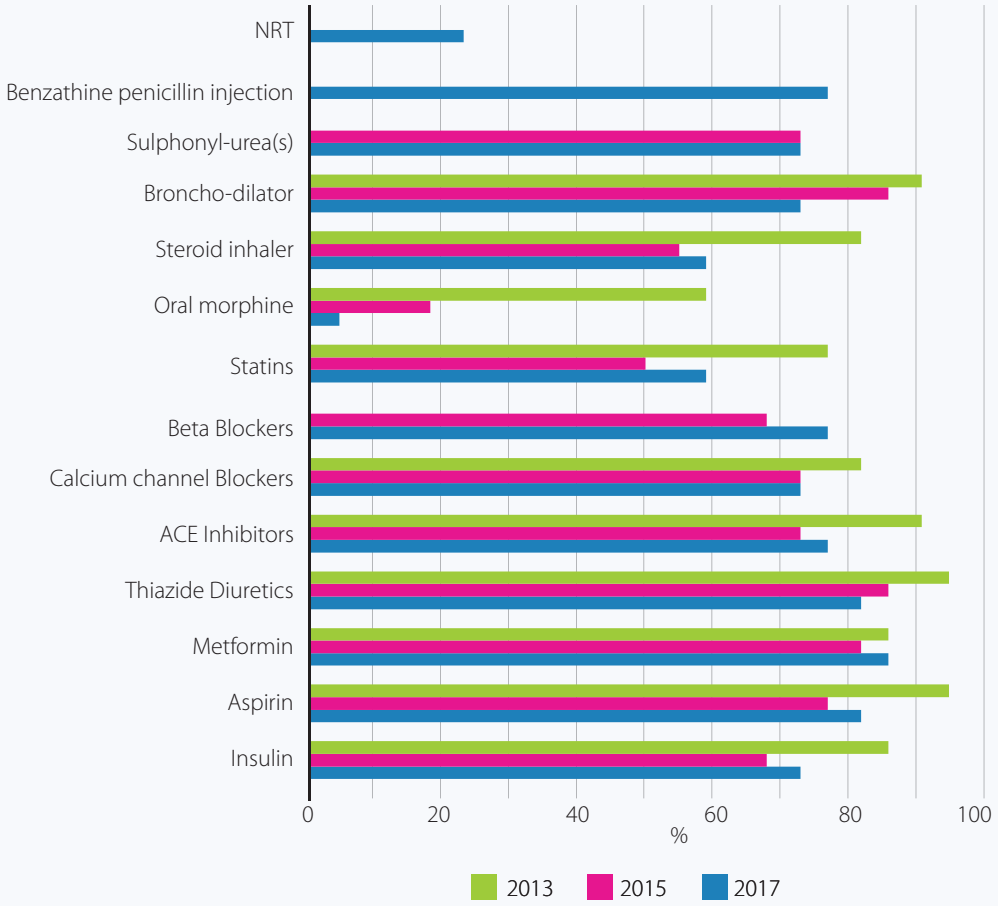
Availability of the 14 essential noncommunicable disease medicines at primary health care facilities of the public health sector

	Country	Insulin	Aspirin	Metformin	Thiazide diuretics	ACE inhibitors	Calcium channel blockers	Beta blockers	Statins	Oral morphine	Steroid inhaler	Broncho-dilator	Sulphonylurea(s)	Benzathine penicillin injection	NRT	Total number of medicines available (out of 14)
Group 1	Bahrain	1	1	1	1	1	1	1	1		1	1	1	1	1	13
	Kuwait	1	1	1	1	1	1	1	1		1	1	1	1		12
	Oman	1	1	1	1	1	1	1	1		1	1	1	1		12
	Qatar	1	1	1	1	1	1	1	1		1	1	1	1	1	13
	Saudi Arabia	1	1	1	1	1	1	1	1		1	1	1	1		12
	United Arab Emirates	1	1	1	1	1	1	1	1		1	1	1	1	1	13
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**0%**	**100%**	**100%**	**100%**	**100%**	**50%**	**12.5***
Group 2	Egypt		1	1	1	1	1	1				1	1	1		9
	Iran (Islamic Republic of)	1	1	1	1	1	1	1	1		1	1	1	1		12
	Iraq	1	1	1	1	1	1	1	1		1	1	1	1	1	13
	Jordan	1	1	1	1	1	1	1	1		1	1	1	1		12
	Lebanon	1	1	1	1	1	1	1	1		1	1	1	1		12
	Libya	1		1		1							1			4
	Morocco	1	1	1	1	1	1		1		1	1		1		10
	Syrian Arab Republic	1	1	1	1	1	1	1	1		1	1	1	1		12
	Tunisia	1	1	1	1	1	1	1				1		1	1	10
	Palestine	1	1	1	1	1	1	1	1	1	1	1	1	1		13
	Total	**90%**	**90%**	**100%**	**90%**	**100%**	**90%**	**80%**	**70%**	**10%**	**70%**	**90%**	**80%**	**90%**	**20%**	**10.7***
Group 3	Afghanistan		1													
	Djibouti	1		1	1	1	1	1				1	1	1		9
	Pakistan		1	1	1			1								4
	Somalia		1	1	1			1					1	1		6
	Sudan															0
	Yemen															0
	Total	**16.7%**	**50%**	**50%**	**50%**	**16.7%**	**16.7%**	**50%**	**0%**	**0%**	**0%**	**16.7%**	**33%**	**33%**	**0%**	**3.3***
Eastern Mediterranean Region		**72.7%**	**81.8%**	**86.3%**	**81.8%**	**77.2%**	**72.7%**	**77.2%**	**59%**	**4.5%**	**59%**	**72.7%**	**72.7%**	**77.3%**	**22.7%**	**9.2***

* = average number

Fig. 24.

Comparision of regional average availability of essential noncommunicable disease medicines at primary health care facilities of the public health sector in 2013, 2015, and 2017



Regional average availability of specific procedures for noncommunicable disease management in public health systems varied from 54.5% for renal replacement by transplantation, to 81.8% for renal replacement therapy by dialysis. Availability of such procedures was lowest in Group 3 countries. In addition, renal transplantation, coronary bypass, and stenting were completely unavailable in Group 3 countries (Table 52). A comparison of regional average availability of these procedures in public health systems in 2015 and 2017 is illustrated in Figure 25.

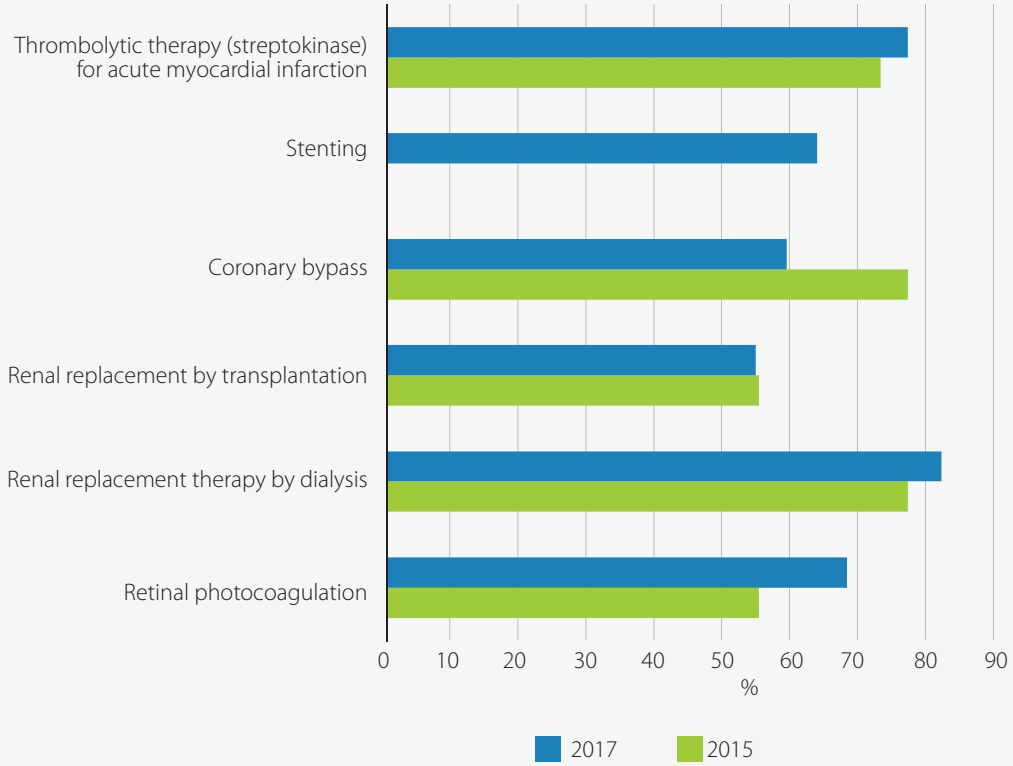
Table 52.

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

	Country	Availability of procedure for treating noncommunicable diseases in public health systems					
		Retinal photocoagulation	Renal replacement therapy by dialysis	Renal replacement by transplantation	Coronary bypass	Stenting	Thrombolytic therapy (streptokinase) for acute myocardial infarction
Group 1	Bahrain	1	1	1	1	1	1
	Kuwait	1	1	1	1	1	1
	Oman	1	1	1	1	1	1
	Qatar	1	1	1	1	1	1
	Saudi Arabia	1	1				1
	United Arab Emirates	1	1	1	1	1	1
	Total	**100%**	**100%**	**83.3%**	**83.3%**	**83.3%**	**100%**
Group 2	Egypt	1	1	1	1	1	1
	Iran (Islamic Republic of)	1	1	1	1	1	1
	Iraq	1			1	1	1
	Jordan	1	1	1	1	1	1
	Lebanon		1			1	1
	Libya	1	1				1
	Morocco	1	1	1	1	1	1
	Syrian Arab Republic		1	1	1	1	1
	Tunisia	1	1	1	1	1	1
	Palestine	1	1	1	1	1	
	Total	**80%**	**90%**	**70%**	**80%**	**90%**	**90%**
Group 3	Afghanistan						
	Djibouti		1				1
	Pakistan	1	1				1
	Somalia						
	Sudan						
	Yemen		1				
	Total	**16.7%**	**50%**	**0%**	**0%**	**0%**	**33.3%**
Eastern Mediterranean Region		**68.2%**	**81.8%**	**54.5%**	**59.1%**	**63.6%**	**77.3%**

Fig. 25.

Comparison of regional average availability of specific procedures for treating noncommunicable diseases in public health systems, 2015–2017



Availability of cancer diagnosis and treatment services in the public sector was relatively high in the Region, ranging between 68.2% in Group 3 countries and 90.9% in Group 1 countries. In countries in Groups 1 and 2, the availability of such services in the public sector ranged between 80% and 100%, but dropped dramatically in Group 3 countries for some services such as radiotherapy, which was only available in 16.7% of countries in this group (Table 53).

Table 53.

Availability of cancer diagnosis and treatment services in the public sector

	Country	Availability of cancer diagnosis and treatment services in the public sector				
		Cancer centres or cancer departments at tertiary level	Pathology services (laboratories)	Cancer surgery	Subsidized chemotherapy	Radiotherapy
Group 1	Bahrain	1	1	1	1	1
	Kuwait	1	1	1	1	1
	Oman	1	1	1	1	1
	Qatar	1	1	1	1	1
	Saudi Arabia	1	1	1	1	1
	United Arab Emirates	1	1	1	1	1
	Total	**100%**	**100%**	**100%**	**100%**	**100%**
Group 2	Egypt	1	1	1	1	1
	Iran (Islamic Republic of)	1	1	1	1	1
	Iraq	1	1	1	1	1
	Jordan	1	1	1	1	1
	Lebanon	1	1	1	1	
	Libya	1	1	1	1	1
	Morocco	1	1	1	1	1
	Syrian Arab Republic	1	1	1	1	1
	Tunisia	1	1	1	1	1
	Palestine	1	1	1	1	
	Total	**100%**	**100%**	**100%**	**100%**	**80%**
Group 3	Afghanistan					
	Djibouti	1	1	1		
	Pakistan	1	1	1	1	
	Somalia					
	Sudan	1	1			
	Yemen	1	1		1	1
	Total	**66.7%**	**66.7%**	**33.3%**	**33.3%**	**16.7%**
Eastern Mediterranean Region		**90.9%**	**90.9%**	**81.8%**	**81.8%**	**68.2%**

Palliative care for patients with noncommunicable diseases was available in only three countries of the Region: Bahrain in Group 1, Tunisia in Group 2, and Yemen in Group 3 (Table 54). Since the 2015 country capacity survey was carried out, there has been a slight regional decrease in the availability of palliative care in community or home-based care systems.

Table 54.

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

Country		Availability of palliative care for patients with noncommunicable diseases in public health systems	
		In primary health care	In community or home-based care
Group 1	Bahrain		1
	Kuwait		
	Oman		
	Qatar		
	Saudi Arabia		
	United Arab Emirates		
	Total	**0%**	**16.7%**
Group 2	Egypt		
	Iran (Islamic Republic of)		
	Iraq		
	Jordan		
	Lebanon		
	Libya		
	Morocco		
	Syrian Arab Republic		
	Tunisia	1	1
	Palestine		
	Total	**10%**	**10%**
Group 3	Afghanistan		
	Djibouti		
	Pakistan		
	Somalia		
	Sudan		
	Yemen	1	
	Total	**16.7%**	**0%**
Eastern Mediterranean Region		**9.1%**	**9.1%**

Less than half of the countries (40.9%) reported that greater than 50% of primary health care facilities offered cardiovascular risk stratification for the management of patients at high risk to prevent heart attacks and strokes. The majority of those countries were in Group 1 (80% of the Group 1), followed by Group 2 (40% of Group 2). None of these countries were in Group 3. A larger proportion of countries (77.3%) reported the availability of care for acute stroke patients: all countries in Group 1, 90% of countries in Group 2 and 33.3% of countries in Group 3.

A regional average of 63.6% of countries reported the availability of rehabilitation services for stroke patients, and a country group availability distribution pattern similar to that for cardiovascular risk stratification was observed for this type of care. Only Bahrain reported the availability of a register of patients who have had rheumatic fever and rheumatic heart disease, and systems for follow-up/recall to deliver long-term penicillin prophylaxis (Table 55, Figure 26).

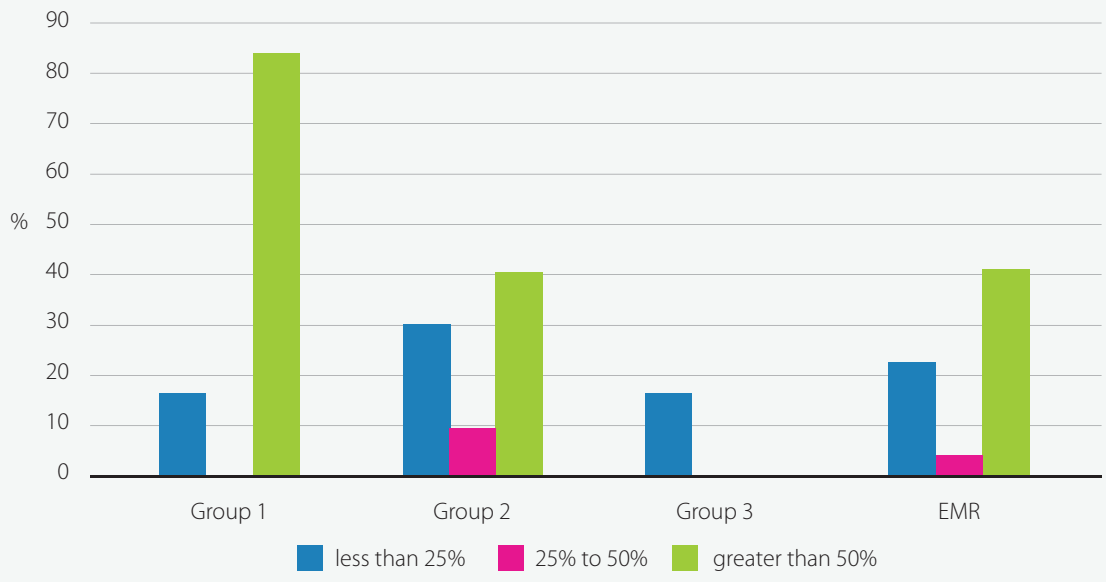
Table 55.

Availability of services for patients at high risk to prevent heart attacks and strokes in public health systems

	Country	Proportion of primary health care facilities offering cardiovascular risk stratification for the management of patients at high risk to prevent heart attacks and strokes			Provision of care for acute stroke patients	Rehabilitation for stroke patients	A register of patients who have had rheumatic fever and rheumatic heart disease	Systems for follow-up/recall to deliver long-term penicillin prophylaxis
		Less than 25%	25% to 50%	Greater than 50%				
Group 1	Bahrain			1	1	1	1	1
	Kuwait			1	1	1		
	Oman			1	1	1		
	Qatar	1			1	1		
	Saudi Arabia			1	1	1		
	United Arab Emirates			1	1	1		
	Total	**16.7%**	**0%**	**83.3%**	**100%**	**100%**	**16.7%**	**16.7%**
Group 2	Egypt				1	1		
	Iran (Islamic Republic of)			1	1	1		
	Iraq	1			1			
	Jordan			1	1	1		
	Lebanon			1	1			
	Libya	1			1			
	Morocco	1			1	1		
	Syrian Arab Republic		1		1	1		
	Tunisia				1	1		
	Palestine			1				
	Total	**30%**	**10%**	**40%**	**90%**	**60%**	**0%**	**0%**
Group 3	Afghanistan	1						
	Djibouti				1	1		
	Pakistan							
	Somalia							
	Sudan				1	1		
	Yemen							
	Total	**16.7%**	**0%**	**0%**	**33.3%**	**33.3%**	**0%**	**0%**
Eastern Mediterranean Region		**22.7%**	**4.5%**	**40.9%**	**77.3%**	**63.6%**	**4.5%**	**4.5%**

Figure 26.

Percentage comparison of primary health care facilities offering cardiovascular risk stratification for the management of patients at high risk to prevent heart attacks and strokes, by country group



Discussion

The findings of the 2017 country capacity survey reveal a significant improvement in the achievement levels of all 19 progress indicators/sub-indicators compared to the results reported in the 2015 country capacity survey. The only indicator that witnessed a reduction in achievement level in 2017 was Progress indicator 2: Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis. The overall percentage of countries fully achieving this indicator fell from 4.5% in 2015 to 0% in 2017.

In 2017, the progress indicators most fully achieved by countries were 1, 6b, 7b, 8, and 6a. Half, or slightly more than half, of the countries have fully achieved these indicators/sub-indicators (between 50% and 55%). The progress indicators/sub-indicators with the lowest achievement level were Indicator 2, Indicator 3, and Sub-indicators 5a, e, and c.

Despite the progress observed in the 2017 country capacity survey compared to the 2015 survey, the achievement level of many progress indicators and sub-indicators was poor, with full achievement levels below 50%. A discussion of the achievement levels of the 10 progress indicators targeting the areas of intervention of governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care is detailed below.

Governance

The Region has witnessed general progress in noncommunicable disease governance since the 2015, with improvements both in terms of the degree of infrastructure in place for noncommunicable disease governance and the development of policies and programmes tackling noncommunicable diseases and their risk factors.

Leadership and planning

The majority of countries (91%) reported the presence of a unit/branch/department within the ministry of health responsible for noncommunicable diseases, with one or more full time professional staff. However, the proportion of countries reporting the existence of a unit/branch/department at the ministry of health responsible for noncommunicable diseases has remained stagnant at 91% since 2013. This indicates that the high level of commitment of countries needs to be revived to maintain a momentum for noncommunicable disease prevention and control in the Region.

Less than half of the countries reported the presence of an operational national multisectoral commission, agency or mechanism to oversee noncommunicable disease engagement, policy coherence and accountability of sectors beyond health. The highest achievement levels in this regard were in Group 1 countries, followed by countries in Group 2 and lastly by those in Group 3. This implies that Group 1 countries have a stronger government leadership capacity, which allows for stricter adherence to regulations and higher levels of governmental control over health care. Furthermore, country group analysis of this information reveals clear improvement in national capacity to carry out and operationalize collaboration within a multisectoral mechanism or partnerships, and the level of health system development. Compared to the 2015 survey results, despite a reduction in the number of countries reporting the existence of a national multisectoral body to oversee noncommunicable disease engagement, policy coherence and accountability in sectors beyond health from 15 countries in 2015 to 12 countries in 2017, the number of countries reporting that these bodies were operational has increased since 2015.

The majority of countries reported the inclusion of noncommunicable disease prevention and control in their national health plan (81.8%), and a slightly lower proportion (72.7%) reported that noncommunicable disease prevention and control was also included in their national development agenda. Overall, 59.1% and 68.2% of countries reported the presence of time-bound national targets for noncommunicable diseases based on the nine global targets of the WHO Global monitoring framework and national indicators for these targets based on the Global monitoring framework respectively; these figures represented a significant increase in achievement level in this regard across all country groups. All Group 1 countries reported the presence of time-bound national targets for noncommunicable diseases based on the nine global targets of the Global monitoring framework compared to 60 % in Group 2 and 16.7% in Group 3 (Sudan). There was a notable increase in the number of countries reporting that noncommunicable diseases were included in their current national health plan in 2017 (81.8%) compared to 2015 (68%).

A substantial number of countries (18 countries, 81.8%,) reported having an integrated national noncommunicable disease policy, strategy or action plan; exceptions were Syrian Arab Republic, Djibouti, Pakistan, and Somalia (half of Group 3 countries). However, only 55% of countries reported that the policy, strategy or action plan was operational. A noncommunicable disease policy, strategy or action plan was present and operational in all Group 1 countries (with the exception of Oman, where the national noncommunicable disease policy, strategy or action plan was under development), 60% of Group 2, and in only 16.7% of Group 3 countries. It is worth mentioning that a larger proportion of countries – 55% – reported that their policy, strategy or action plan were operational in 2017 compared to 2015 (36%). The national policy, strategy or action plan integrated the three key risk factors (unhealthy diet, physical inactivity, and tobacco) in 82% of countries, while national policy,

strategy or action plan coverage of the four major noncommunicable diseases ranged between 63.6% and 77.3% in countries of the Region. . Measures to reduce the harmful use of alcohol were integrated in the noncommunicable disease policy, strategy or action plan of only one third of the countries (27%). This could be attributed to two factors: firstly, harmful use of alcohol surveillance is conducted in only 59% of the countries, and hence the magnitude of the harmful use of alcohol is not well established; and secondly, the stigma associated with alcohol use in many Islamic countries may hinder policy makers from integrating harmful use of alcohol in national polices and strategies.

Funding

Regarding the funding allocated in the government budget for noncommunicable diseases and their risk factors, the majority of countries reported that funding is allocated to the areas of noncommunicable disease health care and treatment (90%), while the lowest funding allocations were reported for research and palliative care (50–54.5%). This confirms that a large number of countries of the Region have a high degree of allocative inefficiency, a key characteristic of health system financing in developing countries, whereby more resources are allocated to curative care and fewer for promotional and preventive services. This situation is also supported by other findings in this survey which indicate that only 9% of countries (Islamic Republic of Iran and Morocco) reported that the fiscal interventions are earmarked for health promotion and health service provision.

Regarding the major sources of regular funding for noncommunicable diseases and their risk factors, government revenues were the most widespread source of funding for noncommunicable diseases in all 3 Groups (81.8%). However, it should be noted that international donation was reported as a source of noncommunicable disease funding in 50% of Group 3 countries compared to 30% in Group 2 and 16.7% in Group 1 (Qatar). Two countries in Group 3 – Afghanistan and Yemen – did not report any source of regular funding for noncommunicable diseases and their risk factors. These findings highlight the financial constraints facing these countries in their battle to prioritize noncommunicable disease prevention and control.

Additional fiscal interventions to support noncommunicable disease activities were also reported by many countries. The most widespread fiscal intervention was taxation on tobacco, which was reported by almost all of the countries of the Region (21/22). Other fiscal interventions such as taxation on sugar-sweetened beverages, taxation incentives to promote physical activity, and taxation of unhealthy foods were not reported by any of the countries.

These findings show that the governments of countries of the Region should seek to allocate a greater share of public funds to noncommunicable disease prevention and control. In addition, they reveal that governments should further explore the many other ways to boost fiscal capacity, which include improving tax compliance and the efficiency of revenue collection, increasing tax rates and broadening the tax base, introducing social health insurance contributions for health services, and introducing excise taxes on tobacco, alcohol and unhealthy foods and beverages. Increased revenue from taxation and long-term economic growth, coupled with commitments to proportionally increase the amount of government expenditure earmarked for noncommunicable diseases, represents the most sustainable way of financing noncommunicable disease prevention and control in low- and middle-income countries. Furthermore, the many sources of external financing, including overseas development assistance, development loans, engaging the private sector, and innovative financing mechanisms such as voluntary contributions, compulsory levies or taxes, and financial mechanisms and facilities are also areas that governments of countries of the Region could engage with to fund noncommunicable disease activities. (8)

Governance: summary of findings

1. Countries of the Region have become increasingly committed to the prevention and control of noncommunicable diseases since 2015. This was demonstrated by the significant increase in the number of countries which have included noncommunicable diseases in their current national health plans and development agenda, set of time-bound national targets for noncommunicable diseases based on the nine global targets from the WHO-GMF, and have an integrated national noncommunicable disease policy, strategy or action plan.
2. The Governance of noncommunicable diseases remains a challenge in the Region. The number of countries with a unit/branch/department for noncommunicable diseases has remained stable since 2013. The most commonly funded noncommunicable disease-related activities were in the areas of noncommunicable disease treatment and health care, while earmarked taxes for the funding of noncommunicable disease health promotion and health service provision were rarely utilized by countries. A multisectoral commission for noncommunicable diseases was operational in less than half of the countries, and similarly an integrated national noncommunicable disease policy, strategy or action plan was operational in only half of the countries.

3. Funding for noncommunicable disease activities relied heavily on government revenues, and was adversely affected by allocative inefficiencies. Furthermore, securing funds for noncommunicative disease prevention and control was absent in half of the countries in Group 3.
4. Group 3 countries are currently lagging behind Group 1 and Group 2 countries in their achievement of many of the indicators required to meet national commitments related to the area of governance.

Prevention and reduction of risk factors

Vertical programmes

The countries of the Region reported that the availability of vertical programmes for noncommunicable diseases and their major risk factors has been relatively stable since 2015, with notable inequalities observed between the 3 country groups. The proportion of countries reporting the availability of vertical programmes for noncommunicable diseases ranged between 18% for chronic respiratory diseases and 64% for cancers. Similarly, the proportion of countries with vertical programmes for noncommunicable disease risk factors ranged between 23% for the harmful use of alcohol to 68% for tobacco use. This underscores the need for more targeted efforts to address noncommunicable diseases and their risk factors through vertical programmes if these are not integrated in one national policy, strategy or action plan.

Policy and implementation

Almost one third of countries (32%) reported the presence of policies to reduce the impact on children of the marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt. This is nearly double the proportion of countries with such policies in place in 2015 (18%). The 2017 survey revealed similar findings with respect to the presence of national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply, with 55% of countries reporting the presence of such policies in 2017 compared to only 23% in 2015. The proportion of countries which had policies to reduce population salt/sodium consumption witnessed a less marked increase, with 63.6% of countries reporting such policies in 2017 compared to 48% in 2015.

It is important to point out that the proportion of countries reporting that these policies are in the form of government legislation rather than voluntary or self-regulating policies has increased remarkably since 2015. For example, none of the countries reported that policies to reduce the impact on children of the marketing of foods and non-alcoholic beverages were in the form of government legislation in 2015, compared to 32% of countries in 2017. Also, the number of countries reporting that policies to limit saturated fatty acids in the food supply and reduce population salt/sodium consumption are in the form of government legislation nearly doubled between 2015 and 2017. This reflects enhanced political commitment to reducing the impact of unhealthy diets as a major risk factor contributing to the elevated morbidity and mortality rates due to noncommunicable diseases in the Region.

Furthermore, there were notable differences in the extent of the presence of these policies between the 3 country groups. For example, the presence of policies to reduce population salt/sodium consumption were reported by 100% of Group 1 countries, 70% of Group 2 countries and by only 16.7% (Afghanistan) of Group 3 countries.

More than half of the countries reported the implementation of both diet and physical activity campaigns in the past 5 years (both campaigns were implemented by 54.5% of countries). None of Group 3 countries reported the implementation of physical activity campaigns, and only Afghanistan reported the implementation of diet campaigns in the past 5 years.

Prevention and reduction of risk factors: summary of findings

1. There is no significant difference in the regional average number of vertical programmes addressing noncommunicable diseases and their major risk factors in 2017 compared to 2015.
2. Since 2015, there has been a significant increase in the proportion of countries adopting policies to reduce unhealthy diets as well as the proportion reporting that these policies form part of government legislation and are not voluntary measures. This not only underscores a high level of general commitment to addressing the burden of noncommunicable diseases in the Region, but also that governments in the Region are contributing to efforts in this regard.
3. There were notable differences in the extent of the presence of these policies in the three country groups, with Group 3 countries adopting the fewest number of policies.

Surveillance, monitoring and evaluation

Registration systems

The 2017 country capacity survey addressed the availability of three key registration systems (mortality, cancer and diabetes), in addition to a newly added inquiry about the availability of patient information systems.

The vast majority of countries reported the presence of a body responsible for the surveillance of noncommunicable diseases and their risk factors.

The proportion of countries reporting the presence of such registration systems did not differ greatly from the figures reported in the 2015 country capacity survey. Nearly 73% of countries reported the existence of a system for collecting mortality data by cause of death on a routine basis, while 86% and 41% of countries reported the presence of cancer and diabetes registries respectively in the 2017 survey, compared to 82% and 41% of countries respectively in 2015.

Although a system for collecting mortality data by cause of death on a routine basis is present in the majority of countries, accurate cause-specific mortality reporting remains a challenge in several countries in Group 3, where death certification is still poorly regulated, often being out of control and subject to under-reporting especially in private hospitals. In many developing countries, including those in the Region, civil registration and vital statistics systems are weak or nonexistent, a situation that WHO and its partners in the Member States are trying to alleviate with the establishment and/or strengthening of the "Civil registration and vital statistics programme" to help countries produce reliable data on mortality and the burden of diseases and improve their preparedness to confront among other health threats (9). Furthermore, according to the *World Health Statistics Quarterly* 2017, only around 28% of global deaths are reported by International Classification of Diseases (ICD) code, and even then many such deaths are assigned a garbage codes, leaving just 23% of deaths reported with precise and meaningful information on their cause. Assessing health system response to noncommunicable diseases is equally problematic. There is as yet no reliable information collected to specifically measure health system performance *(10)*.

As noted in earlier findings, there were clear disparities in the availability of such systems in Group 3 countries compared to the other country groups. For example, cancer registries were available in 100% of the countries in Groups 1 and 2 compared to Group 3 countries, where availability stood at only 50%.

While 68% of countries reported the presence of a patient information system, only 50% reported the availability of an electronic medical record, and an even lower proportion reported that system coverage was nationwide. (36%).

Population surveys

There was an increase in the number of adult surveys on noncommunicable disease risk factors reported in the 2017 survey compared to that of 2015. An average number of 7.2 surveys regarding the nine noncommunicable disease risk factors were conducted in 2017 compared to 6.3 surveys in 2015. The majority of countries reported conducting adult surveys on tobacco use (96%), while 86% or countries conducted surveys on low fruit and vegetable consumption, physical inactivity, overweight and obesity, raised blood glucose, and raised blood pressure. The risk factor least surveyed in the Region was salt intake (in only 50% of countries). The lack of adequate attention to salt/sodium intake in noncommunicable disease surveys calls for immediate remedial measures to fill in gaps in knowledge in light of the high prevalence of hypertension in the Region and the fact that salt/sodium reduction is included in the WHO Global monitoring framework and is among the nine voluntary global targets of the WHO Global action plan for the prevention and control of noncommunicable diseases 2013–2020, which countries are urged to achieve by 2025.

As previously noted, Group 3 countries were less likely to conduct such surveys compared to Group 1 and 2. Surveys on low fruit and vegetable consumption, physical inactivity, overweight and obesity, raised blood glucose, and raised blood pressure were conducted by only half of Group 3 countries compared to 100% of countries in Groups 1 and 2.

Similarly, the findings of the 2017 survey show that the number of adolescent surveys on noncommunicable disease risk factors conducted in the Region has significantly increased in 2017 compared to the findings of the 2015 survey. The regional average number of surveys conducted for the five risk factors in 2017 was four compared to 2.7 in 2015. While the number of surveys conducted on the harmful use of alcohol increased in 2017 relative to 2015, implementation of this activity generally remained low, with only 32% of countries of the Region conducting this type of survey).

Surveillance, monitoring and evaluation: summary of findings

1. Infrastructure for the surveillance of noncommunicable diseases and their risk factors is widely available in the Region; 91% of countries

reported the presence of a body responsible for noncommunicable disease surveillance.

2. There has been no visible progress in the Region with respect to the three key registries (mortality, cancer and diabetes) in 2017 compared to 2015. This is reflected in the achievement levels of countries with regard to the relevant progress indicators. Improvement of registration systems needs to be achieved as part of health system reform to achieve Universal Health Coverage, particularly in those countries with less developed health systems (Group 3 countries).
3. In a comparison of the results of the 2013, 2015 and 2017 regional surveys regarding the number of adolescent and adult surveys on noncommunicable disease risk factors carried out, the 2017 regional survey showed a significant increase in the total number of adolescent and adult surveys. With the exception of surveys on alcohol and salt/sodium, more than 80% of countries have conducted noncommunicable disease risk factor surveys at regular intervals. This indicates that countries of the Region have made significant progress in building their capacities in the area of surveillance related to noncommunicable diseases and their risk factors.

Health care

The 2017 country survey explored the capacities of health systems to carry out noncommunicable disease prevention, early detection, and treatment within the primary health care sector.

Primary care

Diabetes, cancers and cardiovascular diseases were the diseases most commonly covered by evidence-based national guidelines/protocols/standards for the management and referral of major noncommunicable disease cases through a primary care approach, with a regional coverage rate of between 63.6% and 81.8%. The 2017 survey results revealed a slight increase in the number of countries reporting the availability of evidence-based national guidelines/protocols/standards compared to the results of the 2015 survey, with the exception of guidelines for cardiovascular diseases. This could be attributed to the relative stability in the Region which enabled countries to more fully develop evidence-based guidelines (the increase was most evident in countries in Group 2).

More than half of the countries of the Region (59.4%) reported the availability of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases at primary care facilities of the public sector. However, a larger proportion (71%) reported the availability of the 13 basic technologies at primary care facilities of the private sector compared to the public sector, where only59.4% of countries reported the availability of such technologies. The higher level of availability of the basic technologies in the private sector signifies the predominance of the private sector in the provision of basic health services in countries of the Region. This might be explained by the reduced quality of health care services provided by public sector and consequently the increased demand for health services provided by the private sector.

Consistent with earlier findings, the number of available technologies was highest in Group 1 countries, followed by Group 2, and lastly by Group 3 countries. The regional average number of available technologies was higher in 2017 compared to 2015 in both the public and private sectors (7.7/13 and 9.2/13 in the public and private sectors respectively in 2017 compared to 6.4/13 and 6.8/13 in the public and private sectors respectively in 2015).

Cancer diagnosis and management

Breast cancer screening programmes were available in the majority of countries of the Region (77.3%). However, less than half of the countries reported the availability of screening programmes for cervical cancer (40.9%), while 27.3% reported the availability of screening programmes for colon cancer and only 4.5% (Kuwait) reported the availability of screening programmes for prostate cancer.

For all types of cancer screened, the largest proportion of countries providing such screening was in Group 1, followed by Group 2, with the lowest proportion of screening provision in Group 3. Compared to the 2015 survey results, the proportion of countries reporting the availability of screening programmes for breast and cervical cancers increased in 2017 (breast cancer: 68%, 77%, and cervical cancer: 23%, 40.9% in 2015 and 2017 respectively).

A significant number of countries of the Region (68.2%) reported that capacities for the early detection of breast cancer were integrated into primary health care services, but less than half of the countries reported such integration for cancers of the cervix, colon and prostate. Capacities for the early detection of breast, cervix, colon and prostate cancers integrated at the primary care level were notably lacking in Group 3 countries.

Similar to the results of the 2015 survey, 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.

Noncommunicable disease treatment and essential medicines

With regard to the availability of the 14 essential noncommunicable disease medicines at primary care facilities of the public health sector whose availability data appears in the 2013, 2015 and 2017 regional surveys, there was a universal decrease in the availability of these medicines (except for metformin) in the period between 2013 and 2017. However, a slight increase in the availability of some of the essential medicines was observed between 2015 and 2017. The decline in the availability of the noncommunicable disease medicines in 2015 was explained as being due to the fact that more than half of the countries of the Region were in conflict and crisis situations at that time.

The availability of the 14 essential medicines at primary care facilities of the public sector was highest in Group 1 countries, decreased in Group 2 countries, and was lowest in Group 3 countries.

The availability of specific procedures for noncommunicable disease management in publicly funded health systems in countries of the Region varied from 54.5% for renal replacement by transplantation to 81.8% for renal replacement therapy by dialysis. The availability of such procedures was lowest in Group 3 countries. In addition, renal transplantation, coronary bypass and stenting procedures were reported to be completely unavailable in Group 3 countries.

The availability of cancer diagnosis and treatment services in the public sector was relatively high in the Region, ranging between 68.2% and 90.9%. In Group 1 and Group 2 countries, the availability of such services in the public sector ranged between 80% and100%, but dropped to 16.7% for some services such as radiotherapy in Group 3 countries.

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; this type of care was available in only three countries of the Region: Bahrain in Group 1, Tunisia in Group 2 and Yemen in Group 3.

Less than half of the countries of the Region (40.9%) reported that more than 50% of primary health care facilities offered cardiovascular risk stratification for the management of patients at high risk to prevent heart attacks and strokes. The majority of these countries were in Group 1 (80% of Group 1), while 40% of Group 2 countries and no countries in Group 3 reported such risk stratification coverage. A larger proportion of countries of the Region (77.3%) reported the availability of care for acute stroke patients, with all countries in Group 1, 90% of countries in Group 2 and 33.3% of countries in Group 3 reporting the availability of this type of care.

Only Bahrain reported the availability of a register of patients who have had rheumatic fever and rheumatic heart disease, and systems for follow-up/recall to deliver long-term penicillin prophylaxis.

Health care: summary of findings

1. There has been a slight increase in the noncommunicable disease services provided and integrated at primary health care level since the 2015 country capacity survey was carried out. This includes an increase in the availability of evidence-based guidelines for the management and referral of major noncommunicable disease cases, of the 13 basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases, of cancer screening programmes, and of capacities for the early detection of cancers.
2. The increased availability of the 13 basic technologies at primary care facilities was more evident in the private sector compared to the public sector.
3. There are significant differences in the availability of cancer screening programmes by cancer type in the Region. Breast cancer screening programmes were the screening programmes most available in the Region, while screening programmes for prostate cancer were the lease available (only available in Kuwait).
4. With regard to the availability of the 14 essential noncommunicable disease medicines at primary care facilities of the public health sector, there was a universal decrease in the availability of these medicines (except for metformin) in the period between 2013 and 2017. However, a slight increase in the availability of some of the essential medicines was observed between 2015 and 2017.
5. The availability of specific procedures for noncommunicable disease management in publicly funded health systems was lowest in Group 3 countries. In addition, renal transplantation, coronary bypass and stenting procedures were reported to be completely unavailable in Group 3 countries.
6. Palliative care for patients with noncommunicable diseases was available in only three countries of the Region: Bahrain in Group 1, Tunisia in Group 2 and Yemen in Group 3.
7. Less than half of the countries of the Region (40.9%) reported that more than 50% of primary health care facilities offered cardiovascular risk stratification for the management of patients at high risk to prevent heart attacks and strokes. The majority of these countries were in Group 1 (80% of Group 1, while 40% of Group 2 and no countries in Group 3 reported such risk stratification coverage.

Survey strengths and limitations

The strengths of the 2017 survey include the easy administration and accessibility of the questionnaire using the online tool, and the rigorous validation process implemented by the teams at WHO. The validation process included intensive review of the supporting documents as well as checking the consistency of responses with the 2015 survey. There was also a 100% response rate to the questionnaire from countries of the Region.

The limitations of the 2017 survey pertain mainly to the accuracy of the reporting process. For example, reporting depended on respondents' understanding of the survey questions, and given the number of different survey items, there was a risk of different respondents reporting on the same issues under different categories. Also, many data sources were dependent on focal points' knowledge, expertise and degree of liaison with other sectors; the fact that respondents may have been unaware of or been misinformed about relevant policies in their country or the degree to which these were implemented needs to be taken into account in the interpretation of results.

It should also be pointed that the criteria for many of the progress indicators has changed since the 2015 survey was carried out. The only progress indicators/subindicators that remain unchanged are: 1, 4, 5b, 5d, 6a–c, 7b, 7c, and 10. However, where the data sources have remained the same, 2017 is generally more stringent. Taking these points into consideration, the interpretation of comparisons of the present survey with that of 2015 should therefore be made with caution.

Recommendations and the way forward

Based on the findings of this survey, the following specific recommendations are proposed to enhance national efforts for the prevention and control of noncommunicable diseases.

- The high level of commitment of countries of the Region needs to be revived to maintain a momentum for noncommunicable disease prevention and control in the Region.
- Inadequate financing for national noncommunicable disease programmes and interventions is a major impediment in implementing the noncommunicable disease noncommunicable disease road map in many countries of the Region, and calls for realistic approaches to address this gap through the mobilization of domestic resources, combined, in some cases, with increased external funding.
- Fiscal interventions, in particular taxation on sugar-sweetened beverages and foods high in fat/sugar/salt, taxation on unhealthy foods, and taxation to promote physical activity should be promoted and implemented.
- Earmarking taxes for health should be considered, particularly for the prevention and control of noncommunicable diseases. Increased revenue from taxation and long-term economic growth, coupled with commitments to proportionally increase the amount of government expenditure earmarked for noncommunicable diseases, represents the most sustainable way of financing noncommunicable disease prevention and control in low- and middle-income countries.
- More action is required to encourage all countries of the Region to set their time-bound national targets and enforce integrated policies/strategies/action plans for noncommunicable diseases and their risk factors.
- More efforts should be made to engage the whole-of-government and key sectors beyond health; such engagement is a prerequisite in developing national multisectoral noncommunicable disease responses, including the implementation of the "best buys" for noncommunicable diseases. Many countries are still struggling to achieve effective intersectoral action, and the commitment and engagement of other sectors like finance, planning, industry and agriculture remain weak. Difficulties in achieving effective intersectoral action are often based on perceived conflicts of interest and diverging policies.
- More focus should be placed on promoting the adoption and enforcement of government legislation 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 fatty acids from the food supply; and reduce population salt/sodium consumption.
- Noncommunicable disease surveillance, particularly the assessment of morbidity and cause-specific mortality, and the evaluation of health system performance, needs considerable strengthening. Risk factor surveys need to be conducted at regular intervals to determine trends. These challenges need to be addressed by most of the countries as part of efforts to strengthen the structure, functions and capacity of national health information and vital statistics systems *(11)*.
- Countries need to promote the development and implementation of national guidelines/

protocols/standards for noncommunicable disease management at the primary care level that target all noncommunicable diseases.

- The availability of essential medicines and basic technologies should be enhanced, particularly in the public sector.
- Strengthening health systems and national capacity in the four areas of commitment of the regional Framework for action (governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care, is crucial to the advancement of the agenda for the prevention and control of noncommunicable diseases in the Region, particularly in Group 3 countries.

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Annexes

Annex 1. Questionnaire

2017

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

Modules:

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

II Status of ncd-relevant policies, strategies and action plans

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

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

Purpose

- The purpose of this survey is to gauge your country 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

Additional information sources consulted:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 2

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

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

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

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

If at least one Yes to above questions:

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

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

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

taxation on 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) Are any of these funds earmarked for health promotion or health service provision?

◯ Yes ◯ No ◯ Don't Know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to MODULE II

4a) Indicate its stage:

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

If Operational or under development:

4b) Please provide name: .....

4c) Which of the following are members?

(Check all that apply)

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

IF "Private Sector" is one of the members:

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

◯ Yes ◯ No ◯ Don't Know

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

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

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

◯ Yes ◯ No ◯ Don't Know

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

◯ Yes ◯ No ◯ Don't Know

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

◯ Yes ◯ No ◯ Don't Know

If Yes:

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

◯ Yes ◯ No ◯ Don't Know

II a: Integrated policies, strategies, and action plans

3) Does your country have a national NCDs 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 specific key noncommunicable diseases

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 5

If yes:

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

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

4a) Write the title .....

4b) Indicate its stage:

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

If Operational:

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

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

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

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

IF NO: Go to Question 6

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

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

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

5a) Write the title .....

5b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 7

If yes:

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

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

6a) Write the title .....

6b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 8

If yes:

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

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

7a) Write the title .....

7b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 9

If yes:

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

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

8a) Write the title .....

8b) Indicate its stage:

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

If Operational:

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

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

9) Is there a policy, strategy, or action plan for 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

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

Please specify which NCD: .....

9a) Write the title .....

9b) Indicate its stage:

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

If Operational:

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

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

II c: Policies, action plans, strategies for NCD risk factors

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 13

If yes:

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

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

12a) Write the title .....

12b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 14

If yes:

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

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

13a) Write the title .....

13b) Indicate its stage:

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

If Operational:

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

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 15

If yes:

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

14a) Write the title .....

14b) Indicate its stage:

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

If Operational:

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

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

II d: Selected cost-effective policies for NCDs and related risk factors

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 16

If Yes:

15a) Indicate its stage:

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 17

If yes:

16a) Are the policies:

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

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

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

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

◯ Yes ◯ No ◯ Don't Know

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

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 18

17a) If yes, are the policies:

◯ Voluntary/self-regulating

◯ Government legislation

◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 19

18a) Are these targeted at:

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

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

◯ Voluntary/self-regulating

◯ Government legislation

◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 20

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

.....

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to MODULE III

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

.....

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

The questions in this module assess surveillance relating to the mortality, morbidity and risk factor reporting systems of each country and whether NCDs mortality, morbidity and risk factor data were included in their national health reporting systems. Responses to these questions enable reporting against NCDs 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?

.....

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 6

IF YES:

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

◯ Yes ◯ No ◯ Don't Know

5b) What is the coverage of the system?

◯ National (covers the whole population of the country)

◯ Subnational (covers only the population of a defined region or regions or only certain segments of the population)

◯ Don't know

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

◯ Yes ◯ No ◯ Don't Know

IF NO: Go to Question 7

6a) Year of last survey .....

6b) Coverage of last survey:

◯ National

◯ Subnational

◯ Don't know

III b: Risk factor surveillance

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

	7a) Harmful alcohol use	7b) Low fruit and vegetable consumption	7c) Physical inactivity	7d) 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) …………………………………

7e) Raised blood glucose/ diabetes	7f) Raised total cholesterol	7g) Raised blood pressure/ Hypertension	7h) Overweight and obesity	7i) Salt / Sodium intake
◯ Yes ◯ No ◯ Don't know **IF NO: Go to next column.** **IF YES:** i) Was it: ◯ Measured ◯ Self-reported ◯ Don't know ii) Was it: ◯ National ◯ Subnational ◯ Don't know	◯ 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

(continued)

7e) Raised blood glucose/ diabetes	7f) Raised total cholesterol	7g) Raised blood pressure/ Hypertension	7h) Overweight and obesity	7i) 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 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 NCDs Global Action Plan process indicators and UN High Level Meeting national commitment progress indicators.

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

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

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

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

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

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
Other cancer type(s) Specify: ◯ Yes ◯ No ◯ Don't know				

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

	Breast	Cervix	Colon	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

5) 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:

5a) Who is targeted by the programme?

◯ Girls aged ..... to .....

◯ Other (specify: .....)

◯ Don't know

5b) What year did the programme begin? .....

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

◯ Less than 10%

◯ 10% to 50%

◯ more than 50% but less than 70%

◯ 70% or more

◯ Don't know

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

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

Generic drug name	Availability*
6a) Insulin	
6b) Aspirin (100 mg)	
6c) Metformin	
6d) Thiazide Diuretics	
6e) ACE Inhibitors	
6f) Calcium channel Blockers	
6g) Beta Blockers	
6h) Statins	
6i) Oral morphine	
6j) Steroid inhaler	
6k) Bronchodilator	
6l) Sulphonylurea(s)	
6m) Benzathine penicillin injection	
6n) Nicotine Replacement Therapy	

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

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

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

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

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

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

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

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

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

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

PALLIATIVE CARE FOR PATIENTS WITH NCDS:

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

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

10a) In primary health care facilities:

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

10b) In community or home-based care:

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

CARDIOVASCULAR DISEASE:

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

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

If more than none:

11a) Which CVD risk scoring chart is used?

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

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

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

12a) Provision of care for acute stroke:

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

12b) Rehabilitation for stroke patients:

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

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

◯ Yes ◯ No ◯ Don't know

If NO::

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

◯ Yes ◯ No ◯ 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 diseases: A group of disorders of the heart and blood vessels that includes coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism.

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

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

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

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

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

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

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

Early detection/screening: Measures performed in order to identify individuals who have early stages of a disease (with apparent symptoms in the case of 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 programme who actually received the full dose(s) of vaccine.

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

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

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

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

Health care facility: Facilities which provide health services. They may include mobile clinics, pharmacies, laboratories, 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 and conditions. The exact make-up of a healthy, balanced diet will vary depending on the individual needs (for example, 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, and trade.

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

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

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

National focal point, unit or department:

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

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

National health reporting system, survey and surveillance:

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

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

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

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 disease prevention programmes across sectors and disciplines.

National policy, strategy, action plan:

***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.

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

***Action plan*:** A scheme or 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Public health sector: Publicly funded health care sector.

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

Risk factors associated with noncommunicable diseases: The four main risk factors for noncommunicable diseases 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, that is, less than 1% of the total national population, are included in a sample registration system that provides a reasonably reliable picture of the national pattern of vital events at a cost that is feasible and reasonable.

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

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

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

thanks to the programme in the past 2 years, divided by the total number of women aged 50 to 60 in the country.)

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

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

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

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

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

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

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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