Appendix 2: Proposed amendments for the MANA Dashboard indicators

With the completion of three biennial assessments, the PICTs and the Pacific MANA coordinating team have had several fora to critically look at the 31 MANA indicators in terms of relevance, a practical and feasible application within the respective PICTs. The following amendments to the existing indicators have been recommended to further strengthen efforts to monitor and scale up actions.

Indicator L1: Multisectoral NCD Committee
Recommendation: To include Permanent Secretary/Chief Executive Officer in the leadership of the national multi-sectoral committee.

Indicator L2: National strategy addressing NCDs and risk factors
Recommendation: To include Mental health as one of the NCDs.

Indicator T2: Smoke-free environments
Recommendation: To include 'public outdoor places such as parks or beaches and places of worship' in completely smoke-free places.

Indicator T3: Tobacco health warnings
Recommendation: To specify 'health warning' and for standardized packaging to include 'no branding promotional elements or logos allowed on packaging'.

Indicator F3: Unhealthy food marketing to children
Recommendation: To include 'internet based-marketing and electronic screens' in the restricted advertising/marketing platforms.

Indicator F4: Food fiscal policies
Recommendation: For the government measures to include 'reduction of tax on commercially packaged water'; and to include 'Food and nutrition labelling regulation' in the government measures.

Indicator F6: Food-based dietary guidelines

Recommendation: To change from Food-based dietary guidelines to 'Healthy Living Guidelines' which is more inclusive and addresses other risks factors for NCD in addition to food like physical activity, and substance use (tobacco & alcohol).

Indicator T7: Tobacco cessation
Recommendation: To include a 'community support facility' in the cessation services.

Indicator H5: Baby-friendly hospitals
Recommendation: BFH certification to be done internally, considering the external certification previously done by WHO/UNICEF is not in place anymore.

Indicator M1: Population risk factor prevalence surveys – adults
Recommendation: To extend the period from 5 years to 5 – 10 years; and data collected to include 'SSB and Mental health'.

MANA Dashboard Data Dictionary

Note: Proposed amendments are highlighted in blue

Traffic light rating system

N/A	Not applicable
	Not present
	Under development
	Present
Strength of action/implementation (star rating only assigned if 'Present')	
☆	Low
☆☆	Medium
☆☆☆	High

1. Leadership and governance

L1. Multi-sectoral NCD Committee

A multi-sectoral committee is operating, reports regularly, is inclusive of all relevant stakeholders and is catalysing and monitoring actions on NCDs

WHO Equivalent Indicator: No equivalent

	A multi-sectoral NCD committee covering the four main NCD risk factors (tobacco, alcohol, nutrition, physical activity) **has not been established**, or is **inactive** (less than two meetings in the last 12 months)
	There is evidence that a multi-sectoral NCD committee[1] is being established, or a committee exists and has had at least two meetings in the last 12 months, but no public reports are available
	A multi-sectoral NCD committee[2] has had at least 1 meeting per a quarter in the last 12 months, and an annual report (or equivalent) is available
☆	Have developed and endorsed a National NCD Strategic Plan
☆☆	As for ☆, and two of the items listed below
☆☆☆	As for ☆, and chaired by PSH or CEO Health all the items listed below
	1. The committee is led by a Prime Minister, government minister or Permanent Secretary / Chief Executive Officer 2. The NCD committee demonstrates decision-making, monitors implementation, and publicly documents its actions. 3. Platform has established mechanisms for engagement with the private sector (with conflicts of interest managed). Private sector engagement can be through the taskforce or at the national level

[1] Evidence includes PICTs submitting the composition of their multisectoral NCD committee and identify the chair and the secretary/secretariat for the committee

[2] The committee includes senior representation from government sectors, such as attorney general, ministries of agriculture, communications, customs and excise, education, finance and economic planning, health, labour and industry, sport, national statistics, trade, police, urban planning (at least 3 is small island states and 5 in the bigger PICTs). The committee should also include civil society and non-governmental organisations

L2. National strategy addressing NCDs and risk factors

A comprehensive, multi-sectoral national strategy addressing NCDs, and risk factors is operational [1]

WHO Equivalent Indicator #4

	There is no current national multisectoral strategy for tackling NCDs
	There is evidence that a national multisectoral strategy is under development or one exists but is not operational
	A multi-sectoral NCD strategy has been developed (either stands-alone or part of a wider national health plan) to cover at least two individual diseases (cardiovascular disease, diabetes, cancer, respiratory disease, mental health) and two risk factors (tobacco, alcohol, nutrition, physical activity)
☆	A multi-sectoral NCD strategy has been developed and covers the four individual diseases and four risk factors
☆☆	As for ☆, and **one** of the items listed below
☆☆☆	As for ☆ and demonstrates multisectoral engagement especially of non-health agencies in development of the strategy and two other items from the list below
	• Includes a comprehensive set of policies and actions translated from agreed global, regional and national frameworks • Evident of multisectoral responsibilities, timelines, and accountability mechanisms • Evident budget allocations (in plans or government budgets) • Evident monitoring and surveillance plan

[1] A national NCD multisectoral strategy is considered operational if the planned key actions and activities outlined in the strategy are implemented within the timeframe, by the designated responsible persons/agents within the allocated budget

***Note:** if a country's plan has expired but is still in use, the country simply needs to provide evidence that the expired plans have been endorsed for extended use beyond the stated timeframe while awaiting the development of the new plan.*

L3. Explicit NCD indicators and targets

Explicit time-bound targets and indicators have been established for national NCD strategy

WHO Equivalent Indicator #1

	There are no current national targets for tackling NCDs
	National quantitative targets and indicators are under development
	Time-bound indicators and targets cover NCD risk factors, NCD prevalence and NCD actions (e.g., policy change)
☆	As for , and covers two to four of the WHO global targets (listed below)
☆☆	As for , and covers five or more of the WHO global targets
☆☆☆	As for ☆☆, and there is a documented plan for reporting (e.g., national NCD strategy has a surveillance and monitoring plan)

	WHO nine global targets:
	• Risk factors:
	  ○ reduce harmful use of alcohol
	  ○ reduce physical inactivity
	  ○ reduce salt /sodium intake
	  ○ reduce tobacco use
	  ○ reduce raised blood pressure
	  ○ no increase in diabetes/obesity
	• Health system response
	  ○ 50% coverage for drug therapy and counselling
	  ○ 80% coverage essential NCD drugs and technologies
	• Mortality
	  ○ reduce premature mortality from NCDs

2. Preventive policies

Tobacco

T1. Tobacco excise taxes

Legislation is in place to reduce affordability of tobacco products by increasing tobacco excise taxes
WHO Equivalent Indicator #5a

	No excise tax is collected on cigarettes
	Tobacco excise tax legislation is being developed, or cigarette excise tax ≤ 20% of retail price
	21–30% of retail price of cigarettes is excise tax
☆	31–50% of retail price of cigarettes is excise tax
☆☆	51–69% of retail price of cigarettes is excise tax
☆☆☆	≥70% of retail price of cigarettes is excise tax
	Data for this indicator are obtained from the WHO Report on the Global Tobacco Epidemic, which is published every two years. http://www.who.int/tobacco/global_report/2015/en/ For PICTs not covered in the WHO Report on the Global Tobacco Epidemic, this indicator was calculated by the MANA Coordination Team using the same method as used in the report, i.e.: Specific excise amount ($) / cost per pack ($) Denominator for specific excise/number of cigarettes per pack For example, if the most popular brand retails for $28.50 per pack of 30 cigarettes and the excise rate is $494 per 1,000 cigarettes, excise tax as a proportion of retail price = (494/28.50)/ (1,000/30) = 52% Cost per pack: This is the tax-inclusive retail sales price in local currency per pack of 20 sticks of the most popular brand of cigarettes, the brand as determined by the country NCD focal point. The retail price is calculated as the average of the retail prices from at least three different locations (locations include a mix of shop sizes, e.g., supermarket, petrol station, small family-owned shop).

T2. Smoke-free environments

Legislation is in place to create public places that are completely smoke-free environments
WHO Equivalent Indicator #5b

	No legislation for smoke-free environments
	Legislation for smoke-free environments is being developed or currently covers only one area listed below
	Smoke-free environment legislation covers two areas listed
☆	Smoke-free environment legislation covers three areas listed
☆☆	Smoke-free environment legislation covers four to seven areas listed
☆☆☆	Smoke-free environment legislation covers eight or more areas listed

	Completely smoke-free places include: 1. health-care facilities 2. educational facilities other than universities 3. universities 4. government facilities 5. indoor offices and workplaces not considered in any other category 6. restaurants or facilities that serve mostly food 7. cafes, pubs and bars or facilities that serve mostly beverages 8. public transport 9. public outdoor places such as parks or beaches 10. places of worship

T3. Tobacco health warnings

Health warnings are in place to warn of the dangers of tobacco and tobacco smoke

WHO Equivalent Indicator #5c

	No legislation requiring health warnings and/or no health warnings on tobacco products
	Tobacco control legislation and/or health warnings are being developed
	Average proportion of principal display (front and rear combined) mandated to be covered by health warnings is less than or equal to 50%, and no pictorials and only text health warnings in all principal language(s)
☆	Average principal display less than or equal to 50%, with pictorials and text health warnings in all principal language(s)
☆☆	Average principal display less than or equal to 50%, with pictorials and text health warnings in all principal language(s)
☆☆☆	Standardized packaging including an average display of greater than 50% with pictorial health warning and text health warnings in all principal language(s); and no branding, promotional elements or logos allowed on packaging

T4. Tobacco advertising, promotion and sponsorship

Measures are in place to ban all forms of tobacco advertising, promotion and sponsorship

WHO Equivalent Indicator #5d

	No legislation prohibiting tobacco advertising, promotion and sponsorship
	Legislation prohibiting tobacco advertising promotion and sponsorship is being developed
	Legislation exists governing standards of tobacco advertising, promotion and sponsorship in at least two areas of **direct** advertising
☆	Legislation completely bans advertising on national television and radio, local magazines and newspapers, billboards/outdoor advertising, and at point of sale
☆☆	As for ☆, and at least two other areas of direct or indirect advertising are banned
☆☆☆	Legislation completely bans ALL forms of direct and indirect advertising listed

	Direct advertising: • national television and radio • local magazines and newspapers • billboards, outdoor advertising • point of sale • retailers and sellers of tobacco must store all tobacco products out of sight **Indirect advertising:** • free distribution of tobacco products in the mail or through other means • promotional discounts • non-tobacco goods and services identified with tobacco brand names (brand extension) • brand names of non-tobacco products used for tobacco products (brand-sharing) • sponsored events, including corporate social responsibility programmes • appearance of tobacco brands or products in television and/or films (product placement)

T5. Tobacco sales and licencing

Measures are in place restricting tobacco sales and licencing

WHO Equivalent Indicator: No equivalent

	No measures are in place restricting tobacco sales and licencing
	Legislation for tobacco sales and licensing are under development
	The sale of single stick cigarettes and loose tobacco[1] is prohibited by law.
☆	As for , and legislation covers one or two areas listed
☆☆	As for , and legislation covers three areas listed
☆☆☆	As for , and legislation covers four areas listed
	• A licence is required for all manufacturers (where applicable) and importers of tobacco products • A licence is required for all distributors of tobacco products • A license is required for all wholesaler and retailers of tobacco products • Tobacco sales to minors (as defined by the government) are banned

[1] Loose tobacco includes any tobacco sold outside of its original retail packaging

T6. Tobacco industry interference

Government-level policies or laws are in place to prevent tobacco industry interference [1]

WHO Equivalent Indicator: No equivalent

	No government-level tobacco industry interference prevention policies or laws are in place
	Government-level tobacco industry interference prevention policies or laws are planned
	Government-level tobacco industry interference prevention policies (e.g., code of conduct) or laws cover one of the areas listed
☆	Government-level policy or law covers two of the areas listed
☆☆	Government-level policy or law covers three of the areas listed
☆☆☆	Government-level policy or law covers all of the areas listed
	• Requiring transparency by public officials and civil servants when interaction with tobacco industry is necessary • Requiring candidates for public office, public officials and civil servants to disclose any potential conflicts of interest related to tobacco control • Disallowing government, public officials and civil servants from accepting any type of gift or contribution (from the tobacco industry (Exceptions: compensations due to legal settlements or mandated by law or legally binding and enforcement agreements) • Prohibiting public disclosure of activities or expenditure described as 'socially responsible' by the tobacco industry

[1] Tobacco interference is when the tobacco industry applies tactics to interfere with public health including undermining government effort to protect public health, exaggerating the economic benefits of the tobacco industry, pretending to care about the community, feigning community support, ignoring scientific evidence and threatening governments with litigation. *Tobacco industry* includes entities or individuals representing the interests or working to further the interests of the tobacco industry such as manufacturers, importers and distributors.

Alcohol

Alcohol licencing to restrict sales

A1. Licencing regulations are in place to restrict sales of alcohol

WHO Equivalent Indicator #6a

	No licencing regulations are in place to limit the sale of alcohol
	Alcohol licencing regulations are under development to limit the sale of alcohol
	Alcohol licencing regulations exist to limit the sale of alcohol and cover one of the areas listed
☆	Alcohol licencing regulations cover two of the areas listed
☆☆	Alcohol licencing regulations cover three of the areas listed
☆☆☆	Alcohol licencing regulations cover four of the areas listed, and the minimum age to purchase or be served alcohol is 21
	• A licensing system or monopoly exists on retail sales of beer, wine and spirits • Restrictions exist for on- and off-premises sales of beer, wine and spirits regarding hours and locations of sales **and** restrictions exist for off-premises sales of beer, wine and spirits regarding days of sales • Minimum age to purchase or be served alcohol (beer wine spirits) is 18+ years (The alcohol sales licence stipulates who alcohol can be sold to and/or who is allowed on the premises) • All alcohol producers, importers and wholesalers must hold a licence

A2. Alcohol advertising

Regulations for alcohol advertising are in place, with a system to detect infringements

WHO Equivalent Indicator #6b

	No alcohol advertising regulations are in place
	Alcohol advertising regulations are under development
	Some alcohol advertising regulations exist
☆	Restrictions exist on alcohol advertising for beer, wine, and spirits through all national broadcasting (TV, radio, print and cinemas)
☆☆	As for ☆, and restrictions exist for alcohol advertising on outdoors billboards and/or sponsorship of cultural, sports and other events
☆☆☆	As for ☆☆, and a detection system exists for infringement of marketing restrictions

A3. Alcohol taxation

An inflation-adjusted alcohol excise taxation system on beer wine and spirits is in place

WHO Equivalent Indicator #6c

	No alcohol excise tax is collected
	Alcohol excise taxation is being developed, based on beverage type or ethanol content
	Alcohol excise taxation system is in place and is based on beverage type **or** ethanol content
☆	Excise tax is based on ethanol content and is applied across all beverage types, OR if bands are applied, excise tax is based on the ethanol content at the top of each band AND Excise tax is reviewed or adjusted for inflation annually for **at least one** beverage type
☆☆	Excise tax is based on ethanol content and is applied across all beverage types OR if bands are applied, excise tax is based on the ethanol content at the top of each band AND Excise tax is reviewed annually or adjusted for inflation annually for **ALL** beverage types
☆☆☆	As for ☆☆ AND Excise tax is stated by the government as an important public health tool to reduce alcohol consumption/harm

A4. Drink driving

Regulations are in place to control drink driving

WHO Equivalent Indicator: No equivalent

	No drink drive regulations are in place
	Drink drive regulations are being developed
	Drink drive regulations are in place and set a maximum blood/breath alcohol content
☆	Regulation covers one of the areas listed
☆☆	Regulation covers two of the areas listed
☆☆☆	Regulation covers three of the areas listed
	• A maximum blood alcohol content (BAC) at 0.05 g or less per 100 ml (or breath alcohol equivalent) • Drink drive legislation sets a lower BAC for young drivers, compared with older drivers • Random blood/breath alcohol testing is in place

Food

F1. Reducing salt consumption

Policies are in place to reduce population salt consumption

WHO Equivalent Indicator #7a

	No salt reduction plans/activities are in place
	Salt reduction plans/activities are under development
	Activities covers one of the areas listed
☆	Activities cover two of the areas listed
☆☆	Activities cover three of the areas listed
☆☆☆	Activities cover four of the areas listed
	• Salt reduction activities/objectives are articulated in the National NCD strategy or other relevant National

	plans • There is a stipulated population salt/sodium intake reduction goal - Sodium targets of <2g per day (the equivalent of 5mg salt/day) are in place for food groups that are major contributors to sodium intake, based on international best practice • Salt awareness programmes/education are in place • Mandatory salt labelling regulations are in place

F2. Trans-fats

Policies are in place to limit trans-fats (i.e., partially hydrogenated vegetable oils) in the food supply
WHO Equivalent Indicator #7b

	No trans-fats-related policies/activities are in place
	There are no trans-fat prevention and control activities in place, but there is a reference to trans-fats in relevant National strategies or action plans (e.g., NCD plan, nutrition plan)
	The existence of a national dietary guideline that includes reducing the intake of foods containing naturally occurring trans-fats as well as industrially produced trans-fat
☆	plus, a Mandatory food labelling regulation in place that includes total fats and industrially produced trans-fats
☆☆	As for ☆ and covers two of the areas listed
☆☆☆	In addition to having ☆☆, activities cover at least three of the areas listed
	• Ongoing monitoring of industrially introduced trans-fat in processed foods and/or restaurants • Voluntary or mandatory controls on reuse and selling of cooking oils in catering establishments and food vendors regardless of mode of delivery • Awareness campaigns on trans-fat risks and avoidance are being conducted • Mandatory food standards that prevent the sale of foods containing trans fat

**Note: trans-fat is also referred to as trans-fatty acids

F3. Unhealthy food marketing to children

Policies are in place to restrict marketing of unhealthy food to children
WHO Equivalent Indicator #7c

	There are no regulations in place to restrict promotion of unhealthy food to children
	Regulations are under development
	Some regulations are in place to limit 'unhealthy' (in line with WPRO nutrient profiling tool) food advertising/marketing to children, in one area listed
☆	Advertising/marketing is restricted in two or three areas listed
☆☆	Advertising/marketing is restricted in four or five areas listed
☆☆☆	Advertising/marketing is restricted in six or more areas listed
	• national television (times, channels) • radio (times, channels) • local magazines/newspapers (child-focused print, e.g. comics) • billboards (including electronic screens) and outdoor advertising (near schools and early childhood education centres, at children-related events) • internet-based marketing • through sponsorship for child-related events/sports • advertising in settings where children gather at preschools, schools, school sports, school events, cultural events • via packaging • through free distribution of unhealthy products in areas where children gather • at point of sale • Activities to control and restrict marketing of unhealthy foods to children, in relevant National strategy/action plans (e.g. National NCD strategy, etc

F4. Food fiscal policies

Fiscal policies are in place to make healthy food choices easier and cheaper, and to discourage unhealthy food choices

WHO Equivalent Indicator: No equivalent

	Government has taken no specific measures to reduce the cost of healthy food or increase the cost of unhealthy choices
	Government is developing specific measures to reduce the cost of healthy food or increase cost of unhealthy choices
	Government has formulated specific measures to reduce the cost of healthy food and/or increase the cost of unhealthy choices in one area listed
☆	Government measures include two areas listed
☆☆	Government measures include three areas listed
☆☆☆	Government measures include four or five areas listed
	1. Excise duties are levied on imported and/or locally sugar-sweetened beverages (SSB) of at least 20% of the retail price, or fiscal import tax is imposed on raw materials for local producers to an equivalent level 2. Provision is made to increase sugar-sweetened beverage taxation rates to account for inflation 3. Provision is made to reduce tax on commercially packaged water 4. Fruit and vegetables are exempt from added taxes; and/or all unprocessed foods are zero-rated VAT (or equivalent) 5. Excise duties are levied on at least one imported/locally produced 'unhealthy food' not inclusive of SSBs (in line with the WPRO nutrient profiling tool) 6. Food labelling regulation in place 7. The excise taxation system is stated by the government as an important public health tool to confront NCDs

F5. Healthy food policies in schools

Policies are in place relating to the provision and promotion of healthy food choices in schools

WHO Equivalent Indicator: No equivalent

	There are no government (Ministry of Health or Ministry of Education) policies or guidelines encouraging healthy food services in schools
	The Ministry of Health and/or Education is developing policies or guidelines to encourage healthy food services in schools
	There is a mandatory government policy or guideline for healthy food services in schools which covers one area listed
☆	There is a mandatory government policy or guideline which covers two areas listed
☆☆	There is a mandatory government policy or guideline which covers three areas listed
☆☆☆	There is a mandatory government policy or guideline which covers four areas listed
	• Healthy food/beverages are provided in school canteens • Healthy food/beverages are sold in vending machines or school shop • Healthy food/ beverages are used in fundraising • Education and promotion of healthy food/beverage choices • Healthy food/beverages at school events

F6. Healthy Living Guidelines

National guidelines for healthy living, are in place

WHO Equivalent Indicator: No equivalent

	There are no national guidelines for healthy living for adults
	National guidelines for healthy living for adults are under development, or a process is under way to adopt/adapt international or regional guidelines
	National guidelines for healthy living for adults are in place, or international/regional guidelines have been adopted, that cover five of the areas listed
☆	National guidelines for healthy living cover eight of the areas listed
☆☆	National guidelines for healthy living cover eight of the areas listed AND are included in the school curriculum
☆☆☆	National guidelines for healthy living cover eight of the areas listed AND guidelines are included in the school curriculum AND There is evidence that healthy living guidelines are used to inform policymaking
	• Available in all principal languages • Encourage the preparation and consumption of a balanced diet • Recommend the number of serves and portion size from each food group to be eaten each day • Promote minimal consumption of fat, salt and sugar • Promote control of alcohol consumption • Promote control of smoking and use of tobacco products, chew of betel nuts and/or use of drugs • Promote physical activity and maintain a healthy weight • Recommend exclusive breastfeeding for first six months and continued breastfeeding until at least two years of age

Physical activity

P1. Compulsory physical education in the school curriculum

Physical education is a compulsory component of the school curriculum

WHO Equivalent Indicator #8

	Physical education is not a specified element of the national school curriculum
	Physical education is identified as a key learning area of the national school curriculum but has no specific curriculum statement or syllabus OR Implementation of the existing syllabus is not mandatory/enforced/monitored
	Physical education and nutrition is a key learning area of the national school curriculum, there is a curriculum statement or syllabus that covers at least levels K-10 (or equivalent), and implementation of the syllabus is mandatory and enforced in all schools
☆	As for , AND one of the areas listed
☆☆	As for , AND two of the areas listed
☆☆☆	As for , AND three of the areas listed

	• The PE syllabus is mandatory for all pupils (no exclusions for students with disabilities, girls and those from minority groups) • The national PE curriculum statements / syllabus makes the relationship between physical exercise and health promotion clear and explicit to encourage lifelong participation in physical activity • The Ministry of Education has budget allocated to support and develop PE teacher capacity and resources in schools (verbal report is sufficient evidence for this indicator) • The curriculum specifies a minimum of 30 minutes per day or three hours per week physical activity

Enforcement

E1. Enforcement of laws and regulations related to NCD risk factors

A system is in place to monitor and enforce laws and regulations related to NCD risk factors

WHO Equivalent Indicator: No equivalent

	There is no organised system for enforcement of tobacco, alcohol, food (and betel nut if prevalent in the country) laws and regulations related to NCDs other than inspection of imports
	A government-level law and regulation enforcement system is planned for at least one NCD risk factor domain (tobacco, alcohol, unhealthy food and betel nut if prevalent in the country)
	A government-level enforcement system is in place with retail and/or wholesale inspections documented within the past year for one NCD risk domain (tobacco, alcohol, NCD-related foods, betel nut). Note: Import inspections alone are not sufficient for green score.
☆	The enforcement system has had inspections documented within the past year and: • includes two or more NCD risk domains (tobacco, alcohol, NCD-related foods, betel nut) • there is a summary report available showing the compliance rate for each regulation surveyed
☆☆	The enforcement system has had inspections documented within the past year and: • includes three or more NCD risk domains (tobacco, alcohol, NCD-related foods, betel nut) • there is a summary report available showing the compliance rate for each regulation surveyed
☆☆☆	The enforcement system has had inspections documented within the past year and: • includes three or more NCD risk domains (tobacco, alcohol, NCD-related foods, betel nut) • there is a summary report available showing the compliance rate for each regulation surveyed • at least some violators have been prosecuted and sanctioned (e.g., with fines)

3. Health system response programmes

H1. National guidelines for the care of main NCDs

National guidelines are in place for the diagnosis and treatment of the four main NCDs (cardiovascular disease, diabetes, cancer and chronic respiratory diseases) in public sector health facilities

WHO Equivalent Indicator #9

	No national guidelines exist for the management of any of the four main NCDs in public-sector health facilities
	National guidelines for some or all four of the main NCDs are under development, OR exist but are not implemented
	National guidelines for <u>one of the four</u> main NCDs are in place and are being implemented
☆	National guidelines are in place and implemented in public sector health facilities for <u>two of the four</u> main NCDs: • Diabetes • Cardiovascular disease (guidelines MUST include risk stratification)* • Cancer • Chronic respiratory diseases

☆☆	National guidelines are in place and implemented in public sector health facilities for three of the four main NCDs
☆☆☆	National guidelines are in place and implemented in public sector health facilities for ALL four main NCDs

*Refers to CVD risk assessment

H2. Essential drugs

Essential NCD drugs are available and accessible in public-sector primary care facilities

WHO Equivalent Indicator #10

	No essential drug list exists, or not all drugs listed below are on the essential drugs list
	All drugs listed below are on the essential drugs list
	All drugs listed are on the essential drugs list, and a system is in place to monitor the availability
☆	As per , AND monitoring reports are available, AND stock-outs reported in more than 50% of primary care facilities in the last 12 months
☆☆	As per , AND monitoring reports are available, AND stock-outs were reported in less than 50% of primary care facilities in the last 12 months
☆☆☆	As per , AND monitoring reports are available, and no stock-outs reported in primary healthcare facilities in the last 12 months
	• insulin • aspirin (100 mg) • metformin • thiazide diuretics • ACE inhibitors • CC Blockers • statins • sulphonylureas

T7 Tobacco cessation

Tobacco cessation support is available in all communities and is fully cost-covered

WHO Equivalent Indicator: No equivalent

	No cessation services available
	Cessation services are being developed
	Cessation services are available in at least one health care and/or community support facility
☆	Cessation services (at a minimum, brief cessation intervention or 5A's including monitoring mechanism) are available in at least one health care and/or community support facility and cover one area listed
☆☆	Cessation services are available in at least one health care and/or community support facility AND cover two areas listed
☆☆☆	Cessation services are available in at least one health care and/or community support facility AND cover three or more areas listed
	• NRT available • National Quitline • Cessation services at a health care facility by a health care worker • Cessation services at a community support facility • Cessation services are fully cost-covered • Cessation messaging delivered in the community (e.g. by civil society group, community group, etc.)

H4. Marketing of breastmilk substitutes

National policy or regulations govern the implementation of the International Code of Marketing of Breastmilk Substitutes

WHO Equivalent Indicator #7d

	No government policy or self-regulated restrictions exist for marketing of breastmilk substitutes (BMS)
	Government policy or regulations are under development according to the International Code of Marketing of BMS, or laws exist but are not implemented, or restrictions are self-regulated by the BMS industry
	Government policy or regulations are in place and implemented according to the International Code of Marketing of BMS, and cover one area listed
☆	Regulations implemented covering two areas listed
☆☆	Regulations implemented covering three areas listed
☆☆☆	Regulations implemented covering five areas listed
	• Regulations ban all forms of advertising or promotion of BMS to mothers and the general public. This includes point-of-sale advertising, free samples, discount coupons, and tie-in sales • Regulations define products considered BMS to include infant formula, follow-on formula, bottles and teats, and complementary/weaning foods • Regulations note that the marketing of BMS is regulated to promote breastfeeding and ensure safe and adequate nutrition for infants and young children • Regulations ensure that labels are designed to provide the necessary information about the appropriate use of the product, and not to discourage breastfeeding • Regulations are enforced

H5. Baby-friendly hospitals

Government supports the Baby Friendly Hospital Initiative

WHO Equivalent Indicator: No equivalent

	No hospitals are Baby Friendly Hospital (BFH) certified, and none are working toward certification
	The BFH certification process has been adopted but no hospital has been internally BFH certified
	At least one public hospital has been BFH certified through internally assessment
☆	More than 50% of public hospitals are BFH certified
☆☆	As for ☆, and all hospitals with BFH designation are monitored internally to keep track of current status (e.g., 6-monthly)
☆☆☆	As for ☆, and all hospitals with BFH designation are internally reassessed at intervals (e.g. 2 yearly)

** revisit: time frame on the validity of the BFH certification to be included in the criteria

H6. Maternity leave and breastfeeding

Legislation is in place providing maternity leave and breastfeeding breaks/facilities

WHO Equivalent Indicator: No equivalent

	There is no legislation for maternity leave
	Legislation for maternity leave is under development or does not meet the standard required for a green rating
	Legislation is in place providing at least 12 weeks of paid maternity leave, with the mother paid no less than two-thirds of her previous earnings
☆	As for , AND legislation is in place covering one of the following areas below:
☆☆	As for , AND legislation is in place covering two of the areas listed
☆☆☆	As for , AND legislation is in place at least covering three of the areas listed
	As for , AND legislation is in place covering one of the following areas: • Provision of breast-feeding facilities in workplaces and/or public areas • Provision to protect and support the right to breastfeed in workplaces and/or public places

	• Provision of breast-feeding breaks for working mothers • Provision of at least 14 weeks paid maternity leave, with the mother paid no less than two-thirds of her previous earnings

4. Monitoring

M1. Population risk factor prevalence surveys - adults

A population NCD risk factor prevalence survey for ADULTS has been conducted in the last 5 - 10 years which includes physical and biochemical measurements

WHO Equivalent Indicator #3

	Risk factor prevalence data more than ten years old
	Risk factor prevalence data five to ten years old and survey scheduled in the next 18 months
	Risk factor prevalence data collected within the last five years
☆	The survey data collected include at least three of the risk factors listed
☆☆	The survey data collected within the last five years includes six or more of the risk factors listed
☆☆☆	The survey data collected within the last five years includes all of the factors listed below AND there is the intention for regular future surveys (every one or two years, or three to five years)
	• Harmful use of alcohol • Physical activity • Tobacco use • Raised blood glucose/diabetes (objective measurement) • Raised blood pressure/ hypertension (objective measurement) • Obesity and overweight (physical measurement) • Salt/sodium intake (objective measurement, e.g. spot urine sample) • SSB (Sugar-Sweetened Beverages) • Mental Health

M2. Population risk factor prevalence surveys - youth

A population NCD risk factor prevalence survey for ADOLESCENTS (13–17 years) has been conducted in the last two years which includes physical measurements for NCDs

WHO Equivalent Indicator: No equivalent

	Risk factor prevalence data more than five years old
	Risk factor prevalence data more than five years old and survey scheduled in the next 12 months
	Risk factor prevalence data reported within the past three to five years
☆	Risk factor prevalence data reported within the past three to five years and: • includes physical measurement of overweight and obesity • repeat survey scheduled in the next 12 months
☆☆	Risk factor prevalence data reported within the past two years and: • includes physical measurement of overweight and obesity
☆☆☆	Risk factor prevalence data reported within the past two years and: • includes physical measurement of overweight and obesity • includes at least three of the following risk factors: alcohol use, physical activity, tobacco use, betel nut use, dietary information (at least one indicator)

M3. Child growth monitoring

Childhood growth data (age 3-12 years) is routinely monitored and reported

	No growth data was collected for children less than 13 years of age
	Some childhood growth data are collected but not reported
	Childhood growth data are collected and reported
☆	As for , and two of the items listed
☆☆	As for , and three of the items listed
☆☆☆	As for , and four of the items listed
	• Data collected for more than one age/grade • Dataset is available to within-country stakeholders (e.g., other ministries) for analysis • Data reported at least every two years • Training/standardisation of height and weight measurement • Extra risk factor data are collected (e.g., nutrition, physical activity)

M4. Routine cause-specific mortality

There is a functioning system for generating reliable cause-specific mortality data on a routine basis
WHO Equivalent Indicator #2

	A basic vital registration system is not in place (basic system must have all of the following elements capture deaths; certifiers complete the International Form or Medical Certificate of the Cause of Death; and International Certification of Diseases (ICD) is used to code deaths)
	Vital registration is in development
	A vital registration system exists, and cause-of-death data are compiled and publicly reported.
☆	As for , and one of the items listed
☆☆	As for , and two of the items listed
☆☆☆	As for , and three of the items listed
	• At least five years of cause-of-death data have been reported • The most recent year of data reported is no more than five years old • Reliable reporting from outlying districts (e.g. outer islands)