Pacific Community
Communauté du Pacifique

Status of non-communicable diseases policy and legislation In Pacific Island countries and territories, 2018

Prepared by
The Pacific Monitoring Alliance for NCD Action (MANA)

World Health Organization
Pacific Islands Health Officers Association
FNU Fiji National University
C-POND
PHD Public Health Division

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Executive Summary

Background

The Pacific region has some of the highest rates of non-communicable diseases (NCDs) and associated risk factors in the world. At the Joint Forum Economic and Pacific Health Ministers Meeting held in 2014, the ministers endorsed the Pacific NCD Roadmap, which provides specific policy, regulatory and tax measures that can be implemented by Pacific Island countries and territories (PICTs) to address NCDs. The ministers also agreed to report on progress against the roadmap at every Pacific health ministers' meeting.

Methods

To assist PICTs to monitor progress on implementing the roadmap, the Pacific Monitoring Alliance for NCD Action (MANA) developed the Pacific NCD Dashboard. The dashboard uses a 'traffic light' rating scheme to track PICTs' progress on policies and legislation aimed at preventing NCDs. It comprises 31 indicators across the areas of leadership and governance, preventative policies, health system response programmes, and routine monitoring.

In 2017–2018, the Pacific MANA Coordination Team collaborated with national NCD focal points to complete dashboards for all PICTs. To complete the dashboards, a member of the MANA coordination team first pre-filled the dashboard using publicly available information. The draft dashboard was then reviewed and verified by a national NCD focal point, and endorsed by the minister for health or other appropriate signatory.

Dashboards were completed and endorsed for all 21 PICTs in 2017–2018: American Samoa (AS), Commonwealth of the Northern Mariana Islands (CNMI), Cook Islands (CI), Federated States of Micronesia (FSM), Fiji, French Polynesia (FP), Guam, Kiribati, Nauru, Niue, New Caledonia (NC), Palau, Papua New Guinea (PNG), Republic of the Marshall Islands (RMI), Tokelau, Tonga, Samoa, Solomon Islands (SI), Tuvalu, Vanuatu, and Wallis and Futuna (WF). This report presents the results for these dashboards.

Results

Key findings for each domain of the dashboard are summarised below.

1. ***Leadership and governance***

   Fourteen of the 21 PICTs (AS, CI, FSM, Fiji, FP, Guam, Kiribati, Niue, Palau, PNG, Samoa, Tonga, Tuvalu and Vanuatu) have a current national multisectoral strategy addressing NCDs and risk factors; 15 PICTs (AS, CI, Fiji, FSM, Guam, Kiribati, NC, Niue, Palau, PNG, Samoa, Tokelau, Tonga, Tuvalu and Vanuatu) have established NCD indicators and targets, and five (Guam, Palau, Samoa, Tonga and Tuvalu) have an active multisectoral NCD taskforce.

2. ***Preventive policies***

   Tobacco: All PICTs have introduced legislation to reduce tobacco consumption, with 18 (AS, CNMI, CI, Fiji, FSM, FP, Guam, Kiribati, Nauru, NC, Niue, Palau, PNG, Samoa, Tonga, Tuvalu, Vanuatu and WF) implementing tobacco taxation measures. Most PICTs have legislation to create smoke-free public places (the exceptions are FSM, Niue and WF), health warnings on tobacco packaging (16 PICTs: CNMI, CI, Fiji, FP, Kiribati, Guam, Nauru, NC, RMI, PNG, Samoa, SI, Tonga, Tuvalu, Vanuatu and

WF), restrictions on tobacco sales and licensing (14 PICTs: AS, CNMI, CI, Fiji, Guam, Kiribati, Nauru, NC, Palau, PNG, SI, Tonga, Tuvalu and Vanuatu), and restrictions on tobacco advertising (17 PICTs: AS, CI, Fiji, FP, Kiribati, NC, Guam, Nauru, Palau, RMI, PNG, Samoa, SI, Tonga, Tuvalu, Vanuatu and WF). No PICT, however, has a government level policy or legislation in place to prevent tobacco industry interference.

Alcohol: All PICTs included in this report have national licensing regulations in place to restrict the sale of alcohol (except FSM where this is state jurisdiction), national legislation in place to control drink-driving (except FSM where this is state jurisdiction, PNG and Vanuatu), and alcohol taxation mechanisms in place (except RMI). However, only six PICTs (FP, Guam, NC, PNG, Samoa and WF) have regulations governing alcohol advertising.

Food: Fourteen PICTs (CI, Fiji, FSM, FP, Guam, Kiribati, Nauru, NC, Niue, Palau, PNG, Samoa, SI and Vanuatu) have policies or activities in place to reduce population salt consumption. Thirteen (CI, Fiji, FSM, FP, Kiribati, Nauru, Niue, RMI, Samoa, Tokelau, Tonga, Vanuatu and WF) have fiscal policies in place to make healthy food choices easier and cheaper and to discourage unhealthy food choices, but only four PICTs (Kiribati, Nauru and Samoa, Tonga) were rated as having 'strong' (i.e. three-star rating) measures in place. Thirteen PICTs (CI, Fiji, FSM, FP, Guam, Kiribati, NC, Niue, RMI, Samoa, SI, Tonga and Vanuatu) have national food-based dietary guidelines for adults. No PICTs have policies or legislation to limit trans-fats in the food supply. In terms of actions to encourage healthy eating among children, two PICTs (FP and Kiribati) have policies in place to restrict marketing of unhealthy food to children, and 11 (AS, CNMI, CI, Fiji, FP, Guam, Kiribati, NC, Niue, Samoa and Vanuatu) have policies or guidelines encouraging healthy food services in schools.

Physical activity: Fourteen PICTs (AS, CI, FP, Guam, Kiribati, Nauru, Niue, NC, PNG, Samoa, SI, Tokelau, Tonga and WF) have included physical activity as a compulsory component of the school curriculum.

Enforcement: Fourteen PICTs (CNMI, CI, Fiji Guam, Kiribati, Nauru, Niue, NC, PNG, Samoa, SI, Tonga, Tuvalu and WF) have a government-level system in place to support enforcement of tobacco, alcohol, food and betel-nut legislation.

3. Health system response programmes

All PICTs in this report (except CNMI and Palau) have national guidelines in place for the diagnosis and management of at least one of the four main NCDs. Fifteen PICTs (AS, CNMI, CI, Fiji, FP, Guam, Kiribati, Nauru, NC, Niue, Samoa, Tokelau, Tonga, Tuvalu and WF) have included all essential NCD medicines included in the national list of essential medicines and have systems in place to ensure their availability. Smoking cessation support of some kind is available in 15 PICTs (AS, CNMI, CI, Fiji, FP, Guam, Kiribati, Nauru, NC, Niue, Palau, Samoa, SI, Tonga and Vanuatu). Regarding programmes related to infant nutrition, seven PICTs (Fiji, FP, Kiribati, NC, Palau, PNG and SI) have restrictions on the marketing of breast milk substitutes, six PICTs (AS, Fiji, FSM, Kiribati, SI and Vanuatu) have a public hospital certified as a Baby Friendly Hospital, and eight PICTs (Fiji, FP, Kiribati, Nauru, NC, Niue, SI and Vanuatu) have legislation in place providing at least 12 weeks paid maternity leave.

4. Monitoring

Sixteen PICTs (AS, CNMI, CI, Fiji, FSM, Guam, Kiribati, Nauru, NC, Palau, PNG, Samoa, SI, Tokelau, Tonga and Tuvalu) have collected adult NCD risk factor prevalence data, and 15 PICTs (CNMI, CI, Fiji, FSM, FP, Guam, NC, Palau, PNG, RMI, Tokelau, Tonga, Tuvalu, Vanuatu and WF) have collected adolescent NCD risk factor prevalence data in the last five years. Eleven PICTs (CNMI, CI, Kiribati, Nauru, Niue, Palau, PNG, Samoa, SI, Tuvalu and Tokelau) collect and report data on child growth.

All PICTs (except PNG, SI and WF) have established systems for routinely reporting cause-specific mortality.

Conclusion and recommendations

The report highlights the fact that PICTs are at varying stages of developing and implementing NCD policies and legislation. While strong policies and legislation are in place in some areas, there are policy and legislation gaps that need to be addressed to more effectively respond to the Pacific NCD crisis. Key gaps, where very few PICTs have policies and legislation in place, include preventing tobacco industry interference, restricting alcohol advertising, reducing trans-fats in the food supply, limiting marketing of unhealthy food to children, restricting marketing of breast milk substitutes, establishing baby-friendly hospitals, and supporting breastfeeding through provision of paid maternity leave and breastfeeding breaks and facilities. The following recommendations are made for consideration by Pacific health leaders.

1. **At the national level**, that Pacific health leaders use the Pacific NCD Dashboard to identify national priority areas for action and to track progress on NCD policy and legislation.

2. **At the regional level**, that the Pacific NCD Dashboard continues to be used as a mutual accountability mechanism to monitor PICTs progress on NCD action, and to provide updates at every meeting of Pacific heads of health and health ministers.

Background

Non-communicable diseases in the Pacific

Non-communicable diseases (NCDs) include cardiovascular disease, diabetes, cancer and chronic respiratory disease. The Pacific region has some of the highest rates of NCDs and associated risk factors in the world and are the leading cause of death in most PICTs.[1], accounting for 60–75% of mortalities. NCDs are creating a human, social and economic crisis in the Pacific region, warranting an urgent and comprehensive response. There is also a high prevalence of risk factors for NCDs. including tobacco use, unhealthy diet, alcohol abuse and physical inactivity.

The role of public policy in addressing NCDs

Public policy has a key role to play in addressing the NCD crisis. Economic tools, such as taxes and subsidies, can incentivise healthy behaviours, and taxes can generate revenue that can be invested in prevention and healthcare. In addition, policies and legislation can promote healthy lifestyles by increasing the availability, affordability and consumption of a healthier diet, and decreasing the accessibility and affordability of tobacco, alcohol, and less healthy food and drinks. Public policy can also promote physical activity, for example by improving the accessibility of sports equipment and infrastructure, and by supporting active transport such as walking and cycling.

The importance of public policy to address NCDs is recognised globally, and also in the Pacific region. Globally, the critical role of policy and legislation to combat the NCD crisis was acknowledged by global leaders at the 2011 United Nations High-level meeting on the prevention and control of NCDs, at which leaders recognised 'the primary role and responsibility of governments in responding to the challenge of NCDs'.[2] This commitment is also reflected in the World Health Organization's (WHO) Global Action Plan on NCDs, which emphasises that effectively preventing and managing NCDs requires a whole-of-government approach and collaboration between many sectors outside health, including trade, finance, agriculture and education.[3]

In the Pacific region, in 2014 at the Joint Forum Economic and Health Ministers Meeting, Pacific ministers endorsed the *Non-Communicable Disease Roadmap Report*[4], which provides a 'roadmap' of specific policy, regulatory and tax measures that can be feasibly implemented by PICTs to address NCDs in the Pacific. This commitment has been reaffirmed at subsequent regional meetings, including the 2016 Pacific NCD Summit,[5] at which heads of Pacific Island governments and ministers for health pledged to establish and commit to timelines at the national level to implement the key recommendations of the NCD roadmap. At these meetings, health ministers also agreed to report back at every Pacific health ministers' meeting on progress against the NCD roadmap.

1 World Health Organization (2017) Noncommunicable diseases progress monitor. http://apps.who.int/iris/bitstream/10665/258940/1/9789241513029-eng.pdf

2 United Nations General Assembly (2011). *Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.* http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1

3 World Health Organization (2013). *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*. http://www.who.int/nmh/events/ncd_action_plan/en/

4 *Non-Communicable Disease Roadmap Report* (2014). http://www.forumsec.org/resources/uploads/attachments/documents/2014JEHM.BackgroundA.NCD_Roadmap_FullReport.pdf

5 Pacific Community (2016). *Pacific NCD Summit: Translating global and regional commitments into local action.* Summit Report. http://www.wpro.who.int/southpacific/pic_meeting/2017/documents/12thphmm_session04_04_ncd_annex1_16aug.pdf

Pacific Monitoring Alliance for NCD Action

In order to assist PICTs to monitor progress on implementing the Pacific NCD roadmap, the Pacific Monitoring Alliance for NCD Action (Pacific MANA) was established. Pacific MANA is a collaborative alliance that brings together PICTs and technical partners concerned with the collection, analysis, translation and dissemination of data related to NCDs. Pacific MANA aims to provide a mechanism for coordinating and strengthening NCD monitoring across the Pacific.[6] MANA is led by the Coordination Team, which comprises representatives from the Pacific Community (SPC), the World Health Organization, the Pacific Research Centre for Prevention of Obesity and NCDs (C-POND) based at the Fiji National University, the Pacific Islands Health Officers' Association (PIHOA) and the University of Auckland. The Coordination Team reports to the Steering Committee, comprising the current chair of Pacific heads of health, the outgoing chair, and representatives from Micronesia, Melanesia, Polynesia and Francophone PICTs.

Pacific NCD Dashboard

To assist PICTs to monitor progress on policies and legislation aimed at preventing NCDs, Pacific MANA developed the Pacific NCD Dashboard. The dashboard's indicators cover the areas of leadership and governance, preventative policies, health system response programmes, and routine monitoring processes. It is based on the Pacific NCD roadmap and previous commitments by Pacific health ministers, and is informed by global recommendations and evidence on cost-effective actions. The dashboard's focus on systems, policy and legislation complements existing processes for tracking NCD-related health outcomes through the Healthy Island Monitoring Framework.[7] In 2017–2018, the Pacific MANA Coordination Team collaborated with national NCD focal points to complete dashboards for PICTs. This report presents the collated results for the 21 dashboards endorsed in 2017–2018.

6 Tolley H, Snowdon W, Wate J, Durand AM, Vivili P, McCool J, Novotny R, Dewes O, Hoy D, Bell C, Richards N, Swinburn B (2016). Monitoring and accountability for the Pacific response to the non-communicable diseases crisis. BMC Public Health, 16(1), 958. http://doi.org/10.1186/s12889-016-3614-8

7 Report on the progress of the Healthy Islands Monitoring Framework, for Pacific Health Ministers Meeting (2017) http://www.wpro.who.int/southpacific/pic_meeting/2017/documents/12thphmm_session01_himf_16aug.pdf

Methods

Dashboard overview

The dashboard comprises 31 indicators covering four areas:

i. leadership and governance (multi-sectoral NCD taskforce, national strategies addressing NCD and risk factors, national NCD targets);
ii. preventative policies (tobacco, alcohol, food environments and physical activity);
iii. health system response programmes (access to NCD treatment and drugs, tobacco cessation programmes, and maternal and infant nutrition initiatives);
iv. routine monitoring processes (adult and adolescent risk factor surveys, child growth monitoring and NCD-related mortality).

For each indicator on the dashboard, progress towards implementation of a policy or action is scored by a 'traffic light' colour scheme: red for no policy/action present; amber for policy/action under development; and green for policy/action in place. When a policy is in place (green), the strength of the action/implementation/policy is assessed using a star system (zero to three stars) (Table 1). The detailed indicator definitions and assessment criteria are provided in Appendix 2.

Table 1. Key for indicator ratings for the Pacific NCD Dashboard

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

Development of indicators

The dashboard indicators were developed by the MANA Coordination Team. Many were based on existing global indicators from the WHO NCD progress monitor[8], with scoring criteria adapted to reflect the 'traffic light' scoring system. Other indicators were newly-developed by the MANA Coordination Team to complement these existing indicators. The indicators were then refined through several rounds of piloting the dashboard, and subsequent review of the indicators. The dashboard was piloted in 2015, using data for Fiji, and the indicators were subsequently refined. In December 2016, the MANA Coordination Team met to review the dashboard indicators and draft country dashboards, and the indicators were again refined after this review. At the 2017 Pacific Health Ministers' Meeting, the Pacific NCD Dashboard Data Dictionary was endorsed, and it was agreed that the dashboard be used to provide annual updates on the status of NCD actions at every meeting of Pacific heads of health and health ministers, as a mutual accountability mechanism for the region.

8 World Health Organization (2017) *Noncommunicable diseases progress monitor.* http://apps.who.int/iris/bitstream/10665/258940/1/9789241513029-eng.pdf

The dashboard has been designed to complement the existing Healthy Islands Monitoring Framework, a monitoring framework and core indicators endorsed by Pacific health ministers' as a mechanism to track progress towards the vision of Healthy Islands. Whereas the Healthy Islands indicators primarily relate to health outcomes, the dashboard indicators relate to process, policy, action and legislation. Together, the dashboard and Healthy Islands Monitoring Framework provide a comprehensive mechanism for monitoring NCD-related policy change and health outcomes in PICTs.

Completion of dashboards

Initially, dashboards were pre-filled by members of the MANA Coordination Team in 2017–2018, using information obtained during visits to PICTs and from correspondence with PICT NCD focal points, as well as information available online. PICTs were requested to provide supporting documentation to enable validation of responses. The lead agencies for the completion of the dashboards are summarised in Table 2.

Table 2. Lead agencies from the MANA Coordination Team for dashboard completion

Agencies	Allocated dashboards
C-POND	Fiji, Tokelau, Tuvalu
PIHOA	American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Palau, Marshall Islands
SPC	French Polynesia, Nauru, New Caledonia, Niue, Tonga, Wallis and Futuna, Solomon Islands, Kiribati, Papua New Guinea
WHO	Cook Islands, Samoa, Vanuatu

Draft dashboards were then provided to the relevant PICT NCD focal points for review, and the MANA Coordination Team worked with the focal points to amend the dashboard as required. These reviews were done by a mix of email correspondence, teleconferences and visits to PICTs, as appropriate to each PICT's needs. The completed dashboards were then sent to the minister for health or other appropriate national authority for endorsement. Finally, the dashboards were cross-checked by the MANA Coordination Team to ensure consistent interpretation of indicators across countries, and any discrepancies were resolved by correspondence with countries.

In 2017–2018, dashboards were endorsed by the minister for health or other relevant national authority for all 21 PICTs. All 21 endorsed dashboards are included in this report. Individual profiles for each PICT are available in a supplementary report.

Results and discussion

Results presented below are for the 21 dashboards endorsed in 2017–2018. The authors acknowledge that changes in policy and legislation may have occurred since the completion and endorsement of the dashboards.

Leadership and governance

Thirteen of the 21 PICTs included in this report have a current national multisectoral strategy addressing NCDs and risk factors, 15 have established NCD indicators and targets, and five have an active multisectoral NCD taskforce. Substantial efforts are required to strengthen leadership and governance of NCDs in PICTs. The NCD crisis is driven by multiple factors, both within and outside the health sector, so a multisectoral approach is essential to address this issue. Pacific health ministers have already committed to taking a multisectoral approach to address NCDs.[9,10] Establishing a multisectoral NCD strategy with target indicators and taskforces are essential activities to operationalise this commitment.

Table 3. Summary of findings for Pacific NCD dashboard leadership and governance indicators

Description	Pacific Island Countries and Territories (N=21)						
	Not present		Under development		Present		
	n	%	n	%	n	%	Country
L1. Multi-sectoral NCD taskforce	4	19%	12	57%	5	24%	Guam, Palau, Samoa, Tonga, Tuvalu
L2. National strategy addressing NCDs and risk factors	2	10%	5	24%	14	67%	American Samoa, Cook Islands, FSM, Fiji, French Polynesia, Guam, Kiribati, Niue, Palau, PNG, Samoa, Tonga, Tuvalu, Vanuatu
L3. Explicit NCD indicators and targets	3	14%	3	14%	15	71%	American Samoa, Cook Islands, Fiji, FSM, Guam, Kiribati, New Caledonia, Niue, Palau, PNG, Samoa, Tokelau, Tonga, Tuvalu, Vanuatu

9 Honiara Communique on the Pacific NCD Crisis (2011) http://www.pihoa.org/fullsite/newsroom/wp-content/uploads/downloads/2014/09/Honiara-Communique-2011-MOHs.pdf

10 Pacific Community (2016). *Pacific NCD Summit meeting report* http://www2008.spc.int/images/stories/highlights/2016/NCD-summit/NCD-summit-meeting-report.pdf

Table 4. PICT ratings for Pacific NCD Dashboard leadership and governance indicators

Description	Pacific Island countries and territories (21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
L1. Multi-sectoral NCD taskforce							☆☆☆					☆☆			☆☆☆			☆☆☆	☆☆		
L2. National strategy addressing NCDs and risk factors			☆☆☆		☆☆☆		☆☆☆			☆☆☆			☆☆☆		☆☆☆			☆☆☆	☆☆☆	☆☆☆	
L3. Explicit NCD indicators and targets	☆☆		☆☆☆	☆☆☆	☆☆☆		☆☆☆	☆☆				☆☆☆	☆☆☆		☆☆		☆☆☆	☆☆☆	☆☆	☆☆☆	

Preventive policies

Tobacco

All PICTs have introduced legislation to reduce tobacco consumption, with 18 PICTs implementing tobacco taxation measures. Most PICTs have legislation to create smoke-free public places (18 PICTs), health warnings on tobacco packaging (16 PICTs), restrictions on tobacco sales and licensing (14 PICTs), and restrictions on tobacco advertising, promotion and sponsorship (17 PICTs). However, no PICT currently has a national policy or legislation in place to prevent tobacco industry interference.

Pacific leaders have already committed to taking action on tobacco as part of Tobacco Free Pacific 2025[11] and WHO Framework Convention for Tobacco Control (FCTC) commitments.[12] Based on findings from this report, preventing tobacco industry interference is a key policy gap in PICTs, requiring urgent national action. Other areas that need strengthening include further raising taxes, increasing the use of graphic health warnings and their pack coverage, and tobacco licensing and sales controls.

11 Tobacco Free Pacific http://www.tfp2025.org/tobacco-free-pacific-2025/

12 World Health Organization. Framework Convention on Tobacco Control http://www.who.int/fctc/en/

Table 5. Summary findings for Pacific NCD Dashboard tobacco indicators

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under development		Present		
	n	%	n	%	n	%	Country
T1. Tobacco exercise taxes	0	0%	3	14%	18	86%	American Samoa, CNMI, Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, PNG, Samoa, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
T2. Smoke-free environments	0	0%	3	14%	18	86%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Palau, PNG, Marshall Islands, Samoa, Solomon, Tokelau, Tuvalu, Tonga, Vanuatu
T3. Tobacco health warnings	3	14%	2	10%	16	76%	CNMI, Cook Islands, Fiji, French Polynesia, Kiribati, Guam, Nauru, New Caledonia, Marshall Islands, PNG, Samoa, Solomon, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
T4. Tobacco advertising, promotion and sponsorship	1	5%	3	14%	17	81%	American Samoa, Cook Islands, Fiji, French Polynesia, Kiribati, New Caledonia, Guam, Nauru, Palau, Marshall Islands, PNG, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
T5. Tobacco sales and licencing	4	20%	2	10%	14	70%	American Samoa, CNMI, Cook Islands, Fiji, Guam, Kiribati, Nauru, New Caledonia, Palau, PNG, Solomon Islands, Tonga, Tuvalu, Vanuatu
T6. Tobacco industry interference	15	71%	6	29%	0	0%	

**T5 not applicable for FSM*

Table 6. PICT ratings for Pacific NCD Dashboard tobacco indicators

Description	Pacific Island Countries and Territories (N=21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
T1. Tobacco exercise taxes	☆☆	☆☆	☆☆			☆☆☆					☆☆☆	☆☆☆			☆☆			☆☆☆	☆☆	☆	☆☆☆
T2. Smoke-free environments	☆☆☆	☆☆	☆☆			☆☆☆	☆☆☆	☆☆	☆☆☆		☆☆☆	☆☆	☆☆☆	☆☆	☆☆	☆	☆☆	☆☆	☆☆☆	☆☆☆	
T3. Tobacco health warnings						☆☆☆					☆		☆☆		☆☆	☆☆		☆☆	☆	☆☆☆	
T4. Tobacco advertising, promotion and sponsorship						☆☆☆			☆☆☆		☆☆☆	☆☆☆	☆☆	☆☆	☆☆☆			☆☆	☆☆☆	☆☆	☆☆☆
T5. Tobacco sales and licencing	☆☆☆	☆☆☆			☆☆☆				☆☆			☆☆☆	☆☆☆			☆☆☆		☆	☆☆☆	☆☆☆	
T6. Tobacco industry interference																					

Alcohol

All PICTs included in this report have national licensing regulations in place to restrict the sale of alcohol (except FSM where this is state jurisdiction, and Tuvalu), and 18 PICTs have legislation in place to control drink driving. However, only six PICTs have regulations governing alcohol advertising. Nineteen PICTs have alcohol taxation mechanisms in place but, in most cases, taxation is based on beverage type, rather than on ethanol content, the recommended mechanism for discouraging consumption of beverages with high ethanol content, thereby reducing alcohol-related harm.

Based on findings from this report, there are two key areas where very few PICTs have an established alcohol policy: alcohol taxation based on ethanol content, and regulating alcohol advertising.

Table 7. Summary findings for Pacific NCD Dashboard alcohol indicators

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under development		Present		
	n	%	n	%	n	%	Country
A1. Alcohol licencing to restrict sales	0	0%	0	0%	20	100%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, PNG, Marshall Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
A2. Alcohol advertising	12	60%	1	5%	7	35%	French Polynesia, Guam, New Caledonia, PNG, Samoa, Tuvalu, Wallis and Futuna
A3. Alcohol taxation	0	0%	1	5%	20	95%	American Samoa, CNMI, Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, PNG, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
A4. Drink driving	0	0%	2	10%	18	90%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, Marshall Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Wallis and Futuna

**A1, A2, A4 not applicable for FSM*

Table 8. PICT ratings for Pacific NCD Dashboard alcohol indicators

Description	Pacific Island countries and territories (N=21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
A1. Alcohol licencing to restrict sales	☆☆☆	☆☆☆	☆☆	NA	☆☆	☆☆	☆☆☆	☆☆	☆☆	☆☆	☆☆☆	☆☆☆	☆☆	☆☆	☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆	☆☆	☆☆
A2. Alcohol advertising				NA							☆☆										
A3. Alcohol taxation					☆☆☆				☆☆☆		☆☆☆				☆	☆☆			☆☆☆		
A4. Drink driving	☆☆☆	☆☆☆		NA	☆☆	☆☆	☆☆	☆	☆☆	☆	☆☆	☆☆		☆		☆☆		☆☆	☆		☆☆☆

Food

Fourteen PICTs have policies or activities in place to reduce population salt consumption. Thirteen PICTs have fiscal policies in place to make healthy food choices easier and cheaper and to discourage unhealthy food choices, but only four PICTs were rated as having 'strong' (i.e. three-star rating) measures in place. Thirteen PICTs have national food-based dietary guidelines for adults. No PICTs have policies or legislation to limit trans-fats in the food supply. In terms of actions to encourage healthy eating among children, only two PICTs have policies in place to restrict marketing of unhealthy food to children, and 11 PICTs have policies or guidelines encouraging healthy food services in schools.

Based on findings from this report, there are two key areas where very few PICTs have established policy: limiting trans-fats and restricting marketing of unhealthy foods to children. Banning trans-fats is recommended by WHO as a cost-effective intervention[13], given the evidence that eliminating trans-fats from the food supply is expected to impact directly on cardiovascular disease mortality.[14,15] The *Report of Commission on Ending Childhood Obesity* recommends implementing the *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*[16] to reduce the power of the marketing of unhealthy foods and the exposure of children and adolescents to it. Further work on other areas of food policy is also critical.

Table 9. Summary findings for Pacific NCD Dashboard food indicators

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under develop-ment		Present		
	n	%	n	%	n	%	Country
F1. Reducing salt consumption	4	19%	1	5%	15	71%	Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, PNG, Samoa, Solomon Islands, Tuvalu, Vanuatu
F2. Trans-fats	10	48%	11	52%	0	0%	
F3. Unhealthy food marketing to children	15	71%	4	19%	2	10%	French Polynesia, Kiribati
F4. Food fiscal policies	5	24%	3	14%	13	62%	Cook Islands, Fiji, FSM, French Polynesia, Kiribati, Nauru, Niue, Marshall Islands, Samoa, Tokelau, Tonga, Vanuatu, Wallis and Futuna
F5. Healthy food policies in schools	3	15%	6	30%	11	55%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, New Caledonia, Niue, Samoa, Vanuatu
F6. Food-based dietary guidelines	1	5%	7	33%	13	62%	Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, New Caledonia, Niue, Marshall Islands, Samoa, Solomon Islands, Tonga, Vanuatu

**F5 not applicable for FSM*

13 World Health Organization (2017). 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases http://apps.who.int/iris/bitstream/10665/259232/1/WHO-NMH-NVI-17.9-eng.pdf

14 Restrepo BJ, Rieger M (2015). Denmark's Policy on Artificial Trans Fat and Cardiovascular Disease. Am J Prev Med 50(1):69-76. doi: 10.1016/j.amepre.2015.06.018.

15 Restrepo BJ, Rieger M (2016). Trans fat and cardiovascular disease mortality: Evidence from bans in restaurants in New York. J Health Econ 45:176-96. doi: 10.1016/j.jhealeco.2015.09.005.

16 World Health Organization (2010). Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children. http://apps.who.int/iris/bitstream/10665/44416/1/9789241500210_eng.pdf

Table 10. PICT ratings for Pacific NCD Dashboard food indicators

Description	Pacific Island countries and territories (N=21)																				
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
F1. Reducing salt consumption			☆☆	☆☆☆	☆☆☆	☆☆	☆☆	☆☆	☆		☆☆	☆	☆		☆☆☆						
F2. Trans-fats																					
F3. Unhealthy food marketing to children								☆☆☆													
F4. Food fiscal policies			☆	☆	☆	☆		☆☆☆	☆☆☆	☆☆				☆	☆☆☆		☆☆	☆☆☆		☆☆	☆
F5. Healthy food policies in schools	☆☆		☆	NA	☆	☆☆☆	☆☆☆	☆		☆☆	☆				☆						
F6. Food-based dietary guidelines			☆☆		☆	☆☆	☆☆	☆☆☆		☆☆☆	☆☆			☆	☆☆☆	☆☆☆		☆☆			

Physical activity

Fourteen PICTs have included physical activity as a compulsory component of the school curriculum.

Table 11. Summary findings for Pacific NCD Dashboard physical activity indicator

Description	Pacific Island countries and territories (N=21)*					
	Not present		Under develop-ment		Present	
	n	%	n	%	n	%	Country
P1. Compulsory physical education in school curriculum	2	9%	5	24%	14	67%	American Samoa, Cook Islands, French Polynesia, Guam, Kiribati, Nauru, Niue, New Caledonia, PNG, Samoa, Solomon Islands, Tokelau, Tonga, Wallis and Futuna

Table 12. PICT ratings for Pacific NCD Dashboard physical activity indicator

Description	Pacific Island countries and territories (N=21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
P1. Compulsory physical education in school curriculum	☆☆☆		☆☆			☆☆☆	☆	☆☆☆	☆☆☆	☆☆☆			☆☆		☆☆	☆☆	☆☆	☆			☆☆☆

Enforcement

Fourteen PICTs have a government-level system in place to support enforcement of tobacco, alcohol, food and betel-nut legislation, although the strength of enforcement systems varies greatly.

Table 13. Summary findings for Pacific NCD Dashboard enforcement indicator, February 2018

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under de-velopment		Present		
	n	%	n	%	n	%	Country
E1. Enforcement of laws and regulations related to NCD risk factors	2	10%	5	23%	13	67%	CNMI, Cook Islands, Fiji, Guam, Kiribati, Nauru, Niue, New Caledonia, PNG, Samoa, Solomon Islands, Tonga, Tuvalu, Wallis and Futuna

**E1 not applicable for FSM*

Table 14. PICT ratings for Pacific NCD Dashboard enforcement indicator, February 2018

Description	Pacific Island countries and territories (N=21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
E1. Enforcement of laws and regulations related to NCD risk factors		☆☆☆		NA			☆	☆								☆		☆	☆☆		☆☆☆

Health system response programmes

Nineteen PICTs have national guidelines in place for the diagnosis and management of at least one of the four main NCDs (cardiovascular disease, diabetes, cancer and chronic respiratory disease). Fifteen PICTs have included all essential NCD medicines in the national list of essential medicines and have systems in place to ensure their availability. Smoking cessation support of some kind is available in 15 PICTs. Regarding programmes related to infant nutrition, seven PICTs have restrictions on the marketing of breast milk substitutes, six have a public hospital certified as a baby-friendly hospital, and eight provide at least 12 weeks paid maternity leave.

Based on findings from this report, there are three key areas where very few PICTs have an established policy: restricting marketing of breast milk substitutes, baby-friendly hospitals accreditation, and provision of paid maternity leave and breastfeeding breaks and facilities. Action in these areas are identified by the Commission on Ending Childhood Obesity as key strategies to address childhood obesity.

Table 15. Summary findings for Pacific NCD Dashboard health system response programme indicators

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under development		Present		
	n	%	n	%	n	%	Country
H1. National guidelines for care of main NCDs	1	5%	1	5%	19	90%	American Samoa, Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Marshall Islands, PNG, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
H2. Essential drugs	1	5%	4	20%	15	75%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Samoa, Tokelau, Tonga, Tuvalu, Wallis and Futuna
H3. Smoking cessation	3	15%	2	10%	15	75%	American Samoa, CNMI, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, Samoa, Solomon Islands, Tonga, Vanuatu
H4. Marketing of breast milk substitutes	11	52%	3	14%	7	33%	Fiji, French Polynesia, Kiribati, New Caledonia, Palau, PNG, Solomon Islands
H5. Baby-friendly hospitals	8	38%	7	33%	6	29%	American Samoa, Fiji, FSM, Kiribati, Solomon Islands, Vanuatu
H6. Maternity leave and breastfeeding	4	19%	9	43%	8	38%	Fiji, French Polynesia, Kiribati, Nauru, New Caledonia, Niue, Solomon Islands, Vanuatu

**H2, H3 not applicable for FSM*

Table 16. PICT ratings for Pacific NCD Dashboard health system response programme indicators

Description	Pacific Island countries and territories (N=21)																				
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
H1. National guidelines for care of main NCDs	☆☆		☆		☆	☆☆☆	☆☆	☆	☆	☆☆☆	☆☆☆		☆		☆	☆☆☆	☆☆	☆☆☆	☆☆	☆	☆☆☆
H2. Essential drugs		☆☆☆		NA	☆	☆☆☆		☆☆	☆☆	☆☆	☆☆☆				☆☆		☆☆☆	☆☆☆	☆☆		☆☆☆
H3. Smoking cessation	☆	☆☆	☆☆	NA	☆	☆☆	☆☆		☆	☆☆☆	☆☆☆	☆				☆☆		☆☆☆		☆	
H4. Marketing of breast milk substitutes					☆☆☆							☆☆☆									
H5. Baby-friendly hospitals					☆																
H6. Maternity leave and breastfeeding					☆	☆☆☆		☆													

Monitoring

Risk factor prevalence

Sixteen PICTs have established mechanisms to monitor NCD risk factor prevalence in adults, typically via population-based surveys such as STEPS, and have collected data within the last five years. Fourteen PICTs have collected adolescent NCD risk factor prevalence data in the last five years, typically via school-based surveys such as the Global School-based Student Health Survey and the Global Youth Tobacco Survey. While several PICTs have completed at least one adult and one adolescent risk factor survey, further action is required to ensure that surveys are planned and implemented at defined intervals.

Child growth monitoring

Ten PICTs collect and report data on child growth. Given that most PICTs already have mechanisms for monitoring childhood growth, there is a need to harmonise and strengthen these mechanisms, and to collate and publish these data to monitor trends in child over- and underweight in the Pacific.

Routine cause-specific mortality

Eighteen PICTs have established systems for routinely reporting cause-specific mortality. Of these, 11 PICTs were rated as having a 'strong' (i.e. three-star rating) system in place. Further efforts are required to strengthen reporting of cause-specific mortality data in PICTs, including improving data quality (particularly reporting from remote areas such as outer islands), and improving timeliness of public reporting of aggregated mortality data.

Table 17. Summary findings for Pacific NCD Dashboard monitoring indicators

Description	Pacific Island countries and territories (N=21)*						
	Not present		Under develop-ment		Present		
	n	%	n	%	n	%	Country
M1. Population risk factor prevalence surveys – adults	0	0%	4	19%	17	81%	American Samoa, CNMI, Cook Islands, Fiji, FSM, Guam, Kiribati, Nauru, New Caledonia, Palau, PNG, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu
M2. Population risk factor prevalence surveys – youth	4	19%	2	10%	15	71%	CNMI, Cook Islands, Fiji, FSM, French Polynesia, Guam, New Caledonia, Palau, PNG, Marshall Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna
M3. Child growth monitoring	0	0%	11	52%	10	48%	CNMI, Cook Islands, Kiribati, Nauru, Niue, Palau, PNG, Samoa, Solomon Islands, Tokelau
M4. Routine cause-specific mortality	1	5%	2	10%	18	86%	American Samoa, CNMI, Cook Islands, Fiji, FSM, French Polynesia, Guam, Kiribati, Nauru, New Caledonia, Niue, Palau, Marshall Islands, Samoa, Tokelau, Tonga, Tuvalu, Vanuatu

Table 18. PICT ratings for Pacific NCD Dashboard monitoring indicators

Description	Pacific Island countries and territories (N=21)																				
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
M1. Population risk factor prevalence surveys - adults	☆☆	☆☆	☆☆☆	☆☆☆	☆		☆	☆☆	☆☆		☆☆☆	☆☆	☆		☆☆☆	☆☆	☆☆☆	☆☆☆	☆☆☆		
M2. Population risk factor prevalence surveys - youth			☆☆☆	☆☆☆	☆	☆☆☆						☆☆☆		☆			☆☆☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆
M3. Child growth monitoring		☆	☆☆						☆☆☆	☆☆☆		☆☆☆	☆☆☆				☆		☆☆		
M4. Routine cause-specific mortality	☆☆☆	☆☆☆	☆☆☆	☆☆	☆	☆☆☆	☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆		☆☆	☆☆☆			☆☆	☆☆☆		

Conclusion and recommendations

This report highlights the fact that PICTs are at varying stages of developing and implementing NCD policies and legislation. While strong policies and legislation are in place in some areas, there are several policy and legislation gaps that need to be addressed to effectively respond to the NCD crisis in the Pacific region. Key gaps, where very few PICTs have policies and legislation in place, include: preventing tobacco industry interference, restricting alcohol advertising, reducing trans-fats in the food supply, limiting marketing of unhealthy food to children, restricting marketing of breast milk substitutes, establishing baby-friendly hospitals, and supporting breastfeeding through provision of paid maternity leave and breastfeeding breaks and facilities.

Overall, the completion of the dashboards was reported to be an informative exercise at national level, with both the process and the completed dashboard informative about current strengths and indicating where more action is needed. As this was the first round of data collection and validation, it was more time-consuming than is expected in subsequent rounds, when the process will be to update existing dashboards.

The following recommendations are made for consideration by Pacific health leaders.

1. **At the national level, it is recommended that Pacific health leaders use the Pacific NCD Dashboard to identify national priority areas for action.**
   The dashboard can be used as an internal accountability mechanism, to identify national priority areas and targets, inform strategic planning, and track progress on NCD policies and legislation. The dashboard can also be used as a mechanism for South-South collaboration, whereby PICTs can access information about policies and legislation in other PICTs, and identify opportunities for sharing resources and lessons learned.

2. **At the regional level, it is recommended that the Pacific NCD Dashboard continue to be used as a mutual accountability mechanism to monitor PICTs progress on NCD action.**
   As agreed at the Pacific Health Ministers' Meeting in 2017 and Pacific Heads of Health Meeting 2018, dashboards will be updated annually by the MANA Coordination Team in collaboration with country staff, and used to provide updates at every meeting of Pacific heads of health and ministers for health. The dashboard indicators will also be subject to ongoing review, and may be refined to reflect emerging health priorities or new data sources.

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Appendix 1: PICT ratings for Pacific NCD Dashboard indicators

Description	Pacific Island countries and territories (N=21)																			
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
Leadership and governance																					
L1. Multi-sectoral NCD taskforce							☆☆☆					☆☆☆			☆☆☆			☆☆☆	☆☆		
L2. National strategy addressing NCDs and risk factors			☆☆☆		☆☆☆		☆☆☆			☆☆☆			☆☆☆		☆☆☆			☆☆☆	☆☆☆	☆☆☆	
L3. Explicit NCD indicators and targets	☆☆		☆☆☆	☆☆☆	☆☆☆		☆☆☆	☆☆				☆☆☆	☆☆☆		☆☆		☆☆☆	☆☆☆	☆☆	☆☆☆	
Preventive policies																					
Tobacco																					
T1. Tobacco excise taxes	☆☆	☆☆	☆☆☆	☆	☆	☆☆☆	☆	☆	☆	☆	☆☆☆	☆☆☆			☆☆			☆☆☆	☆☆	☆	☆☆☆
T2. Smoke-free environments	☆☆☆	☆☆	☆☆		☆	☆☆☆	☆☆☆	☆☆	☆☆☆		☆☆☆	☆☆	☆☆☆	☆☆	☆☆	☆	☆☆	☆☆	☆☆☆	☆☆☆	
T3. Tobacco health warnings			☆☆		☆☆☆	☆☆☆	☆				☆		☆☆		☆☆	☆☆		☆☆	☆	☆☆☆	
T4. Tobacco advertising, promotion and sponsorship						☆☆☆		☆☆	☆☆☆		☆☆☆	☆☆☆	☆☆	☆☆	☆☆☆			☆☆	☆☆☆	☆☆	☆☆☆
T5. Tobacco sales and licencing	☆☆☆	☆☆☆	☆	NA	☆☆☆		☆☆	☆	☆☆			☆☆☆	☆☆☆			☆☆☆		☆	☆☆☆	☆☆☆	
T6. Tobacco industry interference																					
Alcohol																					
A1. Alcohol licencing to restrict sales	☆☆☆	☆☆☆	☆☆	NA	☆☆	☆☆	☆☆☆	☆☆	☆☆	☆☆	☆☆☆	☆☆☆	☆☆	☆☆	☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆	☆☆	☆☆
A2. Alcohol advertising				NA							☆☆										
A3. Alcohol taxation					☆☆☆				☆☆☆		☆☆☆				☆	☆☆			☆☆☆		

Description	Pacific Island countries and territories (N=21)																				
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
A4. Drink driving	☆	☆		NA	☆☆	☆☆	☆☆	☆	☆☆	☆	☆☆	☆☆		☆		☆☆		☆☆	☆		☆☆☆
Food																					
F1. Reducing salt consumption			☆☆	☆☆☆	☆☆☆	☆☆	☆☆	☆☆	☆		☆☆	☆	☆		☆☆☆						
F2. Trans-fats																					
F3. Unhealthy food marketing to children								☆☆☆													
F4. Food fiscal policies			☆	☆	☆	☆		☆☆☆	☆☆☆	☆☆				☆	☆☆☆		☆☆	☆☆☆		☆☆	☆
F5. Healthy food policies in schools	☆☆		☆	NA	☆	☆☆☆	☆☆☆	☆		☆☆	☆				☆						
F6. Food-based dietary guidelines			☆☆		☆	☆☆	☆☆	☆☆☆		☆☆☆	☆☆			☆	☆☆☆	☆☆☆		☆☆			
Physical Activity																					
P1. Compulsory physical education in school curriculum	☆☆☆		☆☆			☆☆☆	☆	☆☆☆	☆☆☆	☆☆☆			☆☆		☆☆	☆☆	☆☆	☆			☆☆☆
Enforcement																					
E1. Enforcement of laws and regulations related to NCD risk factors		☆☆☆		NA			☆	☆								☆		☆	☆☆		☆☆☆
Health system response programmes																					
H1. National guidelines for care of main NCDs	☆☆		☆		☆	☆☆☆	☆☆	☆	☆	☆☆☆	☆☆☆		☆		☆	☆☆☆	☆☆	☆☆☆	☆☆	☆	☆☆☆
H2. Essential drugs		☆☆☆		NA	☆	☆☆☆		☆☆	☆☆	☆☆	☆☆☆				☆☆		☆☆☆	☆☆☆	☆☆		☆☆☆
H3. Smoking cessation	☆	☆☆	☆☆	NA	☆	☆☆	☆☆		☆	☆☆☆	☆☆☆	☆				☆☆		☆☆☆		☆	

Description	Pacific Island countries and territories (N=21)																				
	A Samoa	CNMI	Cook Islands	FSM	Fiji	French P	Guam	Kiribati	Nauru	Niue	New Caledonia	Palau	PNG	RMI	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu	W&F
H4. Marketing of breast milk substitutes					☆☆☆							☆☆☆									
H5. Baby-friendly hospitals					☆																
H6. Maternity leave and breastfeeding					☆	☆☆☆		☆													
Monitoring																					
M1. Population risk factor prevalence surveys - adults	☆☆	☆☆	☆☆☆	☆☆☆	☆		☆	☆☆	☆☆		☆☆☆	☆☆	☆		☆☆☆	☆☆	☆☆☆	☆☆☆	☆☆☆		
M2. Population risk factor prevalence surveys - youth			☆☆☆	☆☆☆	☆	☆☆☆						☆☆☆		☆			☆☆☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆
M3. Child growth monitoring		☆	☆☆						☆☆☆	☆☆☆		☆☆☆	☆☆☆				☆		☆☆		
M4. Routine cause-specific mortality	☆☆☆	☆☆☆	☆☆☆	☆☆	☆	☆☆☆	☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆	☆☆☆		☆☆	☆☆☆			☆☆	☆☆☆		

Appendix 2: Pacific NCD Dashboard Data Dictionary

Key

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

Leadership and governance

L1. Multi-sectoral NCD taskforce

A multi-sectoral taskforce 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 taskforce 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 taskforce is being established, or a taskforce exists and has had at least two meetings in the last 12 months but no public reports are available
	A multi-sectoral NCD taskforce has had at least two meetings in the last 12 months, and an annual report (or equivalent) is available
☆	As for , and one of the items listed below
☆ ☆	As for , and three of the items listed below
☆ ☆ ☆	As for , and four or more of the items listed below
	• The taskforce is led by a government minister or prime minister • The NCD taskforce demonstrates decision-making, monitors implementation and publicly documents its actions. • The taskforce includes senior representation from government sectors, such as: attorney general, and ministries of agriculture, communications, customs and excise, education, finance and economic planning, health, labour and industry, sport, national statistics, trade, police, urban planning and national statistics office (at least five) • The taskforce includes civil society and non-governmental organisations • Platform has established mechanisms for engagement with the private sector (with conflicts of interest managed), EXCLUDING the tobacco industryPrivate sector engagement can be through the taskforce or at national level

L2. National strategy addressing NCDs and risk factors

A comprehensive, multi-sectoral national strategy addressing NCDs and risk factors is operational
WHO Equivalent Indicator #4

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

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 20 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 areas listed
	Completely smoke-free places include: • health-care facilities • educational facilities other than universities • universities • government facilities • indoor offices and workplaces not considered in any other category • restaurants or facilities that serve mostly food • cafes, pubs and bars or facilities that serve mostly beverages • public transport

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 no principal language(s)
☆	Average principal display less than or equal to 50%, with pictorials **or** principal language(s)
☆ ☆	Average principal display less than or equal to 50%, with pictorials **and** principal language(s)
☆ ☆ ☆	Average principal display 51% or greater, with pictorials and principal language(s)

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 or loose tobacco is banned
☆	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

T6. Tobacco industry interference

Government-level policies or laws are in place to prevent tobacco industry interference
WHO Equivalent Indicator: No equivalent

	No government-level tobacco industry interference preventative policies or laws are in place
	Government-level tobacco industry interference preventative policies or laws are planned
	Government-level tobacco industry interference preventative 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 four 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

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-premise sales of beer, wine and spirits regarding hours and locations of sales **and** restrictions exist for off-premise 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 NCD strategy or other relevant plan • There is a stipulated population salt/sodium intake reduction goal • Salt awareness programmes/education are in place • Mandatory salt labelling regulations are in place • Sodium targets are in place for food groups that are major contributors to sodium intake, based on international best practice

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 reference to trans-fats in relevant strategy or action plans (e.g. NCD plan, nutrition plan)
	Activities cover one of the areas listed
☆	Activities cover two of the areas listed
☆ ☆	Activities cover three or four of the areas listed
☆ ☆ ☆	Activities cover five or six of the areas listed
	• Mandatory food labelling regulations that include total fats and trans-fats • Ongoing monitoring of trans-fatty acids in processed foods and/or restaurants • National dietary guidelines refer to reducing intake of trans-fatty acids • Voluntary or mandatory controls on reuse of oils in catering establishments • Awareness campaigns on trans-fat risks and avoidance are being conducted • Mandatory food standards that prevent the sale of foods containing trans fats

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 and outdoor advertising (near schools and early childhood education centres, at children-related events) • through sponsorship for child-related events/sports • advertising in settings where children gather: 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

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
	• Excise duties are levied on imported and/or locally sugar-sweetened beverages (SSB) of at least 20% of retail price; or fiscal import tax is imposed on raw materials for local producers to an equivalent level • Provision is made to increase sugar-sweetened beverage taxation rates to account for inflation • Fruit and vegetables are exempt from added taxes; and/or all unprocessed foods are zero rated VAT (or equivalent) • Excise duties are levied on at least one imported/locally produced 'unhealthy food' (in line with WPRO nutrient profiling tool) • 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. Food-based dietary guidelines

National food-based dietary guidelines are in place
WHO Equivalent Indicator: No equivalent

	There are no national food-based dietary guidelines for adults
	National food-based dietary guidelines for adults are under development, or a process is under way to adopt/adapt international or regional guidelines
	National food-based dietary guidelines for adults are in place, or international/regional guidelines have been adopted, that cover five of the areas listed
☆	National food-based dietary guidelines cover six of the areas listed
☆ ☆	National food-based dietary guidelines cover six of the areas listed AND Dietary food-based guidelines are included in the school curriculum
☆ ☆ ☆	National food-based dietary guidelines cover six of the areas listed AND Food-based dietary guidelines are included in the school curriculum AND There is evidence that food-based dietary guidelines are used to inform policy-making
	• Available in all principal languages • Encourage consumption of a balanced diet • Recommend the number of serves from each food group to be eaten each day • Provide guidance about portion size • Promote minimal consumption of fat, salt and sugar • Promote physical activity and maintaining a healthy weight • Promote healthy cooking practices • Promote local food and traditional recipes • Recommend exclusive breastfeeding for first six months and continued breastfeeding until at least two years of age

Physical activity

P1. Compulsory physical education in 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 existing syllabus is not mandatory/enforced/monitored
	Physical education 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 a 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 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 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)

	Domain 1: Tobacco At least one of the following: • Restrictions on tobacco advertising (see Indicator T4) • Smoke-free environments (see Indicator T2) • Tobacco sales, licensing and registration (see Indicator T5) • Health warnings (see Indicator T3) • Taxation (see Indicator T1) **Domain 2: Alcohol** At least one of the following: • Restrictions on alcohol advertising (see Indicator A2) • Taxation (see Indicator A3) • Restrictions on alcohol sales (see Indicator A1) **Domain 3: Food** At least one of the following: • Regulations on food labelling (trans fats, salt) and food standards (trans fats) (see F1 and F2) • Controls on reuse of oils in catering establishments (F2) • Restrictions on food marketing to children (F3) • Food fiscal policies (see F4) • Healthy food policies in schools (F5) • Compulsory physical education in school curriculum (see P1) • Marketing of breast milk substitutes (see H4) **Domain 4: Betel nut** • Restrictions on use of betel nut in workplaces or public spaces • Betel nut sales to minors are banned • Taxation

Health system response programmes

H1. National guidelines for 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 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 one of the four main NCDs are in place and are being implemented
☆	National guidelines are in place and implemented in public sector health facilities for two of the four 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

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 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 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 health care facilities in the last 12 months
	• insulin • aspirin (100 mg) • metformin • thiazide diuretics • ACE inhibitors • CC Blockers • statins • sulphonylureas

H3. Smoking 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 facility
☆	Cessation services (at a minimum, brief cessation intervention or 5A's) are available in at least one health care facility and cover one area listed
☆ ☆	Cessation services are available in at least one health care facility AND cover two areas listed
☆ ☆ ☆	Cessation services are available in at least one health care facility AND cover three or more areas listed
	• NRT available • National Quitline • Cessation services at all facilities • Cessation services are fully cost-covered

H4. Marketing of breastmilk substitutes

National laws govern the implementation of the International Code of Marketing of Breastmilk Substitutes
WHO Equivalent Indicator #7d

	No government or self-regulated restrictions exist for marketing of breastmilk substitutes (BMS)
	Government 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 regulations are in place and implemented according to the International Code of Marketing of BMS, and cover one area listed
☆	Regulations cover two areas listed
☆ ☆	Regulations cover three areas listed
☆ ☆ ☆	Regulations cover four 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 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

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 externally BFH certified
	At least one public hospital has been BFH certified through external 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. annually)
☆ ☆ ☆	As for ☆, and all hospitals with BFH designation are externally reassessed at intervals (e.g. five years)

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 green rating
	Legislation is in place providing at least 12 weeks 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: • Provision of breast-feeding facilities in workplaces and/or public areas • 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
☆ ☆	As for , AND legislation is in place covering two of the areas listed
☆ ☆ ☆	As for , AND legislation is in place covering three of the areas listed

Monitoring

M1. Population risk factor prevalence surveys - adults

A population NCD risk factor prevalence survey for ADULTS has been conducted in the last 5 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 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)

M2. Population risk factor prevalence surveys - youth

A population NCD risk factor prevalence surveys 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 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: captures 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)

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