Noncommunicable Diseases and Mental Health

Progress Report 2002-2003
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Introduction and major achievements in 2002-2003

Over 38 million deaths per year (or 67% of all deaths) in the world are due to noncommunicable diseases (NCDs), neuropsychiatric disorders and injuries (WHR, 2002). The leading cause of death is cardiovascular disease, responsible for 30% of all deaths. Tobacco causes the death of some 5 million people each year.

NCDs are the leading cause of death and disease burden in all WHO regions, with the exception of Africa. (table below)

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<th>Noncommunicable conditions, including neuropsychiatric disorders, and injuries as causes (%) of death and disease burden by WHO Region (WHR, 2002)</th>
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<td>Disease Burden (DALYs)</td>
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In developing countries, injuries, neuropsychiatric disorders and cardiovascular diseases are the three leading causes of disease burden. The NCD epidemic in developing countries constitutes an enormous challenge to the Governments of these countries many of which are struggling with the double burden caused by both noncommunicable and communicable diseases.

In Africa, South-East Asia and the Eastern Mediterranean half of the people dying due to cardiovascular diseases are from the age group younger than 70 years. More than half of the disease burden caused by neuropsychiatric disorders and injuries comes from the age group younger than 30 years.

Tobacco, alcohol, blood pressure and high cholesterol are among the leading risk factors as causes of disease burden in both developed and developing countries. Even in high mortality developing countries they are among the 12 leading selected risk factors. In these poorest populations of the world nutritional deficiencies are a major cause of morbidity and mortality among children under five. It is estimated that 54% of deaths in this age group are associated with malnutrition.
Strong evidence exists showing that the disease burden caused by the NCD epidemic is preventable to a large extent. The emphasis of the work of the Noncommunicable Diseases and Mental Health cluster during the period under review has been in the development of effective strategies and interventions to prevent these major causes of the disease burden and supporting Member States in the building of health systems which are better equipped to cope with the increasing burden. The cluster has maintained close cooperation with the Regional Offices and a wide range of collaborating partners outside WHO.

Timely information on noncommunicable diseases (NCDs) and their factors is essential for accurate analysis of country-level disease burden, advocacy for health promotion and to provide expert advice on health policy. The NCD Surveillance has focused on two main areas in 2002-2003: (i) assembly, display and dissemination of NCD data from Member States; and (ii) survey tools for gathering data (NCDs, Injuries and Mental Health) in a standard way. Two specific frameworks have been developed to address these areas of work: The STEPwise approach to NCD Risk Factor Surveillance (STEPS) and the WHO Global NCD InfoBase (NCD InfoBase). STEPS provides a framework for developing country capacity to collect data on NCDs in a standard way. The WHO Global NCD InfoBase underpins NMH's efforts to reduce the burden of premature death and disease related to NCD by providing good quality, comparable prevalence data for NCDs and their risk factors. The web interface for the NCD InfoBase is a major achievement for the cluster.

The unanimous adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC) by WHO’s Member States on 21 May 2003 is a crowning achievement for WHO. For the first time in its history the Organization has invoked article 19 of its Constitution in order to advance its public health goals. The WHO FCTC shows that it is possible to harmonize the complex and often contradictory positions of different national sectors - finance, trade, labour, health, agriculture and social affairs ministries – in order to give birth to a treaty that places long-term public health gains above short-term profit.

Following the endorsement of the WHO Global Strategy for the Prevention and Control of Noncommunicable Disease by the World Health Assembly in 2000, major work has been started by the NMH cluster along the lines of the strategy.

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1 The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.
The strategy, endorsed by the World Health Assembly in 2000, called for supporting Member States in upgrading their work for NCD prevention, for establishing regional networks and for global networking. The World Health Assembly in 2002 in its resolution requested the Director General "to develop a global strategy on diet, physical activity and health within the framework of the renewed WHO strategy for the prevention and control of noncommunicable diseases". In accordance with the WHA resolution a comprehensive process has since taken place in preparation for discussions on the strategy at the Executive Board in its 113th session and the 57th World Health Assembly.

With regards to Management of Noncommunicable Diseases and Disabilities, a global Cancer Alliance has been initiated, a set of tools for the integrated prevention and control of cardiovascular disease and diabetes now exist for policy makers and health professionals, the Palplus protocol for chronic respiratory diseases has been finalized. The programme of Blindness and Deafness - Vision 2020 and the rehabilitation programme presently run activities in more than 30 countries. A web-based genomic resource centre has been developed to provide advice to developing countries in genetics technology and ethics. A normative tool about new approaches to the management of chronic conditions has been developed as well as a global report on improving adherence for chronic conditions. In the context of the 25th celebration of the Alma-Ata declaration, primary health care (PHC) policies have been reviewed and a report for the WHA on future strategic directions for PHC has been developed.

Following the success of the “year of mental health” in 2001 at WHO, including the World Health Day, World Health Report and Round Tables in the World Health Assembly, the Department of Mental Health and Substance Dependence has launched the Mental Health Global Action Programme (mhGAP). This new programme endorsed by the WHA 2002 is based on four strategies: (i) information for decision-making and technology transfer; (ii) education and advocacy; (iii) developing comprehensive and effective mental health policies and services; and (iv) stimulating public mental health research. The implementation of this programme within countries has been a priority.

The release of the World report on violence and health in October 2002 was a major achievement for the cluster and for WHO as a whole. For the first time ever WHO brought to the world’s attention a landmark report that raises awareness about the problem of violence as a public health issue, highlighting the crucial role for public health in addressing its causes and consequences, and providing specific recommendations encouraging action to prevent violence across sectors and within all levels of society. The launch of the report was followed by a number
of significant events including the passing of several Resolutions (World Health Assembly, African Union, Commission on Human Rights, the World Medical Association, etc); more than 35 national launches or policy discussions; and the commitment by several countries to develop national reports, national plans of action or networks for violence prevention. World Health Day 2004, dedicated to Road Safety will be a unique opportunity to raise awareness about the health impact and societal costs of road traffic injuries. It will be used to highlight vulnerabilities of different groups of road users and will call for increased efforts to prevent road traffic injuries.
Noncommunicable Disease Prevention and Health Promotion (NPH)

Action and Progress

1. Considerable progress has been made in upgrading NCD prevention in WHO’s agenda and in providing NCD prevention support to Member States. *The WHO Global Strategy for NCD Prevention and Control* (WHA 2000) highlights prevention and emphasizes the need for integrated approach addressing the common risk factors. This concerns tobacco use, with the *Framework Convention on Tobacco Control* passed by WHA 56; and unhealthy diet and physical inactivity, with the ongoing work and multi-stakeholder consultations in developing the *Global Strategy on Diet, Physical Activity and Health*.

2. The WHO Strategy for NCD Prevention and Control also promotes global partnership and global networking, and provides technical support and strategic support for research and development. Considerable progress has been made in establishing the Global Forum for NCD prevention and control and regional networks, for implementing integrated NCD prevention measures and promoting capacity building. The development of surveillance research, advocacy, capacity building and country support has also been emphasized.

The Regional Networks

3. One of the key approaches has been the regional networks for NCD integrated prevention and control, developed as tools for collaboration between active countries, Regional Offices and Headquarters, to disseminate information, exchange experiences, support regional and national initiatives and help implement evidence-based prevention measures.

4. The regional networks are currently at different stages of development. Two well-established networks of national NCD prevention programmes, CINDI network and CARMEN network, are active in European and American countries. EMAN network for the Eastern Mediterranean region of WHO and NANDI network for the Africa region were initiated in 2001. The Western Pacific region is already operating on an informal network basis. The South-East Asia Region is preparing to establish a regional network for integrated NCD prevention and control. These networks involve currently some 80 Member States. The number is increasing especially in the regions with recently established networks.

The Mega Country Health Promotion Network

5. The Mega Country Health Promotion Network was endorsed by the resolution on Health Promotion (WHA51.12) in May 1998, which “noted the efforts made by the 10 countries with a
population of over 100 million (Mexico now makes it 11) to promote the establishment of a network of most populous countries for health promotion”. In 2002-2003 the work of the network was significantly upgraded. The previously started school health component has continued to develop and strengthen. In the Health Behaviour Surveillance component considerable progress was made to help the countries to develop their health behaviour surveillance to serve the national health promotion. In 2002-2003 the work of the Network focused much on national capacity and on addressing the major risk factors: tobacco, unhealthy diet and physical inactivity. This was linked with the work on FCTC and Global Strategy on Diet, Physical Activity and Health.

The Global Forum on NCD Prevention and Control

6. The Global Forum on NCD Prevention and Control was initiated by WHO in 2000 and brings together the Regional Networks and WHO Headquarters with international NGOs, WHO collaboration centres and UN organizations. The Forum functions as an important vehicle to exchange experiences and discusses common actions. It has increased the global visibility of NCD prevention. Three meetings of the Global Forum have so far been held: Geneva in 2001, Shanghai in 2002, and Rio de Janeiro in 2003.

Progress in Health Promotion

7. Further to the Ministerial Statement for Promoting Health (Mexico, 2000), considerable progress has been made in all WHO Regions. The African Region (AFR) has adopted a strategy "Health Promotion: Strategy for the African Region" and has developed guidelines for its implementation. The American Region (AMR) has had follow-up meetings and established three groupings of countries to develop and promote health promotion with particular emphasis on settings and healthy municipalities. The European Region (EUR) has established a centre for Investment for Health and Development (Venice) and has active inter-country networks. The Eastern Mediterranean Region (EMR) works closely with health promotion, healthy lifestyles, NCD prevention and control, and the Basic Development Needs Initiative. The South-East Asian Region (SEAR) too emphasizes capacity building, held an inter-regional workshop (Bangkok, Feb.'03), worked on country capacity for health promotion and education. The Western Pacific Region (WPR) has developed "The Regional Agenda for Capacity Building in Health Promotion 2002 -2005".

8. Progress in reviewing and build evidence of Health Promotion effectiveness, and to translate evidence to policy-making and practice, taking cultural and regional diversities into consideration, is being made through the "Global Programme on Health Promotion
Effectiveness”. This is a joint project between the International Union for Health Promotion and Education and WHO, in collaboration with CDC, Atlanta and with some other with international and national agencies. WHO is working on some 30 projects from Members States in all Regions to document successes and to plan, implement and evaluate interventions with methodological rigour.

9. For innovative means of financing health promotion, two meetings of the International Network of Health Promotion Foundations (HPFs) have been held, leading to a number of countries deciding to establish HPF through imposing a dedicated tax on tobacco and alcohol e.g. in Thailand and Malaysia. A critical review paper has been completed and preparations are in progress for a joint workshop with the International Social Security Association (ISSA), ILO and key partners to explore the potential of social security in the control of major risk factors and promotion of healthy lifestyles.

A Global Strategy for Diet, Physical Activity and Health

10. For Diet, Physical Activity and Health WHO was charged by WHA 2002 with developing the Strategy. This strategy process has involved a complex interaction with multiple stakeholders, as well as enhanced media, communication and advocacy efforts. The strategy development also brought together experts from physical activity, diet and nutrition and NCD prevention both within WHO and outside, to work on these complex issues.

11. The process for preparing the Strategy was divided into three main phases: i) the completion of the WHO/FAO expert consultation report, Diet, Nutrition and the Prevention of Chronic Diseases; ii) extensive consultation with stakeholders with four main tracks: Member States, UN agencies, civil society and the private sector; and iii) the final drafting of the Global Strategy and its approval by WHO governing bodies in 2004.

12. a) Consultation with Member States: Six regional consultations were completed from March-June 2003. More than 80 countries were consulted during this process.
   c) Consultation with civil society: Civil society representatives met for a roundtable discussion with the WHO DG in May 2003. Further, on in May 2003, a formal consultation was held with civil society, and WHO supported an online discussion through Stakeholder
Forum, aimed primarily at civil society. 137 organizations from 49 countries participated in this initiative.

d) Consultation with private sector: WHO interacted both with individual companies and with industry associations. In May 2003 the WHO DG held a roundtable discussion with CEOs and senior executives from major food and sport companies. In June 2003 a consultation meeting with industry and trade associations took place.

13. The final draft of the Global Strategy was completed and circulated to WHO regional offices for final comment at the end of September 2003, and the proposed strategy will be presented at the EB and WHA for consideration.

Move for Health Initiative

14. WHA 2002 also recommended that Member States “celebrate a Move for Health day each year to promote physical activity as essential for health and well being” following the successful World Health Day 2002 on this theme. This recommendation is also backed by the findings of the 2002 World Health Report, which lists physical inactivity among the main risks contributing to NCD. A concept Paper on “Annual Global Move for Health Initiative” was developed in consultations and communicated to Member States. The Move for Health day is considered as part of larger and sustained collaborative actions to promote physical activity and related healthy lifestyles throughout the year within the world population, men and women, of all ages and conditions in the context of an integrated approach to NCDs prevention and health promotion. The initiative triggered considerable interest and commitment by political leaders in many Member States. The Steering Committee met in Geneva in September 2003 to advise on Move for Health implementation in 2004 (sub-theme on Active Youth) and 2005 (sub-theme on Supportive Environments).

The Global School Health Initiative

15. The Global School Health Initiative continues to address major risk factors in the school setting in an integrated approach and is strongly developing in every region. The FRESH initiative by WHO together with UNESCO, World Bank, UNICEF and Education International is an excellent example of inter-agency collaboration and effective school health promotion. WHO’s School Health also works closely with CDC’s Global AIDS Programme, focusing on HIV/AIDS and prevention, particularly in African countries. In 2002, the Teacher Training for HIV Prevention project provided training to over 800 teacher trainers which in turn trained over 7000 teachers in Africa. Initial work is also progressing with youth outside school, and particularly in relation to youth, media and advertising works. The Global School-based Student
Health Survey plan was completed and implemented. The first training was held in Africa in March 2003. Currently 10 countries are preparing to implement the survey and new additional countries are joining to expand the activity.

**Ageing and Health**

16. The work on Ageing and Health in 2002/3 has been mostly focused on the preparation for, participation at and follow up activities to the Madrid UN World Assembly on Ageing. As WHO focal point on ageing for the UN system, WHO has been closely involved with the drafting of the Madrid International Plan of Action on Ageing (MIPAA), contributing in particular to one of its three priority-directions, the one that specifically deals with health. Through substantial consultation with governments, WHO Regional Offices, WRs, academic partners and NGOs, a complementary document to MIPAA was developed: "Active Ageing - a Policy Framework". This document summarizes WHO approaches and perspectives on ageing and health and has been widely circulated worldwide in several languages. A number of countries, in both the developed and the developing world, are now establishing policies on old age care and on health promotion for ageing individuals based on this framework. Closely linked with this and other WHO programmes, a multi-country project was launched on Integrated Health Systems Response to Rapid Population Ageing in developing countries, INTRA" (Botswana, Chile, Jamaica, Lebanon, South Korea and Thailand, now being expanded to 'paired' neighbouring countries: Mozambique, Peru, Suriname, Jordan, the Philippines and Sri Lanka).

**Oral Health**

17. Oral health was moved to the department strengthening the links between oral health and health promotion, school health, ageing, diet and tobacco. The oral health activities have been closely linked with the strong network of WHO Collaborating Centres on oral health. Regional meetings on integration of oral health into national and community health programmes, and within the Global School Health Initiative took place in Thailand, March 2003, Budapest in November 2003, Kuwait, December 2003, and Nairobi, 2003. Oral health is an integral component of the Mega country initiative and the inter-cluster project: Integrated Management of Adolescent and Adult.
Tobacco Free Initiative (TFI)

Background

1. Tobacco use is the single largest preventable cause of death in the world. Killing five million people annually, tobacco is one of the ten leading risk factors in developing countries and the leading risk factor in developed countries.

2. While developing countries still struggle with communicable diseases, the burden of tobacco-caused disease has already begun to take its toll and is increasing. Already, half of all tobacco deaths occur in developing countries. Tobacco along with HIV/AIDS, is the fastest growing cause of death globally. Unless action is taken, it is likely that the number of deaths will double in the next two decades.

WHO Framework Convention on Tobacco Control (WHO FCTC)

3. The adoption and ongoing ratification of the WHO FCTC is the culmination of years of work by WHO and others. It is a major achievement for WHO and a landmark in the history of the Organization.

4. Negotiations on the WHO FCTC began in October 2000 and continued until February 2003, when delegates at the sixth negotiating session agreed that a final draft text should be submitted to the next World Health Assembly. The treaty was adopted unanimously by the 56th World Health Assembly on 21 May 2003. Twenty-eight countries and the European Community signed the Convention on the first day it opened for signature. As of 10 October 2003 the WHO FCTC has been signed by seventy-four countries and ratified by three. It remains open for signature at the UN headquarters in New York until 29 June 2004.

5. The ratification phase is critical for the WHO FCTC entry interface. It is during this time that countries will be examining their national tobacco control capacity and ability to ratify and implement the treaty.

Capacity building

6. After the adoption of the FCTC, TFI has shifted its focus from the global negotiating table to the tobacco control situation in individual countries. TFI is launching a series of sub-regional and national workshops as well as the provision of seed grants to selected countries, with the aim of laying the foundation for FCTC implementation. The focus will be on how to counter
the negative influence of the tobacco industry and how to build a national plan of action for tobacco control.

**Smoking cessation**

9. Evidence has shown that cessation is the only viable way to reduce tobacco-related mortality in the short- and medium-term. TFI has recently published a set of policy recommendations for smoking cessation and treatment of tobacco dependence. The recommendations were developed following a WHO meeting on Global Policy for Smoking Cessation, which took place in Moscow in June 2002. The publication is being translated into WHO’s six official languages for widespread dissemination.

**World No Tobacco Day**

10. World No Tobacco Day is celebrated around the world on 31 May each year. The theme for 2002 was “Tobacco Free Sports”. In 2003 TFI turned its attention to the entertainment industry with the theme “Tobacco Free Sports Tobacco Free Fashion”.

**Tobacco control Legislative Guide**

11. A legislative guide reviewing the information needed to develop tobacco control legislation at national, subnational and local levels was published in early 2003, in response to requests from Member States. The guide considers the role of legislation, key terms and concepts, capacity building, strategic choices in legislation, elements of comprehensive legislation, the drafting and legislative processes, and implementation of legislation. Its release coincided with the adoption of the WHO FCTC by WHO’s Member States in May 2003.

**United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control**

12. Currently the only UN inter-agency group chaired by WHO, the task force meets at least once a year to discuss collaboration on tobacco control. It will be vital to ensure that the global tobacco work carried out by other UN agencies (FAO, ILO, UNDCP, UNEP, and UNICEF) and the World Bank is relevant to the FCTC-related work being undertaken at country level.

**Scientific Advisory Committee on Tobacco Product Regulation**

13. Tobacco product regulation is an important aspect of any comprehensive tobacco control strategy. TFI’s Scientific Advisory Committee on Tobacco Product Regulation (SACTob), composed of national and international experts on product regulation, smoking cessation and policy making, advises WHO on scientifically sound recommendations to Member States on the most effective ways to achieve a coordinated regulatory framework for tobacco products. The
Committee has published five recommendations related to testing methods, nicotine regulation, evaluation of new or modified tobacco products, tobacco product ingredients and emissions, and smokeless tobacco products.

Next steps

14. There are considerable challenges involved in translating the global provisions of the WHO FCTC into reality on the ground. The basic infrastructure needed to establish a tobacco control programme is lacking in many Member States. The voice of willing governments is often drowned by that of the tobacco companies, which wield huge power and influence in many countries. In other instances the Ministry of Health may be supportive of action but is unable to make its case successfully above the voices of other, more influential, ministries who may have concerns arising from tobacco industry misinformation.

15. TFI will continue to work closely with countries to assist them as they move forward with the process of ratification and implementation of the WHO FCTC. TFI will, in parallel, continue to counter the nefarious influence of the tobacco industry by continuing to monitor its activities at global, regional and country-level. It will also assist Member States that request inquiries into tobacco industry activities in their country and will continue to organize training sessions for NGOs and other individuals on how to search tobacco industry documents. Another priority will be to ensure that tobacco continues to receive widespread coverage in the media and that civil society and NGOs continue to play an active role in promoting the WHO FCTC. Finally, TFI will work to expand the scientific knowledge that provides the basis for tobacco control policies by continuing to fund economic studies, tobacco use surveys, as well as research on product regulation.
Management of Noncommunicable Diseases (MNC)

1. A global strategy for the prevention and control of NCDs has been developed and endorsed by the 53rd World Health Assembly (WHA resolution 53.17). As far as MNC is concerned, this strategy focuses on assessing the national capacity; implementing cost-effective and equitable interventions for the management of common NCDs; and preparing health systems to better meet the needs of patients with NCDs.

2. The Management of Noncommunicable Diseases Department (MNC) supports the implementation of both Health Services and Disease-specific programmes and aims at integrating prevention into clinical services. It supports the application of policies and practical tools designed for developing countries to adapt their health systems to deal with chronic conditions and to resolve issues related to long-term care, and the provision of comprehensive vision/hearing care and rehabilitation services. It strengthens health systems' capability to deliver basic drugs and diagnostic technology for treatment and prevention of noncommunicable diseases. It pays particular attention to genetic services and community genetics.

A) Health Services Group

3. Building the capacity of health systems to address chronic conditions, and provide quality health services to better meet the needs of patients with chronic conditions is a priority of the Management of Noncommunicable Diseases Department. The Health Services Group focuses on three main areas: Adherence to long-term therapies, Primary Health Care and Innovative Care for Chronic Conditions.

Adherence to long-term therapies project

4. In the last two years the Adherence to Long-term Therapies project integrated the previously dispersed scientific evidence and presented solutions for improving adherence rates from a public health perspective. This was reflected in a major report that was published in May 2003 "Adherence to Long-Term Therapies: Evidence for Action". Globally, the project gained the technical and political support of different stakeholders willing to contribute towards improving rates of adherence to long-term therapies. The project team has now the necessary scientific and policy knowledge, combined with a strong networking capacity and political support, to articulate fast and effective response to country adherence needs for the following diseases and risks: diabetes, hypertension, depression, HIV/AIDS, smoking, epilepsy, and asthma.
Primary Health Care

5. In March 2000, a global review of primary health care (PHC) was initiated as a joint project between two clusters, the Noncommunicable Diseases and Mental Health cluster and the Evidence and Information for Policy cluster. The purpose of the review was to look at the changing context of international health 25 years after the Declaration of Alma-Ata, and the challenges these changes pose on PHC. The outcomes of the review are a global report and 6 regional reports.

6. In May 2003, the 56th World Health Assembly adopted a resolution (WHA56.6) on the International Conference on Primary Health Care, Alma-Ata: Twenty-fifth anniversary. The resolution requests the Director-General to convene a meeting, and to prepare a progress report to the 57th World Health Assembly. The project is being transformed now from a review to a document which proposes future strategic directions for PHC. A Global Meeting will be held in Spain during 27-29 October 2003 (Global Meeting on Future Strategic Directions for Primary Health Care) towards this end.

Innovative Care for Chronic Conditions

7. The Health Care for Chronic Conditions (CCH) team was established to assist countries to bridge the gap between that which is typical: health care systems that are fragmented and focused on acute symptoms; and that which is achievable: coordinated, comprehensive systems of care.

8. Based on a two-year review of health care models and best practices from around the world, CCH has created a comprehensive guide, the ICCC Framework, which provides a "road map" for decision-makers who want to improve their health system’s capacity to manage chronic conditions. The framework is comprised of fundamental components within the levels of patient interactions, organization of health care, community, and policy. It is presented in a global report "Innovative Care for Chronic Conditions: Building Blocks for Action", which was released in May 2002 and translated into several languages (English, Spanish, Portuguese, French, Russian and Arabic).

9. In 2002, the Observatory on Health Care for Chronic Conditions was launched as a dynamic, web-based resource centre that offers hands-on information for policy-makers, health managers and administrators on innovative approaches to organizing care for chronic conditions and to connect people worldwide in an effort to disseminate and spread innovative ideas.
10. Several networks have been established to provide advice and contribute to the work of this team. The Network of Innovators consists of leading experts in health care for chronic conditions who have committed themselves to sharing their knowledge and experience via the Observatory, and serve as informal advisors for the team. The Professional Alliance, represents over 400 health care actors from 67 different countries, including government officials, nongovernmental organizations, insurers, health care opinion leaders, content experts, providers, professional and consumer organizations, and private sector representatives who have expressed interest in CCH work and who contribute to areas of work of common concern like human and financial resources.

11. The achievements so far have been reflected in the political commitment for change from health care leaders around the world, such as, Mexico, Brazil, Chile, Costa Rica and five countries of the Middle East.

B) Disease-specific Programmes

Cardiovascular Diseases

12. Cardiovascular diseases (CVDs) programme is assisting Member States to control the CVD epidemic by targeting vulnerable sectors of the population with cost effective interventions; those with established CVD and those at high cardiovascular risk.

13. To achieve the above objective two priority programs have focused on activities at country level. In the first program, health care provided to patients with CVD in terms of Prevention of Recurrences of Myocardial Infarction and Stroke (PREMISE project) has been assessed in defined areas in 10 low and middle income countries; Brazil, Egypt, India, Indonesia, Iran, Pakistan, Russia, Sri Lanka, Tunisia, Turkey. Major gaps have been identified in provision of care for CVD patients. Workshops have been held in the majority of these countries in collaboration with Ministries of Health and a wide range of stakeholders, to generate sustainable medium and long term strategies to address these gaps in service provision. This country-oriented project has helped to increase policy-level awareness of the burden of CVD and raise the profile of CVD on national health policy agenda.

14. In addition an expert consultation held this year developed "recommendations for secondary prevention of myocardial infarction and stroke” (in press) to provide guidance to
health care providers and policy makers to address the gaps that have been identified. The project is been extended to other low and middle-income countries. This country-oriented project has helped to increase policy-level awareness of the burden of CVD and raise the profile of CVD on national health policy agenda.

15. In the second priority project eight countries (Bangladesh, Benin, Chile, Egypt, India, Indonesia Mozambique and Sri Lanka) have been provided technical assistance to initiate cost effective cardiovascular risk management programs using the WHO CVD-risk management package. This innovative package enables the implementation of the cost effective absolute risk approach to cardiovascular risk assessment and management in low resource settings.

16. Efforts are been made to consolidate these two programmes at country level as they have the potential to reduce cardiovascular events by 50% if they are implemented effectively.

**Programme on Cancer Control**

17. The Programme on Cancer Control aims to provide technical expertise and support to Member States on the optimal approaches to the prevention and control of cancer. The research and publication of the latest information on the best way to plan, implement, monitor and evaluate programmes for cancer prevention, early detection, treatment, and palliative care in National Cancer Control Programmes: policy and managerial guidelines (2002) has been the keystone of the last two years’ work in the programme. The launch of this document has generated momentum within Member States to implement and improve programmes. A series of meetings and workshops brought together experts from seven Member States from the Eastern Mediterranean Region to build strategies for future cancer control work. The first phase of a five-country initiative in the African Region has yielded through country-level needs assessment and initial planning for community-based palliative care projects. A regional-level consultation in November 2003 facilitated exchange and debate among eastern and western European countries on strategies to improve and strengthen cancer control programmes. Innovative cross-cluster and interagency cooperation with WHO’s Reproductive Health Department and the International Agency for Atomic Energy drives the programme’s work on cervical cancer, another area of special focus. The latest findings and recommendations on cervical cancer screening in developing countries are being prepared for publication, as are praxis guides.

**Chronic Respiratory Diseases and Arthritis**

18. The WHO Global Strategy against Chronic Respiratory Diseases has been published and expanded with two additional documents: the "Implementation of the WHO strategy for
prevention and control of chronic respiratory diseases" (WHO/MNC/CRA/02.2) and the "Prevention and control of chronic respiratory diseases in low and middle income African countries". A WHO/WAO (World Allergy Organization) collaborative project has been initiated after finalisation of a document on "Prevention of Allergy and Allergic Asthma" (WHO/NMH/MNC/CRA 03.02). A questionnaire to evaluate and monitor the "National Capacity on Surveillance, Prevention and Control of chronic respiratory diseases" has been completed and submitted for publication. In collaboration with Stop-TB, field projects on the PAL strategy (Practical Approach to Lung Health) have been initiated in Tunisia and Cape Verde.

19. A Report of a WHO Scientific Group Meeting on "The Burden of Musculoskeletal Conditions at the Start of New Millennium" has been just published as a WHO Technical Report Series 919. This document will help better prepare nations for the increase in burden brought about by Musculoskeletal and Rheumatic conditions.

**Diabetes Mellitus**

20. National, regional and global estimates for diabetes prevalence and case numbers have been revised for the year 2000, and projections extended to the year 2030. National, regional and global burden of some chronic complications of diabetes has been estimated for the year 2000 (retinopathy and blindness, peripheral neuropathy, diabetic foot and amputation).

21. A report on screening for Type 2 diabetes has been published. A 3-year project of global awareness, advocacy and action in diabetes has been launched in partnership with the International Diabetes Federation.

**C) Vision/hearing Care and Rehabilitation Services**

**Blindness and Deafness**

22. Sensory disabilities affect more than 400 million people, particularly in developing countries. VISION 2020 is a global initiative for the elimination of avoidable blindness launched by WHO in partnership with international civil society organizations and private sector. WHO has played a leading role in global planning and coordination, leading to the development of national plans of action, as requested by the resolution passed during the last World Health Assembly (WHA 52.26). Technical cooperation with Member States included quality assessment of services and coordination of disease control activities for trachoma and onchocerciasis. The launch of *The WHO Guidelines On Hearing Aids And Services For Developing Countries* has led to the creation of a global initiative to provide affordable hearing aids in developing countries,
coordinated by WHO. A training resource on primary ear and hearing care has been produced to be incorporated into primary health care programmes.

**Next Steps**


**Disability and Rehabilitation**

24. An International Consultation on "Rethinking Care was held in Oslo, Norway, to provide a "forum" for persons with disability and chronic conditions to make their own recommendations on the type of "care" that is important to them.

25. An International Conference was held in Helsinki, Finland, to review Community-based Rehabilitation (CBR) and to update its strategy to meet the challenges of the current world situation.

26. The monitoring of Health related UN Standard Rule has been published. Additional four Intercountry workshops were held in order to prepare guidelines on "Strengthening Rehabilitation Services".

27. A tool for early identification of disability in children has been prepared and field-tested in 3 countries. The outcome obtained from the trials indicated that additional work needs to be done.

**D) Human Genetics**

28. To respond to the recommendations of the WHO Advisory Committee on Health Research released in its report on genomics and world health, a group of international experts in medical genetics and bioethics formulated a WHO collaborating strategy which would promote genetic services and collaboration with national centres with special emphasis on developing countries. Pilot studies in two countries of each region were initiated.

29. In order to strengthen the networks of collaborating/cooperating regional centres, WHO Consultations were held in Brazil, Thailand and Bahrain. The main purpose of the Consultations was to discuss medical genetic services in regional countries, initiate a network of cooperating centres and programmes, and increase awareness of medical genetics in the Region.
30. Current and future developments in genetics and genomics cut across health issues throughout the cluster and the Organization. To this end, the web-based Genomic Resource Centre was constructed is an important step in this direction to enhance the transfer of genomic information, to encourage global networks, and to improve health services especially in developing countries.

31. The broadening role of human genetics in research and health systems raises an increased need to examine the ethical, legal, and social issues (ELSI), especially surrounding the control of major non-communicable diseases, in the areas of gene patenting, genetic testing and screening. To address this issue, a Global Survey in Human Genetics and Ethics is being developed. A report on implication of human genetic technology to preventive health care and common diseases was published.
Injuries and Violence Prevention (VIP)

Injuries and Violence Prevention

1. Violence and unintentional injuries due to traffic, burns, falls or drowning, cause more that 5,000,000 deaths annually. The number of deaths is small in comparison to the number of survivors of violence and injuries, many of whom spend weeks in hospitals and often remain permanently disabled. Although people from all social classes are affected, the poor suffer injuries more often and have less chance of survival or rehabilitation when they are injured.

2. Public health agencies have a crucial role to play in addressing the problems of violence and injury. The traditional view of injuries as “accidents” or “random events” has resulted in the historical neglect of this area of public health. Many prevention strategies, including the use of child car seats, seat belts, designated drivers, flame-resistant clothing, smoke detectors, fenced-in pools and water areas, and early childhood and family based strategies to prevent violence, have proven successful.

3. To date, most injury prevention efforts have focused on developed countries. Yet low and middle-income countries have a higher injury mortality rate compared to high-income countries in all regions of the world. It is urgent to develop strategies which are appropriate, cost-efficient and effective in low- and middle-income countries.

Road Traffic Injury Prevention

4. The WHO 5-year strategy for road traffic injury prevention covers three main areas: epidemiology, advocacy and prevention. The implementation of the strategy started in March 2003. The following are the specific projects being implemented:
   a) Support to five countries: Poland, Vietnam, Ethiopia, Cambodia and Mexico. This involves giving technical support as well financial assistance to institutional framework, data collection, community-based initiatives, emergency medical services and helmet use.
   b) Development of normative documents: e.g. manual of good practice and training manual.
   d) Support to the WHO Helmet Initiative.
5. A large amount of attention was also devoted to the development of the first World Report on Road Traffic Injury Prevention. This publication developed in collaboration with the World Bank seeks to present a comprehensive overview of what is known about the magnitude, risk factors, and impact of road traffic injuries and intervention strategies to prevent and mitigate the impact of road crashes. The report is aimed at drawing attention to the seriousness of this issue, with the hope that it will be a wake-up call to respond to this preventable health and development problem.

6. The report will be released on World Health Day 2004 dedicated to "Road Safety". Preparations for WHD have been initiated in 2003. Activities so far include a meeting of the WHD Advisory Committee, a meeting bringing together 12 NGOs representing victims of road traffic injuries, the development of a logo, slogan and other background material as well as a web site. The amount of interest for that day has been very large and predicts a very successful WHD 2004.

**Surveillance**

7. Over the last three years, WHO’s Injuries and Violence Prevention Department (VIP) has developed tools to facilitate data collection and analysis on injuries and violence, particularly in low- and middle-income countries where information systems are often lacking or in need of strengthening. Guidelines on Landmine Injury Surveillance were published in 2000 and widely disseminated, followed by Guidelines for Injury Surveillance in 2002. The third in the series - Guidelines for Injury Surveys – were developed in 2002-3 and are due for release in early 2004. In addition, WHO has provided technical assistance to several countries, including Ethiopia, Sri Lanka, Mozambique, El Salvador, Colombia and Nicaragua, for data collection.

8. A multi-country study on alcohol and injuries was conducted in collaboration with the Department for Mental Health and Substance Dependence – the final report is due out for release in 2004.

9. Injury epidemiology and prevention courses have been conducted in the South East Asia, South America and Africa regions.

10. VIP has collaborated with other departments in the cluster to develop injury and violence modules for STEPS and the Mega Country health promotion network -behavioural surveillance component.
World Report on Violence and Health

11. On the 3 October 2002, the Department of Injuries and Violence Prevention, in collaboration with the Government of Belgium, launched the first World report on violence and health. The goals of the report are to raise awareness about the problem of violence as a public health issue; to highlight the crucial role that public health can play in addressing its causes and consequences and to encourage action. It examines a broad spectrum of violence including child abuse and neglect by caregivers, youth violence, intimate partner violence, sexual violence, elder abuse, self inflicted violence and collective violence. For all of these types of violence, the report explores the magnitude and impact in different cultural, social and economic contexts and summarizes what we know about prevention. Based on the review of current knowledge, the report calls for increased efforts in several areas including, the development of national plans of action, strengthening services for victims of violence, investment in primary prevention, and increased collaboration on research and data collection.

12. The successful global launch of the report provided an occasion to set out a clear agenda for combating violence and to call for collaboration - both internationally and between governments - to implement the Report’s recommendations and support the Global Campaign for Violence Prevention. To date, a number of significant events have taken place in the context of the Campaign; the World Health Assembly endorsed a resolution on Implementing the recommendations of the World report on violence and health; policy documents have been adopted by the African Union, the Commission on Human Rights and the World Medical Association; more than 30 national launches of the report have taken place; a number of countries have committed to the development of national plans of action for violence prevention; and several countries have developed national reports on violence and health.

13. At the 56th World Health Assembly, WHO unveiled two series of posters: the Violence in Red series illustrates the impact of violence on health in general and the Explaining Away Violence series depicts victims of violence and the reasons they frequently give to explain away their injuries, reflecting the shame andtaboos that surround violence. The posters were disseminated widely to Member States, NGOs, academia and other partners. Several countries are planning to use the posters for campaigns.
Violence Prevention

14. The *World report on violence and health (WRVH)* and the Global campaign for violence prevention have created significant demand for assistance with violence prevention policies and programmes. VIP has been working hard to provide tools and technical assistance to meet this need. A framework for interpersonal violence prevention, which specifies practical measures to help countries implement the WRVH recommendations, will be published early in 2004. VIP has completed work on its *Handbook for the documentation of interpersonal violence prevention programmes* and is in the process of using the handbook to collect standard descriptions of violence prevention programmes around the world. Guidelines for medico-legal care for victims of sexual violence, developed in collaboration with Gender and Women's Health, are intended to improve the quality of medical and forensic services provided to victims and will be pilot tested in Nicaragua, Mozambique and the Philippines. In addition to these efforts, VIP continuously seeks to expand collaboration with other international partners. The department has maintained a coordinating role in the UN Collaboration for the Prevention of Interpersonal Violence, which will hold its second consultation at WHO in January 2004 to discuss advocacy for violence prevention. VIP staff have also been involved in advising the UN Study on Violence Against Children, along with UNICEF and the Office of the High Commissioner for Human Rights.

Small Arms

15. Violence arising from the use of small arms and light weapons is a problem that is increasingly preoccupying the international community. WHO’s contribution is focused on understanding the impact on public health and how to prevent it. VIP has contributed to the implementation of a multi-country study involving data collection on armed violence in Mozambique and Brazil. The next phase of this work is likely to shift to a formal collaboration with the UNDP and an expansion of the programme to include capacity development at local, national, and international levels to prevent violence, the documentation of existing violence prevention programmes and the development of more evidence guided violence prevention policies, and the targeted support and evaluation of a number of promising violence prevention programmes.

Landmine Victim Assistance

16. VIP has continued to provide input in the Ottawa process on landmines. The standards developed by VIP through consultation with other stakeholders around data collection for landmine injuries form the basis of the most widely used data collection tool for mine injuries. Through support for injury surveillance in a number of areas where landmine injuries occur, VIP
is helping to provide data and reporting infrastructure that will benefit not just mine action programmes directly, but also health systems in a wider sense to better assess and respond to their injury burden.

**Pre-hospital and Trauma Care**

17. Appropriate pre-hospital care can save hundreds of thousands of lives each year particularly in low and middle income countries. A consultation on pre-hospital care resulted in the creation of a network of experts who drafted a manual on Pre-hospital Care System for victims of trauma. This manual will be available beginning of 2004. Another manual on Emergency Trauma Care is also being finalized for end 2003.

**Capacity Development**

18. VIP has recognized that a crosscutting need in order to address injury related health problems is capacity development. Training in injury and injury prevention will receive a priority focus over the coming years and in connection with this VIP has developed an injury prevention curriculum for public health students. TEACH-VIP is a curriculum that attempts to redress the virtual absence of training provided to public health practitioners around injury and injury prevention related topics. The curriculum is designed to be globally relevant, adaptable to specific contexts, and to provide students with an adequate exposure to key concepts in the area of injury prevention. Currently the curriculum is in the process of external peer review and it will be pilot tested in 2004. In addition, VIP has supported regional training in SEARO and AFRO and the development of regional networks and conferences. Consultations aimed at developing a more comprehensive strategy for capacity development are under way.

**Next Steps**

19. The past biennium has been very rich in activities and was the opportunity to expand considerably WHO’s contributions to violence prevention. The World report on violence and health was very well received and will be the basis for WHO’s work in this area in the years to come.

20. With World Health Day 2004 on Road Safety and the launch of the first *World Report on Road Traffic Injury Prevention* WHO will have a major opportunity to strengthen road traffic injury prevention activities around the world.
21. With an increased number of normative documents at his disposal (e.g. guidelines for services for victims of sexual violence, TEACH VIP course, injury survey guidelines) VIP has the tools to be able to continue and strengthen its support to countries.
Mental Health and Substance Abuse (MSD)

The Mental Health Global Action Programme

1. 2001 was the “year of mental health” at WHO. World Health Day in 2001 was a resounding success. Over 150 countries organized significant activities, including the delivery of major addresses by political leaders and the adoption of new mental health legislation. Furthermore, the theme of the 2001 World Health Report was mental health and its 10 Recommendations have been positively received by all Member States.

2. At last year’s World Health Assembly, over 130 Ministers responded positively with a clear and unequivocal message: mental health, neglected for too long, is crucial to the overall well-being of individuals, societies and countries, and must be universally regarded in a new light.

3. As a result of 2001 activities the Mental Health Global Action Programme (mhGAP) has been created. GAP is our major new effort to put strategic directions in place for addressing the findings in the World Health Report.

   GAP logic is based on four strategies:
   a) Increasing and improving information for decision-making and technology transfer. We should know more about the magnitude and the burden of mental disorders around the world, and know more about the resources (human, financial, socio-cultural) that are available in countries to respond to the burden generated by mental disorders. We should increase and improve the transfer of mental health related technologies.
   b) Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma; we should address not only the general public but policy makers, politicians and other sectors.
   c) Assisting countries in designing policies and developing comprehensive and effective mental health services. The scarcity of resource forces a rational use of them.
   d) Finally, we should build local capacity for public mental health research in poor countries.

4. Information/advocacy/policy/research are the key words of WHO’s new global mental health programme aiming at closing the gap between those who receive care and those who do not.
5. At the Executive Board meeting in January 2002 a resolution on mental health encouraging continued activity in this area was adopted. The language of the resolution strongly supports the direction of mhGAP and urges action by Member States. The resolution was endorsed unanimously by the World Health Assembly in May 2002.

**Main Activities of biennium 2002-2003**

**Advocacy and Human Rights**

6. The dissemination of the World Health Report 2001 has been a powerful way to advocate for mental health in general and specifically for addressing policy makers, professionals and civil society. The ten recommendations of the Report have been the basis for discussing stigma, discrimination and human rights issues in international settings like professional organizations, conferences or in national events. A Manual on Legislation for the mentally ill is being finalized.

The Global Campaign Against Epilepsy has successfully addressed the issue of stigma attached to people with epilepsy and a number of countries have incorporated the principles of the campaign into their policies, i.e. Argentina, China, Senegal and Vietnam. Similar outcomes have been achieved through the global campaign on suicide prevention (Brazil, Estonia, India, Iran, South Africa, and Sri Lanka).

**Policy and Service Development**

7. A mental health policy and service guidance package has been developed. International training for policy makers in policy and service development has been organized and about 100 countries have been involved so far in these training activities. Instruments for Rapid Assessment of Mental Health Systems in country have been prepared and tested. Direct country assistance for policy has been provided to Albania, Barbados, Brazil, Ecuador, Fiji, India, Latvia, Mexico, Mongolia, Mozambique, Palestine, Sri Lanka, Vietnam.

**Information and Evidence**

8. The Atlas of mental health resources has been completed and is regularly updated. It is available on the Internet.

9. Evidence for prevention and promotion in mental health has been collected in order to advise member states on effective and cost-effective interventions in these areas.

10. Information and guidance on prevention of suicide, management of depression and schizophrenia and other mental disorders has been provided to countries. Similarly, information
on the treatment of epilepsy has also been provided. Information and guidance about treatment of children and adolescents with mental disorders has also been provided.

**Substance Abuse**

11. Primary prevention of substance abuse has been undertaken in Belarus, Russian Federation, South Africa, Thailand, Vietnam, Zambia, and Zimbabwe, whilst technical assistance to countries in the area of substance dependence has been provided both in the area of alcohol, opioids and amphetamines. In total the following countries have all been recipients of assistance: Argentina, Brazil, China, Czech Republic, India, Indonesia, Iran, Lithuania, Nigeria, Poland, South Africa, Sri Lanka, Thailand, Ukraine.

12. A global alcohol database is being maintained. Technical assistance on studying alcohol and injuries in emergency rooms has been developed in collaboration with the Department of Violence and Injury Prevention.

13. Two major reports have been prepared: The Second Global Status Report on Alcohol and the Neuroscience of Dependence Report (to be released in 2004). Finally, guidelines on services for people with substance abuse problems living with HIV/AIDS have been developed.

**Next Steps**

14. The growing consistency between the different projects of mental health and substance abuse and the intense collaboration with the Regional Offices will lead during the next biennium to a more clear focus on implementation at country level of the normative work generated by WHO.

15. The number of countries receiving direct assistance in mental health policy, service development and mental and neurological diseases prevention and management, will increase substantially.
Surveillance (CCS)

1. Surveillance has been organised as a Cross-Cluster Initiative in the Noncommunicable Diseases and Mental Health Cluster, because the functional work spans across all of the departments in the cluster as well as the Tobacco Free Initiative. It also links with work in Evidence for Information and Policy as well as the Department of Communicable Disease Surveillance. The Cross-Cluster Initiative helps set surveillance and reporting standards by using technical expertise from the departments in NMH. In addition, the Cross-Cluster Initiative ensures overall coordination of common HQ and regional surveillance activities to ensure that there is no overlap or duplication of activities in countries. This approach is effective in breaking down departmental walls and introducing a more fluid technical communication within the cluster and between the regions.

2. Surveillance is a major function of the cluster’s activities as it underpins disease prevention and health promotion efforts and helps track trends to determine the future burden of disease.

3. Key activities in 2002-3 included the ongoing development of a common approach to surveillance of major NCDs and their risk factors and strengthening of internal WHO, regional and country infrastructure for information exchange. The latter included coordinating work with regional offices, collaborating centres and other partners on developing country assessments and strengthening health information systems. A unified approach to linking with clusters working in trend analysis, health systems development and surveillance of other diseases including communicable diseases and conditions has been established.

4. Specific surveillance products led by this initiative include the following: WHO STEPwise packages for Surveillance (development, testing and dissemination) of major NCD risk factors and selected diseases: this provides a framework for developing country capacity to collect data on NCDs in a standard way. Activities include:
   - Regional training programmes for Member States to build capacity in survey techniques, data analysis and advocacy for NCD prevention and control; 10 workshops have been held for 250 participants from 40 countries during 2003-3; over 20 international faculty from WHO HQ, RO, and country offices, together with staff from WHO Collaborating Centres have contributed to the training workshops.
• Implementation of the STEPS questionnaire to collect NCD risk factor data in a standard way in 40 Member States;
• Development of new optional modules for STEPS including oral health, mental health, and intentional and unintentional injury;
• Validation of the Global Physical Activity Questionnaire (GPAQ) in low and middle income country settings.
• Simplified Stroke Surveillance system using the WHO STEPS approach

5 A second major product developed for the NMH cluster is the WHO Global NCD InfoBase. The InfoBase underpins NMH’s efforts to reduce the burden of premature death and disease related to NCD. It provides a framework for data display, dissemination and analysis, data retrieval and has a report generating capacity such as the SuRF Report 1 (Surveillance of Risk Factors) which displays recent, nationally representative risk factor data for WHO Member States. Activities include:
• Production of a training manual for data managers in Regional Offices for the Regional InfoBases;
• Updating the WHO Global NCD InfoBase for easy access to NCD data;
• Launching the web-based interface for the Global NCD InfoBase;
• Production of comparable country estimates for 8 NCD risk factors;
• Expansion of the NCD InfoBase to include disease specific modules (e.g. stroke, oral health, CVD, respiratory diseases and injury);
• WHO Recommended surveillance and data reporting standards for NMH;
• Collaboration with community based prevention programmes.

Next Steps

6. Obtaining resources, regional office input, and Collaborating Centre support in the ongoing training to test and implement these tools and methods at the country level will be priority. The STEPS Framework will continue to help countries build their capacity to collect, analyse and use NCD data and informing and evaluating NCD prevention programs. The WHO Global NCD InfoBase will rely on Regional Office databases to supply the NCD data, in a standard way, for their Member States. The SuRF Report 1, published in May 2003, summarizes the current status of NCD risk factor data at the country level for 172 countries where data are available. This will provide the baseline against which to measure improved country capacity in NCD surveillance. The new data generated from STEPS and core behavioural health behaviours now used in many national surveys, including the the World Health Survey, will be added in a systematic manner to the NCD InfoBase.