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WHO Action Framework

for the

Prevention and Control

of

Chronic Diseases

- Core package -

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Face to Face with chronic disease

The following story illustrates the benefits of a programme of free cataract surgeries. For the millions of people like Kuzhantiammal governments must help to take action.

Kuzhanthiammal began to worry two years ago when a white film clouding her left eye would not clear away. It was keeping her from working on her land and taking care of her teenage granddaughter. As for many poor Indians, a visit to hospital was out of reach, for both economic and geographical reasons. Soon after the first symptoms appeared, Kuzhanthiammal heard of an eye diagnostic camp that was taking place at a nearby village. She decided to attend, and within a few minutes was diagnosed and registered for free cataract surgery at the Madwai Aravind Eye Hospital the following week. The programme even covered transport costs. "A bus picked me up with seven other cataract patients and drove us to the hospital," she says. Some 70% of Aravind's eye patients are charity cases; the 30% who are paying customers support these free sight-restoring operations. The hospital also sells abroad three quarters of the lenses it produces, to help finance its activities. Now 67 years old, Kuzhanthiammal successfully underwent surgery on her other eye a few months ago. "These artificial lenses are a miracle. It's like waking up with your problems gone," she joyfully explains.

Key messages of WHO Action Framework on the Prevention and Control of Chronic Diseases

- Around 40% of Member States do not yet have a policy, plan or programme on the prevention and control of chronic diseases;
- The causes of chronic diseases are known. Effective intervention is available, Urgent action is required;
- WHO identified a core package of seven steps every Member State is adviced to take:
  1. Estimating need
  2. Advocating for action
  3. Developing a policy (giving direction)
  4. Developing a plan (identifying actions)
  5. Developing programmes (identifiying action details)
  6. Facilitating implementation
  7. Monitoring and evaluation
- Core package interventions to address the burden of chronic diseases are known;
- Aim: to have 95% of the Member States having a policy, plan and/or programme in place by 2010.

1. Introduction

This overview document is part of the WHO Action Framework for the prevention and control of chronic diseases. This WHO Action Framework provides practical information to assist Member States to improve their prevention and control of chronic diseases.

1.1 Need for WHO Action Framework

The Preventing Chronic Diseases report [*1*] illustrated that chronic diseases like heart diseases, stroke, cancer, chronic respiratory diseases and diabetes are by far the leading cause of death in the world and their impact is steadily growing. It is estimated that chronic diseases will account for 60% of all deaths in 2005. Deaths due to chronic diseases are projected to increase by 17% over the next ten years. The major causes of chronic diseases are known, and if these risk factors were eliminated, at least 80% of all heart disease, strokes and type 2 diabetes would be prevented; over 40% of cancer would be prevented. A full range of chronic disease interventions are cost-effective for all regions of the world.

Already in 2000, the World Health Assembly endorsed a resolution on the prevention and control of noncommunicable diseases [*2*]. This resolution urges member states: (1) to develop a national policy framework taking into account several policy instruments and (2) to establish programmes, at the national or any other appropriate level, in the framework of the global strategy for the prevention and control of major noncommunicable diseases.

Despite this urgent call for action, many Member States have not yet started taking action. According to the preliminary results of second global survey conducted by WHO [*3*], 40% of the Member States do not have a national health policy, 43% of Member States do not have a national action plan and 38% of the Member States do not yet have national integrated programmes. Especially in the African Region of WHO, only few countries have managed to start making policies, plans and/or programmes. Next to this there are several countries that have written a policy, plan and/or programme but have not yet managed to implement or monitor and evaluate it.

Although the Preventing Chronic Diseases report made it clear that action has to be taken, many Member States do not yet know how. Several countries have asked WHO for assistance in producing their own action framework to prevent and control chronic diseases[1]. This handbook shows the way forward. It will serve as an adjuvant as well as a follow up support tool to the Preventing Chronic Diseases Report.

1.2 Purpose

The purpose of this WHO framework is to assist policy-makers and planners to develop, implement and evaluate a national policy, plan and/or programme for the prevention and control of chronic diseases. This WHO framework will be accompanied by a WHO training package to provide training to the regional trainers to assist Member States to implement the framework. Our goal is to have 95% of the Member States undertaking action to prevent and control chronic diseases by 2010.

1.3 Focus

This framework focuses on:

- cardiovascular diseases, cancer, chronic respiratory disease and diabetes
- prevention as well as control of chronic diseases
- population and individual approach.

1.4 Target audience

This WHO framework is primarily aimed at representatives of ministries that are responsible for, or could help to prevent and control, chronic diseases. In particular, ministries of health, finance,

[1] Countries that have expressed their need for assistance are:.

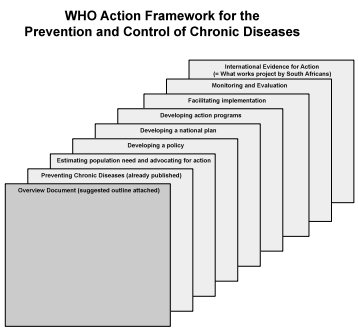
agriculture, education, transportation, physical environment, employment and social welfare can utilize this framework. The framework is primarily intended for Member States who have not started developing a policy, plan and/or programme for the prevention and control of chronic diseases. Secondly the framework is meant to assist Member States to implement developed policies, plans and/or programmes or improving the monitoring and evaluation.

1.5 What is in the framework?

The framework consists of a series of interrelated documents that are designed to address the wide variety of needs and priorities in policy development and action planning. The topic of each document represents a core aspect of chronic disease prevention and control. This overview document summarizes all information provided in these documents.

The WHO Action Framework includes the following documents:

- overview document
- estimating population need (to be developed)
- a practical guide to successful advocacy (almost ready)
- developing a policy (to be developed)
- developing a plan (to be developed)
- developing programmes (to be developed)
- facilitating implementation (to be developed)
- monitoring and evaluation (to be developed)
- international evidence for action (to be developed).



Supplementing the framework will be a WHO training package to assist Member States using the framework. This training package will be used to train regional trainers. These regional trainers will assist Member States directly. It is expected that regional trainings will start in the second half of 2007.

1.6 How to use

Member States are at different stages in the evolution towards a comprehensive and integrated approach to the prevention and control of chronic diseases. Next to this, member states have different needs and resources, as well as political, social and economic environment. This framework therefore offers a flexible and practical approach to assist governments in balancing diverse needs and priorities while implementing evidence-based interventions. The framework covers all steps that are necessary for developing a national action framework, up to and including implementation and evaluation. Member States may go through each of the documents separately or may use a specific document. Member States are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples from Member States' experiences are given throughout to stimulate the search for even better solutions to the still growing problem of chronic diseases.

A framework to assist Member States. There is no reason for not executing a policy, plan and/or programme to prevent and control chronic diseases.

2. The Urgent Need for Action[2]

2.1 Burden of disease

Currently, chronic diseases like heart diseases, stroke, cancer, chronic respiratory diseases and diabetes are by far the leading cause of death in the world and their impact is steadily growing. The Preventing Chronic Diseases report [*1*] projects that approximately 17 million people die prematurely each year as a result of chronic disease. The number of people dying from chronic diseases is estimated to double the number of deaths from all infectious diseases (including HIV/AIDS, tuberculosis and malaria), maternal and prenatal conditions, and nutritional deficiencies combined in 2005. Contrary to common perception, this largely invisible epidemic is worst in low and middle income countries, where 80% of all chronic diseases occur.

2.2 Causes of chronic diseases

The causes of chronic diseases are known; a small set of common risk factors are responsible for most of the main chronic diseases. These risk factors are the same in men and women and in all regions. The three most important modifiable risk factors are: unhealthy diet and excessive energy intake, physical inactivity and tobacco use. Globally these risk factors are increasing as people's dietary habits change to foods high in fats and sugars, and people's work and living situations are much less physically active. Increased marketing and sales of tobacco products in low and middle income countries mean greater exposure to the risks of tobacco. Elimination of the preventable risk factors would prevent: 80% of heart diseases, 80% of strokes, 80% of type 2 diabetes and 40% of cancer [*1*].

2.3 Chronic diseases and poverty

Chronic diseases and poverty are interconnected in a vicious cycle. In almost all countries, it is the poorest people who are most at risk of developing chronic diseases and dying prematurely from them. Poor people are more vulnerable to chronic diseases for several reasons, including greater material deprivation and psychosocial stress, higher levels of risk behaviour, unhealthy living conditions and limited access to good-quality health care.

Chronic diseases on the other hand also cause poverty in individuals and families, and draw them into a downward spiral of worsening disease and poverty. Chronic diseases lead to direct costs like out-of-pocket payments for health services and medications. They also have an impact on people's economic status and employment opportunities.

2.4 The economic impact of chronic diseases

Chronic diseases are a major cost and a profound economic burden to individuals, their families, health systems and societies. The treatment of chronic diseases requires many health-care resources and non-medical goods and services. This depletes savings and investments in for example education. Next to this, chronic diseases reduce the possibility to work and therefore the quantity and productivity of labour in a country. The Preventing Chronic Diseases report [1] estimated accumulated losses from chronic diseases from 2005 to 2015 for China US$ 558 billion, for India US$ 236 billion, and US$ 303 billion for the Russian Federation [*1*].

South Africa passed groundbreaking legislation in 1999, imposing strong warning labels on cigarette packages, banning smoking from enclosed workplaces, and prohibiting tobacco sales to minors. This legislation was to strengthen a previously imposed tax of 50 percent on the value of the retail price of cigarettes. In the 1990s, South Africa witnessed a 30 percent decline in cigarette consumption, especially among youth and the poor. [*26*].

The causes are known. Effective intervention is available.
Urgent action is required.

[2] See for more information the report: Preventing chronic diseaes, a vital investment [*1*].

3. Estimating needs[3]

The purpose of assessing the needs is to: (1) understand the size, nature and severity of the problem, (2) identify the priorities areas and target groups for action, (3) devise appropriate actions, (4) better use the available resources and (5) get political support.

Step 1: Needs assessment

a) Magnitude and nature of the problem in chronic diseases

The fist step is to assess the magnitude and nature of the problem. This can be done using both mortality information and morbidity information.

Mortality information is one of the major and easily accessible measures of disease or health status in the population. However, it only identifies how many people have died from chronic diseases. Mortality data at country level can be found at: http://www.who.int.evidence/bod.

Morbidity data may be more expensive to collect but provide information on any departure from the state of health or well being. The main measures are disease prevalence (proportion of people in a population who have the disease at a specific instant or incidence) and incidence (number of new cases of disease that develop in a population of individuals at risk during a specified time interval). Morbidity data at country level can be found at: (check source).

> The **United States Cancer** Profiles website (http://statecancerprofiles.cancer.gov) is a good example of a tool to retrieve reiliable population-based incidence data to help make more informed decisions about resource allocation for sreening and treatment [*29*]

b) Trends in risk factors for chronic diseases

The key information required for the development of a chronic diseases prevention policy is the distribution of risk factors among the population. Risk factors present today predict disease burden for the future. The three most important modifiable risk factors for chronic diseases are: unhealthy diet and excessive energy intake, physical inactivity and tobacco use. WHO has developed a tool to help low and middle income countries assess their risk factor profiles - the STEPwise approach to Surveillance (STEPS). Please refer to http://www.who.int/chp/steps/Part%201.pdf) or the STEPS manual [*4*] for details about the STEPS surveillance. The WHO Global InfoBase Online (http://infobase.who.int) is a data warehouse with a search engine, providing country-reported data where available, and internationally comparable estimates for risk factors for all chronic diseases.

c) Demand from stakeholders

It is also important to understand the subjective demand, ideas, opinions and experiences from different individuals/organizations which may be affected by the future chronic disease prevention and control policy. Means for collecting this information include: conduct focus groups, undertake personal interviews, organize public hearings and conduct opinion survey.

> **Indonesia** initiated a broad consultative process that resulted in developing national consensus on noncommunicable diseases policy and strategy. The provess involved also establishing a collaborative network for noncommunicable diseases prevention and control. The network involves various health programmes, public and private sectors operating outside health, professional organizations, non governmental organizations, educational institutions and other relevant partners. [*23*].

Step 2: Existing environment

After assessing the needs, the next step is to review the existing environment. This will provide information on: (1) which actions are successful, (2) the *unmet* needs,(3) the programmes or services to be build upon and (4) the possibilities to do so.

[3] See for more information detailed document: Estimating population needs (to be developed).

a) Current responses to the chronic disease burden

It is important to identify the current response as precisely as possible. Types of information:

- national health policies (e.g. the previous chronic disease health policy)
- national and international laws and legislation (e.g. law on tobacco control)
- strategic action plans (e.g. action plan on diet and physical activity)
- programs executed by government bodies at federal, regional and local level, community based organizations, academic institutions, NGOs or private sector
- international agreements (e.g. WHO resolution on Diet, Physical Activity and Health)

An example of an international agreement that limits the possibilities of taking action, is referred to by **Sweden** in their public health policy report. ''Since Sweden's entry into the European Union, the impracticality of pursuing a national alcohol policy has become increasingly obvious [*5*].''

b) Current capacity

It is important to assess the current capacity to respond on chronic diseases prevention and control. The concept of capacity includes: financial possibilities, human resources as well as the health infrastructure.

The needs make clear what needs to be done.

4. Advocating for action[4]

Seeking commitment early for a chronic disease prevention and control action framework is essential. Advocacy helps to set the record straight and to spur action at all levels. Advocacy is most likely to be successful when seemingly divers chronic disease-related interest groups band together to circulate common messages and call for unified action. By combining their voices to deliver the powerful message that comprehensive and integrated action can stop the global epidemic of chronic disease, advocates can make a real difference. There is power in numbers.

Step 1: Establish the goal and objectives for the advocating campaign
Why is advocacy needed? Is it to create awareness for the problem of chronic diseases? Is it to build support for the development of an action framework to prevent and control chronic diseases? Is it to promote the already developed action framework to prevent and control chronic diseases? It is important to identify specifically a goal and objectives for the advocating campaign. Establish a clear long-term goal and SMART (specific, measurable, achievable, relevant and timely) objectives at the beginning of your advocacy work.

Step 2: Identify target audiences
In advocacy work, the two main audiences will usually be decision-makers and influencers. The more specific you are in identifying the audience, the more effective your communications will be.

A. Potential decision-makers:	**B. Potential influencers:**
1. Government (ministries and parliament): • presidents and prime ministers • health ministers and their deputies • budgetary decision makers (e.g. ministers of finance) • ministers of related sectors and their deputies (e.g. ministers of education, transport and/or agriculture) 2. Donors/funding agencies for low-middle income countries; 3. Private sector employers (e.g. national and local businesses, business associations and multinationals); 4. Community leaders; 5. Implementing NGOs.	1. Civil society: formal and informal organizations and groups, NGOs, faith-based groups; 2. Opinion leaders: community and business leaders, authors, activists, religious leaders, media; 3. Entertainment and sports personalities; 4. Teachers, professors and researchers; 5. Consumer groups (e.g. patient organizations, disease support groups or groups of concerned family members) 6. Health-care professionals.

It may be helpful to involve your part of your target audience actively in the policy development process to increase their level of commitment.

The **Dutch** ministry of health asked officers of the ministries of internal affairs, social affairs, education, finance, environment building to join the project group and to write parts of the policy to increase their level of commitment [*6*].

Step 3: Developing key messages to influence your target audience
A key message is the most important element in deciding how an audience perceives you and your arguments. It should be:

- clear, compelling, concice, consistent and convincing;
- simple and direct;
- frequently repeated and reinforced by a combination of sources.

Ideally you should have one primary key message and two or three secondary key messages.

[4] See for more information: Stop the global epidemic of chronic diseases, a practical guide to successful advocacy (to be published soon).

WHO's core chronic disease message is: ''stop the global epidemic of chronic diseases''.
WHO secondary messages on chronic diseases are:

- 80% of chronic disease deaths occur in low and middle-income countries, and they occur in equal numbers among men and women;
- the threat is growing - the number of people, families and communities afflicted is increasing;
- the major causes of chronic diseases are known. If these risk factors were eliminated, at least 80% of all heart disease, stroke and type 2 diabetes would be prevented. Over 40% of cancer would be prevented''.

Step 4: Developing and implementing your advocacy plan

Your advocacy plan will deliver your messages to your target audience. Advocates usually have to deliver messages many times and in different ways to have an impact. A wide range of communication methods is available and these usually work better when used together than individually. Communication channels to your audience could include face-to-face meetings, letters, events and the media.

Some issues to consider developing and implementing your advocacy plan:

- choose effective spokespeople;
- communicate with decision-makers;
- use partnerships and coalitions;
- use research (www.who.int/chp/chronic_disease_report/media/impact/en/index.html);
- use real-life stories (www.who.int/features/2005/chronic_diseases/en);
- use brainstorm to create effective, creative and innovative campaigning techniques;
- Use a consistent visual style;
- Organize public events
- Maximize opportunities (World No Tobacco Day on 31 May, World Heart Day on last Sunday of September, Word Diabetes Day on 14 November;
- Ensure your strategy has sustainability.

Step 5: Engaging media interest

Working with the media is almost always a vital element of successful education and advocacy because it is a cost-effective, powerful way of communicating messages to a target audience. Common methods for using the media to address health issues are:

- Advertising;
- Media relations and publicity;
- Comment and opinion pieces;
- Education through entertainment.

For WHO's most recent media materials, visit www.who.int/mediacentre.

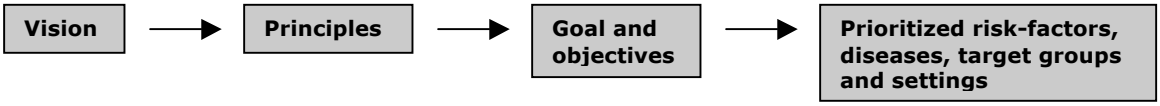
Step 6: Monitoring and evaluation of advocating campaign

For many advocates, time is limited and resources are few, making it difficult to monitor and evaluate advocacy work; yet doing so allows you to assess whether your work is having an impact and to modify your efforts accordingly. This can save you time and effort in the future and ensure that your work is effective.

Advocacy is simply the process of influencing people to create change.

5. Developing a policy (Giving direction)[5]

After estimating population needs and advocating for action, a policy should be formulated.



Step 1: Set out the vision
The vision is a description of the government's expectations as to the ultimate outcome for a country in the realm of chronic diseases . Effective and efficient prevention and control of chronic diseases requires a vision for the next 10-15 years. Vision statements should be [*8*]:

- a guiding image of success
- broad enough to allow a diverse variety of local perspectives;
- realistic, taking into account available resources and technology
- inspiring and uplifting to everyone involved;
- easy to communicate (short enough to fit on a T-shirt)

One example would be the vision of the **WHO** Chronic Diseases and Health Promotion Department [*20*]: ''A world free of preventable chronic diseases''.

Step 2: Clarify the guiding principles
Values and principles are the base on which governments set goals and develop strategies and programmes. It is important to refer consistently to them in order to foster greater coherence, integrity, comprehensiveness and continuity in the implementation of the action framework [*7*]. The following guiding principles are recommended to include in chronic diseases frameworks [*1*]:

1. comprehensive and integrated actions
2. intersectoral action
3. life course approach
4. stepwise implementation

Step 3: Determine the goal
The goal is a desired general end point that an organization or programme wants and expects to accomplish in the future [*8*]. It serves as a catalyst to speed up actions and it makes transparent what the Action Framework should lead to.

WHO's goal is set in 2005 [*1*]: ''To reduce death rates from all chronic diseases by 2% per year over and above existing trends during the next 10 years''.

Step 4: Identify prioritized risk factors, diseases, target groups and settings
In reality, with limited resources, we cannot tackle all risk factors, diseases, target groups or settings at the same time. That is why it is necessary to set priorities. This encourages a rational use of resources. In the context of chronic diseases, priorities for action can be set in terms of: risk factors, diseases, target group setting. Although priorities will vary by the outcomes of the needs assessment, the Preventing Chronic Diseases Report indicated the following priorities [*1*]:

- risk factors: unhealthy diet & excessive energy intake, physical inactivity and tobacco use;
- diseases: cardiovascular diseases, cancer, chronic respiratory diseases and diabetes;
- target groups: children and poor people;
- settings: community, school and workplace;

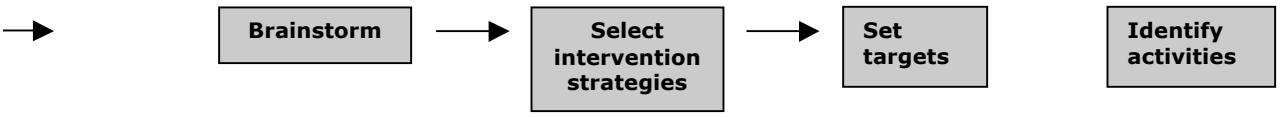
Giving direction does not only mean saying what you are going to do,

[5] See for more information detailed document: Developing a policy (to be developed).

but also what you are not going to do.

6. Developing a plan (Identifying actions)[6]

The third part is to identify the best means by which the policy can be turned into action. A detailed plan with strategies, targets and actions should be developed.



Step 1: Brainstorm

The selection of intervention strategies is a key decision in developing a policy, plan and programmes. Selection should be based on the outcomes of the previous steps (needs assessment, existing environment, guiding principles, vision and goal, prioritized risk factors, diseases, target groups and settings). It is recommended to organize a brainstorm with the key persons involved to list intervention strategies. The areas of interventions may vary between countries or regions and between historical periods. However, some common areas can be defined in most action frameworks [*1*]:

Population approach interventions	High risk individual interventions
• Health financing (tax and price interventions) • Legislation and regulation • Improving the built environment • Advocacy initiatives • Community mobilization (schools, workplaces etc)	• Screening • Clinical prevention • Disease management • Rehabilitation • Palliative care

Step 2: Select intervention strategies

Most countries will not have the resources immediately to do everything implied by the overall policy. Countries are encouraged to go along step-by-step, choosing interventions from the core to a higher desired level [*1*]:

a) Core: interventions that are feasible to implement with existing resources in short term;
b) Expanded: interventions that are possible to implement with a realistically projected increase in, or reallocation of, resources in the medium term;
c) Desired: evidence-based interventions which are beyond the reach of existing resources.

It is recommended to select the intervention strategies using the following criteria:

i. effectiveness
ii. efficiency (are there more efficient ways to address the problem)
iii. feasibility (technically, financially and politically feasible).

The knowledge now exists to prevent and control chronic diseases. Rapid health gains can be achieved with comprehensive and integrated action. Although effectiveness of interventions may vary among different regions and countries, the following interventions have been selected as very cost-effective worldwide by WHO and The World Bank. More specific information about effective interventions can be found at: http://www.who.int/choice and http://www.dcp2.org/pubs/DCP (add results what works South Africa and Lancet article).

List of most effective intervention strategies:

Health financing:

- The cost-effectiveness increasing cigarette prices by 33 percent ranges from US$13 to US$195 per DALY averted globally, with a better cost-effectiveness ratio (US$3 to US$42 per DALY averted) in low-income countries [*28*]
- In regions with a relatively high prevalence of high-risk alcohol use, tax increases to lower alcohol use are extremely cost-effective (US$105 to US$225 per DALY averted)

[6] See for more information detailed document: Developing a plan (to be developed).

Legislation and regulation:

- Advertising bans for tobacco products [*1*]
- Reduction of salt in food [*1*]
- Replacing dietary trans fat from partial hydrogenation with polyunsaturated fat is likely to be extremely effective in populations where the intake of trans fat is high. A cost-effectiveness ratio of US$25 to US$73 per DALY averted can be attained if such replacement is done during manufacture [*28*].
- Advertising bans are among the most cost-effective of all interventions to reduce high-risk drinking in all regions (US$134 to US$280 per DALY averted)

Advocacy initiatives:

- Health education on cardiovascular risk factors via broadcast and print media [*1*]

Community mobilization

- School health programmes to prevent risk factors [*1*]

Screening

- Screening for breast cancer using clinical breast examination is estimated to be cost-effective at US$552 per life year saved for biennial screening of women from age 40 to 60 [*28*].

Clinical prevention

- Combination drug therapy for people with an estimated overall risk of a cardiovascular event above 5% over the next 10 years [*1*]
- Glycemic control in people with poor control of diabetes to reduce microvascular disease [*28*]
- Blood pressure control to reduce macrovascular disease, mirovascular diseases and mortality [*28*]
- Foot care to reduce serious foot diseases and amputations having diabetes [*28*]
- The combination of aspirin and the beta-blocker atenolol has been shown to be highly cost-effective in preventing the recurrence of a vascular event [*28*]

Disease management

- The cost of treating acute myocardial infarction using aspirin and beta-blockers is less than US$25 per DALY averted in all regions;

Some strong country examples of intervention strategies:

Areas for action	**Intervention strategies**
Health financing (tax and price interventions)	**Thailand**: The Thai Health Promotion Foundation is funded by a 2% excise tax on alcohol and cigarettes to support activities that reduce risk factors and promote healthy behaviour [*1*].
Legislation and regulation	**Denmark** introduced legislation, effective January 1, 2004, restricting the use of industrially produced trans fatty acids to a maximum of 2 percent of the fat in any food product [*9*].
Improving the built environment	**India**: Residents collected money to construct a park with bushes, trees, fountains and a play area for children. This increased people undertaking regular physical activity from less than 15% to 45% [*17*].
Advocacy initiatives	**England**: A School Fruit and Vegetable Scheme provided nearly 2 million children aged 4 to 6 years a free piece of fruit or vegetable each school day. As a result over a quarter of children and their families reported that they were eating more fruit at home after joining the scheme, including in lower socioeconomic groups [*1*].
Community mobilization (schools, workplaces etc)	**China**: In Zhejiang a health-promoting school project improved nutrition among 7500 students and their families and 800 teachers and school staff personnel. It actively engaged the target groups in planning, implementing and evaluating interventions [*18-19*].
Screening	**Costa Rica**: Since 1970 cytology screening has been available to women aged 15 years and older. More than 85% of eligible women have been screened at least once. The incidence of cervical cancer remained stable from 1983 to 1991 and decreased with 3.6% annually in 1993-1997 compared with 1988-1992 [*11*].
Clinical prevention	The **United Kingdom**'s National Health Service Stop Smoking Services were set up in 1999. Smokers set a date with the help of their adviser, and are then supported through the first stages of their attempt to stop smoking and follow-up after four weeks. Results for the period April 2004-March 2005 show that around 300,000 smokers had successfully stopped at the four-week follow-up stage compared with about 205,000 the year before (an increase of 45%) [*1*].
Disease management	**South Africa**: A nurse-led chronic disease management programme for high blood pressure, diabetes, asthma, and epilepsy introduced clinic-held treatment cards and registries; diagnostic and management protocols; self-management support services; and regular, planned follow-up with a clinic nurse [*12*].
Rehabilitation	**India**: In rural south India, permanently blind people were supported with

	community based rehabilitation. This included mobility training and training to perform normal daily activities. Quality of life improved for some 95% of participants [*13*].
Palliative care	**Uganda**: Pain relief and palliative care for cancer and HIV-AIDS are included in the home care package, based on a needs assessment of patients and their caregivers. Services include essential drugs for pain and other symptom relief, food and family support [*14-16*].

Step 3: Set targets for each intervention strategy

Once the intervention strategies have been determined, targets should be set. These targets will later on be used to assess whether the framework has been effective or not (see chapter 9). A target should be ambitious as well as SMART, where SMART stands for [*30*]:

- Specific
- Measurable
- Achievable
- Relevant
- Timely

The Department of Health in **England** set in its 'Delivering Choosing Health' paper [*31*] the following target: ''To enhance the take-up of sporting opportunities by 5-16 year olds by increasing the percentage of schoolchildren who spend a minimum of two hours each week on high-quality physical education and school sport, from 25% in 2002 to 75% by 2006 and 85% by 2008''. This target is:

- *Specific*: enhance sporting opportunities by 5-16 year olds;
- *Measurable*: percentage of schoolchildren who spend a minimum of two hours each week on physical education and school sport;
- *Achievable*: four years to reach the first increase from 25% to 75% and then two years to increase a further 10% seems achievable;
- *Relevant*: sporting opportunities certainly will be enhanced when more schoolchildren spend time each week on physical education and school sport;
- *Timely*: the target specifically states that the target should be partly reached by 2006 and fully reached by 2008.

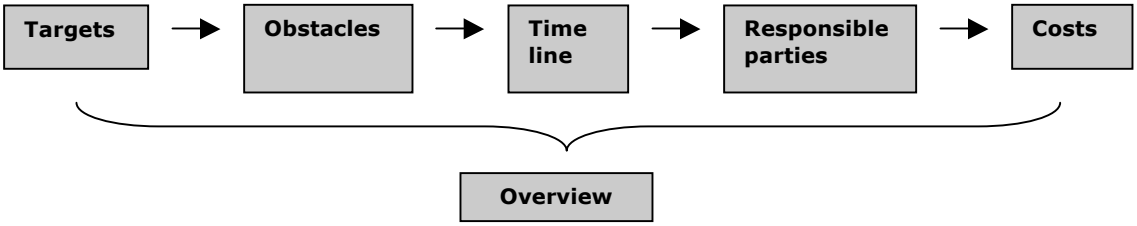
Step 4: Identify all necessary activities

Determine for each strategy what activities are necessary to make the strategy work. It is important to be very specific in this, not to miss essential steps.

Actions are needed to transform plans into results.

7. Developing programmes (Identifying action details)[7]

Detailed activities move a strategy to action. This ensures that important steps are not missed out and avoids time losses. Secondly, by defining activities in more detail, it will be easier to see the progress made. It is important to celebrate the successes!



Step 1: Determine targets for each activity
Like the target for a strategy, the target for an activity should be ambitious as well as SMART (see chapter 5, step 2).

Step 2: Identify possible obstacles
It is important to think in advance about potential obstacles or delays that could inhibit the realization of each activity. What steps could be taken to overcome them?

Step 3: Set timeline
Activities should be set within timeframes. If these time frames are realistic and in fact reached, it is possible to be constantly reinforced by one's own achievements.

Step 4: Determine responsible parties
The programme must also determine who is to take responsibility for each activity. The programme must not only say what must be done but also who must do it. If there are various partners involved in an activity then all these partners should be included. However, it is important to make sure that one party has the final responsibility for each activity, to prevent that partners would withdraw themselves from their responsibilities.

Step 5: Estimate costs, resources needed and budget
Without adequate resources, strategies will only be written statements and can never be translated into real action. Therefore, to enable smooth implementation of the strategy, it is crucial to estimate the costs of all the interventions, identify resources required and even mobilize them at the process of planning [10]. Suggested steps are:

- make an estimate of the cost for each intervention strategy and associated course of activities (including money, people, expertise, goods and services);
- identify and make an assessment of the existing resources;
- maximize the existing resources. This encompasses the consideration for opportunities of reallocation, reengineering and re-programming of existing resources;
- mobilize additional resources by identifying and mobilizing new partnerships and developing a resource network for technical expertise.

Step 6: Overview
Filling in the following table for each intervention strategy, may help keeping an overview over all necessary activities.

[7] See for more information detailed document: Developing programmes (to be developed).

(Fill in with country example)

Strategy: Target:															
Activity	Output	Jan	Feb	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Responsible	Obstacles	Costs

Action details are only there to make sure you are doing what you promised yourself to be doing.

8. Facilitating the Implementation[8]

It is not easy to make sure the policy, plan, and programme will be implemented successfully. The following recommended steps can facilitate the process of the implementation.

Step 1: Gain political support and funding
Supportive political environment and sufficient funding in place are essential for a member state to initiate the implementation of the chronic disease policy, plan and programmes. The importance of preventing chronic diseases should be underscored by interviews and meetings with the authorities of ministry of health and other ministries such as those of finance, social welfare, education, transportation, physical environment, employment, and social welfare. The authorities should be aware that chronic disease represent a significant proportion of the burden of disease and its economic impacts. These activities should last for a few months in order to ensure that enough political support and funding are given for implementation.

> **Morocco** is on track to achieve the elimination of blinding trachoma by 2006. This success has resulted from a combination of high-level political commitment, partnerships and community particpation in prevention and control efforts [*1*].

Step 2: Adopt or approve the policy, plan and programmes
Official adoption and ratification by the several ministries (finance, agriculture, education, transportation, physical environment, employment, and social welfare) is necessary to provide legitimacy for the chronic disease policy, plan and programmes.

> The National Strategy to Prevent and Control noncommunicable diseases for **Tonga** was endorsed by cabinet in 2004. The appointment of the Natinal Noncommunicable Diseases Committee as advisory to cabinet was an important development in that it increased its influence on government decisions and secured funding for its operations [*25*].

Step 3: Disseminate the policy, plan and programme
Once the policy ,plan and programme have been adopted or approved, it is important that the ministry of health disseminate and communicate the policy widely to the state/province, local health offices, and other responsible sectors. Some ways of facilitating the process are suggested as organizing a public event with the media, printing booklets, holding meetings, printing and distributing posters and leaflets which indicate the main ideas of the policy, plan and programme. Country example.

Step 4: Build the workforce capacity and develop supportive organization
The capacity for public health workforce is essential to ensure the successful implementation of the action framework Any single organization or group is unlikely to have sufficient resources to tackle the complex public health issues related to the prevention and control of chronic diseases. To tackle the chronic diseases, a public health system should be established and consists of more ministries (finance, agriculture, education, transportation, physical environment, employment, and social welfare) beyond the ministry of health. The multiple ministries can share the resources and collaborate with each other to attain the shared goals and objectives on chronic diseases prevention and control. In addition, a multidisciplinary group should be in charge of the implementation of the policy, plan and programme for their various perspectives and various expertises for example public health professionals, medical doctors, nurses, mass media communicators, and sociologist.

[8] See for more information detailed document: Facilitating implementation (to be developed).

Step 5. Integrate the policy, plan and programme into the local society
Integrating the national action framework into the regular services is important because it strengthens community participation and improves the availability of community resources. Once the missions and objectives of policy are set, the plan and programme are carried out mainly by citizens, groups, and organizations in the community. The programme strengthens this work by providing materials, training, the necessary official support, media involvement, and follow up.

Step 6 Set up pilot projects in demonstration areas
It is recommended that pilot project should be established in a demonstration area (s) where policy, plans and programmes can be implemented more rapidly and evaluated more thoroughly than elsewhere in the country. Pilot project test whether implementation is possible under the financial restrictions and usual conditions of the country's health system. This can facilitate the process of application on a larger scale subsequently.

The region Bio-Bio of **Chile** (population 2 million) served as a pilot area for cardiovascular health of PLan Auge. Plan Auge is a wide plan in which the government prioritizes 56 health conditions for which there would be: a) guaranteed access to care; b) guaranteed oppportunity of care; c) guaranteed quality of care and d) guaranteed financial coverage. The experience acquired in Bio-Bio will be used to set up regional policies and action plans on health promotion and cardiovascular disease control in the other regions.[*24*].

The most difficult one is implementation: Doing what you planned to do.

9. Monitoring and Evaluation[9]

Monitoring and evaluation helps improve the performance and achieve the goals. It should be fit into the planning of the policy, action plan and programs and taken into account at the beginning of the planning process with the regard of the evaluation plan, responsible parties, and funding.

Step 1: Monitor implementation
Monitoring is a continuous oversight of the implementation of activities that seeks to ensure that input deliveries, work schedules, targeted outputs, and other required action are proceeding according to plan. The monitoring consists of keeping track of the course of activities (please refer to the step 6 of the chapter 7 for more information on the activities) and identifying deviations so that activities can be put back on their right track. The tasks are mostly taken by the groups who implemented the policy, plan and programme and conducted on regular basis (monthly and/or quarterly basis).

Step 2: Evaluate process and outcome
Evaluation is a systematic way of measuring the success of public health programmes. To evaluate the programme success, evaluation plan should be fit in with the policy, plan and programme development process. Compared with monitoring, evaluation is more likely to occur over a finite amount of time (such as mid-term evaluation and/or end-line evaluation). The evaluation can be conducted by internal evaluator only, or external evaluator only or both. The objective evaluation results will provide the evidence for the financial donors and/or donors to provide continuous financial support and scale up the programme in larger scales. Both the process (how the plans and programmes are operated) and the outcome (whether the performance are achieved) should be evaluated.

Recommended programme evaluation consists of the following steps:

a. Engage Stakeholders

Engage those who might have an interest or stake in the issues addressed by the programme from the beginning stages of the programme. *In the step 3 of chapter 8, the identification of stakeholders has been elaborated.*

b. Describe the Programme

This description should convey the mission and objectives of the programme and set the frame of reference for evaluation decisions. *The mission and objectives of the programme have been elaborated in the step 1 and 2 in chapter 5.*

c. Focus the Evaluation Design

To conduct an evaluation, the following issues are recommended to consider:

- Identify issues of greatest concern to stakeholders:
  Different stakeholders have different concerns. The ministry of finance may be more concerned with the outcome. For the ministry of health may be more concerned with the operation of programme and will reorient the implement the policy, plan and programme to ensure the achievement of goals.
- Identify indicators to measure and judge the performance
  Evaluation can be achieved by using indicators that can be measured repeatedly, directly or indirectly, over time. The selection of indicators for evaluation should be guided by the usefulness of the information generated, availability of data, ease of accessing the data, feasibility and cost-effectiveness of generating the required data. The indicators should be the base-line information before the implementation of policy, plan and

[9] See for more information detailed document: Monitoring and evaluation (to be developed).

programme. It could be the reference values such as the cut-off value of blood pressure, the indicators used by the similar programmes etc.

- The questions to be asked in the evaluation.
  Regarding the questions to be asked in the evaluation also depends on the purpose of the evaluation. Process evaluation need to answer the questions as the follows: how many training are delivered, how many participant attend the training, etc. Outcome evaluation need to answer the following questions: what is the change of awareness on healthy eating and cardiovascular diseases among the target population, what is the change of BMI among the target population etc.
- The methods used to collect information
  Both qualitative study (e.g. interview) and quantitative study (e.g. survey) are recommended to use to collect information. Quantitative data are more statistically powerful and qualitative data can collect more insights.
- The evaluation design,
  To gain the convincing evidence on the contribution of the implementation of policy, plan and programme to the outcome changes, intervention group (among them, the policy, plan and programme are implemented) and control group (among them, no policy, plan and programme is implemented) are recommended to be used to attribute the difference in the outcome changes between the intervention group and control group to the implementation of policy, plan and programme.

d. Gather Credible Evidence

The more credible the evidence is, the more credible will be the evaluation findings and the recommendations that follow from them. To ensure the credibility of evaluation findings, evaluation design with intervention group and control group should be used to provide convincing findings on the attributability of the performance to the policy, plan and programme. Triangulation data collection methods, including quantitative study and qualitative study should be used to collect from variety of resources. Moreover, more indicators should be used to take into account the performance from various perspectives.

e. Justify Conclusions

Evaluation conclusions should be based on the evidence gathered, and programme's success should be judged against agreed–upon values or standards set by the stakeholders prior to conducting the evaluation.

f. Ensure That Lessons Learned are Shared and Applied

Programme participants should make a deliberate effort to disseminate the evaluation processes they use and the findings of their evaluations so that other entities conducting similar programmes can learn from their experience.

Canada evaluated the Canadian Heart Health Initiative, a 15 year 'policy-driven' systematic and evidence-based approach to implement health promotion interventions and build public health capacity in health promotion [*26*]. The main lessons learned were:
• the degree to which communities took ownership of a project was seen to be extremely important;
• clear goals, direction and purpose developed and adopted by the committee and clearly defined roles and expectations for project personnel facilitated the program success;
• relationship problems between individuals, organizations and coalitions hindered the program
• training is necessary to enhance abilities of staff/volunteers to carry out designated responsibilities.

Step 3: Provide evaluation information to WHO (Global Survey)

By providing the evaluation results to WHO, the information can be shared among member states.

Learn from what you are doing and disseminate your lessons learned to others.

10. Review of existing policies, plans and programmes

11. Conclusion

Chronic diseases are by far the leading cause of death in the world and their impact is steadily growing. Effective interventions are available. A comprehensive and integrated response of Member States is necessary. This framework provides Member States practical suggestions for developing a policy, plan and programmes to prevent and control chronic diseases. The framework also assist Member States in implementing its plans and in monitoring and evaluating the results.

This overview document of the WHO Action Framework for the Prevention and Control of Chronic Diseases provides only a brief overview of the assistance provided to Member States. For each chapter a more detailed document is available to provide further assistance. As a next step a training package will be developed to assist Member States using this framework.

Developing, implementing, monitoring and evaluating an action framework for the prevention and control of chronic diseases is a complex process. We hope this framework will lighten this difficult task and make more Member States undertaking action.

Our aim is 95% of the Member States having a policy, plan and/or programme into place by 2010. We hope you will help us reaching this!

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Annex I: WHO Action Framework for the Prevention and Control of Chronic Diseases