Multisectoral action plan for the prevention and control of noncommunicable diseases in Timor-Leste (2018–2021)

Ministério da Saúde

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Contents

Abbreviations and acronyms

CHC	community health centre
COPD	chronic obstructive pulmonary disease
CRD	chronic respiratory disease
CVD	cardiovascular disease
DHS	Demographic and Health Survey
GATS	Global Adult Tobacco Survey
GBD	Global Burden of Disease
GSHS	Global School-based Student Health Survey
GYTS	Global Youth Tobacco Survey
IARC	International Agency for Research on Cancer
MoH	Ministry of Health
MSAP	Multisectoral Action Plan
NCD	noncommunicable disease
NGO	nongovernmental organization
PEN	Package of Essential NCD interventions
PPP	purchasing power parity
SEA	South-East Asia
SD	standard deviation
STEPS	WHO STEPwise approach to NCD Surveillance
UN	United Nations
WHO	World Health Organization

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Message from Vice Minister Primary Health Care and Acting Minister of Health

Non-communicable diseases are among the major killers of the people of Timor-Leste and it is critical that we address them effectively and immediately. This three year Action Plan represents the resolve of the government to do so. We have made an international commitment to reduce premature mortality due to NCDs by 25% by 2025 and to achieve the SDGs. If we have to achieve our goal of Healthy Timor, then all of us need to act together. The roots of these diseases lie outside health sector, and with changing lifestyles and globalization, these diseases will only increase.

This action plan is based on the consensus of the stakeholders and embodies our collective commitment to make a heathier society. However, we do not have the luxury of time and money. We must act fast and collectively to make the best use of our limited resources. We must move away from doing the business- as -usual approach as we will not be able to achieve the targets; instead should transform the way we do things in NCD prevention and control. All our prevention programmes must reach the communities, schools and work places and institute vibrant programmes that engages whole-of-Timorese. As a government, we will engage government sectors and civil society to play their part in our efforts to save lives from stroke, heart attack, cancers, diabetes and respiratory diseases which continue to burden our communities. We must tackle tobacco, alcohol, salt consumption and other unhealthy diet, make urban communities in particularly active.

I compliment the Ministry of Health and other stakeholders for developing the document and seek your commitment in its implementation.

Dr. Élia A. A. dos Reis Amaral, SH
Vice Minister for Primary Health Care and Acting Minister of Health, RDTL

1. Introduction

Timor-Leste has a population of 1 183 643, according to the 2015 Census. Administratively, the country is divided into 13 districts, 65 subdistricts, 442 *sucos* and 2225 *aldeias*. Thirty per cent of the population lives in urban areas. The life expectancy at birth is 66 years. The gross national income per capita was (PPP int $) 6410 in 2013. The Government of Timor-Leste, through the Ministry of Health (MoH), is committed at the highest level to achieving the health of its population. It is moving full steam ahead with its mission of ensuring available, accessible and affordable health services for all Timorese people.

In 2014, Timor-Leste adopted an Noncommunicable disease (NCD) National Action Plan 2014–2018 with the following overall vision: All Timorese people enjoy healthy and productive lives free of avoidable morbidity, disability and premature death due to NCDs. The goal was to reduce preventable morbidity, avoidable disability and premature mortality due to NCDs in Timor-Leste. This document builds on the previous actions and achievements in NCD prevention and control and lays out implementation steps till 2021. It has been prepared in consultation with all stakeholders and represents a consensus of priority actions to be taken over the next three years.


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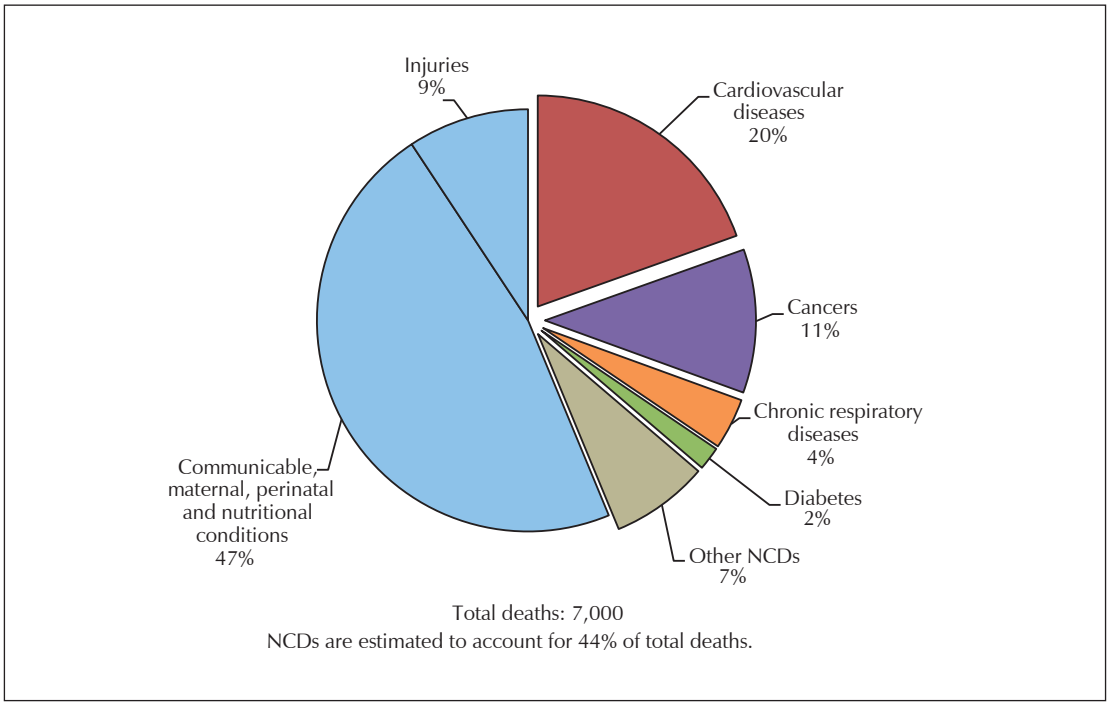
2. Situational analysis of noncommunicable diseases in Timor-Leste

2.1 NCD burden and health system response

Noncommunicable diseases include cardiovascular disease (CVD), cancers, diabetes and chronic obstructive pulmonary disease (COPD). They are among the major causes of mortality in Timor-Leste. Mortality data are scarce due to limitations in the vital registration system and because nearly 90% of deaths occur outside hospital. WHO estimates for 2010 indicate that in Timor-Leste, NCDs accounted for 44% of all deaths and that the probability of premature mortality from NCDs was 24%.[1] The Institute of Health Metrics and Evaluation, in its Global Burden of Disease (GBD) report, ranks ischaemic heart disease and stroke as the fifth- and seventh-highest causes of death, respectively, for 2010 in Timor-Leste.[2]

Figure 1. Propertional mortality (% of total deaths, all ages, both sexes



1 Noncommunicable diseases country profiles 2014. Geneva: WHO; 2014
2 GBD profile: Timor-Leste. Seattle: Institute for Health Metrics and Evaluation; 2010

Timor-Leste conducted an NCD risk factor survey using the WHO STEPwise approach to NCD Surveillance (STEPS) in October–November 2014. Its key results are summarized below. According to it, there is a high prevalence of NCD risk factors. About half (56%) of the adults used some form of tobacco product. The prevalence of current alcohol consumption was 42.8% in men. The prevalence of raised blood pressure (BP), raised total cholesterol and raised fasting blood glucose were 39.3%, 21% and 1.5%, respectively.

Table 1. Risk factors for NCDs among adults (18–69 years) in Timor-Leste, 2014

Risk factor	Men	Women	Combined
Tobacco use			
Percentage who currently smoke tobacco daily	49.6	7.8	35.0
Percentage who currently use smokeless tobacco daily	14.0	13.4	13.8
Percentage who currently use tobacco in any form (smoked and/or smokeless)	70.6	28.9	56.1
Alcohol consumption			
Percentage who drank alcohol in the past 30 days	42.8	2.0	28.6
Percentage who engage in heavy episodic drinking (>5 drinks on an occasion) in the past 30 days	21.8	1.0	14.5
Inappropriate diet			
Percentage who ate less than 5 servings of fruits and vegetables on average per day	70.7	90.4	77.5
	74.7	84.1	78.0
Percentage who always or often add salt/salty sauce to their food before eating or as they are eating	15.8	7.3	12.9
Percentage who always or often eat processed food high in salt			
Physical inactivity	12.8	23.3	16.7
Percentage with physical inactivity (<150 min of moderate activity or equivalent per week)			
Overweight/obesity			
Percentage who are overweight	8.2	16.7	11.2
Raised blood pressure	45.3	28.0	39.3
Percentage with raised blood pressure or on medication for hypertension			
Raised blood glucose			
Percentage with raised fasting blood glucose or on medication for diabetes	1.5	1.6	1.5
Raised blood cholesterol			
Percentage with raised blood cholesterol or on medication for raised cholesterol	18.5	25.5	21.0
Percentage with three or more of the risk factors			
(current daily smoking, inadequate intake of fruits and vegetables, insufficient physical activity, overweight and raised blood pressure)	21.1	16.6	19.4
Solid fuel use			
Percentage of households that use solid fuel for cooking	87% (DHS 2016)		

The proportion of households using solid fuel for cooking was estimated at 87% in the country as per the Demographic and Health Survey (DHS), 2016. The results of the STEPS survey also suggest a low coverage of NCD interventions and high treatment gaps (Table 2). For example, among women aged 30–49 years, only 1.1% had ever had a screening test for cervical cancer and 97.3% with raised blood pressure were not on medications. Health facility surveys to assess their preparedness for addressing NCDs have not been carried out.

Table 2. Review of the health system response to NCDs in Timor-Leste

Health system response	Men	Women	Combined
Percentage of women aged 30–49 years who have ever had a screening test for cervical cancer	-	1.1%	-
Percentage with raised blood pressure who are not currently on medication for the same	98.1	94.7	97.3
Percentage aged 40–69 years with a 10-year CVD risk of ≥30% or with existing CVD	0.9	2.4	1.4
Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities	Information not available		
Availability of human papillomavirus vaccines as part of a national immunization schedule	No		
Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants (12–23 months)	62% (DHS 2016)		
Existence of a policy to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt	No		
Consumption of morphine-equivalent strong opioid analgesics (excluding methadone) per death from cancer	No palliative care available		

2.2 Brief review of progress on the NCD Action Plan 2014–2018

It is evident from Table 3 shows that significant progress has been made in Timor-Leste in preventing and controlling NCDs in the past five years. This is across all the four strategic objectives with maximum progress in health systems strengthening due to the piloting of WHO's Package of Essential NCD (PEN) interventions in two of the thirteen districts. Among prevention of risk factors, tobacco control is leading with a law in place. However, mechanisms for implementing this law still need to be fully established. Alcohol prevention and control are lagging behind with no regulatory framework to address these. While food-based dietary guidelines have been issued, a comprehensive approach to modifying the diet is not in place. This includes increasing awareness, establishing an enabling environment and regulatory approaches.

The NCD prevention and control got a boost with strengthening of the NCD department in the MoH and a higher budgetary allocation during the period 2014–2018. Involvement of other ministries in addressing NCDs is suboptimal. The population-based survey on risk

factors has helped to identify the focus areas well, though strengthening mortality surveillance and conducting a health facility survey need to be prioritized. NCD-related indicators are not included in the routine monitoring matrix of the MoH, which comprises about two dozen indicators.

Table 3. Key achievements and areas of deficiency in implementation of the NCD Action Plan 2014–2018 in Timor-Leste

Strategic areas	Significant achievements in 2014–2018	Areas of deficiency
Advocacy and leadership for a multisectoral response	NCD department strengthened Increase in budgetary allocation for NCDs Formation of multisectoral NCD working group	Interministerial committee not constituted Sector-specific policy briefs/guidelines/ workplans not developed
Health promotion and primary prevention to reduce the risk factors for NCDs	Framework Convention on Tobacco Control being implemented and Tobacco Control Decree promulgated Development of national food-based dietary guidelines Implementation of food labeling guidelines being discussed Development of physical activity guidelines School curriculums revised Sporadic campaigns on physical activity	Alcohol prevention and control strategy not in place Regulation of salt/fat/sugar in processed food not in place Regulation of marketing of foods and non-alcoholic beverages to children not in place Health-setting guidelines not formulated Systematic and sustained media campaign addressing all key risk factors comprehensively not held
Health systems strengthening for early detection and management of NCDs	Standard treatment guidelines (STGs), list of essential medicines and technologies for primary care developed Successful pilot of WHO's PEN interventions for NCDs in 2 districts	STGs for secondary care not developed Poor linkage of primary care centres to secondary and tertiary centres Curriculum for health professionals not revised
Surveillance, monitoring and evaluation, and research	Presence of a monitoring and evaluation and surveillance unit in the MoH Conduct of NCD risk factor surveys among adults and adolescents	No representative mortality surveillance system in the country Health facility readiness for NCDs not assessed Weak health information systems for chronic disease monitoring Absence of any disease registry including for cancer

3. Multisectoral Action Plan for Prevention and Control of NCDs (2018–2021)

This operational plan for three years (2018–2021) is based on the unfinished agenda of the previous plan and is in keeping with the targets laid down under the national monitoring framework. It has been prepared based on a situational analysis and the actions identified are as per the recommendations of the SEA Regional Action Plan, WHO best buys for NCD prevention and control, and in keeping with global strategies and instruments such as the Framework Convention on Tobacco Control, Global Strategy for Reduction of Harm from Alcohol Use, among others. The recommendations from global guidance have been prioritized keeping in mind the national situation, capacity and resource availability. This Action Plan identifies a set of actions to be taken over the next three years with almost half of them focusing on primary prevention and risk factor reduction of major risk factors such as tobacco, alcohol, inappropriate diet, inadequate physical activity and household air pollution.

3.1 Strategic Area 1. Advocacy, partnership and leadership for a multisectoral response

Despite considerable progress in NCD prevention and control in the past few years, an effective multisectoral coalition is still not visible in Timor-Leste. The work of many ministries has both beneficial as well as adverse impacts on the health of the population, and aligning their work for the greater good of the population requires dialogue as well as transparent mechanisms to arrive at mutually acceptable solutions. This requires strong political will, health ministry leadership and partnership with all stakeholders. This is critical, as regulatory approaches are among the major pillars of interventions to address the upstream determinants of NCDs.

This Action Plan proposes a two-layered arrangement, wherein the political leadership across ministries provides the guidance and push, and is ably supported by the technical groups working together to identify and implement solutions. As the national capacity for implementing multisectoral actions is limited, this plan recommends that this be initiated with one ministry at a time and then proceed to being truly multisectoral as lessons are learnt and capacity strengthened. For the health ministry to lead multisectoral action, it needs to be strengthened in both quantitative and qualitative terms. It is also proposed that an annual stock-taking meeting/summit be held wherein the annual report of the multisectoral action plan is presented to all partners/stakeholders and plans for the next year are formulated together.

3.2 Strategic Area 2. Health promotion and primary prevention to reduce the risk factors for NCDs

Tobacco control. The existing tobacco control policies and legislation are summarized in Annexure 1. Tobacco use continues to be a major problem as seen by its continued high prevalence in population-based surveys. Although there are smoke-free laws, they are not comprehensive, nor is there a legal ban on tobacco sponsorship and advertising. There is little support for people wishing to quit tobacco in the country.

In the next Action Plan period, the focus has to be on strict implementation of the law by working with a strong coalition of partners, including civil society. Raising taxes on tobacco products and establishing mechanisms to monitor the implementation of the existing law are other important tobacco control activities suggested in the Action Plan.

Reduction of the harmful use of alcohol. Despite alcohol use being a major problem, it has not been addressed adequately so far. Almost 50% of adult males consume alcohol and binge drinking is common. There is no comprehensive legislation that addresses alcohol use in the country, including availability and advertising. Cultural acceptability and availability of locally produced alcohol such as *tusabu* also pose a problem in enforcing legislation. There is no comprehensive legislation addressing alcohol use in the country which addressed availability and advertising.

There is an immediate need for Timor-Leste to initiate discussion on a legislation that focuses on the advertising and availability of alcohol. Taxes on alcohol need to be increased and the additional revenue generated can be earmarked for the NCD-related budget. Stricter implementation of laws on drinking and driving is also essential. Efforts are also needed to change perceptions and attitudes through mass media campaigns and social mobilization activities. Institutional mechanisms for alcohol and tobacco needs to be reviewed and strengthened.

Promoting healthy diet. Among the dietary habits, low intake of fruits and vegetable and high intake of salt and monosodium glutamate seem to be the most important issues. Although there are no 24-hour urine studies for salt consumption, level of salt consumption is perceived to be high among Timorese. The fact that every 2 in 5 Timorese have raised blood pressure indicate influence of salt consumption. Overweight/obesity rates are modest, but it is important to stop them from increasing.

As dietary habits are a part of the culture and develop in childhood, it is important to restrict marketing of unhealthy dietary products (foods high in fats/sugar or salt) to this age group through regulations, guidelines for which have been drafted by WHO. It is important to work with the food industry (domiciliary and global) to frame regulations for the salt/sugar/fat content of processed foods, elimination of trans-fats and introduction of food labelling to promote healthy choices. Increasing fruit and vegetable intake is a more complex process and needs to be debated within the country and an action plan formulated in consultation with the Ministry of Agriculture. Adopting the South-East Asia (SEA) regional nutrient profile

(http://www.who.int/iris/handle/10665/253459) for identification of foods that need attention (regulation or marketing, labelling, etc.) would be a useful first step.

Promoting physical activity. Population surveys show that inadequate physical activity is not much of problem in Timor-Leste, especially in rural areas. It would be good to focus current efforts in promoting physical activity in urban areas, especially Dili, through expansion of cycle/skating tracks and public gymnasiums,and conducting mass awareness campaigns on physical activity.

Promoting healthy settings. One of the approaches used in health promotion is to create an enabling environment in places where people study or work, as in educational institutions or workplaces. There is sufficient regional experience as well as guidelines on the subject, which can be adapted to the national context. There is already good work being done in revising school curriculums. A comprehensive approach that addresses all four major risk factors – tobacco, alcohol, diet and physical activity – through a concept of health-promoting schools needs to be expanded to the whole country. Similar activities need to be carried out in workplaces in conjunction with the Labour Department. Municipalities and local governments have to consider the inclusion of appropriate activities in their own annual workplans.

Reduction in exposure to indoor and outdoor air pollution. Indoor air pollution has been added as an additional indicator with a target in the SEA Region. However, Timor-Leste has identified it as an indicator but has not fixed a target, as it faces some fundamental challenges. In order to address both indoor and outdoor air pollution, the first step would be to define national standards for different air-quality parameters and strengthen the air quality monitoring process. An action plan needs to be prepared to replace solid fuels with alternative safer fuels. Establishing and implementing vehicular emission norms and improving public transport are components aimed at addressing outdoor air pollution.

Increasing the capacity for health promotion. Health promotion is one of the major focus areas of intervention against NCDs and, in general, it has been observed that the capacity for health promotion within the MoH as well as within the health system is weak. If the planned health promotion activities, including conducting mass campaigns and developing guidelines, are to be executed, it would need a major strengthening of the capacity of the health promotion unit within the MoH and of other stakeholders by developing training modules and programmes for them.

3.3 Strategic Area 3. Health systems strengthening for early detection and management of NCDs

It is recommended that NCDs be addressed through a primary health care approach as that is affordable and accessible, in addition to being effective. Timor-Leste has already initiated interventions with the WHO PEN package of interventions; this needs to be scaled up to cover all districts within next four years. Based on the experience gained and the improved capacity of the health system, it may be necessary to revise the package of interventions.

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Family- and community-based interventions are a great initiative for addressing NCDs at the domiciliary level and this should include health promotion and screening programmes. In order to ensure continuity of care, referral and national hospitals need to be strengthened to manage acute cases as well as cases with complications. To reduce its dependence on other countries, Timor-Leste should start developing its own dialysis and oncological services, including palliative care. Health facility strengthening cannot happen without simultaneous capacity-building of human resources, which should be both in-service as well as at the entry level. It is also important to use technology such as telemedicine and electronic medical records to strengthen care. Strengthening deaddiction services against substance abuse (tobacco, alcohol, drugs) is also necessary.

3.4 Strategic Area 4. Surveillance, monitoring and evaluation, and research

Timor-Leste has already formulated its national NCD monitoring framework, including indicators and targets. It conducted its first NCD risk factor survey in 2014. This needs to be repeated in 2019 as it is recommended to do so after every five years. Mortality surveillance is weak in the country and is a generic issue and not limited to NCDs. There has to be a system to count all deaths and also to ascertain causes of death such as medical certification or conducting verbal autopsies. Including NCD components in health facility surveys to assess their preparedness for addressing NCDs and measuring risk factors among adolescents through a school-based survey should also be completed during these periods as they provide information on indicators that have targets as per the national and global NCD monitoring framework. Along with strengthening oncological services, it might be good to establish a hospital-based cancer registry at the national hospital. Strengthening hospital-based information systems for monitoring of patients with NCDs and regular monitoring of the implementation of the Action Plan are among the key monitoring activities identified during the Plan period. Priority research areas for programme implementation of NCDs need to be identified through a stakeholder consultation. Some of the possible areas are estimating population intake of foods high in salt/sugar and fats as well as quality of care. Conducting joint evaluation of PEN implementation and the Multisectoral Action Plan (MSAP) with independent agencies is important to learn lessons and make mid-course corrections.'

Table 4. Strategic Areas and activities planned in each area over the Plan period

Strategic Area 1. Advocacy, partnership and leadership for a multisectoral response						
Activities	Implementation time frame				Lead agency	Implementing partners
	2018	2019	2020	2021		
1.1 Conduct advocacy for the multisectoral action for the prevention and control of NCDs						
1.1.1 Constitute an NCD Ministerial Committee and hold at least six-monthly meetings					Directorate of Public Health	Different ministries
1.1.2 Conduct a parliamentarians' forum annually for advocacy of NCD-related actions					Secretariat	Commission F
1.1.3 Constitute a multisectoral regulatory and legislative working group and ensure that it meets regularly					Secretariat	Different ministries/ partners
1.1.4 Establish a technical working group for health services that will meet quarterly					Secretariat	All stakeholders
1.1.5 Prepare a plan for integrating NCD-related work in the annual workplan of implementing partners					Secretariat	Concerned ministry
1.1.6 Advocate for increased budgetary allocation with the possibility of earmarking taxes on tobacco/ alcohol/unhealthy foods for the NCD programme					Secretariat	WHO
1.2 Strengthen leadership capacity of the NCD Secretariat and focal points						
1.2.1 Upgrade the NCD department to a National Directorate of NCDs with disease/risk factor-specific departments (cancer, CVD and diabetes, CRD, tobacco and alcohol)					Directorate of Public Health	
1.2.2 Establish a full-time NCD Secretariat with a minimum of three staff (1 technical and 2 support staff)					MoH	Director General, Health
1.2.3 Prepare and present an annual appraisal report to the Prime Minister/cabinet					Secretariat	NCD Ministerial Committee
1.3 Establish and strengthen partnerships for prevention and control of NCDs						
1.3.1 Hold an annual NCD advocacy partnership meeting for partners					Secretariat	WHO
1.3.2 Establish a national NCD alliance					MoH	WHO, civil society

Strategic Area 2. Health promotion and primary prevention to reduce the risk factors for NCDs						
Activities	Implementation time frame				Lead agency	Implementing partners
	2018	2019	2020	2021		
2.1 Tobacco control						
2.1.1 Establish a National Council for Tobacco Control	■				Secretariat	Relevant ministries
2.1.2 Conduct advocacy to replace the current decree by an act of Parliament		■			MoH	Parliament
2.1.3 Enforce implementation of the current legislation on tobacco control		■			Tobacco Unit	AIFEASA, civil society, relevant ministries
2.1.4 Develop, implement and evaluate a mass media campaign for tobacco		■	■	■	Tobacco Unit	SEKOMS, Alfandega, (MDS) AEFAESA I.P.
2.1.5 Raise taxes on tobacco products from 28% to 100%			■		Tobacco Unit	Finance Ministry
2.1.6 Set up an online/telephonic mechanism to register complaints and follow up violations of the tobacco law	■	■	■	■	Tobacco Unit	MoH
2.2 Reduction of the harmful use of alcohol						
2.2.1 Enact and implement comprehensive legislation on the reduction of harmful use of alcohol covering advertising/licensing/sale of alcohol	■	■	■	■	MoH	Relevant ministries WHO
2.2.2 Develop, implement and evaluate a mass media campaign for alcohol		■	■	■	MoH	Communication
2.2.3 Enact and enforce drink–driving laws and blood alcohol concentration limits	■	■	■	■	MoH	Law/legal
2.2.4 Establish pilot/demonstration projects on community mobilization against alcohol			■	■	MoH	Civil society, AIFAESA
2.2.5 Raise taxes on alcohol and alcohol-containing products		■	■	■	MoH	Finance
2.3 Promotion of a healthy diet						
2.3.1 Adapt the SEA Region's nutrient profile model to the country context	■				Nutrition Unit	Department of Health Promotion, WHO
2.3.2 Disseminate food-based dietary guidelines through the media		■			Department of Health Promotion	Nutrition Unit, media partners
2.3.3 Enact legislation on regulation of marketing of food and non-alcoholic beverages to children as per WHO recommendations		■			Nutrition Unit	Communication, Law/legal
2.3.4 Hold a national consultation to draft regulations on salt/fat/sugar content of processed/pre-packaged foods, including front-of-pack labelling			■		Nutrition Unit	Law/legal
2.3.5 Adapt and implement the WHO SHAKE strategy for population salt reduction			■		Nutrition Unit	WHO

2.3.6 Impose taxes on specific identified unhealthy food products (high in fats/salt/sugar – HFSS)					Nutrition Unit	Finance Ministry
2.3.7 Hold a national consultation to develop a national strategy for increasing the intake of fruits and vegetables					Nutrition Unit	Ministry of Agriculture
2.4 Promotion of physical activity						
2.4.1 Scale up introduction of cycle/skating tracks in Dili					Urban Development /	MoH
2.4.2 Instal open-air gyms in parks and public spaces in Dili					Department of Health Promotion	Municipalities
2.4.3 Develop and implement mass media campaigns for promotion of physical activity					Department of Health Promotion	Department of Sports
2.4.4 Organize mass physical activity programmes in different parts of the country					Department of Health Promotion	MoH, Department of Sports
2.5 Promotion of healthy settings						
2.5.1 Strengthen the enforcement of health-promoting schools using the WHO guidelines in a phased manner over the entire country					Education Department	Department of Health Promotion/ MoH
2.5.2 Establish health-promoting workplaces					Labour,	Department of Health Promotion/ MoH
2.5.3 Train district public health officers (DPHOs) in municipalities to integrate promotion of healthy lifestyles in their workplans					Municipalities	MoH
2.6 Reduction in exposure to indoor and outdoor air pollution						
2.6.1 Develop national standards for indoor and outdoor air quality					MDHO/ Ministeriu Ambiente	Transport Department
2.6.2 Establish/expand outdoor air quality monitoring stations					Relevant ministries	MoH
2.6.3 Develop an action plan for replacing solid fuels with alternative safer fuels					Renewable energy/gas	MoH
2.6.4 Establish and notify vehicular emission norms					Pollution control agency	Transport/Police Department
2.6.5 Improve public transport in Dili and other urban settlements					Public Transport Department	MoH
2.7 Increase in capacity for health promotion						

2.7.1. Strengthen institutional capacity to design mass media campaigns for behaviour change					Department of Health Promotion	WHO
2.7.2 Develop standardized training packages/programmes on health promotion for different groups of stakeholders					Department of Health Promotion	Media agencies / Information and Broadcasting Ministry
Strategic Area 3. Health systems strengthening for early detection and management of NCDs						
Activities	**Implementation time frame**				**Lead agency**	**Implementing partners**
	2018	**2019**	**2020**	**2021**		
3.1 Strengthening the primary health care level to address NCDs						
3.1.1. Implement the second phase and scale up WHO's primary health care package for NCDs, including the RHD component, by covering all districts over the next four years					NCD Unit	MoH, subnational governments
3.1.2 Establish clear referral linkages, transfer and follow-up mechanisms from primary care to secondary care facilities and vice versa					NCD Unit	MoH, local governments
3.1.3 Develop patient education materials for hypertension, diabetes mellitus and chronic respiratory diseases					NCD Unit	WHO
3.1.4 Scale up community- and family-based health promotion and screening programmes, including follow-up and treatment for hypertension, common cancers, diabetes mellitus					NCD Unit	MoH
3.1.5 Strengthen and standardize diagnostic services and technology, including laboratory services, at the CHC level for provision of key NCD-related services					National laboratory	NCD Unit, WHO
3.1.6 Revise the package of interventions included under PEN after evaluation					NCD Unit	WHO
3.2 Strengthening secondary care services for addressing NCDs						
3.2.1 Strengthen secondary care facilities for providing ambulatory care for NCDs by ensuring the availability of integrated services through the establishment of properly staffed and equipped NCD clinics					MoH	MoH, subnational governments
3.2.2 Revise the list of medicines and technologies related to NCDs for secondary care to include management of acute conditions					NCD Unit	MoH
3.2.3 Establish specialized care facilities for acute events (acute coronary event or stroke or acute exacerbations of NCDs) at selected health facilities					MoH	MoH
3.2.4 Establish integrated deaddiction services for substance abuse (tobacco, alcohol, drugs) at national and referral hospitals					NCD Unit	MoH
3.2.5 Update standard treatment guidelines for the management of key NCDs at all levels					NCD Unit	National Hospital, University, WHO
3.2.6 Develop palliative care standards and a manual					NCD Unit	National Hospital

3.3 Strengthening human resources required for NCD prevention and control						
3.3.1. Develop training manuals for all levels of health workers based on national standard treatment guidelines	■				NCD Unit	MoH
3.3.2 Conduct in-service training of all human resources in the management of NCDs		■	■	■	NCD unit	MoH
3.3.3 Revise the curriculum for different health staff to include NCD management protocols			■		University	MoH
3.4 Strengthening the National Hospital for providing tertiary-level care						
3.4.1 Set up/strengthen NCD-specific services at the National Hospital (HNGV)					National Hospital	MoH, WHO
• Diabetic clinic	■					
• CVD clinic	■					
• Renal clinic & dialysis	■					
• Respiratory diseases clinic		■				
• Cancer care, including palliative therapy facilities			■			
3.5 Utilizing information technology for patient care						
3.5.1 Strengthen information technology (equipment and structural) support to enable telemedicine linkage of all levels of facilities with each other for providing continuity of NCD care				■	MoH	
3.5.2. Improve the use of a computerized system of record-keeping for patients, including electronic medical records for ease of access across sectors and levels		■			MoH	
Strategic Area 4: Surveillance, monitoring and evaluation, and research						
Activities	**Implementation time frame**				**Lead agency**	**Implementing partners**
	2018	**2019**	**2020**	**2021**		
4.**1 Strengthening NCD surveillance systems**						
4.1.1 Identify an NCD focal point in the existing Department of Surveillance and train the person in NCD surveillance	■	■			MoH	
4.1.2 Conduct the WHO STEPS survey for risk factors, including urinary sodium		■			MoH	University, WHO
4.1.3 Assess the preparedness of health facilities for provision of NCD care		■				
4.1.4 Conduct training of doctors in medical certification of causes of death/ICD coding using the WHO death certificate/online modules	■	■	■	■	University	WHO
4.1.5. Conduct a pilot study on inclusion of cause-of-death ascertainment using verbal autopsy at the time of domiciliary visits to the community and family		■			MoH	WHO
4.1.6 Conduct a school-based survey among adolescents using available WHO tools			■		MoH	University, WHO
4.1.7 Establish a hospital-based cancer registry at the National Hospital			■	■	National Hospital	IARC, WHO

4.2 Monitoring programme implementation						
4.2.1 Identify and Include key NCD-related service indicators in the MoH routine monitoring system (25 indicators at present)					M & E Unit MoH	WHO
4.2.2 Prepare an M&E plan for implementation of the multisectoral action plan					M & E Unit, MoH	WHO
4.2.2 Prepare and submit annual and quarterly performance appraisal reports of implementing the multisectoral action plan to the NCD Ministerial Committee					Directorate of Public Health	MoH
4.2 .3 Strengthen the hospital information system for cohort monitoring of patients with diabetes and hypertension under treatment					M & E unit	MoH
4.2.4 Monitor enforcement of the tobacco law through count of violations, response time and mystery client surveys					M & E Unit MoH	Civil society, AIFAESA
4.2.5 Strengthen public health laboratory capacity for biochemical analysis – nutrients, pollutants, tobacco and alcohol contents – through purchase of equipment and human resource development					Directorate of Public Health, Nutrition Unit	WHO
4.3 Strengthening evidence generation						
4.3.1 Hold a national consultation to identify priority research areas in NCD prevention and control					INS	WHO
4.3.2 Estimate the effectiveness of different health promotion strategies in changing behaviour (tobacco/alcohol/diet/physical activity)					NCD Unit	University
4.3.3 Assess the consumption of sugar-sweetened beverages/foods high in fats, sugar, salt) in the population, especially children and adolescents					NCD Unit	University
4.3.4 Conduct cost-of-illnesses studies for common NCDs (CVD, diabetes mellitus, cancer and CRD)					NCD Unit	WHO
4.3.5 Assess the quality of care, including adherence to treatment, for hypertension and diabetes and determinants of adherence					NCD Unit	MoH
4.4 Programme evaluation						
4.4.1 Conduct joint evaluation with an independent agency of implementation of the multisectoral action plan					Directorate of Public Health	MoH, WHO
4.4.2 Conduct evaluation of the WHO-PEN scale-up programme					Directorate of Public Health	MoH, WHO

4. Monitoring and evaluation of the Action Plan

A comprehensive NCD monitoring framework includes relevant process and outcome indicators. The WHO Global NCD monitoring framework has been adapted to the national context for identifying national indicators and fixing national targets. As a part of the national monitoring framework, a total of 24 indicators have been identified (Annexure 3), out of which targets have been set for 12 indicators (Annexure 4). Targets have been set only for those indicators that are critical for monitoring, for which the strategies being planned are expected to start showing results, and for those indicators where data collection appears feasible in the time frame proposed.

Demographic and Health Surveys (DHS), WHO STEPS surveys, global tobacco surveys (Global School-based Health Survey [GSHS], Global Youth Tobacco Survey [GYTS], Global Adult Tobacco Survey [GATS]) provide information that can be used to track the progress being made in NCD prevention and control. While these would measure the overall impact of the Action Plan, it is also important to establish process and output indicators. For each of the strategic areas, key process and output indicators are listed in Table 5. They are measurable either in quantitative terms or can be answered as achieved or not achieved at the end of the Action Plan, and provide an objective way to evaluate the programme. These indicators, along with outcome indicators, would enable a comprehensive evaluation of the MSAP in Timor-Leste. A joint evaluation of implementation of the MSAP by an independent agency is recommended.

Table 5. Monitoring framework for the Action Plan, 2018–2021

Monitoring framework for the Strategic Area on Advocacy and leadership for a multisectoral response	
Strategic area	**Key process and output indicators and targets for 2021**
1. Conduct advocacy for multisectoral action for the prevention and control of NCDs	1. Number of meetings of NCDMC MC/working groups held annually and their attendance 2. At least five ministries have included NCDs in their annual action plan. 3. All selected ministries have identified a focal point for NCDs. 4. The budget for NCDs has increased with a focus on primary care. 5. A number of meetings of the technical working groups are held annually.
2. Strengthen the leadership capacity of NCD focal points/units	6. Directorate of NCDs established with disease-specific departments 7. Number of NCD full-time staff increased

3. Establish and strengthen partnerships for the prevention and control of NCDs	8. Number of agencies attending the annual partnership meeting 9. Number of nongovernmental organizations (NGOs)/civil society agencies in alliance
Monitoring framework for Strategic Area on Health Promotion and Primary Prevention to reduce the risk factors for NCDs	
Strategic area	**Key process and output indicators and targets for 2021**
1. Tobacco control	1. National Council on Tobacco Control established and meets regularly 2. Taxes on tobacco products raised 3. Presence and wide reach of mass media campaigns 4. Number of violations reported in the online complaint mechanism or other law enforcement agencies
2. Reduction in the harmful use of alcohol	5. Enactment of a comprehensive legislation on reduction of the harmful use of alcohol 6. Tax on alcohol raised 7. Increase in registration of the number of drink–driving violations 8. Number of demonstration projects on community mobilization against alcohol initiated 9. Presence and wide reach of mass media campaigns
3. Promotion of a healthy diet	10. The SEA Region nutrient profile adapted to the national context to identify unhealthy foods 11. Tax on unhealthy food items increased 12. WHO SHAKE strategy adapted and implemented 13. Regulation on marketing of food and beverages to children present 14. Regulation on salt/fat/sugar content of processed packages and nutrient labeling passed
4. Promotion of physical activity	15. Cycle tracks/walking trails introduced in select public roads in Dili 16. Number of public gyms increased 17. Number of mass physical activity programmes organized in different areas and number of people who participated
5. Promotion of healthy settings	18. Number of health-promoting schools established 19. Number of healthy workplaces 20. Number of municipalities/village LSGs with a plan to promote healthy lifestyles increased
6. Reduction in exposure to indoor and outdoor air pollution	21. National standards for outdoor air quality set 22. Decrease in the proportion of households using solid fuels 23. Vehicular emission norms established and notified
7. Increase in the capacity for health promotion	24. Availability of training modules on health promotion 25. Number of people trained in health promotion

Monitoring Framework for Strategic Area on Health Systems Strengthening for early detection and management of NCDs	
Strategic area	**Key process and output indicators and targets for 2021**
1. Strengthen the primary health care level to address NCDs	1. Number of districts fully covered by PEN 2. Number of primary care facilities implementing the PEN package increased 3. Number of patients diagnosed with hypertension/diabetes mellitus/ cancers at the primary care level 4. Number of home visits for NCD patients under Saude Na Familia
2. Strengthen secondary care services for addressing NCDs	5. Standard treatment guidelines for key NCD conditions available 6. Medicine and technology list for secondary care facilities finalized and procurement mechanism put in place 7. Number of patients attending secondary care facilities for NCD conditions 8. Deaddiction services started at referral hospitals
3. Strengthen human resources required for NCD prevention and control	9. Training manuals on NCDs available 10. Number of health personnel trained in NCD management 11. Revised curriculum on NCDs available for health personnel
4. Strengthen the National Hospital for providing tertiary-level care	12. Diabetes mellitus, chronic respiratory diseases, cardiovascular diseases and dialysis services available at the National Hospital 13. Cancer care, including palliative care, available at the National Hospital
5. Utilize information technology for patient care	14. Telemedicine consultation between National Hospital and five referral hospitals established 15. Pilot EHR project in one district completed
Monitoring framework for Strategic Area on Surveillance, Monitoring and Evaluation, and Research	
1. Strengthen NCD surveillance systems	1. Surveys conducted on adult and adolescent risk factors 2. Survey conducted for national health facility readiness to treat NCDs 3. Information available on time trends of key indicators of the national monitoring framework 4. Recent mortality data on NCDs available 5. Hospital-based cancer registry established
2. Monitor programme implementation	6. NCDs included in the routine monitoring of health programmes 7. Information available on awareness, treatment and control of diabetes mellitus and hypertension 8. Annual/quarterly report of implementation of the Multisectoral Action Plan (MSAP) submitted and available
3. Strengthen evidence generation	9. Priority research areas in NCDs identified 10. Key pieces of evidence required for NCD prevention activities available
4. Programme evaluation	11. Evaluation report of the MSAP available and disseminated 12. Evaluation report of the PEN programme available

5. Implementation mechanism

For effective implementation, an MSAP requires ownership by each stakeholder. This can be achieved only by embedding the Plan within all levels and ministries of the government and other implementing partners. Effective mechanisms to coordinate the activities of stakeholders need to be established to ensure successful implementation.

A multilayered mechanism has therefore been adopted at the political, executive and technical levels. Table 5 shows the composition of the committees and their responsibilities.

Valid and reliable information is essential to track progress in implementing any plan. Stakeholders should be motivated by periodically informing them about the progress and the performance of other stakeholders. In addition, the government and donors require information on implementation of the Plan. Six-monthly progress reports from implementing agencies would be optimal. The focal officials should be given the responsibility of compiling and submitting the reports to the NCD Unit/proposed Directorate of NCDs of MoH, which will serve as the Secretariat.

An annual national NCD report consolidating the national action on NCDs should be released at the end of each financial year. The report should highlight the overall achievements and performance of each implementing agency, document successes, identify challenges and recommend solutions to overcome barriers to implementing the NCD Action Plan. The NCD Ministerial Committee will review the report and submit the annual NCD report to the Prime Minister and Government. The report should also be made available to the other stakeholders and donors.

5.1 Financing of the Plan

Implementation of the MSAP will require additional allocation of funds. While most of the funding should come from government grants and budgetary support, funds can be mobilized from other sources such as United Nations (UN) agencies and other development partners. As a first step, it would be prudent to prepare a cost estimate of the Plan – year-wise and stakeholder-wise. While the MoH should ask for its share in its annual budget proposal, other ministries can ask for funds for their activities as a part of their annual budget proposal. This is also true for subnational agencies. This will promote greater decentralization of NCD plans and generate ownership and accountability at the grass-roots level.

Table 5. Composition and mechanisms for implementation of the NCD Multisectoral Action Plan 2018–2021

Agencies	Composition	Terms of reference/responsibilities	Guidelines for working
NCD ministerial Committee	This will be chaired by the Minister of Health and will comprise of ministers from other relevant sectors – MoS, SEJI, MoE, MoF, MoCI, Police	• Providing political support and guidance by writing to all ministries for preparation of their multi-sectoral action plan • Provide a platform for dialogue and agenda setting for multi-sectoral actions • Review the multisectoral action plan of all ministries • Make recommendations for allocation of adequate budget for the plan • Review the annual report of the action plan	• Hold six monthly meetings • Quorum would be two third of participants. If not available to be postponed by 2 weeks. • Can be delegated to Vice-minister • Directorate of Public Health/NCDs will be the secretariat.
Regulatory and legislative Working Group	This will comprise of focal points within each relevant ministry – MOCI. MoH, MoF (customs), MoE, Police, AIFAESA, MoComm, SEJI, and Civil Society members and Development partners	• Draft a regulatory framework for addressing NCDs • This would include tobacco, alcohol and dietary aspects • Prepare draft bills for introduction in parliament/ cabinet • Review the implementation of the laws related to NCDs	• Hold three monthly meeting • 10-15 member Working Group • Quorum would be two third of participants. If not available to be postponed by 2 weeks. • Secretariat will be the Department of Health Promotion under Directorate of Public Health
Technical Working Group(s) on Health Services	Comprise of specific technical experts for risk factors or diseases or experts from other areas - environment/ health promotion / surveillance etc.	• Provides a technical overview and supervision of the program • Provides technical opinion to the higher authorities. • Draft guidelines for different aspects of NCD prevention and control.	• Hold quarterly meetings • Chaired by National Directorate Public Health and NCD program manager to be secretary. • Can constitute Sub-committees for specific areas

5.2 Subnational coordination of activities

There is also a need to implement many of these activities at the subnational level. At the municipality level, a committee has to be formed, which should be chaired by the president of the authority of the municipality and will comprise members related to education, the police, agriculture, civil society and elected members of the municipality. They should meet every three months and the Secretariat will be the Director of Health Services of that municipality.

5.3 Roles of the Ministry of Health and other stakeholders

The MoH has to play a leadership and coordination role in implementing this Action Plan. The Secretariat has to be housed in the MoH. For this purpose, it is recommended that the NCD Department be upgraded to a Directorate of NCDs with disease-/risk factor-specific departments such as CVD and diabetes, cancer and CRD, tobacco and alcohol, diet and physical activity. The MoH and other key agencies responsible for implementation of the Action Plan and their roles are listed in Tables 6 and 7.

Table 6. Responsibilities of different subunits within the Ministry of Health for MSAP implementation

Unit	Staffing recommendations	Responsibilities
Directorate of Public Health/NCD	At least three full time staff devoted to NCDs - One technical and two support staff.	• Serve as secretariat of the NCDMC. • Hold meetings of the NCDMC and Working groups as per their defined interval. • Co-ordinate/liaison /correspond with all the partners and stakeholders • Prepare reports for the meetings and share with all stakeholders. • Follow-up for the implementation of the decisions of NCDMC • Hold Annual NCD Summit and follow up on decisions taken at the annual summit
NCD Unit, Department in Ministry of Health	Disease or risk factor Specific officers (CVD, Cancers, Diabetes, Tobacco& alcohol, Diet and Physical activity)	• Focus on implementing the health System strengthening initiatives in the MSAP. • Establish and conduct meetings of technical working groups as per the need. • Formulate and disseminate guidelines
Department of Health Promotion	Existing Department to be strengthened	• Focus on implementing the Health Promotion Components of the MSAP • Develop, implement and monitor mass media campaigns with partners. • Prepare health promotion training modules for different stakeholders. • Serve as secretariat of the Working Group on Regulatory and legislative aspects.
M & E Unit	Needs orientation of the existing staff	• Develop an M& E plan for MSAP • Include NCD service indicators in routine monitoring of health programs
Surveillance Unit	Needs training of the existing staff	• Integrate NCD surveillance in their routine work plan • Strengthen mortality surveillance for cause of death data • Integrate NCD data into other population and health facility surveys

Table 7. Role of key ministries in implementing the MSAP

Ministry	Indicative activities that can be undertaken
Ministry of Education, Youth and Sport	• Establishing health-promoting schools • Revising the health component of the school curriculum to include healthy living • Banning the sale of junk foods within schools • Supporting enforcement of tobacco and alcohol laws within and outside schools
Secretary of State for Youth and Sport	• Organizing sports and mass physical activity campaigns • Establishing open gyms in parks and public spaces • Supporting physical activity champions
Ministry of Defence and Interior	• Enforcing tobacco- and other NCD-related regulations, including drink–driving
Ministry of Agriculture and Fisheries	• Promoting the production of fresh vegetables at affordable prices • Establishing cold chains for transport of perishable goods such as fruits and vegetables
Ministry of Economic Affairs (Commerce/ Information & Broadcasting	• Regulating the marketing of food products and non-alcoholic beverages to children • Supporting mass media campaigns against tobacco, alcohol and unhealthy foods
Ministry of Finance	• Raising taxation on tobacco, alcohol and unhealthy food products • Earmarkinging the revenue generated from these taxes forcontrolling NCDs • Subsidizing the cultivation, transport and sale of fruits and vegetables
Ministry of Finance (Customs)	• Enforcing and implementing regulations on pricing and taxation on tobacco, alcohol and unhealthy food products, and illegal smuggling of these products into the country
Ministry of Public Works; Ministry of Transport and Communication	• Enforcing implementing urban design and healthy urban planning to promote physical activity • Improving public transport in Dili and other urban areas
Secretariat of State for the Environment	• Establishing indoor and outdoor air quality standards • Measuring air pollution using outdoor air quality monitors • Establishing vehicular emission norms and mechanisms for their implementation
Ministry of Petroleum and Minerals	• Preparing an action plan to replace solid fuels with cleaner fuels such as natural gas/solar, etc.)


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World Health Organization
COUNTRY OFFICE FOR Timor-Leste
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AUTORIDADE MUNICIPAL DE ERMERA
SERVISU MUNICIPAL DE SAÚDE ERMERA
PROGRAMA DE CONTROLO TABACO
TELEFONE: 3830012
Ha'u nia saude iha ita nia liman rasik

Annexures

Annex-1
Status of tobacco control

S. no.	Key indicators	Status for 2016
1	Specific national government objectives for tobacco control	Yes
2	National agency or technical unit for tobacco control	Yes
3	Number of full-time equivalent staff	One
4	Presence of smoke free laws	Covers closed places only
5	Does the law entail imposition of fines to smokers in public places?	Yes
6	Availability of a tobacco cessation helpline	No
7	Availability of tobacco cessation services in the country	No
8	Law mandates that health warnings appear on tobacco packages	Yes
9	What percentage of the principal display areas of the package is legally mandated to be covered by health warnings? FRONT AND REAR COMBINED	50%
10	Health warnings on packages include a photograph or graphic	No
11	Laws mandate plain packaging	No
12	Presence of a national campaign against tobacco involving mass media	Yes
13	Evaluation of a national mass media campaign	No
14	Ban on direct advertising of tobacco	Yes
15	Comprehensive ban on tobacco promotion and sponsorship	Yes
16	Highest slab of tax imposed on cigarettes	28%

(Decree Law No.14/2016)

Annex-2
Status of policies related to the reduction of harmful use of alcohol

Written national policy (adopted/revised)/national action plan	No/ —
Excise tax on beer/wine/spirits	Yes/Yes/Yes
National legal minimum age for off-premise sales of alcoholic beverages (beer/wine/spirits)	No/No/No
National legal minimum age for on-premise sales of alcoholic beverages (beer/wine/spirits)	No/No/No
Restrictions for on-/off-premise sales of alcoholic beverages	None
National maximum legal blood alcohol concentration (BAC) when driving a vehicle (general/young/professional), in %	0.05/0.05/0.05
Legally binding regulations on alcohol advertising/product placement	No/No
Legally binding regulations on alcohol sponsorship/sales promotion	No/No
Legally required health warning labels on alcohol advertisements/ containers	No/No
National government support for community action	Yes
National monitoring/surveillance system(s)	No

Source: Noncommunicable diseases country profiles 2014. Geneva: WHO; 2014 (http://apps.who.int/iris/bitstream/handle/10665/128038/9789241507509_eng.pdf;jsessionid=17AF0974F233D3C99E11CE7C5B045201?sequence=1, accessed 24 September 2018).

Annex-3
Indicators identified under the National NCD Monitoring Framework

	Outcomes (mortality and morbidity)
1.	Unconditional probability of dying between the ages of 30 and 70 years from CVD, cancer, diabetes or chronic respiratory disease
2.	Cancer incidence, by type of cancer, per 100 000 population
	Exposures (risk factors)
3.	Age-standardized prevalence of current tobacco use among persons aged 18+ years
4.	Prevalence of current tobacco use among adolescents (13–17 years)
5.	Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context
6.	Age-standardized prevalence of heavy episodic drinking among persons aged 18+ years
7.	Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 g) of fruits and vegetables
8.	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
9.	Prevalence of insufficient physical activity (defined as less than 60 min of moderate- to vigorous-intensity activity daily) among adolescents (1–17 years)
10.	Age-standardized prevalence of insufficient physical activity in persons aged 18+ years (defined as less than 150 min of moderate-intensity activity per week, or equivalent
11.	Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (fasting plasma glucose value ≥7.0 mmol/L (126 mg/dL) or on medication for diabetes
12.	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg); and mean systolic blood pressure
13.	Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation [SD] body mass index for age and sex, and obese – 2 SD BMI for age and sex)
14.	Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥25 kg/m2 for overweight and body mass index ≥30 kg/m2 for obesity)
15.	Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dL); and mean total cholesterol
16.	Proportion of households with solid fuel use as their primary source of cooking

Health system response
17. Proportion of women between the ages of 30 and 49 years screened for cervical cancer at least once
18. Proportion of eligible persons screened for oral cancer at least once
19. Proportion of eligible persons (defined as age 40 years and over with a 10-year cardiovascular risk ≥30%, including those with existing CVD) receiving drug therapy and counselling (including glycaemic control) to prevent heart attack and stroke
20. Availability and affordability of essential NCD medicines, including generics, and basic technologies as per the national package in both public and private facilities
21. Proportion of primary health care workforce trained in integrated NCD prevention and control
22. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants
23. Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt
24. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes

Annex-4
National targets set for NCD prevention and control for 2020 and 2025

Indicator	Targets	
	Mid-term (2020)	End-term (2025)
1. Unconditional probability of dying between the ages of 30 and 70 years from four major NCDs	7% relative reduction	20% relative reduction
2. Age-standardized prevalence of current tobacco use among persons aged 18+ years	10% relative reduction	20% relative reduction
3. Prevalence of current tobacco use among adolescents (13–17 years)	15% relative reduction	30% relative reduction
4. Age-standardized prevalence of heavy episodic drinking among adults	5% relative reduction	10% relative reduction
5. Prevalence of insufficient physical activity among adolescents (13–17 years)	5% relative reduction	15% relative reduction
6. Age-standardized prevalence of insufficient physical activity persons aged 18+ years	5% relative reduction	10% relative reduction
7. Age-standardized prevalence of overweight and obesity in adults aged 18+ years	Not set	Halt the rise (0% increase)
8. Age-standardized prevalence of raised blood glucose/diabetes among adults	Not set	Halt the rise (0% increase)
9. Age-standardized prevalence of raised blood pressure among adults aged 18+ years	10% relative reduction	25% relative reduction
10. Drug therapy to prevent heart attack and stroke (includes glycaemic control), and counselling for people aged 40 years and over with a 10-year cardiovascular risk greater than or equal to 30% (includes those with existing CVD)	25%	50%
11. Availability of generic essential NCD medicines and basic technologies in both public and private facilities	50%	80%
12. Proportion of primary health care workforce trained in integrated NCD care	50%	80%
13. Coverage with vaccination against hepatitis B virus (HBV)	80%	95%


Ministério
da Saúde