World Health Organization

REGIONAL OFFICE FOR Europe

European Regional Technical Consultation on Noncommunicable Disease Surveillance, Monitoring and Evaluation

Oslo, Norway, 9–10 February 2012

Report of the Consultation

ABSTRACT

During 9–10 February 2012, 85 participants including noncommunicable disease technical counterparts from 28 Member States, 2 intergovernmental organizations, 7 WHO collaborating centres, 10 temporary advisers, observers from 5 nongovernmental organizations, the Norwegian Directorate of Health and the WHO Regional Office for Europe met for a technical discussion of targets and indicators proposed for the global monitoring framework being developed as an outcome of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases. This was intended to inform the country consultation process and gain a regional perspective relevant for monitoring and evaluation of the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 and Health 2020. There were also opportunities to share country and international experience on surveillance, consider integrating the social determinants of health and identify the needs of Member States in this field.

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Introduction

Opening session

The European Regional Technical Consultation on Noncommunicable Disease Surveillance, Monitoring and Evaluation was held on 9–10 February 2012 in Oslo, Norway, hosted by the Government of Norway. It brought together national counterparts for noncommunicable disease (NCD) surveillance, technical experts and other stakeholders for technical discussion of the targets and indicators proposed for the global monitoring framework being developed as an outcome of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases held on 19–20 September 2011.

Dr Bjørn-Inge Larsen, Norwegian Directorate of Health, Norway, welcomed participants and outlined his expectations for the meeting. The year 2011 had been a turning point for NCD with the important global ministerial conference in Moscow in April and the United Nations High-level Meeting in New York in September. Within Norway, the efforts to respond to the risk factors for NCD were at different stages: aggressive steps had been taken against tobacco and alcohol, which were bearing fruit, but physical inactivity was a serious problem, and the prevalence of obesity and type 2 diabetes were increasing. He hoped for excellent technical discussions during the Consultation that would make a real contribution to developing the NCD agenda and that countries would actively participate both within this Consultation and the global consultation process.

Objectives and scope

Dr Gauden Galea, Division of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe, thanked Norway for hosting the meeting: their continued support enabled the European Region to be the first WHO region to have a consultation on the global monitoring framework and voluntary global targets for preventing and controlling NCDs. He explained that the meeting was held in response to WHO's clear mandate arising from the Political Declaration of the General Assembly on the Prevention and Control of Noncommunicable Diseases (resolution 66/2) and the WHO Executive Board resolution[1] to prepare a global monitoring framework and set of voluntary global targets. Further, the WHO Regional Committee for Europe resolution[2] required targets and indicators for the Action Plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases to be informed by those for the global framework. Discussion papers had been prepared to inform discussions, but these reflected the opinion of their authors rather than positions of WHO. There were also opportunities to share country and international experience on surveillance, consider the integration of social determinants of health and identify the needs of Member States in this field. He commented that the Consultation was liberated from

[1] *Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases*, Resolution EB130.R7, 20 January 2012.

[2] *Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016*, EUR/RC61/R3, September 2011.

having to reach consensus and would be purely technical. A report on issues relating to applying the global monitoring framework in the European Region would be a product of the meeting.

Ms Frederiek Mantingh, Division of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe, invited participants to introduce themselves. There were 85 participants attending, including representatives of 28 Member States, 2 intergovernmental organizations, 7 WHO collaborating centres, 10 temporary advisers, observers from 5 nongovernmental organizations, the Norwegian Directorate of Health, the WHO Regional Office for Europe and representatives of 2 WHO regional offices and WHO headquarters (Annex 2).

The global and European context

Mr Bernt Bull, Ministry for Health and Care Services, Norway chaired the session and introduced the speakers.

Ms Leanne Riley, Department of Chronic Diseases and Health Promotion, WHO, briefed participants on the outcomes of the High-level Meeting on Noncommunicable Diseases and the global monitoring framework and voluntary targets. The framework was intended to provide a foundation for sound monitoring of NCD progress within countries and a means of measuring overall global progress, with mutual accountability between the levels. Five principles[3] underpinned the framework, which aimed to monitor exposure, outcomes and health system response. The framework had been prepared based on learning from other global initiatives and a set of criteria devised for selecting targets. She then explained the detail behind each of the 10 targets, their respective indicators and data sources (Annex 3).

Dr Gauden Galea presented the European context for the monitoring framework. Within the WHO European Region, in addition to the development of a monitoring and evaluation framework for the European NCD Action Plan already mentioned, targets and indicators are being developed for the European health policy – Health 2020. The Health 2020 target-setting process is using the global monitoring framework as a basis for discussions relating to NCD. It is useful that the sequence is such that the consultation process for the global monitoring framework will be completed before the Health 2020 targets and indicators are submitted to the WHO Regional Committee for Europe for discussion in September 2012. The framework for the European NCD Action Plan will follow and benefit from both processes as well as the ongoing work on social determinants of health and that to develop indicators of well-being. Although only 4 of the 10 areas covered by the voluntary global targets overlap with the European NCD Action Plan, there is also potential for aspects to be picked up within the Health 2020 process.

Panel discussion

A panel discussion then followed in which participants gave their first impressions and perspectives on the global monitoring framework and voluntary global targets.

Professor Knut-Inge Klepp, Division of Public Health, Norwegian Directorate of Health, considered the framework and targets to be an important step. In drawing up a roadmap on how

[3] Targets should be relevant, coherent, achievable with evidence-based interventions and measurable.

to reach the targets, he suggested examining the experience within the European Region, which in turn has a responsibility to share its strategies. He urged including physical inactivity in the framework and proposed that indicators be included on implementing global policies. Finally, he suggested that more flexibility in measures might lower the threshold for adoption.

Ms Sigurlaug Hauksdottir, European Commission, outlined the work they had carried out in surveillance of NCD risk factors, drawing on experience gained through the European Health Interview Survey implemented by Eurostat and the European Health Examination Survey, which is active in 13 countries and will report its results in Brussels on 6–7 March 2012. She recognized the difficulty in harmonizing tools and gathering comparable data.

Professor Hans van Oers, National Institute for Public Health and the Environment (RIVM), Netherlands, emphasized the need to start from a common conceptual framework and to learn from similar processes. He was keen to place a low administrative burden on countries and to use data that already exist and that is in accordance with country health information systems. Finally, he added his support for including physical activity explicitly within the framework.

Dr Liis Rooväli, Health Information and Analysis Department, Ministry of Social Affairs, Estonia, agreed that NCD surveillance needs to be integrated within national health information systems, that indicators have to be highly relevant to national systems and that additional burden for data collection should be avoided. Apart from agreeing on including physical inactivity, she suggested that targets be considered by sex, age and socioeconomic group.

Discussion

In the subsequent discussion, Estonia, Hungary, Ireland, Netherlands, Norway, the former Yugoslav Republic of Macedonia, several WHO collaborating centres, the United Nations Children's Fund (UNICEF) and the WHO Secretariat made contributions. WHO clarified the process and timetable for the consultation on the global monitoring framework and the set of voluntary global targets and Health 2020 target-setting. There was some discussion on the value of specific indicators such as life expectancy, healthy life expectancy and premature mortality, and the relative advantages of health examination versus interview survey tools and methods.

Policy level targets and social determinants of health

Dr Nata Avaliani, National Center for Disease Control and Public Health, Tbilisi, Georgia, chaired the session in which there were two keynote presentations and a briefing on the tobacco target and indicator proposed.

Dr David Stuckler, Cambridge University, United Kingdom presented potential areas for setting targets in public policy, with tobacco control as an example. He spoke of the long history of target-setting in Europe and emphasized that target-setting is a political process that provides opportunities for win-wins such as revenue from fiscal policies. He described effective targets as being: few and focused; evidence-based; linked to mechanisms and resources; matched to the appropriate political level; and sufficiently bold to be both aspirational and inspirational. At such a time of austerity, there was an opportunity for leadership has an opportunity in taking a positive view of health.

Professor Martin Bobak, Department of Epidemiology & Public Health, University College

London, United Kingdom, presented the social determinants of health in NCD monitoring and surveillance. Social determinants play a powerful role in shaping health, with the social gradient starting early in life and very few diseases have no social pattern. He recommended both monitoring NCDs with disaggregation of actions and outcomes by social determinants and monitoring social determinants by life-course stage. He drew attention to the importance of data linkage in research on and monitoring of social determinants of health.

The chair then invited **Dr Edouard Tursan d'Espaignet**, Comprehensive Information Systems for Tobacco Control, WHO, to present the target and indicator on tobacco. The Regional workshop on implementation of the WHO Framework Convention on Tobacco Control in Chisinau, Republic of Moldova on 15–18 November 2011 reviewed the target and indicator, and the target was found to be achievable across the Region, even if specific countries would find this challenging. Efforts were underway to harmonize tobacco survey tools. The target was considered likely to be achievable even where substantial reductions had taken place already, although the evidence from countries indicates that this requires strong political involvement, with implementation of the measures to reduce demand from the Framework Convention at the highest level. Within Europe, there is also evidence of this further acceleration in declining smoking prevalence, such as in Norway. A review of the trend in countries that have strongly reduced the prevalence of tobacco use suggests the possibility that, once a low rate of prevalence is achieved, the epidemic might bottom out, with accelerated decline ensuing.

Discussion

France, the Netherlands, Norway, the United Kingdom, several WHO collaborating centres and temporary advisers, the European Commission and the WHO Secretariat contributed to the subsequent discussion. There was support for tracking trends in inequities and social determinants of health. The effects of public policy on inequities and the relative merits of population or personal approaches were noted. Concern was expressed over the effects of data protection and access on data linkage and the importance that good public health monitoring be preserved. There was support for breakdown by age, sex, socioeconomic status and other parameters under each indicator. It was suggested that the relevant best-buy policy be presented alongside each indicator to help countries set priorities as well as focusing on only a few, simple, low-cost, effective interventions that are practical, sensible and achievable. Examples of the demonstration of inequalities and relevant initiatives within Germany, Norway, Poland and the United Kingdom were shared.

Regional perspectives on targets and indicators, policies and social determinants I

Dr Véronique Tellier of L'Observatoire Wallon de la Santé, Jambes, Belgium, chaired the session.

Mortality from NCDs

Professor Kari Kuulasmaa, WHO Collaborating Centre for Noncommunicable Disease Prevention, Health Promotion and Monitoring, Helsinki, Finland presented on the target and indicator for mortality from NCDs from within the group for monitoring outcomes. Generally, the target was perceived to be realistic. For the indicator, data are available and largely useful

although of suboptimal quality in places, and even within Europe, the quality of vital registration varies. Within the European Region, cardiovascular diseases and cancer dominate the levels of and trends in NCD mortality; mortality from both these groups of conditions has been declining, although to different extents. A 25% target, therefore, was considered realistic and would require maintaining a decline in NCD mortality for some countries and a steeper decline in mortality for others.

Dr Gauden Galea demonstrated trends in the relationship between premature mortality from circulatory diseases and the gross domestic product of a country. Since this mortality was sensitive to the socioeconomic environment, he wondered whether the decline could be set to change in response to the economic downturn.

Discussion

In the subsequent discussion, Belgium, Ireland, Poland, Romania, the United Kingdom, several WHO collaborating centres and temporary advisers and the WHO Secretariat made contributions. The term "unconditional" within the indicator was clarified, and it was suggested that the background paper by Kari Kuulasmaa make clearer that cancer is largely preventable. It was suggested that, in some countries, analysing cardiovascular disease subsets such as ischaemic heart disease and heart failure separately would be useful since they follow different trends. The poor quality of death registration was discussed, with some suggestions on how this might be improved. Some countries appear to overestimate and others underestimate deaths from cardiovascular diseases, and this is a particular problem when deaths occur pre-hospital and necropsy is not carried out. For death certification, the limitations of using a single "cause of death" that did not recognize the multiple diseases frequently prevalent at death were noted. Although the age range for the target was explained, it was suggested that most countries consider younger than 65 years as premature, and one country mentioned that nongovernmental organizations have complained that focusing on people younger than 70 years is discriminatory. In the interests of equity, there was support for disaggregation and/or subsidiary indicators for highlighting age, sex, socioeconomic status, education and rural–urban differences, although it was noted again that data linkage could become more difficult. Alternative or supplementary indicators were suggested, such as disability-adjusted life-years (DALYs), disability-free years, well-being and avoidable or amenable mortality, as possibly taking a positive view of health and being in some cases potentially more useful for policy-makers.

Alcohol

Dr Jürgen Rehm, WHO Collaborating Centre for Addiction and Mental Health, Toronto, Canada, presented on the target and indicator for alcohol from within the group for monitoring exposure. Overall, the target was thought to be achievable, with 46 countries having reduced adult per capita consumption of alcohol by more than 10% in recent years, although this might be more difficult for low-income countries such as India, where adult per capita consumption of alcohol is likely to increase with development. The indicator was considered good, being reliable, feasible and meaningful. For the European Region, the target might not be so difficult to achieve: trends in adult per capita consumption of alcohol have been stable overall, although diverging across subregions, and 17 countries have reduced adult per capita consumption of alcohol by more than 10% already. Achieving the target is likely to significantly affect NCD mortality and morbidity, even more so if mental health is included.

Discussion

In the subsequent discussion, France, Georgia, Norway, Poland, the United Kingdom, several temporary advisers and WHO collaborating centres, the European Commission and the WHO Secretariat made contributions. Although the strengths of the indicator were appreciated, particularly given the likely underreporting of alcohol intake within surveys, it was noted that triangulation with survey data is still required and efforts are underway to improve on survey methods. Previous Member State interest in having an indicator on binge drinking was mentioned, and the relative merits of an indicator of adult per capita consumption of alcohol over one on hazardous drinking were discussed: for example, adult per capita consumption of alcohol, in addition to being more measurable, correlates better with NCD mortality, and reduction in adult per capita consumption of alcohol is very highly correlated with hazardous drinking. In terms of equity, it was explained that decreasing alcohol consumption would favour those of lower socioeconomic status, who would have greater health gain per litre reduced. Increasing alcohol taxes is considered cost-effective for more than 90% of European Region countries, with brief interventions costly in comparison, but few governments seemed to agree, and the contrast with tobacco control was noted. Several countries were interested in having a minimum price per unit of alcohol, which could also potentially have a good effect from a public health and distributional viewpoint.

Regional perspectives on targets and indicators, policies and social determinants II

Dr Alban Ylli, Sector of Chronic Diseases and Health Policies, Institute of Public Health, Albania, chaired the session.

Cervical cancer screening

Dr Lawrence von Karsa, International Agency for Research on Cancer, Lyon, France, presented on the target and indicator for cervical cancer screening of the group for monitoring system performance. He welcomed including cervical screening because it addresses both health system strengthening and quality improvement aspects, and because this is preventable. He expressed some concern at the feasibility of the indicator, which was likely to be difficult to determine and might have issues of comparability. He suggested that "annual coverage of the screening population" might work better as an indicator, for the European Region at least, and specifying collection from organized screening programmes could underline the emphasis on quality. He suggested a two-tier target of at least 70% coverage as acceptable and at least 85% coverage as desirable, and that this need not be considered at odds with the WHO recommendation of 80% coverage. Again stressing the importance of quality, he thought that, for the European Region, the number of countries with an organized population-based screening programme could be more important than coverage. Overall, he considered including cancer screening within both the global set and the European NCD Action Plan as presenting an opportunity for re-examining and strengthening the approach to cancer screening in Europe; although work has been done to report on and strengthen the situation within the European Union (EU) countries, there is interest and opportunity to extend this to the countries in the European Region that are outside the EU.

Discussion

In the subsequent discussion, Belgium, France, Hungary, Norway, Romania, several temporary advisers and WHO collaborating centres, the European Commission and the WHO Secretariat made contributions. Some concerns were expressed that cervical screening may not be appropriate for resource-limited countries and might distract from other preventive measures. Nevertheless, evidence indicates that screening could be cost-effective, particularly when the burden of disease is high and within the context of a population-based organized screening programme; too often, however, screening is opportunistic, without quality assurance, and evidence indicates that resources are wasted. Further, as developments occur and human papillomavirus testing becomes part of screening programmes, there is an opportunity to focus further the use of resources. Frequent mention was made of the importance of quality assurance and organized screening programmes; these can take up to 10 years to develop within a country, building up slowly from pilot and demonstration site and necessitating improvements in diagnosis, treatment and care to fulfil the objectives of the programmes to reduce cancer incidence and/or mortality. The importance of an effective cancer registry was also underlined, noting that these have been threatened in some countries. Concern was also expressed that human papillomavirus vaccination might be a distraction, but the response was rather that there should be a symbiotic relationship with screening and that both should be integrated into surveillance in the future. In terms of equity, gaps in coverage between socioeconomic groups were noted, reflecting differences in access, attitudes and expectations, and suggestions were made for how to reduce these, for example, through communication. The importance of monitoring and acting on such differences was emphasized.

Discussion on other targets and indicators

The chair then proposed a discussion on the four targets that had not been covered individually through the briefing papers and/or presentations: diabetes; *trans*-fats; multi-drug therapy for treating heart attack and stroke; and hypertension. Belgium, France, Montenegro, Norway, several WHO collaborating centres and the WHO Secretariat made contributions.

It was explained that the target for diabetes had been set based on what had been achievable in the top percentile of countries. No correlation was intended with the obesity target, which had been set independently. Clarification was sought, since the indicator includes people receiving treatment, in contrast to the indicator for hypertension, because people with diabetes are deemed to be still at risk for complications even if they are receiving treatment.

Regarding the target and indicators for hypertension and cardiometabolic risk, some concern was expressed about whether such a focus on drugs and health systems is inappropriate for the poorest countries and diverts attention. On the other hand, the view was expressed that this would help in attracting attention to the issue of access and help protect the poor, for example from catastrophic expenditure. Within the European Region, the view was that the 25% reduction for raised blood pressure might be achieved relatively easily, with the suggestion that the target could be even more challenging. Progress could be made with measures such as reducing salt consumption, increasing fruit and vegetable consumption and promoting physical activity, but focus is also needed on treatment and improved control of hypertension in Europe given the evidence that this is still poor overall.

Regarding eliminating *trans*-fats, this was regarded to be effective and should be part of a package of simple, low-cost, effective interventions.

Regional perspectives on targets and indicators, policies and social determinants III

Professor Graham MacGregor, Wolfson Institute of Preventive Medicine, London, United Kingdom chaired the session. Before introducing the speaker, he thanked the host for the excellent reception and dinner the evening before.

Dietary salt intake

Dr Francesco Cappuccio, WHO Collaborating Centre for Nutrition, Coventry, United Kingdom, presented on the target and indicator for dietary salt intake from within the group for monitoring exposure. Many countries are already using such a target, and the level of less than 5 g per day of salt is considered practical and well above physiological needs (1 g per day). The components of a strategy for reducing salt intake have been identified, and the relative emphasis depends on the pattern of salt intake identified, requiring either engagement with the consumer on added salt or the industry on reformulating foods. The greatest challenge appeared to be in the feasibility of the indicator, which WHO does not currently routinely monitor. The gold standard for measurement is the 24-hour urine collection method, but other options are also being explored. Within the European Region, the target might be considered aspirational, since in all countries the mean population intake of salt is currently considerably higher than this level and is likely to prove challenging for some countries. The target should be retained at the absolute level of 5 g per day.

Discussion

In the subsequent discussion, Belgium, France, Ireland, Montenegro, several WHO collaborating centres and temporary advisers, the European Commission and the WHO Secretariat made contributions. Several expressed doubts over the feasibility of using the 24-hour urine collection method within countries given the participation demand and whether a representative sample could be achieved. Nevertheless, it was explained that a protocol, training and support existed as well as examples from a wide range of countries, including resource-limited countries. It was suggested that if 24-hour urine measurement of salt were achieved as a baseline, then spot urine tests could be used to show relative change over time. It was also questioned whether all countries needed to do this before starting interventions. Policy options need to be tailored according to the pattern of salt use, which might even differ between regions within the same country. In setting priorities for the use of resources, examples were given of countries giving priority to action to reduce salt in processed foods, which are the main contributors to salt intake, rather than the whole food supply. To some extent, reformulation is a relatively cheap option, since the food industry bears the costs and globalization means that countries might benefit from action taken in other countries. The relationship with the food industry needs balance: collaboration is needed on reformulation, but there are also potential vested interests.

Obesity

Professor Harry Rutter, National Obesity Observatory, Oxford, United Kingdom, presented on the target and indicator for obesity from within the group for monitoring exposure. He noted that the target focuses on adults, but many countries in the European Region also collect prevalence data at much younger ages. The intention was that the indicator be assessed using measured body mass index, but he wondered whether self-reported data might also be used and would be good enough in some cases. Self-reported data gives a lower prevalence of obesity, but the trends are similar, and they could be calibrated against a subsample of measured data. Within the European Region, there is good and well-established child obesity surveillance (COSI), and the European Charter on Counteracting Obesity gave a special mandate for action.

Discussion

In the subsequent discussion, Albania, Norway, Romania, several WHO collaborating centres and temporary advisers, a nongovernmental organization and the WHO Secretariat made contributions. There was a great deal of interest in the notion of pragmatic use of data and evidence and the relative merits of using measured versus self-reported data were discussed further. The distribution of data within the population is also important and not just the threshold for obesity, and shifts can be seen in the population distribution over time. The policy approach for counteracting obesity requires political acceptability, and interventions for obesity and physical inactivity are proving even more challenging than those for tobacco and alcohol. Obesity is a complex issue, and interventions have potential unintended consequences. The focus on the individual can also be misplaced and may exacerbate inequity. Although empowerment is important, choice also needs to be facilitated through environmental measures. The link between obesity and alcohol consumption was noted and the importance of labelling food products and the calorie content of alcohol. There was also concern that a biomedical bias regarding evidence might discount more intersectoral interventions, such as those promoting physical activity. There was wide support for a separate target for physical inactivity, not just because it is related to obesity.

Summary of discussions on the regional perspectives on targets and indicators, policies and social determinants

Dr Gauden Galea opened and chaired the session.

Dr Jill Farrington, WHO Regional Office for Europe, summarized the proceedings of the meeting so far. Taking each indicator in term, she outlined the presenter's main points with regard to the target and indicator and its implications for the European Region. She then recounted the main themes of the discussions that followed. She finished by noting the tension between both extending and narrowing the targets and indicators and drew out some overarching points.

She noted there was some interest in narrowing the list of indicators to a few well-established ones such as NCD mortality, tobacco and alcohol and interest in focusing on a few simple, low-cost, effective interventions that work, such as tobacco, salt reduction and eliminating *trans*-fats. In contrast to this reductionist approach is the need to maintain a sufficiently effective policy package. There was also some interest in broadening the list of targets and indicators: for

example, including physical inactivity and monitoring the implementation of policy measures, and including subsidiary targets and indicators such as showing breakdown by age, sex and other factors under each indicator and social distribution under each target.

Linking ambitions to the best-performing countries was welcomed, as it shows what is possible in countries. She noted that effective interventions are frequently unpopular and ineffective interventions frequently popular. There was interest in presenting the policy best buys or things to be done alongside the targets and indicators to increase acceptance and to help countries to set priorities. There is interest in flexibility in targets (acceptable versus desirable levels or gold standard versus alternatives), which are thought to lower the threshold for adoption in countries. There was a plea for avoiding placing additional burden on countries' existing health information systems and support for considering whether the present systems are good enough for measurement. This pragmatic approach to data extends to interventions, with the need to build in research so that interventions can be tested and monitored and the evidence base built. It was recognized that there is no universal prescription for everybody – individual countries have to decide what is practical for them. The package has implications for capacity-building, but several had commented that the European Region has experience and a responsibility to take a potential leadership role in sharing its strategies. Finally, she noted the need to be clear on the purpose: not dry monitoring of data but to drive action.

Dr Bjørn-Inge Larsen responded with his views from the perspective of a Member State. He felt that about 10 targets or indicators would be the right level of ambition, especially if these are to be measured and presented by age, sex and social dimension. He thought it would be good if these were presented along with WHO's advice on best-buy policy. He noted the difficulty in showing success in intersectoral action and proposed that a target or indicator on physical inactivity might be used as a tracer for this. Finally, while he recognized the need to develop good health systems, he advised caution on promoting drug treatment lest this divert the use of resources and put countries under pressure from the pharmaceutical industry.

Discussion

In the subsequent discussion, Belgium, Georgia, the Netherlands, the former Yugoslav Republic of Macedonia and the WHO Secretariat made contributions. Support is needed for policy-makers in setting priorities for interventions. The potential danger of targets is that they can take the focus away from policies, whereas indicators and surveillance could be considered more valuable. There was concern to avoid placing an additional burden on countries, especially those that need support in strengthening their surveillance systems. It was noted that the targets are voluntary and a country may opt out of certain targets that they do not consider appropriate to their situation. There was a suggestion that if the whole set of targets or indicators is considered too much for a country, it might be useful to indicate a core set. On the other hand, it was noted that the elements of the package are interrelated, as there are so many connections between them.

Integrated mechanisms and tools for NCD surveillance

Dr Jerzy Leowski, Division of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe, chaired the session.

Ms Leanne Riley presented the WHO Stepwise approach to chronic disease surveillance (STEPS), a household survey of people aged 25–64 years developed by WHO and used in all

WHO regions. This had three steps – an interview, physical measurement and biochemical samples – and three modules – core, expanded and optional – which could vary according to the resources available within the country.

Professor Kari Kuulasmaa presented the European Health Examination Survey, a collaboration to collect nationally representative data that are comparable between countries and over time. The target population and sampling are based on permanent residents of entire countries with a core group aged 25–64 years (can extend to 18+), with a sample size of at least 4000. There is a group of core measurements from all countries, and countries can include additional measurements based on national interest, experience and resources.

Panel discussion

A panel discussion followed in which participants informed about their experience with integrated NCD surveillance.

Dr Sylvie Stachenko, School of Public Health, University of Alberta, Edmonton, Canada and representing the countrywide integrated noncommunicable disease intervention (CINDI) programme, described the CINDI programme as being the "grandmother of all the efforts" on integrating NCD surveillance. The CINDI programme is a network modelled around the North Karelia project to build capacity around integrated surveillance systems. The package is linked to action and capacity and also measures NCD policy development, largely at the local and regional levels. The training courses by CINDI are perceived as being practical and the networks powerful. An NCD policy toolkit is being developed and an NCD policy academy is being designed, with the first course this year in Lithuania.

Professor Stefano Campostrini of the Global Working Group on Surveillance of the International Union for Health Promotion and Education used the metaphor of "a captain who needs to know which harbour he is heading for to find the right wind". He explained that there are three pillars of surveillance: theory, analysis and data use. Surveillance is not research; it must be clear what it is for and the analysis for action must be embedded. What policy-makers need is adequate data. In addition, he stressed the importance of trends, since policy-makers need to know whether or not they are successful and why.

Dr Branka Legetic, Pan American Health Organization, presented her experience with integrated NCD surveillance in the WHO Region of the Americas. She explained their way of working by setting up a minimum list of indicators, searching through various sources and then getting a comprehensive picture with a minimum data set. The starting-point for collecting data is to serve the country. In the Region of the Americas, the STEPS tool is widely used, with some regional modifications and additions.

Professor Maximilian de Courten, European Chronic Disease Alliance, informed that the Alliance was founded in 2009. The Alliance listed targets and indicators missing in the discussion and suggested existing NCD plans as an indicator, with global coordination on action on NCD. Integration can have lots of dimensions, for example across different diseases, integration of information on policy and risk factors or integration of various activity budgets. He summarized that there is a need for an eleventh indicator on integrated NCD action as opposed to outcomes, and that indicators are being used as interventions because interventions drive action.

Discussion

In the subsequent discussion, Albania, Belgium, several WHO collaborating centres, the European Chronic Disease Alliance, International Union for Health Promotion and Education and the WHO Secretariat made contributions. There was discussion on a multiple risk score, or dashboard, that could be used as an NCD preparedness card informing how well a country is dealing with NCD indicators and policies. However, this scorecard could also be used to show differences in exposure to various risk factors and the proportion of a population with multiple risk factors. The question of the need for a clear and better information system was raised. There is a need to move away from data ownership to data sharing, and at the international level, the collaboration on surveillance should be strengthened. It was also stressed that, whatever system a country is using, tackling trends and changes requires harmonized or integrated data collection. However, if there is no system in place, the suggestion was to investigate what would be needed and the resources available and to choose a system that fits the goal.

Closing session

Dr Gauden Galea thanked the host, the Member States, the experts, the chairs and panellists.

Dr Bjørn-Inge Larsen closed the Consultation and urged the Member States to submit their enriched views on the global monitoring framework through the web-based consultation being conducted by the WHO until the end of February 2012.

Annex 1.Provisional Programme

Thursday, 9 February 2012

8:15 – 09:00	Registration
09:00 - 09:30	**Opening** Welcome & introduction • Bjørn-Inge Larsen, Director General, Norwegian Directorate of Health, Norway • Gauden Galea, Director, Division of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe
09:30 - 11:00	**Plenary 1: The Global and European context** Chair: Bernt Bull, Ministry for Health and Care Services, Norway Keynote presentation Briefing on the outcomes of the UN High-level meeting on NCD, and the Global Monitoring Framework and voluntary targets Leanne Riley, WHO Headquarters Towards a monitoring framework within the context of the European NCD Action Plan and target setting for Health 2020 Gauden Galea, WHO Regional Office for Europe Panel discussion Knut-Inge Klepp, Norwegian Directorate of Health Sigurlaug Hauksdottir, European Commission Hans van Oers, National Institute for Public Health and the Environment, Netherlands Liis Rooväli, Ministry of Social Affairs, Estonia

11:00 – 11:30	Coffee break
11:30 - 12:30	**Plenary 2: Policy level targets and Social Determinants of Health** Chair: Nata Avaliani, National Center for Disease Control and Public Health, Georgia Keynote presentation Potential areas for target setting in public policy with tobacco control as an example David Stuckler, University of Cambridge, United Kingdom Keynote presentation Social determinants of health in NCD monitoring and surveillance Martin Bobak, UCL Research Department of Epidemiology and Public Health, United Kingdom Discussion
12:30 -13:45	Lunch
13:45 - 15:45	**Plenary 3: Regional perspectives on targets and indicators, policies and social determinants I** Monitoring outcomes: Premature mortality from NCDs Kari Kuulasmaa, WHO Collaborating Centre for NCD Prevention, Health Promotion and Monitoring, Finland Discussion Monitoring exposure: Alcohol Jürgen Rehm, WHO Collaborating Centre on Addiction and Mental Health, Canada Discussion
15:45 – 16:15	Coffee break
16:15 - 18:00	**Plenary 4: Regional perspectives on targets and indicators, policies and social determinants II** Monitoring system performance: Cervical cancer screening Lawrence von Karsa, International Agency for Research on Cancer, France Discussion Other targets/indicators not on the programme
18:00	Close of the day
19:00	Dinner hosted by Norwegian Directorate of Health

Friday, 10 February 2012

9:00 - 11:00	**Plenary 5: Regional perspectives on targets and indicators, policies and social determinants III** Monitoring exposure: Dietary salt intake Francesco Cappuccio, WHO Collaborating Centre for Nutrition, United Kingdom Discussion Monitoring exposure/outcome: Obesity Harry Rutter, National Obesity Observatory, England Discussion
11:00 - 11:30	Coffee break
11:30 - 12:30	**Plenary 6: Summary of discussions on the regional perspectives on targets and indicators, policies and social determinants** Summarizing regional perspectives on targets and indicators, policies and social determinants Jill Farrington, WHO Regional Office for Europe Bjørn-Inge Larsen, Director General, Norwegian Directorate of Health, Norway
12:30 - 13:30	Lunch
13:30 – 15:00	**Plenary 7: Integrated NCD surveillance mechanisms and tools** Chair: JerzyLeowski, WHO Regional Office for Europe Keynote presentation Presentation of the STEPS tool Leanne Riley, WHO Headquarters Panel discussion Stefano Campostrini, Global Working Group on Surveillance of the International Union for Health Promotion and Education Maximilian de Courten, European Chronic Disease Alliance Branka Legetic, Pan American Health Organization Sylvie Stachenko, CINDI
15:00 – 15:15	**Closure** • Gauden Galea, Director, Division of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe • Bjørn-Inge Larsen, Director General, Norwegian Directorate of Health, Norway
15:15	Close of the meeting

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Annex 3. A preliminary set of proposed global targets and indictors for review

	Outcome targets	Indicator	Data Source(s)	Has Strongest Adherence to all criteria*
1	**Mortality from NCDs** 25% relative reduction in overall mortality from cardiovascular disease[4], cancer, diabetes, or chronic respiratory disease	Unconditional probability of dying between ages 30-70 from, cardiovascular disease, cancer, diabetes, or chronic respiratory disease	Civil registration system, with medical certification of cause of death, or survey with verbal autopsy	*
2	**Diabetes** 10% relative reduction in prevalence of diabetes[5]	Age-standardized prevalence of diabetes among persons aged 25+ years	National survey (with measurement)	
	Exposure targets			
3	**Tobacco smoking** 40% relative reduction in prevalence of current tobacco smoking	Age-standardized prevalence of current tobacco smoking among persons aged 15+ years[6]	National survey	*
4	**Alcohol** 10% relative reduction in persons aged 15+ alcohol per capita consumption (APC)	Per capita consumption of litres of pure alcohol among persons aged 15+ years	Official statistics and reporting systems for production, import, export, and sales or taxation data; and national survey	*
5	**Dietary salt[7] intake** Mean population intake of salt less than 5 grams per day	Age-standardized mean population intake of salt per day	National survey (with measurement)	*
6	**Blood pressure/Hypertension** 25% relative reduction in prevalence of raised blood pressure[8]	Age-standardizedprevalence of raised blood pressure among persons aged 25+ years	National survey (with measurement)	*
7	**Obesity** No increase in obesity[9] prevalence	Age-standardized prevalence of obesity among persons aged 25+ years;	National survey (with measurement)	

[4] Cardiovascular disease includes coronary heart disease (heart attack), cerebrovascular disease (stroke), peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure
[5] Diabetes is defined as fasting plasma glucose ≥ 7.0 mmol/L (126, g/dl) or on treatment for diabetes
[6] Achieved through full implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), and in particular demand reduction measures
[7] For the purpose of this target, the term salt refers to sodium chloride and 5 grams of salt is approximately 2g of sodium
[8] Raised blood pressure is defined as systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90
[9] Obesity is defined as Body Mass Index (BMI) equal or greater than 30kg/m^2

	Health Systems Response targets			
8	**Prevention of heart attack and stroke** 80% coverage of multidrug therapy (including glycaemic control) for people aged 30+ years with a 10 year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease	Percentage of estimated people aged 30+ years with a 10 year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease who are currently on multiple drug therapy (including glycaemic control).	National survey (with measurement)	
9	**Cervical cancer screening** 80% of women between ages 30-49 screened for cervical cancer at least once	Prevalence of women between ages 30-49 screened for cervical cancer at least once	National survey; health facility data	
10	**Elimination of industrially produced trans-fats from the food supply** Elimination of industrially produced trans-fats (PHVO)) from the food supply	Adoption of national policies that eliminate partially hydrogenated vegetable oils (PHVO) in the food supply	Policy review	*

* Relevance, Coherence, Interventions, Achievability, and Measurability.