Handbook for

Process Evaluation

in Noncommunicable Disease Prevention

WHO Collaborating Centre for Policy Development in the Prevention of Noncommunicable Disease
Health Canada, Ottawa, Canada

WHO Regional Office for Europe
Copenhagen, Denmark
1999
TARGET 4

REDUCING CHRONIC DISEASE

By the year 2000 there should be a sustained and continuing reduction in morbidity and disability due to chronic disease in the Region.

Abstract

The countrywide integrated noncommunicable diseases intervention (CINDI) programme of the World Health Organization (WHO) is a collaborative effort aimed at preventing disease and promoting health. The *handbook for process evaluation in noncommunicable disease prevention* is intended to serve as a tool for documenting preventive intervention projects and the processes that determine the impact of intervention. It will complement two earlier CINDI documents: the *Protocol and guidelines — countrywide integrated noncommunicable disease intervention programme* (1995), which explains the structure of the CINDI programme and outlines evaluation procedures that emphasize outcome indicators; and *Positioning CINDI to meet the challenges: a WHO policy framework for noncommunicable disease prevention* (1992), which discusses policy directions and describes collaborative projects that may be undertaken using various CINDI strategies.

The handbook sets out a framework for evaluation which can assist individual CINDI programmes to further develop the capacity to carry out process evaluations, and to select those indicators and systems that are best suited to track their particular project inputs, outputs and processes.

Full implementation of a process evaluation system requires the development of instruments for data collection, the training of personnel in gathering and processing information, as well as the piloting of the evaluation protocols. While this handbook provides guidance in a number of areas, more experience is needed in the use of process evaluation to recommend specific procedures in some areas. To this end, a second version of this handbook will be considered in the future.

Keywords

NONCOMMUNICABLE DISEASE CONTROL
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Preface

The countrywide integrated noncommunicable diseases intervention (CINDI) programme of the World Health Organization (WHO) is a collaborative effort aimed at preventing disease and promoting health in Europe and Canada. The *Handbook for process evaluation* is intended to serve as a tool for documenting preventive intervention projects and the processes that determine their effects. It is also intended to complement two earlier CINDI documents: the *Protocol and guidelines – Countrywide integrated noncommunicable diseases intervention (CINDI) programme*, which explains the structure of the CINDI programme and outlines evaluation procedures that emphasize outcome indicators; and *Positioning CINDI to meet the challenges: a WHO policy framework for noncommunicable disease prevention*, which discusses policy directions and describes collaborative projects that may be undertaken using various CINDI strategies.

Individual CINDI programmes are already collecting process evaluation data according to instruments specified in the protocol and guidelines document. The present handbook sets out a framework for evaluation that can assist individual CINDI programmes in further developing the capacity to carry out process evaluations, and selecting the indicators and systems that are best suited to track their particular project inputs, outputs and processes.

Full implementation of a process evaluation system requires the development of instruments for data collection, the training of personnel in gathering and processing information, and the piloting of the evaluation protocols. While this handbook provides guidance in a number of areas, it does not cover some aspects of process evaluation. This is because we feel that more experience is needed with the use of process evaluation before specific procedures can be recommended in these areas, possibly in a second version of this handbook.

Once programme personnel gain experience working with the procedures recommended in this version of the handbook, a wealth of information will become available on the implementation of programmes for noncommunicable disease prevention. This will help to pave the way for a more effective exchange of experiences among individual CINDI programmes and provide programme personnel with the feedback they need to improve the quality of their work. While the CINDI programmes are the primary target audience for the handbook, we hope that it will also be useful to other individuals and organizations working on initiatives to promote health and prevent all types of disease.

The *Handbook for process evaluation in noncommunicable disease prevention* is the product of a collaborative effort among members of the Ad Hoc Working Group on Process Evaluation of the CINDI Working Group on Monitoring, Evaluation and Research, representing eight CINDI countries. In developing the document, the Ad Hoc Working Group met face to face on a number of occasions, as well as holding periodic teleconferences.

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Acknowledgement

1. Introduction

Assessing the impact of preventive interventions is at the heart of policy and practice in the countrywide integrated noncommunicable diseases intervention (CINDI) programme of the World Health Organization (WHO). Traditionally, assessments of the efficacy of noncommunicable disease (NCD) prevention programmes have sought to measure changes in risk factor prevalence, rates of disease or mortality. Relating these outcomes to programme activities requires long-term observation.

As CINDI interventions grow in complexity, programme directors will need to pay more attention to the ways in which programmes work and how they can be made more cost-effective. They will also want to identify the variables and processes that either facilitate or hinder the uptake and dissemination of effective interventions. Process evaluation is concerned with documenting the intensity of interventions, their outreach costs, their short- and medium-term impacts. Most importantly, it seeks to track the processes that lead to those impacts. The primary aim of this type of evaluation is to provide practical feedback to those responsible for an intervention, so that they can improve its design and performance.

The *Handbook for process evaluation in noncommunicable disease prevention* builds on the experience accumulated within CINDI programmes over more than a decade. It provides a framework and practical advice to help health agencies, community programme workers and health professionals develop evaluation plans that fit their particular mix of interventions and programme conditions.

For any given project, the process evaluation scheme is driven by a number of considerations. These include:

- the project’s overall goals, as well as specific objectives, strategies and target populations;
- the scope and level of the evaluation (national, regional or local); and
- the cost and practicality of gathering various types of data.

This handbook offers guidance in the preparation of a process evaluation protocol, including an evaluation framework, indicators for tracking inputs, processes and outputs, and procedures for implementation.
2. Process evaluation in the context of CINDI

CINDI is, first and foremost, an intervention programme. Its paradigm for preventing NCD is based on the scientific literature on risk factors and on pioneering intervention studies focusing on entire populations and high-risk groups in Europe and North America.

There is no shortage of information on the implementation of effective interventions. Some five years ago, *The Victoria Declaration: bridging the gap: science and policy in action* made it clear that we already have the knowledge required to prevent most cardiovascular diseases. Three years later, *The Catalonia Declaration: investing in heart health* presented a number of concrete approaches and experiences that were based on effective interventions undertaken at the national, regional and local levels in countries all over the world.

CINDI programmes generally use interventions that have already been shown to be efficacious in preventing disease and promoting health in both populations and high-risk groups. Typically, interventions are implemented through the primary care and public health systems, in partnership with nongovernmental organizations.

Health professionals and others involved in NCD prevention face two main challenges: to take advantage of current knowledge about prevention, and to share their implementation experiences with others. Understanding how to disseminate interventions that work is essential if CINDI is to reorient health care toward prevention, and to deploy large-scale disease prevention interventions. Through process evaluation of its NCD programmes and dissemination of these experiences, CINDI can make an important contribution to the goals of health care reform and to the WHO strategy for health for all.

The purpose of process evaluation is to monitor how a particular intervention works, in contrast to traditional outcome evaluations, which focus on whether an intervention has produced changes (for example, in disease outcomes and risk factor patterns). Outcome evaluation often requires an experimental design involving intervention and control groups. The North Karelia Project provides an example of an outcome evaluation study carried out over an extended period.

Process evaluation enables programme personnel to assess the quality and cost of delivering preventive interventions, and to demonstrate accountability to the funding source, whether a government or an agency. It also yields information on the programme and project designs that are most suitable for demonstration, dissemination and large-scale deployment. More specifically, process evaluation is needed to:

- identify factors, links and processes that may help to explain success and/or failure in terms of the underlying programme rationale (such as behavioural theory);
- contribute to a better understanding of the organizational or situational context of a given intervention; and
- identify the process indicators that would be most useful to track.

Ultimately, the utility of any evaluation lies, not merely in determining whether the programme works, but in clarifying which components have contributed most to its success or failure.
3. Implementation

A process evaluation may focus on a single project or on an entire programme (a set of projects linked by common goals or objectives – see glossary comprising Appendix A). The process evaluation of a programme is likely to be more complex, since information may be needed on how several different projects interact and how they contribute jointly to the overall impact. Further research and experience are required in this area before any meaningful guidelines can be developed. Accordingly, no attempt has been made to address this aspect of programme evaluation in the present handbook.

3.1 Planning the evaluation

Experience within CINDI suggests that, for any given project, it is good practice to prepare a protocol outlining the overall approach and providing details of the process evaluation. Developed in collaboration with the major partners or stakeholders, a protocol is essentially a working document that can be revised as circumstances change. In developing a process evaluation protocol, one should:

- consider the project’s goals and objectives (in this context, a goal is a general direction or overall aim, whereas an objective is more specific, and preferably measurable);
- describe the conceptual model that underlies the project interventions; and
- specify whether the project is operating at the local, regional, countrywide and/or international level(s), and by extension, the level(s) to which the process evaluation will apply.

Process evaluation is concerned with how a project operates in the context of its goals and objectives. These may be explicitly stated in project protocols or they may be implicit (unstated). They may also change over time. It is advisable to involve stakeholders in identifying the goals and objectives that are to form the basis for the evaluation. This process may reveal different categories of goals and objectives. Some may be related to health (such as reducing the prevalence of smoking), others to the health system (such as training community workers) and still others to policy and governmental change (such as legislation). Goals and objectives may be set at local, regional, country and international levels. The time frame for their achievement may be short, medium or long term.

The development of a conceptual model can help to clarify how a specific project functions and how the interventions are linked to current knowledge in the areas of interventional epidemiology, behaviour modification, community mobilization and/or policy development. The conceptual model also helps to identify the key components of the intervention and how these are expected to lead to the desired impacts and outcomes. Appendix B provides three examples of conceptual models (CINDI projects in Estonia and the Russian Federation, and the Pawtucket Heart Health Program in the United States).

The project protocol should also specify at what levels the project operates: where its effects can be expected to be achieved. For example, evaluation at the local or regional levels may focus on partnership development and community decision-making processes. At the countrywide level, it may focus on intersectoral and intrasectoral collaboration, dissemination of interventions across health districts and/or development of government policy. At the
international level, the focus may be on technology transfer of interventions across CINDI programmes (a process facilitated by the WHO Regional Office for Europe). “Quit and Win”, a collaborative tobacco control project coordinated by CINDI Finland, is an example of a project with a process evaluation component spanning several different levels.

The hallmark, indeed the strength, of many CINDI programmes is their aim at multiple levels. While multilevel links and interactions can be crucial to programme success and sustainability, they are challenging to document and understand. This is an area in which CINDI has not yet accumulated a great deal of experience. Further, the literature offers little guidance, presenting an opportunity for CINDI programmes to make a significant contribution to evaluation methodology.

3.2 Inputs, processes and outputs

Process evaluation requires a description of the project’s inputs, implementation strategies and outputs (proximal impacts or intermediate outcomes). In a professional education project, for example, an output would be the number of general practitioners trained through the project, while an outcome might be changes in the risk profiles of patients who receive primary care from the general practitioners participating in the project.

The Protocol and guidelines: countrywide integrated noncommunicable diseases intervention (CINDI) programme outlines procedures for the collection of outcome data on, for example, prevalence of risk factors, morbidity and mortality. The primary reason for collecting data is to monitor the health of the population, rather than to estimate the extent to which health indicator changes are attributable to programme activities. Outcome data can be used in setting priorities and long-term goals for the health system as a whole. For example, the data could help to determine cumulative effects of prevention programmes, policies (from the health and non-health sectors) and external factors (such as socioeconomic changes) on the occurrence of NCDs and their risk factors.

Fig. 1 shows how process evaluation fits within the broader context of an evaluation framework that includes the measurement of outcomes. The model implies that there is feedback among the various processes, inputs and outputs.

The CINDI strategies whereby inputs are converted into outputs are: policy development and coordination; legislation and regulation; marketing and organizational development; public education and mass media; community mobilization; preventive practice guidelines; professional education and involvement; monitoring, research and evaluation; and international collaboration in the context of CINDI. These strategies (described in Appendix C) are explained more fully in two basic CINDI documents: Protocol and guidelines: countrywide integrated noncommunicable diseases intervention (CINDI) programme and Positioning CINDI to meet the challenges: a WHO policy framework for noncommunicable disease prevention.
In seeking to identify appropriate tracking processes, it is important to recognize that a typical CINDI programme may consist of several projects, each employing one or more strategies (Fig. 2). For example, a worksite project may call for the development of preventive guidelines, as well as community mobilization and public education approaches. Thus, the protocol will provide for the tracking of implementation processes under all three of these strategies, using appropriate indicators.

The indicators selected should help to document how a project achieves its effects. For example, in a television project, indicators may include: the acceptability of messages to focus groups; the extent of project promotion to different socioeconomic groups prior to the airing; the size and composition of the target audience; and the extent to which the programme leads to the desired changes in viewers.

3.3 Evaluation questions and issues
Change processes and programme effects may be observed at various levels: in individuals or groups, at the community level, in the health system and/or in the wider environment. At each of these levels, the evaluation issues and the questions asked will differ.

At the individual, group or community level, it may be important to examine the factors that influence healthy or unhealthy lifestyles and to determine whether people are ready to make positive lifestyle changes. The processes tracked may include behavioural change (in random samples of individuals or in sentinel groups), and the marketing of risk factor survey results to communities.
Fig. 2. Projects within a programme may straddle strategies

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From a health system perspective, one focus of the evaluation might be the mechanisms used to mobilize health professionals, while another might be the introduction of multidisciplinary approaches to prevention. Processes to be tracked might include the diffusion and dissemination of information on interventions, assessment of the relative cost–effectiveness of various alternative professional education methods, and the integration of activities into the primary care system.

At the community level, the focus might be on creating partnerships among medical and nonmedical organizations, voluntary agencies and scientific associations. Another evaluation issue might be collaboration with other WHO health promotion programmes, such as those for healthy cities, healthy schools and healthy workplaces. Processes may be tracked and effects defined with respect to:

- the creation, organization and performance of community health coalitions;
- the ways in which various project activities within a programme complement and support each other; and
- the development of technical and organizational capacity within various associations participating in the project.

At the social, environmental and policy levels, an evaluation might examine how different groups of individuals and communities (such as displaced populations) participate in project development and implementation. Another question might relate to the key obstacles to implementing tobacco control legislation. Processes to be tracked might include: procedures to ensure target group participation in a project, advocacy training for community action against smoking and mechanisms for sharing knowledge and experience among CINDI countries (as in the “Quit and Win” campaign).
4. Developing a monitoring system

Trying to track large numbers of inputs, processes and outputs for every project in a CINDI programme would be impractical. For the evaluation to be useful, it is critical to select a few indicators that can be monitored practically and regularly at all the levels where the project operates. Further, the resources devoted to evaluation and those applied to the intervention itself must be properly balanced. Some CINDI programmes suggest that 10% of total resources may be an appropriate amount to commit to evaluation.

4.1 Selecting the indicators

Appendix D lists processes and indicators for various strategies and outputs that might be associated with any given project. These lists are based on the pooled experience of CINDI programmes, and are not intended to be exhaustive.

Lists 1–8 should be used as a menu of indicators, from which only a few are chosen. The importance of selecting indicators sparingly cannot be overstated. Most programmes collect information on too many indicators, perhaps trying to emulate published evaluations from major international research projects. An evaluation protocol designed for research purposes, however, is unlikely to prove practical or affordable for evaluation within a demonstration programme or of the routine delivery of preventive interventions by health systems. Collecting too much information can reduce data quality, increase processing costs and create long delays in the preparation of reports to management, making the evaluation irrelevant to decision-making. (In addition, the time and cost involved in analysing qualitative data are easy to underestimate.)

If process evaluation is to lead to programme improvements, those responsible for managing and implementing the programmes will need feedback. Major stakeholders at the intervention level will be able to use the information (from the indicators tracked) to assess the impact of the intervention relative to the cost of delivering the programme.

4.2 Collecting the data

The lists in Appendix D identify various information systems that can be used to capture data on different implementation processes. Examples include administrative or financial records, surveys of preventive practices of health professionals, computerized databases of newspaper articles and continuing health promotion or risk factor surveys. Where the required data are not already available from such sources, ad hoc systems may need to be set up.

A critical step in a successful process evaluation is designing appropriate forms or instruments to capture information on selected indicators. Several CINDI programmes have developed forms that may be adapted to track various indicators, such as the local health information system used for the German cardiovascular prevention study and the Evaluation guidelines for heart health prepared for the Canadian Heart Health Initiative.

The form shown in Appendix E can be used to profile a project in terms of its target group, the strategy used, the risk factors addressed, the resources utilized, its current evaluation status and its prospects for sustainability, among other characteristics. Appendix F is a sample log of local activities, an all-purpose instrument that can capture various types of information for different projects on a continuing basis (on, for example, approaches used, intended effects, intervention methods, collaborating institutions and resources used).
4.3 Organizing the evaluation

As a management responsibility, the organization of the evaluation falls within the purview of the director of a CINDI programme, and should be explicitly addressed in an evaluation protocol. Critical tasks for organizing the evaluation include:

- defining responsibilities for the technical direction and various operational aspects of the evaluation (the latter are best identified in the context of a system flow chart showing decision points and data flow from the field stages through to report preparation);
- providing for regular reporting to management and specifying easily understood formats for reports and data summaries;
- arranging to have the data summaries validated through alternative assessments of narrative and field reports (qualitative information may be subject to individual interpretation);
- assigning dedicated resources to evaluation tasks (such as resources for training, acquisition of appropriate computer software and time set aside from regular duties for carrying out the evaluation);
- arranging for partners and stakeholders periodically to review the information obtained in the course of the evaluation; and
- marketing the evaluation results to communities or health authorities, to motivate public and professional target groups and, if appropriate, publishing results in scientific or professional journals.

Currently, most CINDI programmes conduct internal evaluations. This helps to build evaluation capacity and makes use of internal resources. Outsourcing, however, can lend added credibility to an evaluation and could be a viable option, provided that management and stakeholders have defined and agreed upon an evaluation framework. If knowledgeable external personnel can be found at a reasonable cost, the contracting out of routine data collection and reporting may have advantages. If the evaluators’ learning curve promises to be steep, however, any efficiencies derived from using external resources risk being eliminated.

Fig. 3 summarizes the framework and steps for organizing a process evaluation. The upper left-hand side shows the conceptual aspects, and the upper right-hand side, the practical aspects. It may be advisable to conduct a pilot study before implementing the evaluation plan. This would provide an opportunity to ensure that personnel are properly trained in data collection and analysis, to test the data forms and to estimate the cost of implementing the protocol in its entirety.
Fig. 3. Organization of process evaluation

- Clarify goals and objectives
- Specify the conceptual model
- Establish the level(s) at which the project operates
- Select and define the inputs to be counted over a given period of time
- Identify strategies involved in the project and the key processes to track each strategy involved
- Select and define the project outputs to be documented

- Decide on indicators to observe inputs, processes and outputs
- Write the evaluation protocol
- Prepare and test forms to gather the data on inputs and outputs
- Organize: resourcing; training; data gathering; processing and analysis; other provisions to implement the evaluation plan
- Review periodically process evaluation reports and feed back to management
5. Process evaluation: a tool for international collaboration

Collecting comparable process evaluation data across CINDI programmes could bring considerable benefits. It would not only enhance exchanges among countries but also expand the pool of knowledge on NCD prevention interventions, prevent costly false starts and increase accountability to health authorities and international agencies for the use of programme resources.

CINDI programmes already collect comparable process evaluation data through a variety of mechanisms. All CINDI countries use the CINDI process evaluation questionnaire (Appendix G) to collect information on community participation in their programmes, as well as population awareness and behavioural changes. The Data Management Centre (CINDI Germany, Heidelberg) processes and analyses the data.

Periodic site visits to CINDI programmes, sponsored by the WHO Regional Office for Europe, provide another mechanism for process evaluation. These visits assess capacity, programme content, methodology and the nature of effects obtained, and form part of the evaluation of CINDI at the international level. Site visit reports follow a predefined check-list (Appendix H). Besides their intrinsic consultative value, the site visits provide an opportunity for CINDI programmes to raise their visibility with community organizations and stakeholders in both the public and private sectors.

The annual reports submitted by CINDI countries and demonstration projects are an important repository of information. Prepared according to a prescribed format (Appendix I), the reports contain potentially valuable information on process, which could be used to market CINDI to international health, social and economic development agencies.

In 1995, the “Quit and Win” campaign was conducted simultaneously in 12 CINDI countries. A common process evaluation questionnaire, used by all participating countries (Appendix J), gathers information on:

- the lead agency organizing the campaign;
- experience with funding arrangements;
- the added value derived from participation at the primary care level;
- the partnerships established;
- the use of the mass media; and
- the spin-off benefits: how the “Quit and Win” campaign has stimulated other CINDI interventions.

The comparative analysis of policy development and implementation processes in the CINDI programmes provides another instance of international collaboration. Here, 17 CINDI countries participated in an evaluation, using a semi-structured questionnaire (Appendix K), that study examined planning, marketing, evaluation and programme sustainability. This information was then related to the origins of the CINDI programme in each country, to the amount of activity at the demonstration area versus that countrywide, and to the amount of programming directed to the population at large versus that aimed at high-risk groups. Further, the study and design of the computerized qualitative database developed cooperatively by CINDI Russia (National Centre for Preventive Medicine, Moscow) and CINDI Canada (Health Canada). The
qualitative database should serve as a model to support the implementation of process evaluation in CINDI programmes.

As mentioned, Appendix D provides a menu of indicators related to certain strategies of special concern to CINDI: policy development, marketing, professional education and practice guidelines, and monitoring, evaluation and research.

The coordination of process evaluations at the international level would provide CINDI countries with a mechanism whereby they could compare their respective programme activities and delivery costs. Encouraging CINDI programmes to implement the approaches recommended in this handbook would be a step in this direction.
6. **Horizons**

Implementing a system for the process evaluation system of NCD prevention efforts is a continuously evolving project. This handbook is intended to provide NCD prevention and control programmes with a starting point to establish their own process evaluation systems. Moreover, if it encourages CINDI programmes to develop pilot projects, this in turn will help expand the base of experience derived from using the concepts and methods proposed. An important element of the work will be the development of capacity. Programme managers need to pay special attention to the training of their personnel in the concepts that underlie process evaluation, the preparation of instruments for data collection, and the analysis of qualitative data. The CINDI network provides an important forum and resource for exchanging the knowledge and experience that will undoubtedly accrue as various CINDI projects and programmes implement their process evaluations.

Qualitative information will comprise a large proportion of the data obtained through these evaluations. Computer technology is now available to meet the challenges involved in retrieving and analysing process evaluation data. Similarly, new computer information technologies and the Internet offer unprecedented opportunities for sharing information and analyses, and disseminating results.

It is hoped that CINDI’s efforts to implement process evaluation will produce a qualitative database that captures the breadth and depth of intervention experience across member countries. Such a database would provide a unique policy and health services research platform for investigating the cost-effective delivery of preventive and health promotion services. It would also allow the systematic assessment of interactions among the different jurisdictions and sectors involved in particular projects, and the clarification of the optimal strategic mix for a programme.

Today, some ten years after being launched, CINDI has mature programmes in most of its 24 member countries. The North Karelia project and other pioneering research demonstration programmes have proven that NCD prevention intervention programmes work. The challenge now is to sustain implementation. Coupled with a commitment to information sharing among CINDI programmes, process evaluation can make an important contribution to the WHO strategy and targets for health for all, and to ongoing health care reform efforts in both Europe and North America.
Bibliography


*Bridging the health gap in Europe: a focus on noncommunicable disease prevention and control*. *The CINDI-EUROHEALTH action plan*. Copenhagen, WHO Regional Office for Europe, 1995 (document EUR/ICP/CIND 94 02/PB01).


Comparative analysis of policy development and implementation processes in the CINDI programmes, Health Canada, Ottawa, 1995.


*Health for all targets. The health policy for Europe*. Copenhagen, WHO Regional Office for Europe, 1991 (European Health for All Series, No. 4).


Appendix A. Glossary

Accountability
Accountability results when decision-makers at all levels fulfil their obligations and are made answerable for their actions. (Setting explicit objectives and targets for health and defining how progress towards them will be monitored make it easier to achieve accountability.)

Advocacy
Advocacy is the action taken by health professionals and others with perceived authority to influence the decisions of communities and governments.

Capacity building
Capacity building is the development of the technical expertise to plan, implement and evaluate interventions aimed at preventing or controlling NCD in a variety of settings. Areas of expertise in capacity building include problem identification, epidemiological and behavioural risk factor analysis, coalition building, programme planning, marketing, programme implementation, knowledge of intervention methodologies, process, impact and outcome evaluation, and the ability to obtain ongoing support and funding through administrative and legislative means, beyond the life of any particular source of funding.

Coalition building
Coalition building is the establishment of a temporary alliance of factions, parties, individuals or groups for a specific purpose (in the case of programme development, to support or collaborate on a programme).

Community
A community is a collective of people identified by common values and mutual concern for the development and wellbeing of their group or geographical area.

Community mobilization
Community mobilization is a process aimed at enabling communities to understand and control the circumstances affecting their health. It acknowledges that agents of change can be found wherever the decisions that affect people’s ability to influence their health are made and implemented.

Data-collection method
A data-collection method is a way of collecting data about a project and its outcomes. In the context of project evaluation, frequently used data-collection methods include literature search, file review, natural observation, surveys and case studies.

Demonstration models
A demonstration model is an experimental health care facility, programme or system with built-in provision for measuring such aspects as cost per unit of service, rates of use by patients or clients, and outcomes of encounters between providers and users. The aim of a demonstration model is usually to determine the feasibility, efficacy, effectiveness or efficiency of a service.

Evaluation framework
An evaluation framework is a description of how a programme is to be evaluated.
Experimental design
An experimental design seeks to ensure the initial statistical equivalence of a comparison (control) group and one programme (experimental) group through the random assignment of individuals to each group.

Experimental study
In an experimental study, the investigator directly controls conditions. In the field of epidemiology, an experimental study is one in which a population is selected for an intervention and the effects of the intervention are measured by comparing the outcomes in the experimental group with those in the control group. Ideally, the allocation of individuals to experimental and control groups is random.

Guidelines
Guidelines define the steps to be taken in performing a task or implementing a policy and the way in which they are to be executed. Guidelines are more specific and more detailed than the guiding principles upon which they are based.

Health promotion
Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health. The actions may be those of individuals, groups or communities, of policy-makers, employers, teachers or others whose actions control or influence the determinants of health. The purpose of health promotion is to enable people to gain greater control over the determinants of their own health.

Health promotion is also the process of enabling people to increase their control over, and to improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realize aspirations, satisfy needs, and change or cope with the environment. In health promotion, therefore, health is seen as a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capabilities. Thus, health promotion is not just the responsibility of the health sector, and its concerns go beyond healthy lifestyles to wellbeing, as stated in the Ottawa Charter for Health Promotion.

Implementation plan
An implementation plan is a list of activities to be organized or carried out, in a set order and according to a schedule, to accomplish a certain goal. The plan stipulates who does what, and when, and may include information on the costs associated with each phase of the work. Implementation is also the act of converting program objectives into actions (for example, through policy changes, regulation and organization).

Input
Inputs generally refer to resources such as money, materials and the time and skills of staff and volunteers.

Intersectoral action
In intersectoral action, the health sector and other relevant sectors collaborate to achieve a common goal. For practical purposes, intersectoral and multisectoral action are synonymous.

Lifestyle
A lifestyle is an aggregate of decisions made by individuals that affect their health. The potential
health hazards referred to as behavioural risk factors are related to such lifestyle decisions. Individual exposure to lifestyle-related determinants of disease is to a large extent voluntary, and can be modified. In addition, lifestyle is taken to mean a general way of living, based on the interplay between living conditions, in the wide sense, and individual patterns of behaviour, as determined by sociocultural factors and personal characteristics. The range of behaviour patterns open to individuals may be either limited or extended by social and environmental factors, and for this reason, lifestyles are usually considered in the context of both collective and individual experiences and conditions of life.

**Mass media**
The mass media are all the impersonal means by which visual and/or auditory messages are directly communicated to the public. Examples of mass media include television, radio and newspapers.

**Monitoring**
Monitoring means regularly observing changes in some condition, either in a population or an individual (such as health status) or in an environment (such as levels of pollution) in order to determine whether an initiative is proceeding according to plan. Monitoring includes keeping track of achievements, staff movements and deployment, supplies, equipment, and money spent. The information gained from monitoring is used in evaluating the initiative.

**Multifactorial**
The term refers to the concept that a given disease or other outcome may have more than one cause.

**Network**
The term network refers to the number and types of social relations and links between individuals (and institutions) that may provide access to or mobilize social support for health.

**Outcome**
An outcome is a change in current or future health status or health-related behaviour that can be attributed to an intervention. In the field of health, the desired result or impact of a policy measure or other health intervention would be a positive change in health status or health behaviour.

**Outcome assessment**
An outcome assessment is used to determine the short-term effects of an intervention on an identified population.

**Output**
Outputs are the products, services and other items (such as clinical preventive guidelines, regulations, tax law provisions) directly produced by a programme or organization.

**Planning**
Planning is the process of defining needs, establishing priorities, diagnosing causes of problems, assessing resources and barriers, and allocating resources to achieve objectives.

**Policy**
A policy is an agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies needed to deal with the issues.
Policy framework
A policy framework is a conceptual structure, based on consensus among major stakeholders, that shows the relationships between the philosophy, intentions and principles that will guide decision-making and actions concerning specific issues.

Prevention
Prevention refers to approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability. Primary prevention reduces the likelihood that a disease or disorder will develop; secondary prevention interrupts, prevents or minimizes the progress of a disease or disorder at an early stage, and tertiary prevention focuses on halting the progression of damage already done.

Process evaluation of a programme
The process evaluation of a programme is an assessment of how the programme achieves its effects. It includes evaluation of the amount of resource inputs used, as well as a description of activities implemented and of outputs (intermediate outcomes, proximal impacts) of the programme.

Profile
A profile is a set of data, often presented in graphic form, that portrays the most significant features of a situation: for example, the extent to which individuals or groups exhibit certain traits or characteristics.

Programme
A programme is a set of projects designed to achieve common, long-term goals.

Programme evaluation
A programme evaluation is a periodic review and assessment of a programme to determine, in light of current circumstances, the adequacy of its objectives and its design, as well as its intended and unintended results.

Project
A project is a group of planned activities linked by common short- to long-term objectives and managed by a single centre of responsibility.

Qualitative data
Qualitative data are categorical rather than quantifiable observations, and often involve descriptions of attitudes, perceptions, intentions and activity.

Skill
A skill is the ability to use knowledge effectively and readily in the performance of a task.

Social marketing
Social marketing refers to the development and implementation of programmes aimed at influencing people’s ideas through the use of techniques and approaches similar to those employed in the marketing of goods and services (such as market research, product planning, communication and distribution).
**Stakeholders**

Stakeholders are the parties who have a common interest in the project and have agreed in principle to support it. Depending on their affiliation, they will provide assistance with technical, material, financial or human resources.

**Strategy**

A strategy is a plan of action that is designed to achieve long-term goals, taking into account the resources available and barriers anticipated, as well as possibilities for collaboration among relevant stakeholders.
Appendix B. Examples of conceptual models

B1. Outcome and process evaluation: CINDI worksite project

This project, representing the first stage of the CINDI programme in Estonia, was implemented at a demonstration site in Tallinn and involved approximately 15 000 employees in 9 industrial enterprises. The research team began by gathering epidemiological research data and health and demographic statistics in order to prepare a scientific profile of the population’s health situation. It included information on:

• diseases (prevalence, incidence, mortality data);
• risk-factor levels;
• environmental factors;
• psychological factors; and
• the attitudes, beliefs and knowledge of public and professional workers in the fields of health promotion and disease prevention.

Preventive measures were implemented through both population and high-risk strategies. The former consisted of health promotion activities organized by the management of the nine industrial enterprises, coupled with a range of educational efforts designed to promote healthy lifestyles. The high-risk strategy involved an annual examination for all employees.

Partners involved in these intervention activities included representatives from the medical sector (Institute of Cardiology, Institute of Experimental and Clinical Medicine, outpatient clinics and the health departments of the participating worksites) and the non-medical sector (worksite administration personnel, trade unions and voluntary organizations, among others).

For the purposes of outcome evaluation (to determine prevalence of NCD, risk-factor levels, nutritional status and habits, psychological factors), three surveys were carried out: a baseline survey at the beginning of the programme, an interim survey after two years and a final survey after five years. Sixteen hundred men and women aged 25–64 participated in each survey.

The processes evaluated in this programme were largely related to the following CINDI strategies: professional education and involvement, public education, community mobilization, and monitoring, evaluation and research. Indicators of professional education included educational events (lectures, seminars on NCD prevention held for factory physicians and nurses) and attendance at these events. The knowledge and attitudes of health professionals were tested by self-administered questionnaires: the modified WHO Kaunas-Rotterdam Intervention Study questionnaire, and the CINDI (core) process evaluation questionnaire (Appendix G). The adoption of preventive guidelines by health professionals was tracked by the actual use of such guidelines in practice.

Public education was evaluated using three indicators:
• the availability of educational materials such as leaflets, posters and wall newspapers at worksite health departments in the participating enterprises;
• educational events such as worksite lectures, talks through factory radio and invited presentations from researchers; and
• awareness levels and attitudes with respect to healthy lifestyles, assessed by questionnaires.

Attendance at CINDI committee meetings and proposals made by partners were used to track community mobilization (coalition building). Processes involved in monitoring, evaluation and research included the creation of a conceptual model of the CINDI Estonia Programme’s first stage, development of evaluation systems, promotion of research, and dissemination of results through publications, reports and presentations.

**Fig. B1.1. CINDI worksite project**
Tallinn, Estonia

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Source: Volozh, O. personal contribution.
B2. Conceptual model for the CINDI Russia Programme

This Programme was initiated in 1987 in seven industrial enterprises in various regions of the Russian Federation. Risk-factor surveys were carried out to establish epidemiological baselines in the target populations, and with agreement from the respective ministries of industry, the health services of the participating enterprises undertook delivery of a number of preventive modules. Since 1990, the Programme has focused on the rebuilding of partnerships and extension of interventions such as breastfeeding and prevention of bronchial asthma in children into community settings (such as schools and kindergartens).

The CINDI Russia Programme focuses on risk-reduction activities in four main areas: epidemiological research, risk-factor interventions, community programmes and monitoring and evaluation. It is organized, at both the country and regional levels, with the National Centre for Preventive Medicine in Moscow; the Centre coordinates the activities of seven CINDI regional centres (Chelyabinsk, Electrostal, Minsk, Novosibirsk, Rostov-on-the-Don, Tomsk and Tver). An additional five centres applied to join in 1996. The CINDI programme provided an entry point and support system for several specific preventive efforts.

The CINDI Russia Programme is a multilevel system based on partnerships with country-level organizations (such as the Ministry of Health of the Russian Federation and national research institutes), regional CINDI centres, city administrations and regional and local health services. The interventions are targeted at various population groups (such as adults or children) in a range of settings (such as worksites, schools and kindergartens). The National Centre for Preventive Medicine links the various levels, and provides technical support and access to programme resources. It does so through policy development initiatives, the preparation of standards and the provision of training to set up and maintain epidemiological databases, and the development of clinical guidelines and modules for preventive interventions at demonstration sites.

The monitoring and evaluation component provides the scientific basis for planning and evaluating preventive interventions: namely, the tracking of major risk factors for noncommunicable diseases, as well as psychosocial factors and environmental and occupational hazards. Surveys conducted in 1986/1987, 1990/1991 and 1993/1994 have been supplemented with official statistics (on morbidity and mortality, for example) and environmental scans.
Fig. B2.1. CINDI Russia Programme, Ministry of Health of the Russian Federation

Ministry of Health

- Research institutes (centres)
- National Centre for Preventive Medicine
- Regional CINDI centres
- Interventions
- Medical services of regions, cities
- Administration of cities, plants, schools, etc.

Coordinating centre (CINDI – Russia)

Target groups: adults, workers, children, etc.
Sites: worksites, schools, kindergartens, etc.

Monitoring and evaluation

- Risk factors:
  - smoking
  - alcohol
  - cholesterol
  - hypertension
  - obesity
  - physical inactivity

- NCD:
  - CHD, stroke
  - lung diseases
  - diabetes
  - dental diseases

- Official statistics:
  - morbidity
  - mortality
  - disability

- Environment:
  - food
  - cigarettes

Surveys

Baseline survey  Interim survey  Final survey

Source: Kamardina, T. personal contribution
B3. Conceptual model of the Pawtucket Heart Health Program (USA)

Pawtucket, Rhode Island is a city with a stable population of about 71,000 inhabitants (around 1986). The Pawtucket Heart Health Program (PHHP) is one of three community research and demonstration studies in CVD prevention in the United States that were funded from 1980 to 1991 by the National Institutes of Health. The primary hypotheses of the project were:

- community health change using lay volunteers is feasible and effective;
- health promoting, population-wide risk-factor behaviour change will occur through a process of community activation with involvement by individuals, groups, organizations and the entire community;
- the creation of social networks in support of behaviour change will result in changes in attitudes about change related to risk-factor behaviour, and in maintenance of these changes;
- actual risk-factor intensity or prevalence, measured in successive random samples of the population, will decrease;
- and the reduced estimated cardiovascular risk will later be manifest as a reduction in atherosclerosis-related morbidity and mortality in Pawtucket, compared with changes in a reference city.

The evaluation consisted of biennial random household risk-factor surveys in Pawtucket and in the reference city, and continuous surveillance of myocardial infarction and stroke in eight community hospitals. In addition, community tracking surveys provided an ongoing assessment of intervening variables, impact variables and the use of new or existing interventions (such as content analysis of major newspapers for health-related articles and the monitoring of sociodemographic profiles of participants).

The PHHP intervention activities were theory driven. The essential intervention strategy was community activation. Social action best represents the community organization practice of the PHHP; goal and strategies are generated externally (by experts), but the actual change techniques involve coalitions of concerned interests to attack the problem (through provision of facts, mass media and advocacy to legislative bodies, for example). Within this general approach, specific programmes have been designed to stimulate, facilitate and maintain behaviour changes, such as control of high blood pressure, smoking cessation and regular physical activity.
Fig. B3.1. Pawtucket Heart Health Program, United States

Appendix C. Strategies used by CINDI programmes

C1. Policy development and coordination

Policy development and coordination includes the building of coalitions among relevant partners, development of consensus among stakeholders on goals and strategies, and preparation of policy documents.

C2. Legislation and regulation

Legislation and regulation include enforcement and administration of the relevant laws and regulations.

C3. Marketing and organizational development

Marketing and organizational development include collaborating with the mass media; forging partnerships with donors and stakeholders, creating displays and presentations, making public relations plans and conducting monitoring and feedback to programme participants on accomplishments and problem areas.

C4. Public education and mass media

Public education and mass media include the training of trainers, development of educational programmes, involvement of mass media in health education, organization of workshops and meetings, development of social marketing modules, and monitoring and feedback.

C5. Community mobilization

Community mobilization includes assessing needs and capacities, inventorying a community resource, identifying community leaders and securing their support, building coalitions and providing technical support to community volunteers and coalitions.

C6. Preventive practice guidelines

Strategies related to preventive practice guidelines include disseminating guidelines, and tracking their utilization by health professionals and policy-makers.

C7. Professional education and involvement

Professional education and involvement aim for behaviour change in health professionals, patient counselling to improve skills to promote healthy behaviour, understanding of intervention techniques (feedback from patients), collaboration with other professionals at different levels of the health care system, and preparation of tools (such as patient charts), to facilitate implementation of prevention guidelines.

C8. Monitoring, evaluation and research

Monitoring, evaluation and research strategies include identification of relevant indicators to monitor processes and outcomes, utilization and analysis of indicators for decision-making and programme improvement, development of efficient and economical evaluation methods, promotion of relevant research priorities and projects, and utilization of new computer and communication technologies to expedite all aspects of programme development.

C9. International collaboration in the context of CINDI

International collaboration includes developing international consensus, creating networks, fundraising, marketing, disseminating practice guidelines, conducting continuous professional education, developing an international database for process and outcome evaluation, and sharing experience among participating countries.
Appendix D. Menu of process indicators for CINDI strategies

D1: Policy development and coordination ................................................................. 28
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D3: Marketing and organizational development ............................................................. 31
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**D1. Policy development and coordination**

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Consensus development           | 1. Published policy report  
2. Declaration made by key stakeholders  
3. Meetings, consultations, workshops with key constituents  
4. Agreements on stated goals, strategies, priorities and collaborative activities  
5. Disagreements resolved          |
| B. Coalition building              | 1. Participating partners, organizations represented (health and non-health sectors)  
2. Missing stakeholders and reasons for absence  
3. Existence of terms of reference  
4. Participation of members in meetings, workshops, events, joint activities  
5. Type and extent of support by visible stakeholders for follow-up on collaborative activities  
6. Recorded minutes of meetings with decisions made  
7. Identification of partners supporting/not supporting decisions  
8. Decisions implemented  
9. Existence of mechanisms or systems to follow up on decisions |
| C. Interagency, intersectoral collaboration | 1. Joint intersectoral projects or activities undertaken  
2. Sectors and partners involved  
3. Type and extent of participation (presence and endorsement)  
4. Commitment of resources and actual contributions  
5. Conditions under which resources are contributed  
6. Types of contributions (financial, in-kind, technical) |
| D. Goal setting                    | 1. Situation analysis performed: changes in CINDI environment, barriers, opportunities, sectors involved, degree of involvement  
2. Needs assessment carried out: process, clients, target population involved  
3. Involvement of partners/clients in goal development  
4. Endorsement of goals by various groups/organizations/authorities (legislative, executive), professional organizations, voluntary agencies  
5. Non-endorsement: identification of relevant stakeholders that do not support the goals  
6. Visible signs of political commitment and accountability to achieving the goals on the part of various stakeholders  
7. Extent of visible support by various stakeholders |
### D1. Policy development and coordination (contd)

**Processes** | **Indicators**
---|---
E. Development of strategic frameworks | 1. Consultations among key stakeholders: type of consultations, participants involved, follow-up and implementation processes  
2. Conferences and workshops organized at various levels: published proceedings, level of stakeholder participation (e.g. present, absent, active, passive)  
3. Documents prepared and available: extract of content, supporting organization  
4. Existence of dissemination plan and publications to publicize the framework  
5. Stakeholders committed to implementation: degree of commitment, accountability and visibility, stakeholders not involved  
6. Resources committed to implementation: type and extent of resources, use made of resources to support various strategies  
7. Process mechanisms established to follow up on strategies implemented  
F. Changes in health agencies (ministries, health services, institutes) | 1. Organizational changes supportive of policy and programme development and implementation  
2. Evidence of value added (or lost) as a result of new organizational arrangements  
G. Resourcing of CINDI programmes | 1. Proposals prepared to obtain resources (purpose, destination)  
2. Types of resources requested (financial, in-kind, technical)  
3. Requests for equipment and facilities  
4. Budgets approved (financial, in-kind, technical)  
5. Availability of telecommunication facilities  

### Results/Outputs/Impacts
1. Working partnerships committed to common goals and to the implementation of agreed strategies  
2. Implications of absence of relevant stakeholders from coalition  
3. Policy and strategy documents widely disseminated  
4. Absence of significant opposing action by public and health-oriented groups  
5. Public awareness of tangible activities resulting from policies, strategies  
6. Evidence of increased resources dedicated to CINDI and other NCD prevention programmes  

### Sources/Systems to capture indicator information
1. Monitoring of news, editorial content of scientific and general press  
2. Monitoring of relevant administrative documentation (e.g. minutes)  
3. Log of activities
## D2. Legislation and regulation

### Processes

<table>
<thead>
<tr>
<th>A. Creation of public demand</th>
<th>1. Type and extent of social marketing activities to garner public support for legislation/regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Media accounts highlighting the need for legislative/regulatory measures</td>
</tr>
<tr>
<td></td>
<td>3. Briefs, proposals to legislators</td>
</tr>
<tr>
<td></td>
<td>4. Meetings with public, parliament members</td>
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<td></td>
<td>5. Policy and technical submissions in support of legislative/regulatory changes</td>
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<tr>
<td></td>
<td>6. Participation in hearings on legislative proposals</td>
</tr>
<tr>
<td>B. Organization, creation of advocacy groups</td>
<td>1. Type and extent of support provided to advocacy groups</td>
</tr>
<tr>
<td></td>
<td>2. Existence of terms of reference, plans of action for advocacy groups</td>
</tr>
<tr>
<td></td>
<td>3. Participation in the work of advocacy groups</td>
</tr>
<tr>
<td></td>
<td>4. Specific contributions to activities of advocacy groups</td>
</tr>
<tr>
<td>C. Drafting of legislation</td>
<td>1. Reviews, reports, and minutes from parliamentary committees</td>
</tr>
<tr>
<td></td>
<td>2. Task forces and working groups established to support the work of parliamentary committees concerned with legislation</td>
</tr>
<tr>
<td>D. Tracking enforcement of legislation and regulation</td>
<td>1. Actions to support and collaborate with the authorities and communities to enforce legislation</td>
</tr>
<tr>
<td></td>
<td>2. Prosecution and convictions for breaches</td>
</tr>
<tr>
<td></td>
<td>3. Complaints in the media with respect to breaches of legislation/regulation</td>
</tr>
<tr>
<td></td>
<td>4. Mechanisms and resources for enforcement of legislation/regulation</td>
</tr>
</tbody>
</table>

### Results/Outputs/Impacts

1. Existence of new legislation/regulation
2. Legislation/regulation enforced
3. Public, consumer support for legislation/regulation

### Sources/Systems to Capture Indicator Information

1. Monitoring of governmental/parliamentary gazettes at the national, regional and local levels
2. Monitoring of police reports and criminal statistics
3. Media reports
4. Scans by advocacy groups
## D3. Marketing and organizational development

### Processes

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Preparation of a marketing plan | 1. Existence of a written marketing plan integrated with the broader CINDI strategic plan  
2. Dedicated CINDI resources allocated to marketing  
3. Steps and activities in the marketing plan that have already been implemented |
| B. Organized fundraising | 1. Programme kits and audiovisual material developed for donors  
2. Existence of fundraising plan integrated into the yearly operational plans  
3. Presentations to, and meetings with, donors  
4. Commitments of resources (financial, in-kind, technical), conditions of funding by donors |
| C. Development of efficient, appropriate programme management capacity | 1. Existence of yearly operational plans  
2. Existence of (concrete) operational objectives  
3. Systems to monitor achievement of objectives  
4. Extent of achievement of objectives  
5. Existence of plans to train CINDI personnel in good management practice  
6. Qualifications and skills of key CINDI personnel |
| D. Coalition building in support of CINDI | 1. Type and extent of interdisciplinary participation in CINDI activities  
2. Representation from the health/non-health sectors and public/private sectors in CINDI activities |
| E. Working with the media at national, regional and local levels | 1. Joint promotional activities with the media resulting in increased public exposure to NCD issues  
2. Media reports on CINDI and CINDI activities  
3. Information, stories, articles on NCD issues  
4. Demand for media interviews with CINDI personnel |
| F. Feedback to the public on results, data | 1. Events to disseminate results of research, surveys  
2. Participation in organized marketing events aimed at decision-makers, health professionals, public  
3. Publications in scientific journals and lay literature  
4. Public demand for information on CINDI |
D3. Marketing and organizational development (contd)

Processes | Indicators
--- | ---
G. Marketing to health professionals | 1. Categories of health professionals to whom marketing activities are directed
2. Categories and numbers of health professionals participating in CINDI activities
3. Statements of support by professional health organizations
4. Types and number of activities to inform health professionals about CINDI and to obtain their commitment to NCD prevention
5. Types and nature of interactions with health professionals
6. Length of time during which various professional health organizations are collaborating with CINDI

H. Marketing to politicians and legislators | 1. Public statements of support by political leaders
2. Lobbying, demands made by the public to politicians for support of NCD activities

I. Design, development and dissemination of promotional materials | 1. Existence of printed and audiovisual materials targeted to professional health organizations and the public
2. Existence of a dissemination plan
3. Types and number of individuals reached

2. Target groups
3. Impact on programme development
4. Responsibility

Results/Outputs/Impacts
1. Awareness of CINDI activities by health professionals
2. Formal adoption of preventive policies and guidelines
3. Resources received from donors and stakeholders
4. Trends over time of resources controlled, available and mobilized by CINDI in support of NCD prevention

Sources/Systems to capture indicator information
1. Monitoring of radio and television programmes (news, special broadcasts on NCD issues)
2. Monitoring of press (news, reviews, special publications on CINDI issues, authors of these publications: CINDI collaborators, health workers, others)
3. Monitoring of the contents of scientific medical journals (availability of publications on CINDI issues, consistency with CINDI approach)
4. Interviews with managers and representatives of key organizations
5. Monitoring of relevant CINDI documents and protocols
6. Analysis of CINDI annual reports
7. Analysis of CINDI site visits
8. Special surveys targeted to the public and health professionals, policy-makers, representatives from organizations concerned with NCD
### D4. Public education and mass media

#### Processes

<table>
<thead>
<tr>
<th>A. Development and implementation of a social marketing plan</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social marketing plan formulated (and published)</td>
<td></td>
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<tr>
<td>2. Perceptions of target groups surveyed</td>
<td></td>
</tr>
<tr>
<td>3. Definition of issues associated with target group</td>
<td></td>
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<tr>
<td>4. Clear, measurable objectives defined</td>
<td></td>
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<td>5. Messages, “hooks” developed</td>
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<tr>
<td>6. Medium chosen</td>
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<td>7. Linkage to ongoing initiatives at community, regional and country levels</td>
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<tr>
<td>8. Existence of a funded operational plan</td>
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<td>9. Partners involved in implementation plan</td>
<td></td>
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<tr>
<td>10. Percentage of target population reached by various activities</td>
<td></td>
</tr>
<tr>
<td>11. Hours of average exposure per year to various education messages</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Development and implementation of multifactorial educational programmes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Needs assessment carried out</td>
<td></td>
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<tr>
<td>2. Goals, objectives defined</td>
<td></td>
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<tr>
<td>3. Protocol prepared</td>
<td></td>
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<tr>
<td>4. Resources committed by various stakeholders</td>
<td></td>
</tr>
<tr>
<td>5. Educational materials prepared, activities defined</td>
<td></td>
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<tr>
<td>6. Channels used</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Involvement of media, voluntary education</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Types and extent of collaborative activities</td>
<td></td>
</tr>
<tr>
<td>2. Types of messages delivered to various target groups</td>
<td></td>
</tr>
<tr>
<td>3. Types, sizes and locations of groups reached</td>
<td></td>
</tr>
<tr>
<td>4. Linkages to community programmes/events</td>
<td></td>
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<tr>
<td>5. Organizations/companies delivering messages</td>
<td></td>
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<tr>
<td>6. Organizations sponsoring media programmes</td>
<td></td>
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<tr>
<td>7. Resources utilized (financial, in-kind, technical)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Training of health educators, peer training</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Types and numbers of programmes, courses and training events</td>
<td></td>
</tr>
<tr>
<td>available</td>
<td></td>
</tr>
<tr>
<td>2. Types and numbers of individuals trained</td>
<td></td>
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<tr>
<td>3. Application of new training skills in daily activities</td>
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</tr>
</tbody>
</table>

#### Results/Outputs/Impacts

1. Increased technical capacity to set up/organize/implement social marketing and public education campaigns
2. Follow-up support provided by community organizations to media programmes
3. Increased public awareness and knowledge of risk factors
4. Adoption of healthy lifestyles
5. Number of contacts with individuals made by the project, per year
6. Average number of hours of exposure to messages, per person, per year
7. Reception, acceptance, understanding and retention of messages by various target groups

#### Sources/Systems to capture indicator information

1. Reports from focus-group testing
2. Surveys of target population
3. Needs assessments
4. Monitoring of training opportunities in health education and social marketing
### D5. Community mobilization

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Community needs assessment, diagnosis and dissemination of results | 1. Situational environmental assessment carried out  
2. Epidemiological profiles prepared  
3. Community profiles/inventory of community resources made  
4. Community leaders/advocates identified  
5. Availability and accessibility of primary care services  
6. Perceived community needs assessed  
7. Surveys of risk factors, nutritional status, etc.  
8. Needs assessment through community tracking surveys  
9. Presentations to community groups, professional organizations and health authorities  
10. Type and extent of media coverage (e.g. form to be supplied)  
11. News releases  
12. Dissemination of surveys results  
13. Launching of community projects |
| B. Coalition building | 1. Composition and description of coalition  
2. Sharing of experiences among communities in the coalition  
3. Existence of terms of reference  
4. Participation of members in meetings, workshops and coalition activities  
5. Programme framework defined  
6. Relevant community stakeholders absent from the coalition  
7. Recorded minutes of meetings with decisions made  
8. Identification of partners supporting (and not supporting) decisions |
| C. Work planning | 1. Existence of goals and specific objectives for the coalition  
2. Periodic meetings of partners and retreats, to develop and monitor implementation of the work plan  
3. Existence of written work plans, with time lines |
| D. Implementation activities | 1. Types of preventive activities initiated, groups targeted, sites, number of individuals participating  
2. Existence of project targets  
3. Community groups participating in CINDI projects  
4. Types and extent of resources contributed by various partners  
5. Linkages between CINDI projects in the community  
6. System to refer individuals at risk to appropriate health and social services  
7. Advocacy actions to reduce social, physical and environmental risks  
8. Involvement of target groups and coalition members in evaluation of CINDI activities |
D5. Community mobilization (contd)

Processes | Indicators
---|---
E. Capacity building | 1. Positions and resources assigned to CINDI community programmes at community level 2. New trained personnel with technical skills 3. New equipment, facilities 4. New information systems to assess community needs, goal attainment 5. Inventory of personnel and training over the project period 6. Development of small groups

F. Provision of technical support to communities | 1. Clear terms of reference and plan for provision of technical support by CINDI personnel 2. Qualifications of provider personnel 3. Consultation services provided 4. Response time to queries and requests for support 5. Types and extent of assistance provided

G. Development of leadership | 1. Individuals in leadership positions supporting CINDI programmes 2. Trained community leaders 3. Participation by community leaders in workshops, meetings conferences 4. Participation by volunteers in community programmes 5. Time and resources contributed to various projects

Results/Outputs/Impacts
1. Community needs profile (report) 2. Public awareness of NCD risk factors and importance of NCD prevention 3. Intersectoral cooperation in addressing public health problems (e.g. horizontal coordination) 4. Resources utilized by CINDI in projects at the community level 5. Matching resources from private and public sectors 6. Community actions to reduce social, physical and environmental risks 7. New or changed policies and innovations created/adopted/replicated

Sources/Systems of indicator information
### D6. Preventive practice guidelines

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| **A. Identification of topics, contents for guidelines** | 1. Setting priorities for guidelines development  
2. Background studies to support the setting of priorities  
3. Health professionals’ demand for guidelines  
4. Awareness levels of health professionals |
| **B. Gathering of and agreement on scientific evidence favouring guidelines** | 1. Collaborative efforts to arrive at consensus  
2. Existence of scientific criteria for guidelines development  
3. Conferences and workshops  
4. Reports from scientific groups  
5. Task force/Committee charged with guidelines development |
| **C. Piloting of guidelines before their implementation into practice** | 1. Research experience in using guidelines  
2. Extent to which guidelines are used in demonstration areas  
3. Extent to which guidelines are used by health professionals |
| **D. Incorporation of guidelines into practice** | 1. Increased knowledge and skills of health professionals with respect to guidelines  
2. Changes in time utilization by health professionals consistent with implementation of guidelines |
| **E. Dissemination of guidelines** | 1. Availability (cost, access) of guidelines in user-friendly form  
2. Existence of a dissemination plan  
3. Publication of guidelines to reach various types of health professional  
4. Training events  
5. Endorsement of guidelines by scientific and professional health organizations |
| **F. Facilitation of adoption of guidelines by health professionals** | 1. Decision tools and algorithms available for distribution, and distributed  
2. Educational support materials for provider and/or policy clients and/or users  
3. Existence of positive incentives to practice prevention  
4. Type and number of professionals using guidelines  
5. Improved preventive practices  
6. Presentations to scientific meetings, adoption of models by jurisdictions |

#### Results/Outputs/Impacts
1. Adoption of guidelines by health professionals  
2. Recognition of practice guidelines by health insurance systems  
3. Reports on rate of counselling of patients on risk factors for noncommunicable diseases and others
Sources/Systems to capture indicator information

1. Tracking of policies, administrative regulations which recognize practice guidelines in health insurance systems
2. Ad hoc monitoring
3. Successive surveys
4. Patient charts for each risk factor
5. Risk-factor information chart for each individual in contact with programme
6. Information system for primary health care
## D7. Professional education and involvement

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Creation of educational opportunities for medical nursing and other undergraduates | 1. Availability of internships on health promotion and disease prevention at undergraduate level  
2. Access to courses/curricula, with modules for health promotion and disease prevention |
| B. Development of curricula (undergraduate)                               | 1. Inclusion of health promotion and disease prevention theory and practice in curricula                                                  |
| C. Delivery of curricula                                                 | 1. Hours, credit devoted to health promotion, disease prevention  
2. Attendance at courses                                           |
| D. Evaluation of curricula                                               | 1. Scores from tests and examinations  
2. Degree of student satisfaction with curriculum                         |
| E. Training in public health and social medicine (postgraduate)           | 1. Trained professionals  
2. Existing or newly established faculties, and schools of public health  
3. Seminars, lectures and presentations given  
4. Symposia, courses offered  
5. Certification of health professionals in health promotion and disease prevention  
6. Availability of, and accessibility to, innovative training (e.g. telemedia) |
| F. Continuing medical education (CME)                                     | 1. Existence of requirements, incentives for CME on health promotion and disease prevention  
2. Accessibility of courses in various regions of the country  
3. Attendance at courses  
4. Certification of health professionals  
5. Opportunities for education through telemedia                           |
| G. Development of educational tools, information networks                | 1. Availability of and accessibility of educational materials, information (newsletters, bulletins) and tools (algorithms, networks) |
| H. Participation in community, regional, national health promotion activities and policies | 1. Health professionals participating in health promotion and disease prevention activities, committees at different levels |
### D7. Professional Education and Involvement (contd)

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acquisition of preventive knowledge, attitudes and skills</td>
<td>1. Test scores</td>
</tr>
<tr>
<td></td>
<td>2. Attendance to training and continuing education events</td>
</tr>
</tbody>
</table>

#### Results/Outputs/Impacts
1. Adoption of preventive practices by the health professionals
2. Health professionals practising state-of-the-art NCD prevention
3. Adoption of healthy lifestyles by patients
4. Patient compliance with management regimen
5. Informed patients who are partners in management of NCD

#### Sources/System to capture indicator information
1. CINDI process evaluation questionnaire
2. Surveys of preventive practices of health professionals
3. Chart audits
4. Questionnaires, tests, and self-evaluation
5. Financial reports of educational and medical departments (institute, college, etc.)
6. Staff time sheets at education and medical departments
### D8. Monitoring, evaluation and research

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Building technical capacity and training | 1. Capacity assessment at various levels (country, regional, community)  
2. Existence of qualified personnel and teams  
3. Training courses taken or given to enhance skills  
4. Technologies transferred  
5. Tools developed to collect data |
| B. Development and maintenance of quantitative and qualitative databases for process and outcome evaluation | 1. Description of the data source (e.g. survey, phone, registry)  
2. Time reference and type of analysis  
3. Turnaround time to access data/information  
4. Type and number of queries received and responded to  
5. Existence of complete documentation on the database  
6. Type and amount of technical resources allocated  
7. Reports produced from the database |
| C. Dissemination of data, results, models | 1. Locations and times of events  
2. Materials disseminated to policy-makers, public, media  
3. Demands received to obtain programme information, reports produced  
4. Types of materials disseminated, and target groups (e.g. decision-makers, professionals, public) |
| D. Define most relevant indicators for monitoring and evaluation | 1. Decisions made using process evaluation indicators  
2. Policy, programme or scientific insights obtained through indicators |
| E. Development of methodologies for qualitative research (policy, evaluation) | 1. Evidence of application of new methodologies, techniques |
| F. Introduction of state-of-the-art computer technical communication technology | 1. Evidence of use and sharing of new technology  
2. Publications of qualitative case study designs  
3. Utilization of state-of-the-art computer software to process qualitative information  
4. Review of data available for entry into a computerized system |
| G. Feedback of information to health authorities | 1. Reports and briefings prepared  
2. Decisions and changes made on the basis of indicators  
3. Continuous changes to improve the project |
D8. Monitoring, evaluation and research (contd)

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| H. Institution of routine acquisition and monitoring of process evaluation and outcome data | 1. Agreements with institutions to commit resources to routine acquisition of data on indicators according to specified protocols  
2. Publications prepared through routine acquisition of evaluation data  
3. Centralization and analysis of data and preparation of reports |
| I. Translation of data into practical information | 1. Publications prepared  
2. Information provided to media  
3. Presentations, seminars to public, health professionals, policy-makers |
| J. Promotion of relevant research in support of CINDI priorities | 1. Research proposals submitted  
2. Research monies levered  
3. Research projects implemented |
| K. Research on NCD prevention and health promotion | 1. Publications and reports  
2. Presentations to scientific management  
3. Resources (financial, in-kind, technical)  
4. Reallocations to research  
5. Availability of periodic information on health status and determinants |
| L. CINDI site visits | 1. Existence of CINDI intervention protocols  
2. Recommendations made to CINDI programmes  
3. Action plans for compliance with recommendations  
4. Recommendations implemented  
5. Political support by health authorities to the CINDI programme as a consequence of WHO site visit |

Results/Outputs/Impacts

1. Capacity to monitor, evaluate and carry out research in support of CINDI programmes and policies  
2. Scientific contribution to the science of NCD prevention  
3. Set-up and utilization of databases  
4. Types of organizations reached (governmental, nongovernmental organizations (NGOs))  
5. Numbers of individuals and professionals reached

Sources/Systems to capture indicator information

1. Log of activities  
2. Ad hoc activity surveys of CINDI personnel  
3. List of publications and reports issued  
4. Administrative and financial records, time use (staff, volunteers)
## D9. International collaboration in the context of CINDI

### Policy development

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. International consensus</td>
<td>1. Position papers</td>
</tr>
<tr>
<td></td>
<td>2. Meetings/consultations</td>
</tr>
<tr>
<td></td>
<td>3. Events such as workshops, conferences</td>
</tr>
<tr>
<td></td>
<td>4. Participation in meetings, events</td>
</tr>
<tr>
<td></td>
<td>5. Documented agreements, decisions</td>
</tr>
<tr>
<td></td>
<td>6. Policy reports, strategic frameworks reflecting internationally agreed-upon policy</td>
</tr>
<tr>
<td>B. International collaboration</td>
<td>1. International projects with participation by CINDI member countries</td>
</tr>
<tr>
<td></td>
<td>2. International projects with participation by international governmental and nongovernmental organizations</td>
</tr>
<tr>
<td></td>
<td>3. Commitment of resources to CINDI priority projects</td>
</tr>
<tr>
<td></td>
<td>4. Availability of funds for international projects</td>
</tr>
<tr>
<td>C. International networking</td>
<td>1. Meetings</td>
</tr>
<tr>
<td></td>
<td>2. Regular exchange of reports</td>
</tr>
<tr>
<td></td>
<td>3. Electronic media and telematics collaboration</td>
</tr>
</tbody>
</table>

### Marketing

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Seeking endorsement of the CINDI policy</td>
<td>1. Mailing CINDI policy reports to health ministries</td>
</tr>
<tr>
<td></td>
<td>2. Visits to the health ministries by CINDI groups</td>
</tr>
<tr>
<td></td>
<td>3. Marketing events in CINDI member countries (with international participation)</td>
</tr>
<tr>
<td></td>
<td>4. Presentations of CINDI policy-related reports to WHO decision-making bodies (executive management, advisory councils, regional committees)</td>
</tr>
<tr>
<td>B. International fundraising</td>
<td>1. Incorporation of the CINDI foundation, NGOs</td>
</tr>
<tr>
<td></td>
<td>2. International fundraising events</td>
</tr>
<tr>
<td></td>
<td>3. Grant requests</td>
</tr>
<tr>
<td></td>
<td>4. Project proposals (types, destination, purpose, resources requested, follow-up process)</td>
</tr>
<tr>
<td>C. Development of international marketing skills</td>
<td>1. Meetings/workshops/consultations</td>
</tr>
<tr>
<td></td>
<td>2. Reports</td>
</tr>
<tr>
<td></td>
<td>3. Jointly organized events</td>
</tr>
<tr>
<td></td>
<td>4. Survey of decision-makers on awareness of and willingness to act on CINDI issues</td>
</tr>
</tbody>
</table>
## D9. International collaboration in the context of CINDI (contd)

Professional education and practice guidelines

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Support of and participation in CINDI Working Group on Guidelines and Training for Preventive Practices in Primary Care</strong></td>
<td>1. Meetings</td>
</tr>
<tr>
<td></td>
<td>2. Reports</td>
</tr>
<tr>
<td></td>
<td>3. International guides</td>
</tr>
<tr>
<td></td>
<td>4. Exchange between teachers and students</td>
</tr>
<tr>
<td></td>
<td>5. Collaboration through electronic media</td>
</tr>
<tr>
<td><strong>B. Monitoring preventive practices of health professionals</strong></td>
<td>1. Availability of status reports and statistics from various CINDI countries on percentage of patients receiving advice on preventive measures and on preventive screening practices</td>
</tr>
<tr>
<td><strong>C. Dissemination of practice guidelines</strong></td>
<td>1. Availability of dissemination budget</td>
</tr>
<tr>
<td></td>
<td>2. Expert teams assembled</td>
</tr>
<tr>
<td></td>
<td>3. Degree of professional support for dissemination</td>
</tr>
<tr>
<td></td>
<td>4. Assessment of relevant scientific literature</td>
</tr>
<tr>
<td></td>
<td>5. Consensus developed</td>
</tr>
<tr>
<td></td>
<td>6. Existence of a dissemination plan</td>
</tr>
<tr>
<td></td>
<td>7. Joint international workshops in primary care</td>
</tr>
<tr>
<td></td>
<td>8. Professional education events and activities</td>
</tr>
<tr>
<td></td>
<td>9. Inclusion of practice guidelines in the health care reform agenda</td>
</tr>
<tr>
<td></td>
<td>10. Mechanisms for ongoing professional education</td>
</tr>
<tr>
<td></td>
<td>11. Application of guidelines</td>
</tr>
<tr>
<td><strong>D. Promotion of international collaboration among health professionals to implement guidelines for prevention of NCD</strong></td>
<td>1. Meetings</td>
</tr>
<tr>
<td></td>
<td>2. Guidelines</td>
</tr>
<tr>
<td></td>
<td>3. Launching conferences</td>
</tr>
<tr>
<td></td>
<td>4. Scientific articles published</td>
</tr>
<tr>
<td></td>
<td>5. Recommendations</td>
</tr>
<tr>
<td><strong>E. Organization of professional education events and activities</strong></td>
<td>1. Priorities selected</td>
</tr>
<tr>
<td></td>
<td>2. Curricula and modules</td>
</tr>
<tr>
<td></td>
<td>3. Courses, workshops, seminars</td>
</tr>
<tr>
<td></td>
<td>4. Professional educational materials, guidelines, recommendations</td>
</tr>
<tr>
<td></td>
<td>5. Workshops for teachers/trainers</td>
</tr>
<tr>
<td></td>
<td>6. Inventory of participating organizations/individuals</td>
</tr>
</tbody>
</table>
## D9. International collaboration in the context of CINDI (contd)

### Professional education and practice guidelines

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| F. Establishment of mechanisms for ongoing/continuing professional education | 1. Decisions of CINDI working groups on priorities  
2. Interdisciplinary agreements on priorities  
3. Institutions/organizations involved with professional education (medical faculties, school of public health, post-graduate schools of medicine, research institutes, others)  
4. Publications (WHO/CINDI, member countries)  
5. CINDI audiovisual and computer educational centres  
6. Exchanges between professional education projects (at country level) |

### Monitoring, evaluation and research

<table>
<thead>
<tr>
<th>Processes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| A. Creation and development of international database for process and outcome evaluation | 1. Consensus on the data sets to be used for monitoring  
2. Resources available  
3. Participation in data collection  
4. Documentation on data and information sets available  
5. Data sets available  
6. Type and frequency of data use  
7. Documented use of database in support of policy  
8. Yearly reports  
9. Turnaround time to access data/information  
10. Description of data sources (e.g. survey, phone, registry)  
11. Time reference and type of analysis |
| B. Promotion of relevant research in implementation of NCD prevention programmes | 1. Dissemination of research results/data to target groups through presentations and community events  
2. Reports  
3. Joint projects |
| C. Sharing of experience/information on mortality, risk factors and process evaluation data | 1. Meetings  
2. Reports  
3. Publications  
4. Access to on-line data |
| D. Implementation of process evaluation in CINDI programmes | 1. Development of country-specific process evaluation protocols  
2. Mechanisms and instruments to acquire process information  
3. Resources dedicated to acquisition of process information  
4. Development of monitoring systems |
Results/Outputs/Impacts
1. International transfer of technology and intervention experience
2. Political visibility, credibility and leverage
3. Optimal utilization of resources at country level (avoiding false starts, benefiting from experience of others)
4. Implementation of recommendations

Sources/Systems to capture indicator information
1. Surveys of activities on policy development, marketing, professional education and practice guidelines, monitoring, evaluation and research
2. Analysis of documents published
3. Minutes/Reports of meetings and consultations
4. Documentation of projects
5. Administrative and financial records
6. WHO resolutions and reports
7. Statements by WHO executive management
8. Reports of events
9. Participation in meetings and events
Appendix E. Example of a form to summarize a typical CINDI project

Contents

I. Description
   1. Name of the project
   2. Target group
   3. Strategy
   4. Objectives
   5. Risk factors
   6. Channel of delivery
   7. Theoretical foundations
   8. Resources
   9. Date planning started
  10. Date implementation started
  11. Date implementation ended (if applicable)
  12. Estimated number of people reached
  13. Evaluation
  14. Perception of success

II. Sustainability
   15. Current status of project
   16. Documentation

Instructions

Please complete the next two pages for each project. A project will meet the following criteria; it:

1. has a set of organized activities aligned with a specific goal
2. has a budget assigned to it
3. would not be in place without the CINDI programme
4. has participation from staff and/or volunteers from the CINDI programme in the activities.

Make as many copies of this form as you need to report all projects that meet the criteria. In the top right corner of both pages, please number the projects.
I. Description

1. Name of project: _______________________
   ______________________________

2. Target group (check one)
   □ General population
   □ Adults (15 years and over)
   □ Children and youth
   □ Women
   □ Other: _____________________________

3. Strategy (check all that apply)
   □ Policy development and coordination
   □ Legislation and regulation
   □ Marketing and organizational development
   □ Public education and mass media
   □ Community mobilization
   □ Preventive practice guidelines
   □ Professional education and involvement
   □ Monitoring, evaluation and research
   □ International collaboration in the context of CINDI

4. Objectives (check all that apply)
   □ Direct education: awareness and knowledge
   □ Direct education: behaviour
   □ Environmental change
   □ Other: ______________________________

5. Risk factors (check all that apply)
   □ Tobacco
   □ Nutrition
   □ Physical activity
   □ Diabetes
   □ Obesity
   □ Hypertension
   □ Stress
   □ Other: ______________________________

6. Channel (check all that apply)
   □ Schools
   □ Worksites
   □ Health care settings
   □ Community agencies
   □ Food service outlets
   □ Media
   □ Other: ______________________________

7. Theoretical foundations (check all that apply)
   □ Information processing theory
   □ Health belief model
   □ Theory of reasoned action or planned behaviour
   □ Social learning theory
   □ Diffusion theory
   □ Social marketing
   □ Other: ______________________________

8. Resources
   Time: ____________ person days
   Budget: US $ ______________________________
   Lead organization: ________________
   Collaborating organizations:
   ____________________________________________

9. Date active planning started:
   ____________
   mm/yy

10. Date implementation started:
    ____________
    mm/yy

11. Date implementation ended:
    ____________
    mm/yy
    If not ended, when is it planned to end?
    ____________
    mm/yy
    OR
    □ No plans to end
12. Estimated number of people reached each year:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Evaluation

Was there a mechanism to monitor implementation? ............................................................ □ Yes □ No
Was there a mechanism to monitor outputs or outcomes ..................................................... □ Yes □ No

If yes, what outputs or outcomes?

_____________________________________________________________________________________
_____________________________________________________________________________________

Did you carry out a process to review information from the evaluation?............................ □ Yes □ No
Did you revise part or all of the project based on evaluation results?............................... □ Yes □ No

14. Perception of success

What best describes your opinion of the success of this project? (check one)

□ Would recommend to others with no revisions
□ Would recommend to others with minor revisions
□ Would recommend to others with major revisions
□ Would not recommend to others

Explain the main reasons for your recommendation: ______________________________________

II. Sustainability

15. What best describes the status of the project? (check one)

□ No longer appropriate; finite life and should not be prolonged artificially
□ Ended with demonstration phase; not adopted by another organization
□ Has a steady source of funding and will continue
□ Was adopted by a permanent organization (e.g. health department, school board/district, hospital, voluntary agency, worksite)
□ Packaged for use by others
□ Others:

___________________________________________________________________________________

16. Documentation

Have goals and objectives been put in writing? ................................................................. □ Yes □ No
Have job descriptions for staff been written? ................................................................. □ Yes □ No
Is there a clear written description of how to implement the project? .............................. □ Yes □ No
**Appendix F. Example of a log of local activities form**

**Activity record – General**

<table>
<thead>
<tr>
<th>Activity name:</th>
<th>______________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting date:</td>
<td>___________________</td>
</tr>
<tr>
<td></td>
<td>dd/mm/yy</td>
</tr>
<tr>
<td>Primary CINDI staff responsible:</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Primary non-CINDI person responsible:</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Initiation:</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Key contact:</td>
<td>___________________________________________</td>
</tr>
</tbody>
</table>

Brief description (include main features, the role of the CINDI, project and reasons for doing the activity):

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Subactivity name: | ______________________________________________________________ |

Brief description (include main features, the role of CINDI, project and main reasons for doing the subactivity):

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Starting date: ___________________ | Ending date: ___________________ |

| dd/mm/yy | dd/mm/yy |
## Approach/intended impact

<table>
<thead>
<tr>
<th>Education</th>
<th>Primary aim</th>
<th>Secondary aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness and knowledge of risk of behaviour, heart health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase motivation to change behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate behavioural change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain behavioural change</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental support</th>
<th>Primary aim</th>
<th>Secondary aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness and knowledge of programmes and policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruit participants for programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruit volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve community relations, establish networks or planning committees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train professionals for programme delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train lay people for programme delivery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy</th>
<th>Primary aim</th>
<th>Secondary aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change organizational policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change municipal by-laws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change provincial legislation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Target

<table>
<thead>
<tr>
<th>Individuals</th>
<th>Primary aim</th>
<th>Secondary aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (0–14 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescents/young adults (15–24 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult men (25–64 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult women (25–64 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seniors (65 years and over)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Organizations

<table>
<thead>
<tr>
<th>Primary aim (check one)</th>
<th>Secondary aim (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cafeterias</td>
<td></td>
</tr>
<tr>
<td>Education institutions</td>
<td></td>
</tr>
<tr>
<td>Grocery stores</td>
<td></td>
</tr>
<tr>
<td>Health care facilities</td>
<td></td>
</tr>
<tr>
<td>Municipal government</td>
<td></td>
</tr>
<tr>
<td>Public places</td>
<td></td>
</tr>
<tr>
<td>Recreational facilities</td>
<td></td>
</tr>
<tr>
<td>Restaurants</td>
<td></td>
</tr>
<tr>
<td>Retail outlets</td>
<td></td>
</tr>
<tr>
<td>Voluntary health organizations</td>
<td></td>
</tr>
<tr>
<td>Worksites</td>
<td></td>
</tr>
<tr>
<td>Other: __________________</td>
<td>________________________</td>
</tr>
</tbody>
</table>

### Focus

(check all that apply)

- Tobacco: prevention
- Tobacco: cessation
- Tobacco: protection
- Nutrition
- Physical activity
- Diabetes
- Blood pressure
- Weight control
- Stress
- General heart health
- Other: ____________________________

### Methods

(check all that apply)

**Face-to-face communication**

<table>
<thead>
<tr>
<th>Classes</th>
<th>No.</th>
<th>No. attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public forums</td>
<td>No.</td>
<td>No. attending</td>
</tr>
<tr>
<td>Seminars</td>
<td>No.</td>
<td>No. attending</td>
</tr>
<tr>
<td>Workshops</td>
<td>No.</td>
<td>No. attending</td>
</tr>
<tr>
<td>Meetings</td>
<td>No.</td>
<td>No. attending</td>
</tr>
<tr>
<td>Others: ________</td>
<td>No.</td>
<td>No. attending</td>
</tr>
</tbody>
</table>
Materials used:

<table>
<thead>
<tr>
<th>Material</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brochures</td>
<td></td>
</tr>
<tr>
<td>Buttons, caps, etc.</td>
<td></td>
</tr>
<tr>
<td>Films</td>
<td></td>
</tr>
<tr>
<td>Newsletters, flyers</td>
<td></td>
</tr>
<tr>
<td>Self-help guides</td>
<td></td>
</tr>
<tr>
<td>Videos</td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

List of materials (name the materials and attach new materials)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mass media

<table>
<thead>
<tr>
<th>Media</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billboards</td>
<td></td>
</tr>
<tr>
<td>Bus shelter posters</td>
<td></td>
</tr>
<tr>
<td>Newspaper articles</td>
<td></td>
</tr>
<tr>
<td>News releases</td>
<td></td>
</tr>
<tr>
<td>Newsletters</td>
<td></td>
</tr>
<tr>
<td>Press conferences</td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td></td>
</tr>
<tr>
<td>Television</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

List of participating organizations (and include number of employees for worksites):

1. ____________________________________  6. ____________________________________
2. ____________________________________  7. ____________________________________
3. ____________________________________  8. ____________________________________
4. ____________________________________  9. ____________________________________
5. ____________________________________ 10. ____________________________________
Funding

CINDI funding: US $ ____________

Community funding:

<table>
<thead>
<tr>
<th>Organization/group/person</th>
<th>Amount (US $)</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________________________</td>
<td>_______</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>2. ________________________</td>
<td>_______</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>3. ________________________</td>
<td>_______</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>4. ________________________</td>
<td>_______</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________</td>
<td></td>
</tr>
</tbody>
</table>

People

No. CINDI staff _____ estimated total hours _____
No. community staff _____ estimated total hours _____
No. volunteers _____ estimated total hours _____

Evaluation (describe results such as participant satisfaction, future plans, spin-offs, and attach any evaluation instruments and reports):

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Comments:

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

### Appendix G. CINDI process evaluation questionnaire

1. Have you participated in any lecture, meeting or other health-related activity dealing with smoking, diet, physical exercise, etc., during the last 12 months?  
   - Yes:  
   - No:  

2. How often have you read, watched or listened to messages about health issues during the last 12 months:  
   - Weekly:  
   - Monthly:  
   - Rarely or never:  
   - in brochures/leaflets:  
   - on television:  
   - on the radio:  
   - in newspapers:  
   - in magazines:  
   - during lectures:  

3. Have any of the following people influenced you during the last 12 months:  
   - Family members:  
   - Friends:  
   - Work-mates:  
   - Health personnel:  
   - Other people:  
   - None:  
   - to stop smoking? (answer only if you have smoked during the last 12 months):  
   - to lose weight:  
   - to eat less fat:  
   - to use less salt:  
   - to increase physical activity:  
   - to drink less alcohol? (answer only if you have consumed alcohol during the last 12 months):  

4. During the last 12 months, have you had:  
   - a general health check-up:  
   - your blood pressure measured:  
   - your cholesterol level measured:  
   - your blood sugar level measured:  

---

*Handbook for Process Evaluation in Noncommunicable Disease Prevention*
### 5. Have you ever been told by health personnel that you have:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>elevated blood pressure?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>elevated cholesterol?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>elevated blood sugar?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>excess body weight? a)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6. During the last 12 months, have you been advised by a physician to:

<table>
<thead>
<tr>
<th>Action</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>stop smoking? (answer only if you have smoked during the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lose weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>eat less fat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>use less salt?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>increase physical activity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drink less alcohol? (answer only if you have consumed alcohol during the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7. During the last 12 months, have you seriously tried to:

<table>
<thead>
<tr>
<th>Action</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>stop smoking? (answer only if you have smoked during the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lose weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>eat less fat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>use less salt?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>increase physical activity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drink less alcohol? (answer only if you have consumed alcohol during the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a) recommended question.
8. Have you succeeded during the last 12 months in:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>• stopping smoking ? (answer only if you have smoked during the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• losing weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• eating less fat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• using less salt?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increasing physical activity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• drinking less alcohol? (answer only if you have consumed alcohol during the last 12 months)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. What is your sex?  
Male:_________  Female:_________

10. What is your age?  
Years:_________________________

11. How many years of education have you had?  
Years:_________________________

---

\(^{b)}\) recommended set of questions.
Appendix H. CINDI check-list for site visits

1. Local CINDI protocol:
   __ availability of protocol
   __ correspondence to WHO CINDI protocol
   __ availability of data on various aggregation levels (e.g. area, age, rural/urban)
   __ demographic data
   __ mortality data
   __ survey data (essential, recommended and optional)
   __ other data

2. Local CINDI design:
   __ countrywide/demonstration area implementation
   __ evaluation and standardization procedures
   __ managerial structure

3. Health intervention modules:
   __ availability
   __ educational materials (for health personnel, the public)

4. Local CINDI manual of operations:
   __ availability
   __ correspondence to WHO CINDI protocol

5. Local CINDI information support:
   __ computing facilities
   __ data-testing procedures
   __ access to statistics

6. Local activities:
   __ availability of a log of activities
   __ intervention activities
   __ evaluation activities

7. CINDI links:
   __ with other health staff and health services
   __ with sector other than health

8. Local CINDI team

9. Budget estimation
Appendix I. CINDI annual report format

Country: ___________________________ Reporting period: _______________________

1. Programme objectives and documentation

2. Programme administration and management

3. Monitoring surveys and data collection

4. Intervention, national level:
   • health related services
   • general education activities
   • community organization
   • regulatory, structural activities

5. Intervention, demonstration area
   • health related services
   • general education activities
   • community organization
   • regulatory, structural activities

6. Resources and financing

7. Reports and publications

8. Other topics
Appendix J. Evaluation questionnaire for “Quit and Win – 94”

1. Who was the initiator of the “Quit and Win – 94” Campaign in your country?

Health structure:
☐ medical research department
☐ primary health care
☐ others

Non-health structure:
☐ government
☐ commercial firms
☐ others

2. What was the trigger for starting this campaign in your country?

Please describe: ____________________________________________________________

3. On what catchment level did you carry out the campaign?

☐ National
☐ Regional
☐ Local (demonstration)

4. What resources devoted to the campaign did you have (in numbers)?

Health scientists: _____
Physicians: _____
Nurses: _____
Technical personnel: _____

5. Did you receive support from your central government?  ☐ Yes  ☐ No

6. Did you receive support from your local government?  ☐ Yes  ☐ No

7. What type of support did you receive from central government and to what extent?

<table>
<thead>
<tr>
<th>Type</th>
<th>Yes</th>
<th>No</th>
<th>Extent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Financial</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Human</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
8. What type of support did you receive from local government and to what extent?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>high</th>
<th>medium</th>
<th>low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. What budget was dedicated to the campaign (please indicate amount and percentage of the total budget)?

<table>
<thead>
<tr>
<th></th>
<th>US $</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-health structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. To what extent did the mass media participate in the campaign?

<table>
<thead>
<tr>
<th></th>
<th>high</th>
<th>medium</th>
<th>low</th>
<th>none</th>
</tr>
</thead>
<tbody>
<tr>
<td>National media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. What barriers did you meet working with mass media?

_______________________________________________________________________________________

12. How did you get over these barriers?

_______________________________________________________________________________________

13. Did primary health care take part in the campaign? □ Yes □ No

14. If yes, please indicate the role of primary health care in the campaign?

_______________________________________________________________________________________

15. How has the campaign changed your partnership (number of partners)?

In government
_______________________________________________________________________________________
In health sector
_______________________________________________________________________________________
In non-health sector
_______________________________________________________________________________________
Changes (please indicate): □ increased number of partners
□ decreased number of partners
□ stable number of partners

16. To what extent did your partnerships change?

□ Marked change
□ Some change
□ No change
17. How did the campaign influence on the coalition in CINDI programme in your country?

_______________________________________________________________________________________

18. How did the campaign help the sustainability of the CINDI programme in your country?

_______________________________________________________________________________________

19. How did the campaign influence on the visibility of the CINDI programme in your country?

_______________________________________________________________________________________

20. Where have you published or presented the results of the campaign?
    ☐ In research journal(s)
    ☐ At scientific conference(s)
    ☐ In mass media
    ☐ In meeting(s)

_______________________________________________________________________________________

21. What new projects in the CINDI programme have been initiated and launched thanks to the campaign?

_______________________________________________________________________________________
Appendix K. Questionnaire*: comparative analysis of policy development and implementation processes in the countrywide integrated noncommunicable diseases intervention (CINDI) programmes

**GENERAL INFORMATION**

- Those participating in the study are encouraged to answer the questions in a free style and to focus on those aspects of the questionnaire which are of most interest.

- The questionnaire may be answered from the perspective of the CINDI demonstration area or from the country level. In either case, it may be completed by one or more individuals. The questionnaire could serve as a basis for discussion among members of the CINDI team.

**ORIGINS**

- What were the pre-existing conditions or the foundations for CINDI; i.e. on which infrastructures was CINDI built? (e.g.: organizations, programmes)

- At the start of CINDI, which major areas of prevention were supported by explicit government policy and legislation? (e.g.: tobacco control, nutrition, environment)

- When did CINDI start? What event or opportunity was the trigger for the establishment of CINDI?

- What challenges had to be overcome to establish CINDI?

- Which institution or individuals were primarily involved in negotiating with WHO for the establishment of CINDI?

- What were seen as the expected benefits from joining CINDI?

- How is the infrastructure for prevention currently organized? How is prevention for noncommunicable diseases delivered for the most part? (e.g.: through the primary care sector, public health or hygienic units, health promotion institutes, voluntary organizations, research institutes, worksites)

**ORGANIZATION AND RESOURCES**

- In which institution or organization is CINDI located? (organizationally)

- To whom does the CINDI Programme Director report? (Note: if there is more than one Director, or more than one organizational location, provide information for each one)

- To which technical/professional resources has the CINDI Programme Director access?

- What are the sources of funding?

- What is the average annual budget available to CINDI over the last three years? (optional: provide information as appropriate)

*Prepared by the WHO Collaborating Centre for Policy Development in the Prevention of Noncommunicable Disease, Health Canada, Ottawa, Canada*
• Has there been growth or decrease in the resources (financial, human) available to CINDI over the years? Describe the type and extent.

• Does the government provide resources to CINDI? What is the type and extent of government support? (provide information as appropriate)

• In which functions are the technical or scientific capacity of CINDI stronger? (e.g.: policy development; community mobilization; epidemiological and other types of needs assessment; advocacy for healthy policies; environmental change; public education; professional education; social marketing; training; planning, coordination, project control; monitoring, evaluation; dissemination)

• Which functions need to be strengthened?

**PARTNERSHIPS**

• Which institutions (or individuals) collaborate on an ongoing basis with CINDI?

• For each of the major partners: what is the type and extent of the support that they provide to CINDI?

• What is the type and the extent of the support that CINDI provides to its partners?

• With which partners is the collaboration of CINDI closer? In which areas is the collaboration most effective?

• What support does CINDI provide to government?

• What support does CINDI obtain from government?

• Are the partners involved in planning, decision-making, allocation of resources, and/or the evaluation of CINDI?

• Is government involved in decision-making?

• How much freedom of action does CINDI have to strike partnerships with organizations in the public and the private sectors? Are there guidelines, limitations?

• Has there been a change in the number and type of partners over the years? Has there been a growth or decline in the contributions of the partners to the CINDI Programme? What factors are responsible for the change?

**SCOPE: CURRENT AREAS OF EMPHASIS, MAIN PROJECTS**

• What prevention issues constitute the priorities for CINDI? (e.g.: smoking, nutrition, obesity, physical activity, alcohol and drug abuse; high blood pressure, lipids, diabetes; multiple risk factors, psychosocial factors; accidents; environmental hazards; breast and cervical cancer screening: children and youth, elderly, disadvantaged, worksites, communities)

• Describe the CINDI priorities with reference to: target group, objectives and extent (e.g. percent) of total CINDI resources applied.

• Which are the main projects or activities of CINDI?

• Describe the major activities in terms of their emphasis on strategies such as: policy development, legislation and coordination; marketing and organizational development; public education and mass media; practice guidelines; professional education and involvement; monitoring, evaluation and research. What is the extent of resources (e.g. percent) allocated to the major activities?
• To what extent are the different CINDI activities integrated or coordinated with existing health promotion and disease prevention infrastructure, namely: programmes run by governments, by health professional organizations, or by voluntary health agencies?

**Programme and Practice Guidelines**

- Has CINDI issued guidelines for design and implementation of interventions targeted at population groups?
- Has CINDI issued clinical prevention guidelines? Has it adopted guidelines issued by WHO/CINDI?
- How are the guidelines disseminated?
- Does CINDI provide support to health professionals to facilitate the implementation of the guidelines?

**Processes of Policy Development and Strategic Planning**

- Are there explicit health goals for prevention of noncommunicable diseases at the country or at the demonstration area levels? Have the goals been developed in the framework of WHO Health for All for the year 2000? Are the goals directional or quantitative?
- Is there a policy document or a policy framework at the country or at the demonstration area levels which provides direction to CINDI? (e.g.: priorities, steps for the implementation of a long-term strategy)
- Was CINDI involved in the preparation of the policy framework? What was the extent of involvement? Was the policy discussed with the major stakeholders?
- Has the policy framework been debated, promoted, marketed? How?
- If no framework is available, what are the main reasons that one has not yet been developed?
- Has CINDI identified specific objectives to support the broader prevention goals?
- What process was followed to set the objectives? What was the involvement, if any, of the partners of CINDI in setting the objectives?
- Are CINDI objectives stated in a manner that their achievement can be monitored?
- Are there monitoring systems in place to track the achievement of CINDI objectives?
- Are the goals and objectives seen by the member of CINDI as useful tools to set programme directions; to set programme priorities?
- How are the priorities for major CINDI activities set? What criteria are used? Are the partners involved? How?
- To what extent are epidemiological and other needs assessment information used in practice to make decisions on priorities?

**Evaluation**

- Have risk factors surveys been carried out? Have the data been released? When? Are there any plans to conduct risk factor surveys in the near future?
- Have process evaluation surveys been carried out? Have the results been released? When? Are there any plans to conduct process evaluation surveys in the future?
• How have the findings of the surveys been used? Have they been publicized? Have the results of the surveys increased the visibility of CINDI?

• Have the results led to increased priority for issues of noncommunicable disease prevention? Have there been any new initiatives launched as a result of the surveys?

• Have the findings had an impact on the design or delivery of the interventions?

• To what extent is process evaluation used in CINDI as a complement to outcome evaluation?

• Has CINDI adopted process evaluation guidelines to track the implementation of its projects? How were the guidelines developed?

• Are there any examples of the application of qualitative research techniques (e.g.: case study methods) to the evaluation of CINDI?

• Is there an understanding in CINDI and its partners on how the findings of the outcome and process evaluations will be used?

• What is the role of the CINDI partners in the design and implementation of the outcome and process evaluations?

**DISSEMINATION**

• What approaches does CINDI use to disseminate interventions (e.g.: tobacco control in schools, professional education) to the country as a whole? (i.e. to areas other than the demonstration area)

• Is CINDI involved in the transfer of skills or of technical and scientific knowledge to communities, professional organizations, government agencies? What means are used to do this?

• From the CINDI perspective, what are the key variables (e.g.: barriers, resources, technical capacity) in the successful dissemination of CINDI Programs?

**MARKETING OF THE CINDI PROGRAMME**

• Is there a systematic, organized effort to market CINDI in order to obtain political and material support? (human, financial)

• To which organizations and groups are marketing efforts addressed?

• Describe instances where marketing was successful. Which were the key factors (e.g. selling points) for successful marketing of CINDI? Were there any barriers?

• What have been the benefits of marketing? Has the marketing led to increased support (e.g. new sources of funding) or to new alliances and coalitions?

• Are marketing activities a part of the strategic plan for CINDI or mostly undertaken on an opportunistic basis?

**INTERACTIONS WITH WHO INITIATIVES AND WITH OTHER CINDI PROGRAMMES**

• Is CINDI in your country currently collaborating on projects with other CINDI countries? What is the type and extent of the collaboration?

• Is CINDI currently participating in WHO initiatives such as Healthy Cities, Healthy Workplaces, Healthy Schools, Tobacco or Health, Action Plan Against Alcohol, MONICA? What is the type and extent of the collaboration?
• What are the benefits of collaboration with CINDI in other countries or with WHO?

• From past experience, which are the key factors that lead to successful collaboration? What are the barriers?

**SUCCESS, SUSTAINABILITY AND CHALLENGES**

• How could the success of CINDI be determined? By which criteria? Taking these criteria into account, what are the key accomplishments of CINDI?

• What are the possibilities for sustaining the activities and maintaining (or increasing) the resource levels of CINDI in the future?

• Is there a strategy to have CINDI projects absorbed into the health system once the demonstration and evaluation phases of the projects are complete? What would help the sustainability of CINDI programme?

• What is the “value added” of CINDI to the existing prevention infrastructure at the country or at the demonstration area levels?
Appendix L. Members of the CINDI Ad Hoc Working Group on Process Evaluation

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