



UPDATED REVISED DRAFT

(Version dated 15 March 2013)

Please note:

- *The paragraphs in this document were renumbered on 21 March 2013 to fully align the paragraph numbering across the English, French and Spanish versions*

UPDATED REVISED DRAFT

**GLOBAL ACTION PLAN
FOR THE PREVENTION AND CONTROL OF
NONCOMMUNICABLE DISEASES
2013-2020**

Background

1. The global burden and threat of noncommunicable diseases constitutes a major public health challenge that undermines social and economic development throughout the world. Urgent action is required at the global, regional and national levels to mitigate this threat, in order to prevent increasing inequalities between countries and in populations.

2. An estimated 36 million deaths, or 63% of the 57 million deaths that occurred globally in 2008, were due to noncommunicable diseases, comprising mainly cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes(3.5%).¹ In 2008, 80% of all deaths (29 million) from noncommunicable diseases occurred in low- and middle-income countries, and a higher proportion (48%) of the deaths in the latter countries are premature (under the age of 70) compared to high-income countries (26%). According to WHO's projections, the total annual number of deaths from noncommunicable diseases will increase to 55 million by 2030, if business as usual continues. Scientific knowledge demonstrates that the noncommunicable disease burden can be greatly reduced if cost effective preventive and curative interventions already available are implemented effectively and in a balanced manner.

Aim

3. As requested by the World Health Assembly in resolution WHA64.11, the Secretariat has developed a draft action plan for the period 2013-2020. The aim is to operationalize the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases². The draft action plan provides a road map for the global community, to act in a coordinated and coherent manner. It is a means of implementing the global monitoring framework to attain the 9 voluntary global targets, including the target on premature mortality of a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025. The action plan covering the period 2013-2020 provides a menu of cost-effective interventions and policy options for the prevention and control of noncommunicable diseases, building on what has already been achieved through the implementation of the global action plan for the prevention and control of noncommunicable diseases for the period 2008–2013.

Process

4. Developing the action plan has brought together multiple stakeholders involved in the prevention and control of noncommunicable diseases, including governments and elected officials, global agencies, development partners, health professionals, academia, civil society, and the private sector. The global consultation process engaged WHO Member States, United Nations funds, programmes and agencies through six regional meetings organized by the Regional Offices of WHO, three web consultations and three informal consultations. Two informal dialogues were held with relevant nongovernmental organizations and selected private sector entities to obtain input for the development of the action plan.

Scope

5. Four categories of disease – cardiovascular diseases, cancer, chronic respiratory diseases and diabetes – make the largest contribution to morbidity and mortality due to noncommunicable diseases and are the main focus of the action plan. These four noncommunicable diseases can be largely prevented or controlled by means of effective interventions that tackle shared risk factors, namely: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, as well as through early detection and treatment. These major noncommunicable diseases and their risk factors are considered together in the action plan in order to emphasize shared aetiological factors and common approaches to prevention. This conjunction does not imply, however, that all the risk factors

¹ http://www.who.int/healthinfo/global_burden_disease/cod_2008_sources_methods.pdf

² United Nations General Assembly resolution 66/2 (http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf)

are associated in equal measure with each of the diseases. Details of disease-related causal links and interventions are provided in the relevant strategies and instruments. There are many other conditions of public health importance that are closely associated with the four major noncommunicable diseases, including: (i) other noncommunicable diseases (renal, endocrine, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and oral diseases); (ii) mental disorders; (iii) disabilities, including blindness and deafness; and (iv) violence and injuries. Noncommunicable diseases and their risk factors are also linked to communicable diseases, maternal, child and adolescent health, reproductive health, ageing, and environmental, occupational and social determinants of health. Despite the close links, one action plan to address all of them in equal detail will be unwieldy. Further some of these conditions are the subject of other WHO strategies, action plans and Health Assembly resolutions. As such, the four noncommunicable diseases that share common risk factors remain the main focus of the action plan. Appendix 1 outlines potential synergies and linkages between major noncommunicable diseases and interrelated conditions to emphasize opportunities for collaboration and maximize efficiencies for mutual benefit. Linking the action plan in this manner also reflects WHO's responsiveness to the organization's reform agenda on the issue of working in a more cohesive and integrated manner.

Relationship to the calls made upon WHO and its existing strategies, reform and plans

6. The global monitoring framework, including 25 indicators and a set of 9 voluntary global targets (see Appendix 2), will be submitted to the Sixty-sixth World Health Assembly for consideration by Member States. The action plan offers a comprehensive set of actions geared to accelerating the reduction in the burden of noncommunicable diseases so that sufficient progress is made by 2020 in reaching the global targets set for 2025.

7. Since the adoption of the Global Strategy for the Prevention and Control of Noncommunicable Diseases in 2000, several Health Assembly resolutions have been adopted or endorsed in support of the key components of the global strategy. This action plan builds on the implementation of these resolutions mutually reinforcing them including, WHO Framework Convention on Tobacco Control (resolution WHA56.1), the Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17) and the Global Strategy to Reduce Harmful Use of Alcohol (resolution WHA63.13) and Sustainable health financing structures and universal coverage (resolution WHA64.9), the Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21), as well, the Outcome of the World Conference on Social Determinants of Health (resolution WHA65.8) and the Moscow Declaration of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (resolution WHA64.11). The action plan provides a framework to support and strengthen implementation of existing regional resolutions, strategies and plans. The action plan has close conceptual and strategic links to the draft comprehensive mental health action plan 2013–2020 (under development)³ and the draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019 (under development)⁴, which will be considered by the Sixty-sixth World Health Assembly. The action plan will also be guided by WHO's twelfth General Programme of Work 2014–2019 (under development)⁵.

8. The actions for the Secretariat are in keeping with WHO's reform agenda, which requires the Organization to engage an increasing number of public health actors, including foundations, civil society organizations, partnerships and the private sector, in work related to the prevention and control of noncommunicable diseases. The roles and responsibilities of the three levels of the Secretariat – country offices, regional offices and headquarters in the implementation of the action plan will be reflected in the biennial programme budget of WHO.

Cost of action versus inaction

9. The cost of inaction far outweighs the cost of taking action on noncommunicable diseases as recommended in this action plan. The average yearly cost to implement a core set of high-impact, prevention and

³ http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_8-en.pdf

⁴ http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_9-en.pdf

⁵ http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_26-en.pdf

treatment interventions (Appendix 3), for all low- and middle-income countries is estimated to be USD11.4 billion⁶. These interventions give a good return on investment, generating one year of healthy life for a cost that falls below the Gross Domestic Product per person. The annual investment required is under USD 1 per person in low-income countries, USD 1.50 in lower middle-income countries; and USD 3 in upper middle-income countries. Expressed as a proportion of current health spending, the cost of implementing such a package amounts to 4 per cent in low-income countries, 2 per cent in lower middle-income countries and less than 1 per cent in upper middle-income countries. A costing tool is available for countries to estimate the cost of national scale-up. The estimated cost of implementing the action plan by the Secretariat is estimated at USD 240 million for the biennium 2014/2015. The above estimates for implementation of the action plan should be viewed against the cost of inaction. Continuing business as usual will result in an escalation of health care costs in all countries. The economic impact of noncommunicable diseases in low- and middle-income countries is an estimated USD 500 billion per year, equivalent to 4 per cent of their current gross domestic product⁷. Over the period 2011-2025, the cumulative lost output in low- and middle-income countries due to noncommunicable diseases is projected to be USD 7.28 trillion. In this context, this action plan should be seen as an investment prospect, because it provides direction and opportunities to (i) safeguard the health and productivity of populations and economies; (ii) create win-win situations that influence the choice of purchasing decisions related to, inter alia, food, media, information and communication technology, sports, and health insurance; and (iii) identify the potential for new, replicable and scalable innovations that can be applied globally to reduce burgeoning health care costs.

Vision

10. A world free of avoidable burden of noncommunicable diseases so that populations reach the highest attainable standards of health and productivity at every age and those diseases are no longer a barrier to well-being and socioeconomic development, through multisectoral collaboration and cooperation at national, regional and global levels.

Overarching principles and approaches

11. The action plan relies on the following overarching principles and approaches:

- Rights based approach: Recognize that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition, as enshrined in the WHO constitution.
- International cooperation and solidarity: Recognize the primary role and responsibility of governments in responding to the challenge of noncommunicable diseases and the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts.
- Multisectoral action: Recognize that effective noncommunicable disease prevention and control require leadership and multisectoral approaches for health at the government level, including, as appropriate, health-in-all-policies and whole-of-government approaches across such sectors as health, agriculture, communication, education, employment, energy, environment, finance, industry and trade, labour, sports, transport, urban planning, and social and economic development.

⁶ Scaling up action against noncommunicable disease: how much will it cost? Geneva, World Health Organization, 2011 http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf

⁷ From burden to best buys ; reducing the economic impact of noncommunicable diseases in low-and middle –income countries. Geneva, World Health Organization and World Economic Forum 2011 http://www.who.int/nmh/publications/best_buys_summary.pdf

- Empowerment of people and communities: People and communities should be empowered and involved in activities for the prevention and control of noncommunicable diseases, including advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.
- Universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.
- Life-course approach: Policies, plans and services for the prevention and control of noncommunicable diseases need to take account of health and social needs at all stages of the life course, starting with maternal health, including preconception, antenatal and postnatal care and maternal nutrition, and continuing through proper infant feeding practices, including promotion of breastfeeding and health promotion for children, adolescents and youth followed by promotion of a healthy working life, healthy ageing and care for people with noncommunicable diseases in later life.
- Evidence-based strategies: Strategies for the prevention and control of noncommunicable diseases need to be based on scientific evidence and/or best practice, cost effectiveness, affordability and public health principles, taking cultural considerations into account.
- Conflict of interest: Public health policies, strategies and multisectoral action for the prevention and control of noncommunicable diseases must be protected from influence by any form of vested interest.

Goal

12. To prevent and reduce the burden of morbidity and mortality due to noncommunicable diseases.

Time frame

13. The action plan will be implemented over the period 2013–2020 and the Secretariat will support its implementation through biennial organization-wide workplans and programme budgets.

Adaptation of framework to regional and national contexts

14. The framework provided in this action plan needs to be adapted at the regional level, taking into account region-specific situations and health priorities. Actions are proposed under six interconnected and mutually reinforcing objectives: (i) international cooperation; (ii) country led response; (iii) risk factors; (iv) health systems; (v) research; and (vi) monitoring. Using the best available evidence and knowledge, the action plan proposes a menu of options for Member States for the prevention and control of noncommunicable diseases, to be adapted, and integrated into existing health and social development plans, in accordance with their national legislation, national priorities and specific national circumstances. There is no blue print action plan that fits all countries, as countries are at different points with respect to progress in the prevention and control of noncommunicable diseases. However, all countries, regardless of the socioeconomic status, can benefit from the comprehensive response to the prevention and control of noncommunicable diseases put forward in this framework. The manner in which sustainable scale-up can be undertaken at the country level depends on the level of socioeconomic development, stage of the noncommunicable disease epidemic, competing public health priorities, budgetary allocations for noncommunicable diseases, an enabling political and legal climate, and type of health system (e.g. centralized or decentralized) and national capacity. On a positive note, there are high-impact, very cost-effective interventions and policy actions across the six objectives, which, if implemented to scale, would enable even low-income countries to make significant progress in attaining the nine voluntary global targets by 2025 (see Appendix 3).

Objective 1. Raise the priority accorded to the prevention and control of noncommunicable diseases in the global, regional and national development agendas and in internationally-agreed development goals through strengthened international cooperation and advocacy

15. In the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, the Rio+20 Declaration on Sustainable Development⁸ and the first report of the UN Task Team on the post-2015 UN Development Agenda⁹ have acknowledged that addressing noncommunicable diseases is a priority for social development and investment in people. Better health outcomes from noncommunicable diseases is a precondition for, an outcome of and an indicator of all three dimensions of sustainable development: economic development, environmental sustainability, and social inclusion.

16. Advocacy and international cooperation are vital for resource mobilization, capacity strengthening and maintaining the political commitment and momentum to address the global threat posed by noncommunicable diseases. Social, economic, environmental and non-health sector factors that influence the prevention and control of noncommunicable diseases are increasingly determined at global level. The action plan provides a global platform that will enable countries, civil society and international organizations to jointly and coherently respond to the challenges of reducing the burden of noncommunicable diseases. Actions listed under this objective are aimed at creating enabling environments at the global, regional and country levels for the prevention and control of noncommunicable diseases.

17. Recognizing the multisectoral nature of addressing noncommunicable diseases, the need to involve myriad actors at the global level requires a coordinated response. The Political Declaration reaffirms the leadership and coordination role of the World Health Organization in promoting and monitoring global action against such diseases in relation to the work of other relevant United Nations system agencies, development banks and other regional and international organizations to address them in a coordinated manner. To this end, the Secretariat will establish a global coordination mechanism on noncommunicable diseases to coordinate the activities of the various stakeholders.

Policy options for Member States¹⁰

18. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States undertake the actions set out below.

a) Advocacy:

- Evidence for advocacy: Generate more evidence and disseminate information about the linkages between noncommunicable diseases and sustainable development, including other related issues such as poverty alleviation, Millennium Development Goals, sustainable cities, non-toxic environment, food security, climate change, disaster preparedness, peace and security, and gender equality based on national situations.
- Advocacy for action: Strengthen advocacy to sustain the interest of Heads of State and Government for implementation of the commitments of the Political Declaration, for instance by involving all relevant sectors, civil society and communities, as appropriate within the national context, with the full and active participation of people living with these diseases.

b) Broader health and development agenda: Integrate the prevention and control of noncommunicable diseases into national health-planning processes and broader development agenda, according to country context and priorities and mobilize the United Nations Country Teams to strengthen the links between noncommunicable diseases, universal health coverage and sustainable development integrating them into the United Nations Development Assistance Framework's design processes and implementation.

⁸ United Nations General Assembly resolution 66/288.

⁹ www.un.org/millenniumgoals/pdf/Post_2015_UNTTreport.pdf.

¹⁰ And, where applicable, regional economic integration organizations.

c) **Partnerships:**

- Forge multisectoral partnerships and strengthen coordination mechanisms to address functional gaps that constrain prevention and control noncommunicable diseases.
- Forge partnerships to promote cooperation among governmental agencies, inter-governmental organizations, civil society and the private sector, to promote the inclusion of universal health coverage as a means of addressing noncommunicable diseases as an important element in the international development agenda and in the internationally-agreed development goals.

Actions for the Secretariat

19. It is envisaged that the Secretariat will take the following actions:

- a) **Leading and convening:** Facilitate through a global coordinating mechanism, collaboration and cooperation between the main stakeholders including Member States, United Nations funds, programmes and agencies (see Appendix 4), civil society and the private sector, as appropriate, guided by the Note by the Secretary-General transmitting the report of WHO Director-General on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership¹¹ and facilitate the establishment of a United Nations Task Force on Noncommunicable Diseases for implementation of the action plan.
- b) **Technical cooperation:** Offer technical assistance to raise public awareness about the links between noncommunicable diseases and sustainable development, to integrate the prevention and control of noncommunicable diseases into national health-planning processes and development agenda, the United Nations Development Assistance Framework and poverty-alleviation strategies.
- c) **Provide policy advise and dialogue:**
- To address, in a coherent manner, the interrelationships between the prevention and control of noncommunicable diseases and initiatives on poverty alleviation and sustainable development in order to promote policy coherence.
 - To strengthen governance, including management of potential conflicts of interest in engaging the private sector in collaborative partnerships for implementation of the action plan.
 - For domestic resource mobilization and budgetary allocations to noncommunicable diseases, ideally linked to the strengthening of primary health care systems and the provision of universal health coverage, and to adopt or expand tobacco and other taxes or surcharges and to apply some or all of the revenues to health care, as appropriate within the national context.
- d) **Dissemination of best practices:** Promote and facilitate international and intercountry collaboration for exchange of best practices in the areas of health in all policies, whole-of-government and whole-of-society approaches, legislation, regulation, health system strengthening and training of health personnel, so as to learn from the experiences of Member States in meeting the challenges.

Proposed actions for international partners

20. The following actions are proposed for international partners:

- a) **International cooperation and capacity strengthening:**

¹¹ <http://www.who.int/nmh/events/2012/20121128.pdf>

- i. Encourage the mainstreaming of the prevention and control of noncommunicable diseases, in development cooperation initiatives, internationally-agreed development goals, economic development policies, sustainable development frameworks and poverty-reduction strategies.
 - ii. Support national authorities to create enabling environments for implementing evidence-based multisectoral action (see Appendix 5) (i.e. to reduce modifiable risk factors of noncommunicable diseases through health-promoting policies in agriculture, education, labour, sports, food, trade, transport and urban planning, to implement existing international conventions in the areas of environment and labour, to strengthen health financing for universal health coverage).
 - iii. Strengthen international cooperation within the framework of North–South, South-South and triangular cooperation, in support of national, regional and global plans for the prevention and control of noncommunicable diseases, inter alia, through the exchange of best practices and research findings in the areas of health promotion, legislation, regulation, monitoring and evaluation and health systems strengthening, strengthening of institutional capacity, training of health personnel, development of appropriate health-care infrastructure and diagnostics, and by promoting the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms and the production of affordable, safe, effective and quality medicines and vaccines, medical technologies and information and electronic communication technologies (eHealth) and the use of mobile and wireless devices (mHealth).
 - iv. Facilitate and support research, development and innovation, institutional capacity and training of researchers to strengthen national research capacity including through creation of research fellowships and scholarships for international study in disciplines and interdisciplinary fields pertinent to the prevention and control of noncommunicable diseases.
 - v. Support WHO in establishing the global coordination mechanism where stakeholders – including nongovernmental organizations, professional associations, academia, research institutions and the private sector – can contribute and take concerted action against noncommunicable diseases.
 - vi. Support the United Nations programmes, funds and agencies to collaborate through an agreed division of labour.
 - vii. United Nations funds, agencies and programmes will provide additional support to Member States through the recently established informal collaborative arrangement among UN agencies, convened by WHO. The objective of the existing collaborative arrangement is to mobilize the UN System to work as one through an agreed division of labour (Appendix 4).
- b) Resource mobilization for the prevention and control of noncommunicable diseases :**
- i. Facilitate the mobilization of adequate, predictable and sustained financial resources and the necessary human and technical resources.
 - ii. Fulfill official development assistance commitments, including the commitments by many developed countries to reach the target of providing 0.7% of gross national product for official development assistance to developing countries by 2015.
 - iii. Support and be part of the social movement to support collaborative to support the implementation of the action plan and to promote health and equity in relation to the prevention and control of noncommunicable diseases.

Objective 2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of noncommunicable diseases

21. As the ultimate guardians of a population's health, governments have the lead responsibility to ensure that appropriate institutional, legal, financial and service arrangements are provided for the prevention and control of noncommunicable diseases.

22. Noncommunicable diseases undermine the achievement of the Millennium Development Goals and are contributory to poverty and hunger. Strategies to address noncommunicable diseases need to deal with health inequities which arise from the societal conditions in which people are born, grow, live and work and mitigate barriers to childhood development, education, economic status, employment, housing and environment.

23. The vicious link between noncommunicable diseases and impoverishment cannot be severed in the absence of universal health coverage, people-centered primary health-care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population.

24. The active participation of civil society in efforts to address noncommunicable diseases, particularly grass-roots' organizations representing people living with noncommunicable diseases and carers, can empower society and improve accountability of public health policies, legislation and services making them acceptable, responsive to needs and respect health as a human right.

25. Effective prevention of noncommunicable diseases requires a whole-of-government, whole-of-society and health-in-all policies approach and multisectoral action facilitated by partnerships¹².

26. The desired outcomes of this objective are strengthened stewardship and leadership, enhanced resources, improved capacity and creation of enabling environments for forging a collaborative multisectoral response at the country level, to attain the 9 voluntary global targets (see Appendix 2).

Policy options for Member States¹³

27. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States undertake the actions set out below.

- a) **Governance:** Integrate the prevention and control of noncommunicable diseases into health-planning processes and development plans, with special attention to social determinants of health and the health needs of vulnerable and marginalized populations, including indigenous peoples and people with mental and psychosocial disabilities.
- b) **Sustained resources:** As appropriate to national context, strengthen the provision of adequate, predictable and sustained resources for action against noncommunicable diseases and for universal health coverage through an increase in domestic budgetary allocations, voluntary innovative financing mechanisms and other means, including multilateral financing, bilateral sources and private sector and/or nongovernmental sources.
- c) **Strengthen the national noncommunicable diseases program:** Strengthen programmes for the prevention and control of noncommunicable diseases with suitable expertise, resources and responsibility for needs assessment, strategic planning, policy development, multisectoral coordination, implementation and evaluation.
- d) **Conduct needs assessment:** Conduct periodic needs assessments of epidemiological and resource needs, including workforce, institutional and research capacity, the health impact of policies in sectors beyond health

¹² Document A/67/373 available at <http://www.who.int/nmh/events/2012/20121128.pdf>

¹³ And, where applicable, regional economic integration organizations.

(e.g. agriculture, communication, education, employment, energy, environment, finance, industry and trade, justice, labour, sports, transport, and urban planning) and financial, social and economic policies on noncommunicable diseases, in order to inform country action, including the required budget.

- e) **Develop a national plan and allocate budget:** As appropriate to national context, develop and implement a national multisectoral noncommunicable disease policy and plan and according to national priorities, and taking into account domestic circumstances, increase and prioritize budgetary allocations for addressing surveillance, prevention, early detection and treatment of non-communicable diseases and the related care and support, including palliative care.
- f) **Strengthen multisectoral action:** As appropriate for national context, set up a national multisectoral mechanism — high-level commission, agency or task force —for shared leadership, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on noncommunicable diseases, for the implementation of health-in-all-policies and whole-of-government and whole-of-society approaches, to convene multisectoral and multi-stakeholder working groups, to secure budgetary allocations to implement and evaluate multisectoral action and to monitor and act on the social and environmental determinants of noncommunicable diseases (see Appendix 5), as well to reverse, stop and decrease the rising trends of obesity in child, youth and adult populations, respectively.
- g) **Improve accountability:** By setting up a monitoring framework with national targets and indicators consistent with the global monitoring framework and using options for applying it at the country level.
- h) **Strengthen institutional capacity and the workforce:** Provide training and appropriately deploy health workforce, and strengthen institutional capacity for implementing the national action plan, through for instance reorientation of teaching curricula for medical, nursing and allied health personnel and establishment of public health institutions to deal with the complexity of issues relating to noncommunicable diseases (e.g. multisectoral action, advertising, human behaviour, health economics, food and agricultural systems, law, business management, psychology, trade, commercial influence and urban planning).
- i) **Forge partnerships:** Lead collaborative partnerships to address implementation gaps (e.g. in the areas of training of health personnel, development of appropriate health-care infrastructure, sustainable transfer of technology for the production of affordable, safe and quality diagnostics, essential medicines and vaccines and product access), as appropriate for national contexts.
- j) **Empower communities and people:** Facilitate social mobilization, engaging and empowering a broad range of actors to facilitate dialogue, to catalyze societal change and to shape a systematic society-wide national response to address noncommunicable diseases, their social environmental and economic determinants and health equity (e.g. engaging human rights organizations, faith-based organizations, labour organizations, organizations focused on children, adolescents, youth, elderly, women, patients and people with disabilities, indigenous peoples, intergovernmental and nongovernmental organizations, civil society, academia, media and the private sector).

Actions for the Secretariat

28. It is envisaged that the Secretariat will take the following actions:

- a) **Leading and convening:** Establish in consultation with Member States, a global coordination mechanism for the prevention and control of noncommunicable diseases. The mechanism will include Member States, United Nations funds, programmes and agencies, intergovernmental organizations, relevant nongovernmental organizations, and selected private sector entities¹⁴. The global coordination mechanism will be guided by the following principles:

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- The primary role and responsibility of preventing and controlling noncommunicable diseases lies with governments.
- The international community and international cooperation play an important role in supporting Member States in the prevention and control of noncommunicable diseases.
- The mechanism will promote the implementation of the recommended actions for international partners included in the action plan.
- The mechanism will engage with Member States, United Nations funds, programmes and agencies, academia, relevant nongovernmental organizations, selected private sector entities, and other relevant partners that are committed to implementing the action plan, while safeguarding WHO from any potential conflict of interest
- The mechanism will be based on WHO's norms, values, treaties, strategies, instruments and commitments
- The mechanism will report through existing WHO channels to the World Health Assembly
- The mechanism will recognize the leading role of WHO as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate.

Key functions of the global coordination mechanism will address functional gaps that are barriers to the prevention and control of noncommunicable diseases, as outlined in the report of the Secretariat on options and a timeline (document A65/7) and the Note of the Secretary-General transmitting the report of the Director-General of the World Health Organization on options for facilitating and strengthening multisectoral action for the prevention and control of noncommunicable diseases through effective partnership (A/67/373).

- b) **Technical cooperation:** Provide support to countries in evaluating and implementing evidence-based options that suit their needs and capacities, health impact assessment of public policies, including trade, management of conflicts of interest and for maximizing intersectoral synergies for the prevention and control of noncommunicable diseases (i.e. for instance, across programmes for environmental health, occupational health, and for addressing noncommunicable diseases during disasters and emergencies), by establishing/strengthening national reference centres, WHO collaborating centres and knowledge-sharing networks.
- c) **Policy guidance and dialogue:** Provide guidance for countries in developing partnerships for multisectoral action to address functional gaps in the response to the prevention and control of noncommunicable diseases guided by the Report of the Secretary-General, in particular to address the gaps identified in the report, including advocacy, awareness-raising and accountability, financing and resource mobilization, capacity strengthening and technical support, product access and market shaping and product development/innovation.
- d) **Knowledge generation:** Develop, where appropriate, technical tools, decision support tools and information products for advocacy, communication, health impact and health equity impact assessment of public policies, engaging the social media, implementation of cost-effective interventions, protecting public health from issues of conflict of interest and monitoring of multisectoral action for the prevention and control of noncommunicable diseases, tailored to the capacity and resource availability of countries.
- e) **Capacity strengthening:**
 - Strengthen the capacity of the Secretariat at all levels, for supporting Member States to implement the action plan, recognizing the key role played by WHO Country Offices working directly with relevant Ministries, different agencies and nongovernmental organizations at the country level.

- Examine the capacity of Member States through capacity assessment surveys to identify needs, and tailor the provision of support from the Secretariat and other agencies.
- Develop a “One-WHO workplan for the prevention and control of noncommunicable diseases” to ensure synergy and alignment of activities across the three levels of WHO based on country needs.

Actions for International partners: see paragraph 22. [Note added on 21 March 2013: As per Corrigendum dated 21 March 2013, this should read “see paragraph 20”]

Objective 3. To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments

29. The Political Declaration recognizes the vital importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for noncommunicable diseases, while strengthening the capacity of individuals and populations to make healthier choices and adopt behaviours that foster good health. Governments should be the key stakeholders in the development of a national policy framework for reducing risk factors through multisectoral action and may choose to allocate defined roles to other stakeholders, while protecting the public interest and avoiding conflicts of interest. Further supportive environments that protect physical and mental health and promote healthy behaviour need to be created using incentives and disincentives, regulatory and fiscal measures, laws and other policy options, and health education, as appropriate within the national context, with a special focus on maternal health (including preconception, antenatal and postnatal care, and maternal nutrition), oral health, children, adolescents and youth including prevention of childhood obesity.

30. Effective implementation of the actions outlined under this objective will enable countries to contribute directly to six voluntary global targets related to risk factors, as well as to the premature mortality target. It is proposed that, in accordance with their legislation, and, as appropriate in view of their specific circumstances, Member States undertake the actions set out below.

Policy options for Member States¹⁵: tobacco control

31. The proposed actions aim to achieve the voluntary global target of a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years.

The proposed actions are as follows:

- a) Accelerate full implementation of the WHO Framework Convention on Tobacco Control (FCTC), the first international treaty negotiated under the auspices of WHO. All Member States that have not yet become a Party to the WHO FCTC should consider action to ratify, accept, approve, formally confirm or accede to it at the earliest opportunity, in accordance with resolution WHA56.1 and the Political Declaration of the High-level meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases.
- b) In order to reduce tobacco use and exposure to tobacco smoke, utilize the guidelines adopted by the Conference of the Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC) for implementation of the following measures as part of a comprehensive multisectoral package, in line with the WHO FCTC :
 - Protect tobacco control policies from commercial and other vested interests of the tobacco industry in accordance with national law, consistent with Article 5.3 of the WHO FCTC.
 - Legislate for 100% tobacco smoke-free environments in all indoor workplaces, public transport, indoor public places and, as appropriate, other public places, consistent with Article 8 (Protection from exposure to tobacco smoke) of the WHO FCTC.

¹⁵ And, where applicable, regional economic integration organizations.

- Warn people about the dangers of tobacco use, including through hard-hitting mass-media campaigns and large, clear, visible and legible health warnings, consistent with Articles 11 (Packaging and labelling of tobacco products) and 12 (Education, communication, training and public awareness) of the WHO FCTC .
- Implement comprehensive bans on tobacco advertising, promotion and sponsorship, consistent with Article 13 (Tobacco advertising, promotion and sponsorship) of the WHO FCTC.
- Offer help to people who want to stop using tobacco, consistent with Article 14 (Demand reduction measures concerning tobacco dependence and cessation) of the WHO FCTC.
- Regulate the contents and emissions of tobacco products and require manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products, consistent with Articles 9 (Regulation of the contents of tobacco products) and 10 (Regulation of tobacco product disclosures) of the WHO FCTC.

In accordance with the Political Declaration and the guidance provided by the Conference of the Parties to the WHO FCTC, raise taxes on all tobacco products, to reduce tobacco consumption, without prejudice to the sovereign right of Member States to determine and establish their taxation policies, consistent with Article 6 (Price and tax measures to reduce demand for tobacco) of the WHO FCTC.

- c) In order to facilitate the implementation of comprehensive multisectoral measures in line with the WHO FCTC, take the following action:
- monitor tobacco use and the implementation of tobacco control policies, consistent with Articles 20 (Research, surveillance and exchange of information) and 21 (Reporting and exchange of information) of the WHO FCTC.
 - establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control, consistent with Article 5 (General obligations) of the WHO FCTC.
 - establish or reinforce and finance mechanisms to enforce adopted tobacco control policies, consistent with Article 26 (Financial resources) of the WHO FCTC.

Policy options for Member States¹⁶: promoting a healthy diet

32. The proposed action is to advance the implementation of global strategies and recommendations to achieve the voluntary global targets set out below:

- A 30% relative reduction in mean population intake of salt/sodium intake
- Halt the rise in diabetes and obesity
- A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances.

Member States should consider developing or strengthening national nutrition policies and action plans and implementation of related global strategies including the global strategy on diet, physical activity and health, the global strategy for infant and young child feeding, the comprehensive implementation plan on maternal, infant and young child nutrition and WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children. Member States consider to implement other relevant strategies to promote healthy diets in the entire population, while protecting dietary guidance and food policy from undue influence of commercial and other vested interests.

Such policies and programme would aim to:

- a) Promote and support exclusive breastfeeding for the first six months of life, continued breastfeeding until two years old and beyond and adequate and timely complementary feeding.

¹⁶ And, where applicable, regional economic integration organizations.

- b) Develop guidelines, recommendations or policy measures that engage different relevant sectors, such as food producers and processors and other relevant commercial operators to:
 - reduce the level of salt/sodium in food¹⁷
 - virtually eliminate trans-fatty acids in the food supply and to replace them with unsaturated fatty acids¹⁸
 - reduce saturated fatty acids in food and to replace them with unsaturated fatty acids¹⁹
 - reduce the content of free sugars in food and non-alcoholic beverages
 - reduce portion size and energy density of foods in order to limit excess calorie intake.
- c) Develop policy measures directed at food retailers and caterers to improve the availability, affordability and acceptability of healthier food products (plant foods, including fruit and vegetables, products with reduced content of salt/sodium, saturated fatty acids, trans-fatty acids, free sugars)²⁰.
- d) Promote the provision and availability of healthy food in all public institutions including schools, other education institutions as well as in workplaces²¹.
- e) As appropriate to national context, consider economic tools, including taxes and subsidies, to improve the affordability and encourage consumption of healthier food products and discourage the consumption of less healthy options²².
- f) Develop policy measures directed at the agricultural sector to reinforce the measures directed at food processors, retailers, caterers & public institutions, and provide greater opportunities for utilization of healthy local agricultural products and foods.
- g) Conduct public campaigns and social marketing initiatives to inform and encourage consumers about healthy dietary practices.
- h) Create health and nutrition promoting environment in schools and other education institutions, work sites, clinics and hospitals, and other public and private institutions including nutrition education.
- i) Provide nutrition labelling for all pre-packaged foods for which nutrition or health claims are made.
- j) Implement WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children, including mechanisms for monitoring.

Policy options for Member States²³: promoting physical activity

33. The proposed actions are to advance the implementation of the Global Strategy on Diet, Physical Activity and Health and other relevant strategies with a focus on policies and actions across multiple settings and emphasis on a life course approach. In addition interventions to increase participation in physical activity in the entire

¹⁷ For example, by negotiating benchmarks for salt content by food category

¹⁸ For example, through regulatory approaches restricting the use of fat, oil, shortening or other ingredients used in food preparation containing industrially produced trans-fatty acids (or partially hydrogenated vegetable oils); regulations limiting the sales of food products containing trans-fatty acids in restaurants and food-vending establishments; and voluntary approaches, based on negotiations with food manufacturers

¹⁹ For example, by providing incentives to manufacturers to use healthier vegetable oils or investing in oil crops with healthier fat profiles

²⁰ For example, by providing incentives to the food distribution system and negotiating with caterers to offer food products with healthier fat profiles

²¹ For example, e.g. through nutrition standards for public sector catering establishments and use of government contracts for food purchasing

²² For example, taxation of categories of products to disincentivate consumption; taxation based on nutrient content; tax incentives to manufacturers engaged in product reformulation; price subsidies for healthier food products

²³ And, where applicable, regional economic integration organizations.

population for which favorable cost effectiveness data are emerging should be promoted. The aim is to make progress in achieving the voluntary global targets listed below:

- A 10% relative reduction in prevalence of insufficient physical activity
 - Halt the rise in diabetes and obesity
 - A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances.
- a. Adopt and implement national guidelines on physical activity for health.
 - b. Promote physical activity through activities of daily living, including through “active transport” as well as through recreation, leisure and sport.
 - c. Develop partnerships with agencies outside the health sector, consider establishing a multisectoral committee or coalitions to provide strategic leadership and coordination and identify and promote the additional benefits of increasing population levels of physical activity, such as improved educational achievement, cleaner air, reduced traffic less congestion, as well as other social and mental health benefits, and the links to healthy growth and child development.
 - d. Create and preserve built and natural environments which support physical activity in schools, work sites, clinics and hospitals, and in the wider community with a particular focus on providing infrastructure to support active transport (i.e. walking and cycling), active recreation and play, and sports participation.
 - e. Develop policy measures directed at
 - national and sub national urban planning and transport policies to improve the accessibility and acceptability of walking and cycling; reflecting the evidence base on the relationship between accessibility, safety, and availability of supportive infrastructure for walking and cycling which can influence travel mode choice
 - educational settings (from infant years to tertiary level) to improve provision of quality physical education, and opportunities for physical activity before, during and after the formal school day.
 - initiatives to support and encourage “sports for all” initiatives for all ages
 - f. Develop strategies to foster community involvement in developing and implementing local solutions and actions aimed at increasing physical activity and for young people and in all age groups.
 - g. Conduct public campaigns through mass media, social media and at the community level, and social marketing initiatives to inform and motivate adults and young people about the benefits of physical activity and to facilitate healthy behaviours. Campaigns should be linked to supporting actions across the community and within specific settings for maximum benefit and impact.
 - h. Develop initiatives to engage all stakeholders, including NGO and civil society, economic operators, in actively and appropriately implementing actions aimed at increasing physical activity across all ages.
 - i. Encourage the evaluation of actions aimed at increasing physical activity to contribute to the development of an evidence base of effective and cost effective actions.

Policy options for Member States²⁴: reducing the harmful use of alcohol

²⁴ And, where applicable, regional economic integration organizations.

34. Proposed action is to advance the adoption and implementation of the global strategy to reduce the harmful use of alcohol and to mobilize political will and financial resources for that purpose in order to achieve the voluntary global target namely:

- At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context

Proposed action for Member States are set out below:

- a) **Multisectoral national policies:** Developing, adopting and implementing, as appropriate, comprehensive and multisectoral national policies and programmes to reduce the harmful use of alcohol as outlined in the global strategy to reduce the harmful use of alcohol, addressing the general levels, patterns and contexts of alcohol consumption and the wider social determinants of health in a population. The global strategy to reduce the harmful use of alcohol recommends the following 10 target areas for national policies and programmes:
- leadership, awareness and commitment
 - health services’ response
 - community action
 - drink-driving policies and countermeasures
 - availability of alcohol
 - marketing of alcoholic beverages
 - pricing policies
 - reducing the negative consequences of drinking and alcohol intoxication
 - reducing the public health impact of illicit alcohol and informally produced alcohol
 - monitoring and surveillance.

The measures should be implemented at the discretion of each Member State depending on national, religious and cultural contexts, national public health priorities and available resources, and in accordance with constitutional principles and international legal obligations.

- b) **Public health policies:** Formulate public health policies and interventions to reduce the harmful use of alcohol based on clear public health goals, existing best practices, best-available knowledge and evidence of effectiveness and cost-effectiveness generated in different contexts.
- c) **Leadership:** Strengthen capacity of health ministries to assume a crucial role in bringing together other ministries and stakeholders as appropriate for effective public policy development and implementation to prevent and reduce the harmful use of alcohol while protecting these policies from undue influence of commercial and other vested interests.
- d) **Capacity:** Increasing capacity of health-care services to deliver prevention and treatment interventions for hazardous drinking and alcohol use disorders, including screening and brief interventions in all settings providing treatment and care for noncommunicable diseases.
- e) **Monitoring:** Developing effective frameworks for monitoring the harmful use of alcohol, as appropriate to national context, based on a set of indicators included in the comprehensive global monitoring framework for noncommunicable diseases and in line with the global strategy to reduce the harmful use of alcohol and its monitoring and reporting mechanisms.

Actions for the Secretariat: tobacco control, promoting healthy diet, physical activity and reducing the harmful use of alcohol

35. It is envisaged that the Secretariat will take the following actions:

- a) **Leading and convening:** Work with the Secretariat of the WHO FCTC and United Nations funds, programmes and agencies (see Appendix 4) to reduce modifiable risk factors at the country level, including as part of

integrating prevention of noncommunicable diseases into the United Nations Development Assistance Framework's design processes and implementation at the country level.

- b. **Technical cooperation:** Provide technical assistance to reduce modifiable risk factors through implementing the WHO FCTC and its guidelines, and other health-promoting policy options including healthy workplace initiatives, health-promoting schools and other education institutions, healthy-cities initiatives, health-sensitive urban development and social and environment protection initiatives, for instance through engagement of local/municipal councils.
- c. **Policy advise and dialogue:** Publish and disseminate guidance ("toolkits") on how to operationalize the implementation and evaluation of interventions at the country level for reducing the prevalence of tobacco use, promoting a healthy diet and physical activity, and reducing harmful use of alcohol.
- d. **Norms and standards:** Support the Conference of the Parties to the WHO FCTC, through the Convention Secretariat in promoting effective implementation of the Convention, including through development of guidelines and protocols where appropriate; develop normative guidance and technical tools to support the implementation of WHO's global strategies for addressing modifiable risk factors; further develop a common set of indicators and data collection tools for tracking modifiable risk factors in populations, including the work on the feasibility of composite indicators for monitoring the harmful use of alcohol at different levels.

Actions for International partners: see paragraph 22 [Note added on 21 March 2013: As per Corrigendum dated 21 March 2013, this should read "see paragraph 20"]

Objective 4. To strengthen and reorient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage

36. The Political Declaration recognizes the importance of universal health coverage, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular, to the poorest segments of the population (paragraph 45(n)).

37. Comprehensive care of noncommunicable diseases encompasses primary prevention, early detection/screening, treatment, secondary prevention, rehabilitation, palliative care and attention to improving mental health as a priority for social development and investment in people. The aim is to ensure that all people have access, without discrimination to a nationally determined set of the needed promotive, preventive, curative, rehabilitative and palliative, basic health services for the prevention and control of noncommunicable diseases while making sure that the use of these services does not expose the users to financial hardship including ensuring the continuity of care in the aftermath of emergencies and disasters.

38. A reoriented and strengthened health system should aim to improve early detection of people with cardiovascular disease, cancer, chronic respiratory disease, diabetes and other noncommunicable diseases and those at high risk, prevent complications, reduce the need for hospitalization and costly high technology interventions and prevent premature death, as well health systems should establish and partnerships with other sectors to ensure social determinants are considered in service planning and provision within communities.

39. The actions outlined under this objective aim to strengthen the health system, set policy directions for moving towards universal health coverage and make progress in achieving two voluntary global targets listed below as well as the premature mortality target.

- At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes

- An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.

Policy options for Member States²⁵

40. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States undertake the actions set out below.

a) **Leadership:** Actions to strengthen effective governance and accountability include:

- Exercise responsibility and accountability for ensuring the availability of noncommunicable disease services within the context of overall health-system strengthening.
- Use participatory community-based approaches in designing, implementing, monitoring and evaluating noncommunicable disease programmes across the life course and continuum of care to enhance and promote effectiveness of an equity-based response.
- Integrate noncommunicable disease services into health-sector reforms and/or plans for improving health systems' performance and orient health systems towards addressing social determinants of health and universal health coverage.

b) **Financing:** Actions to establish sustainable and equitable health financing include:

- Shift from reliance on user fees levied on ill people to the solidarity and protection provided by pooling and prepayment, with inclusion of noncommunicable disease services.
- Make progress towards universal health coverage through a combination of domestic revenues, innovative financing and external financial assistance, giving priority to financing a combination of cost effective preventive, curative and palliative care interventions at different levels of care covering heart attacks, strokes, hypertension, cancer, diabetes, asthma and chronic respiratory disease and comorbidities (see Appendix 3).
- Develop local and national initiatives for financial risk protection and other forms of social protection (for example, through health insurance, tax funding and cash transfers), covering prevention, treatment, rehabilitation and palliative care for all conditions including noncommunicable diseases and for all people, including for those who are not employed in the formal sector.

c) **Expanded coverage:** Actions to improve efficiency, equity, coverage and quality of noncommunicable disease services with a special focus on cardiovascular disease, cancer, chronic respiratory disease and diabetes and their risk factors and other noncommunicable diseases which may be domestic priorities, include:

- Strengthen and organize services and referral systems around close-to-client and people-centered networks of primary health care that are fully integrated with the rest of the health-care delivery system, including rehabilitation and specialized ambulatory and inpatient care facilities.
- Enable all providers (e.g. nongovernmental organizations, for-profit and not-for-profit providers, and involving a range of services) to address noncommunicable diseases equitably while safeguarding consumer protection and also harnessing the potential of a range of other services to deal with noncommunicable diseases (e.g. traditional medicine, prevention, rehabilitation, palliative care and social services).
- Determine standards for organization of service delivery and set national targets consistent with voluntary global targets for increasing the coverage of cost-effective, high-impact interventions to address cardiovascular disease, diabetes, cancer, and chronic respiratory disease in a phased manner (see Appendix 3), linking noncommunicable disease services with other disease-specific programmes, including mental health.
- Meet the needs for long-term care of people with noncommunicable diseases, related disabilities and comorbidities through innovative and effective models of care, connecting occupational health services and community health resources with primary health care and the rest of the health-care delivery system.

²⁵ And, where applicable, regional economic integration organizations.

- Establish quality-assurance and continuous quality-improvement systems for management of noncommunicable diseases with emphasis on primary health care, including the use of evidence based guidelines and tools for the management of major noncommunicable diseases and comorbidities adapted to national contexts.
- Take action to empower people with noncommunicable diseases to manage their own condition better and provide education, incentives and tools for self-care and self-management, based on evidence-based guidelines including through information and communication technologies.
- Review existing programmes, such as the nutrition, HIV, tuberculosis, reproductive health, maternal and child health and mental health including dementia for opportunities to integrate service delivery for the prevention and control of noncommunicable diseases.

d) **Human resource development:** Actions to strengthen human resources for the prevention and control of noncommunicable diseases include:

- Identify competencies required and invest in improving the knowledge, skills and motivation of the current health workforce to address noncommunicable diseases, including common co-morbid conditions (e.g. mental disorders) and plan to address projected health workforce needs for the future, also in light of population ageing.
- Incorporate the prevention and control of noncommunicable diseases in the training of all health workers, social workers, professional and non-professional (technical, vocational), with an emphasis on primary health care.
- Provide adequate compensation and incentives for health workers to serve underserved areas including, location, infrastructure, training and development and social support and paying due attention to the Global Code of Practice in recruiting and retaining them²⁶.
- Develop career tracks for health workers through strengthening postgraduate training, with a special focus on noncommunicable diseases, in various professional disciplines (for example, medicine, allied health professionals, nursing, pharmacy, public health administration, nutrition, health economics, social work and medical education) and career advancement for non-professional staff.
- Strengthen capacities for planning, implementing, monitoring and evaluating service delivery for noncommunicable diseases through government, public and private academic institutions, professional associations, patients' organizations and self-care platforms.

e) **Access:** Actions to improve equitable access to prevention programmes (e.g. health information), essential medicines and technologies, with emphasis on medicines and technologies required for delivery of essential interventions for cardiovascular disease, cancer, chronic respiratory disease and diabetes through a primary health care approach:

- Promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of non-communicable diseases, including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including, where appropriate, through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities.
- Adopt country-based strategies to improve affordability of medicines (for example, include essential medicines in national essential medicines lists, separate prescribing and dispensing, control the wholesale and retail mark-ups through regressive mark-up schemes, and exempt medicines required for essential noncommunicable disease interventions from import and other forms of tax, where appropriate, within the national context).
- Promote procurement and use of generic medicines for the prevention and control of noncommunicable diseases by quality assurance of generic products, preferential registration procedures, generic substitution, financial incentives and education of prescribers and consumers.
- Improve the availability of life-saving technologies and essential medicines for managing noncommunicable diseases in the initial phase of emergency response.

²⁶ WHO global code of practice on the international recruitment of health personnel (WHA 63.16)

- Facilitate access to preventive measures, treatment and vocational rehabilitation, as well as financial compensation of occupational noncommunicable diseases, such as cancer and chronic respiratory disease, consistent with international and national laws and regulations on occupational diseases e.g. asbestosis, silicosis.

Actions for the Secretariat

41. It is envisaged that the Secretariat will take the following actions:

- a) **Leading and convening:** Position the response to noncommunicable diseases at the forefront of efforts to strengthen health systems.
- b) **Technical cooperation:**
 - Provide support to countries in integrating cost-effective interventions for noncommunicable diseases and their risk factors into health systems, including essential primary health care packages, and improve access to prevention programmes, essential medicines and affordable medical technology.
 - Deploy an inter-agency emergency health kit for treatment of noncommunicable diseases in humanitarian disasters and emergencies.
 - Encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and is consistent with the provisions in the TRIPS agreement and other World Trade Organization instruments related to that agreement and meets the specific research and development needs of developing countries.
- c) **Policy advise and dialogue:** Provide policy guidance using existing strategies that have been the subject of resolutions adopted by the World Health Assembly to advance the agenda for people-centered primary healthcare and universal health coverage.
- d) **Norms and standards:** Develop guidelines, tools and training material (i) to strengthen the implementation of cost-effective noncommunicable diseases interventions for early detection, treatment, rehabilitation and palliative care; (ii) to facilitate affordable and evidence-based self-care with a special focus on populations with low health awareness and/or literacy; (iii) to establish diagnostic and exposure criteria for early detection, prevention and control of occupational noncommunicable diseases,(iv) to support patient/family centered self-management of noncommunicable diseases, including mobile phone based tools, and (v) on the use of the Internet for the prevention and control of noncommunicable diseases, including health education, health promotion and communication among support groups.
- e) **Dissemination of best practices:** Facilitate exchange of lessons, experiences and best practices, adding to the global body of evidence to enhance the capacity of countries to sustain achievements and face challenges, as well as to develop new solutions to address noncommunicable diseases and to progressively realize universal health coverage.

Actions for International partners: see paragraph 22 [Note added on 21 March 2013: As per Corrigendum dated 21 March 2013, this should read “see paragraph 20”]

Objective 5. To promote and support national capacity for high quality research and development for the prevention and control of noncommunicable diseases

42. Although effective interventions exist for the prevention and control of noncommunicable diseases, their implementation is inadequate worldwide. Comparative, applied and operational research, integrating both social and biomedical sciences, is required to scale-up and maximize the impact of existing interventions in order to meet the 9 voluntary global targets (see Appendix 2).

43. The Political Declaration calls upon all stakeholders to support and facilitate research related to the prevention and control of noncommunicable diseases and its translation into practice so as to enhance the knowledge base for national, regional and global action. The global strategy and plan of action on public health, innovation and intellectual property (WHA61.21), encourages needs-driven research to target diseases that disproportionately affect people in low- and middle-income countries, including noncommunicable diseases. WHO's prioritized research agenda for the prevention and control of noncommunicable diseases elaborated through a participatory and consultative process provides guidance on future investment in noncommunicable disease research²⁷. The agenda prioritizes (i) research for placing noncommunicable diseases in the global development agenda and for monitoring; (ii) research to understand and influence the multisectoral, macroeconomic and social determinants of noncommunicable diseases and risk factors; (iii) translation and health systems research for global application of proven cost effective strategies; and (iv) research to enable expensive but effective interventions to become accessible and used appropriately in resource constrained settings.

Policy options for Member States²⁸

44. It is proposed that, in accordance with their legislation and as appropriate in view of their specific circumstances Member States undertake the action set out below:

- a) **Investment:** Increase investment in research, innovation and development and its governance as an integral part of the national response to noncommunicable diseases.
- b) **National research policy and plans:** Develop, implement and monitor – jointly with academic and research institutions – a prioritized national policy and plan on noncommunicable disease-related research.
- c) **Capacity strengthening:** Strengthen national institutional capacity for research and development, including research infrastructure, equipment and supplies in research institutions, and the competence of researchers to conduct quality research.
- d) **Innovation:** Make more effective use of academic institutions and multidisciplinary agencies to promote research, retain research workforce, incentivize innovation and encourage the establishment of national reference centres and networks to conduct policy relevant research.
- e) **Evidence to inform policy:** Strengthen the scientific basis for decision-making through noncommunicable disease-related research and its translation to enhance the knowledge base for ongoing national action.
- f) **Accountability for progress:** Track the domestic and international resource flows for noncommunicable disease-related research at a national level and national research output and impact related to the prevention and control of noncommunicable diseases.

Actions for the Secretariat

45. It is envisaged that the Secretariat will take the following actions:

- a) **Leading and convening :** Engage WHO collaborating centres, academic institutions, research organizations and alliances to strengthen capacity for research on noncommunicable diseases at the country level based on key areas identified in WHO's prioritized research agenda.
- b) **Technical cooperation:** Provide technical assistance upon request to strengthen national and regional capacity: (i) to incorporate research, development and innovation in national and regional policies and plans

²⁷ A prioritized research agenda for the prevention and control of noncommunicable diseases. Geneva, World Health Organization, 2011

²⁸ And, where applicable, regional economic integration organizations.

on noncommunicable diseases; (ii) to adopt and advance WHO's prioritized research agenda on the prevention and control of noncommunicable diseases, taking into consideration national needs and contexts; and (iii) to formulate research and development plans, enhance innovation capacities and better use all the flexibilities that international legislation on intellectual property offers, to support the prevention and control of noncommunicable diseases, including, where appropriate, through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities.

- c) **Policy advise and dialogue:** Promote sharing of inter-country research expertise and experience and publish/disseminate guidance ("toolkits") on how to strengthen links between policy, practice and products of research on prevention and control noncommunicable diseases.

Actions for International partners: see paragraph 22 [Note added on 21 March 2013: As per Corrigendum dated 21 March 2013, this should read "see paragraph 20"]

Objective 6. To monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control

46. The actions listed under this objective will assist in monitoring the global and national progress in the prevention and control of noncommunicable diseases, using the global monitoring framework consisting of 25 indicators and 9 voluntary global targets (see Appendix 2). Monitoring will provide internationally comparable assessments of the trends in noncommunicable diseases over time, help to benchmark the situation in individual countries against others in the same region or development category, provide the foundation for advocacy, policy development and coordinated global action and help to reinforce political commitment.

47. In addition to the indicators outlined in the framework, countries and regions may include other indicators to monitor progress of national and regional strategies for the prevention and control of noncommunicable diseases, taking into account country- and region-specific situations.

48. Financial and technical support will need to increase significantly for institutional strengthening and modernization of information technology systems, in order to strengthen capacity of countries to collect, analyse and communicate data for surveillance and global and national monitoring.

Policy options for Member States²⁹

49. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States undertake the actions set out below.

- a) **Monitoring:** Update legislation pertaining to collection of health statistics, including vital registration, strengthen vital registration systems and cause of death registration, define and adopt a set of national targets and indicators, based on the global monitoring framework and integrate monitoring systems for the prevention and control of noncommunicable diseases into national health information systems.
- b) **Disease registries:** Develop, maintain and strengthen disease registries, including for cancer, if feasible and sustainable, with appropriate indicators to better understand regional and national needs .
- c) **Surveillance:** Integrate surveillance into national health information systems and undertake periodic data collection on the behavioural and metabolic risk factors (harmful use of alcohol, physical inactivity, tobacco use, unhealthy diet, overweight and obesity, raised blood pressure, raised blood glucose, and hyperlipidemia), disaggregated, to monitor trends and to measure progress on addressing inequalities.

²⁹ And, where applicable, regional economic integration organizations.

- d) **Capacity strengthening:** Strengthen technical capacity to manage and implement surveillance and monitoring systems that are integrated into existing health information systems' capacity, with a focus on capacity for data management, analysis and reporting in order to improve availability of high-quality data on noncommunicable diseases and risk factors.
- e) **Dissemination and use of results:** Contribute, on a routine basis, information on trends in noncommunicable diseases with respect to morbidity, mortality by cause, risk factors and other determinants, disaggregated by age, gender, disability and socioeconomic groups, and provide information on progress made in the implementation of national action plans, and effectiveness of national policies and strategies, coordinating country reporting with global analyses.
- f) **Budgetary allocation:** Increase and prioritize budgetary allocations for surveillance and monitoring systems for the prevention and control of noncommunicable diseases.

Actions for the Secretariat

50. It is envisaged that the Secretariat will take the following actions:

- a) Technical cooperation: Provide support to Member States to:
 - Establish or strengthen national surveillance and monitoring systems, including improving collection of data on risk factors and other determinants, morbidity and mortality, and national responses for the prevention and control of noncommunicable diseases.
 - Develop national targets and indicators based on national situations, taking into account the global monitoring framework, including indicators, and a set of voluntary global targets.
- b) Monitor global trends, capacity and progress in achieving the voluntary global targets:
 - Undertake periodic assessments of Member States' national capacity to prevent and control to noncommunicable diseases.
 - Convene a representative group of stakeholders, including Member States and International partners , in order to evaluate progress on implementation of the action at mid-point of the plan's seven-year time frame and at the end of the period.
 - Review global progress made in the prevention and control of noncommunicable diseases, through monitoring and reporting on the attainment of the voluntary global targets, and set intermediate targets in 2015 and 2020 based on linear progress towards the 2025 targets so that countries can remove impediments to progress.
 - Monitor global trends in noncommunicable diseases and their risk factors, and country capacity to respond, and publish periodic progress reports outlining the global status of the prevention and control of noncommunicable diseases in 2013, 2016 and 2019, and publish risk factor specific reports such as reports on the global tobacco epidemic and on alcohol and health.
 - Convene a representative group of stakeholders, including Member States and international partners, in order to evaluate progress on implementation of this action plan at the mid-point of the plan's eight-year time frame and at the end of the period. The mid-term evaluation will offer an opportunity to learn from the experience of the first four years of the plan, taking corrective measures where actions have not been effective and reorient parts of the plan, as appropriate, in response to the post-2015 development agenda.

Actions for International partners: see paragraph 22 [Note added on 21 March 2013: As per Corrigendum dated 21 March 2013, this should read “see paragraph 20”]

Appendix 1

Synergies between major noncommunicable diseases and other conditions

Comorbidities

Major noncommunicable diseases, predominantly affecting middle-aged and elderly people, often coexist with other conditions. Thus, the presence of other diseases plays an integral role in the development, progression and response to treatment of major noncommunicable diseases. Examples of comorbidities include mental disorders, cognitive impairment and other noncommunicable diseases, including renal, endocrine, neurological including epilepsy, Alzheimer's and Parkinson's diseases, haematological including haemoglobinopathies, hepatic, gastroenterological, musculoskeletal, cutaneous and oral diseases, disabilities and genetic disorders. This comorbidity burden results in higher rates of admission to hospital and worsened health outcomes and needs to be addressed through approaches that are integrated within noncommunicable disease programmes.

Other modifiable risk factors

The four main shared risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol – are the most important risk factors of noncommunicable diseases. In addition, environmental pollution, climate change and psychological stress contribute to morbidity and mortality from cancer, cardiovascular disease and chronic respiratory diseases. Exposure to carcinogens such as diesel exhaust gases, asbestos and ionizing and ultraviolet radiation in the living and working environment increases the risk of cancer. Air pollution, with fumes from solid fuels, ozone, airborne dust and allergens, causes chronic respiratory disease and lung cancer. Air pollution, heat waves and chronic stress related to work and unemployment are also associated with cardiovascular diseases. Similarly, indiscriminate use of agrochemicals in agriculture and discharge of toxic products from unregulated chemical industries can cause cancer and other noncommunicable diseases. Simple, affordable interventions to reduce environmental and occupational health risks are available, and prioritization and implementation of these interventions can contribute to reducing the burden due to noncommunicable diseases (United Nations General Assembly resolution 66/115, Health Assembly resolutions WHA49.12 on WHO global strategy for occupational health for all, WHA58.22 on cancer prevention and control, WHA60.26 on workers' health – global plan of action, and WHA61.19 on climate change and health).

Mental disorders

As mental disorders are an important cause of morbidity and contribute to the global burden of noncommunicable diseases, equitable access to effective programmes and health-care interventions is needed. Mental disorders affect, and are affected by, other noncommunicable diseases: they can be a precursor or consequence of a noncommunicable disease, or the result of interactive effects. For example, there is evidence that depression predisposes people to heart attacks and, conversely, heart attacks increase the likelihood of depression. Risk factors of noncommunicable diseases such as sedentary behaviour and harmful use of alcohol also link noncommunicable diseases with mental disorders. Close connections with characteristics of economically underprivileged population segments such as lower educational level, lower socioeconomic status, stress and unemployment are shared by mental disorders and noncommunicable diseases. Despite these strong connections, evidence indicates that mental disorders in patients with noncommunicable diseases as well as noncommunicable diseases in patients with mental disorders are often overlooked. The comprehensive mental health action plan (under development) will be implemented at the country level in close coordination with the action plan for the prevention and control of noncommunicable diseases.

Communicable diseases

The role of infectious agents in the pathogenesis of noncommunicable diseases, either on their own or in combination with genetic and environmental influences, has been increasingly recognized in recent years. Many noncommunicable diseases including cardiovascular disease and chronic respiratory disease are linked to communicable diseases in either aetiology or susceptibility to severe outcomes. Increasingly cancers, including some with global impact such as cancer of the cervix, liver, oral cavity and stomach, have been shown to have an infectious aetiology. In developing countries, infections are known to be the cause of about one fifth of cancers. High rates of other cancers in developing countries that are linked to infections or infestations include herpes virus

and HIV in Kaposi sarcoma and liver flukes in cholangiocarcinoma. Some significant disabilities such as blindness, deafness and cardiac defects and intellectual impairment can derive from preventable infectious causes. Strong population-based services to control infectious diseases through prevention, including immunization (e.g. vaccines against hepatitis B, human papillomavirus, measles, rubella, influenza, pertussis, and poliomyelitis), diagnosis, treatment and control strategies will reduce both the burden and the impact of noncommunicable diseases.

The interaction of noncommunicable diseases and infectious diseases also increases the risk of infectious disease acquisition and susceptibility in people with pre-existing noncommunicable diseases. Attention to this interaction would maximize the opportunities to detect and to treat both noncommunicable and infectious diseases through alert primary and more specialized health-care services. For example, tobacco smokers and people with diabetes, alcohol-use disorders, immunosuppression or exposed to second-hand smoke have a higher risk of developing tuberculosis. As the diagnosis of tuberculosis is often missed in people with chronic respiratory diseases, collaboration in screening for diabetes and chronic respiratory disease in tuberculosis clinics and for tuberculosis in noncommunicable disease clinics could enhance case finding. Likewise, integrating noncommunicable disease programmes or palliative care with HIV care programmes would bring mutual benefits since both cater to long-term care and support as a part of the programme and also because noncommunicable diseases can be a side-effect of long-term treatment of HIV infection and AIDS.

Demographic change and disabilities

The prevention of noncommunicable diseases will increase the number and proportion of people who age healthily and avoid high health-care costs and even higher indirect costs in older age groups. About 15% of the population experiences disability and the increase in noncommunicable diseases is having a profound effect on disability trends; for example, these diseases are estimated to account for about two thirds of all years lived with disability in low-income and middle-income countries. Noncommunicable disease-related disability (such as amputation, blindness or paralysis) puts significant demands on social welfare and health systems, lowers productivity and impoverishes families. Rehabilitation needs to be a central health strategy in noncommunicable disease programmes in order to address risk factors (e.g. obesity and physical activity), as well as loss of function due to noncommunicable diseases (e.g. amputation and blindness due to diabetes and stroke). Access to rehabilitation services can decrease the effects and consequences of disease, hasten discharge from hospital and slow or halt deterioration in health and improve quality of life.

Violence and unintentional injuries

Exposure to child maltreatment (which includes physical, sexual, and emotional abuse, and neglect or deprivation) is a recognized risk factor for the subsequent adoption of high-risk behaviours such as smoking, harmful use of alcohol, drug abuse, and eating disorders, which in turn predispose individuals to noncommunicable diseases. There is evidence that ischaemic heart disease, cancer and chronic lung disease are related to experiences of abuse during childhood. Similarly, experiencing intimate partner violence has been associated with harmful use of alcohol and drug abuse, smoking, and eating disorders. Programmes to prevent child maltreatment and intimate partner violence can therefore make a significant contribution to the prevention of noncommunicable diseases by reducing the likelihood of tobacco use, unhealthy diet, and harmful use of alcohol.

The lack of safe infrastructure for people to walk and cycle is an inhibitor for physical exercise. Therefore, well known road traffic injury prevention strategies such as appropriate road safety legislation and enforcement, as well as good land use planning and infrastructure supporting safe walking and cycling can contribute to the prevention of noncommunicable diseases as well as help address injuries.

Impairment by alcohol is an important factor influencing both the risk of all injuries. These include road traffic crashes, falls, drowning, burns and all forms of violence. Therefore, addressing harmful use of alcohol will be beneficial for prevention of noncommunicable diseases and injuries.

Appendix 2

Comprehensive global monitoring framework, including 25 indicators, and a set of 9 voluntary global targets for the prevention and control of noncommunicable diseases

Framework element	Target	Indicator
Mortality and morbidity		
Premature mortality from noncommunicable disease	(1) A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	(1) Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases
Additional indicator		(2) Cancer incidence, by type of cancer, per 100 000 population
Risk factors		
Behavioural risk factors		
Harmful use of alcohol ³⁰	(2) At least 10% relative reduction in the harmful use of alcohol ³¹ , as appropriate, within the national context	(3) Total (recorded and unrecorded) alcohol per capita (aged 15 + years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context (4) Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context (5) Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context
Physical inactivity	(3) A 10% relative reduction in prevalence of insufficient physical activity	(6) Prevalence of insufficiently physically active adolescents defined as less than 60 minutes of moderate to vigorous intensity activity daily (7) Age-standardized prevalence of insufficiently physically active persons aged 18 + years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)
Salt/sodium intake	(4) A 30% relative reduction in mean population intake of salt/sodium ³²	(8) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18 + years
Tobacco use	(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	(9) Prevalence of current tobacco use among adolescents (10) Age-standardized prevalence of current tobacco use among persons aged 18+ years
Biological risk factors		
Raised blood pressure (6)	(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	(11) Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg) and mean systolic blood pressure
Diabetes and obesity ³³	(7) Halt the rise in diabetes and obesity	(12) Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18 + years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose) (13) Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index

³⁰ Countries will select indicator(s) of harmful use as appropriate to national context and in line with WHO's global strategy to reduce the harmful use of alcohol and that may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality among others

³¹ In WHO's global strategy to reduce the harmful use of alcohol the concept of the harmful use of alcohol encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes

³² WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per day

³³ Countries will select indicator(s) appropriate to national context

		for age and sex, and obese – two standard deviations body mass index for age and sex) (14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m ² for overweight and body mass index ≥ 30 kg/m ² for obesity)
Additional indicators		(15) Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years ³⁴ (16) Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day (17) Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥ 5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration
National systems response		
Drug therapy to prevent heart attacks and strokes	(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk $\geq 30\%$, including those with existing cardiovascular disease) receiving drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes
Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases	(9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	(19) Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities
Additional indicators		(20) Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer (21) Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes (22) Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies (23) Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt (24) Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants (25) Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies

³⁴ Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations

Appendix 3

(Note: This appendix needs to be updated as evidence and cost-effectiveness of interventions evolve with time)

Policy options and cost-effective interventions for prevention and control of major noncommunicable diseases, which Member States are encouraged to implement, as appropriate, for national context, in order to achieve the 9 voluntary global targets.

- When making public health decisions to implement the interventions listed in objectives 3 and 4, consideration should be given to cost-effectiveness and affordability, implementation capacity, feasibility, impact on equity and poverty, as well as the balance between population wide interventions and individual interventions.
- The list is not exhaustive, but when resource are limited, WHO recommends, giving priority to the core set of interventions⁺⁺⁺ listed in green under objectives 3 and 4, as resources allow. The rationale for this recommendation include:
 - The core set of interventions have a high impact, and are feasible and affordable for implementation, even in resource-constrained settings.
 - They are very cost-effective, i.e. they generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.
 - The costs of implementation are low. Amounts to an annual per capita investment of under USD 1 in low-income countries, US\$1.50 in lower middle-income countries and USD 3 in upper middle-income countries³⁵.
 - Expressed as a proportion of current health spending, the cost of implementation amount to 4 per cent in low-income countries, 2 per cent in lower middle income countries and less than 1 per cent in upper middle income countries.
- For other interventions, information available on cost-effectiveness are:
 - * Quite cost-effective, i.e. they generate an extra year of healthy life for a cost that falls between 1-3 gross domestic product per person,
 - **Cost saving, but moderately feasible, & scarce data on cost-effectiveness.

Obj.	Menu of options	Voluntary global targets	WHO tools
1	<ul style="list-style-type: none"> – Raise public and political awareness and understanding about prevention and control of NCDs – Integrate NCDs into the social and development agenda and poverty alleviation strategies – Strengthen international collaboration including for training the health workforce and exchange information on lessons learned and best practices – Implement other policy options in objective 1, to strengthen international cooperation and advocacy 	Contributes to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	WHO Global status report on NCDs 2010 WHO Fact Sheets Global Atlas on Cardiovascular disease 2011 IARC GLOBOCAN 2008 Existing regional and national tools
2	<ul style="list-style-type: none"> – Increase and prioritize budgetary allocations for NCDs – Assess national capacity for prevention and control of NCDs – Integrate the national policy and plan for the prevention and control of noncommunicable diseases including a multisectoral strategy to engage relevant sectors outside health – Implement other policy options in objective 2, to strengthen national capacity, leadership, governance, multisectoral action and partnerships. 	Contributes to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	UN Secretary-General's report A/67/373 NCD country capacity survey tool NCCP Core Capacity Assessment tool Existing regional and national tools

Obj.	Menu of options	Voluntary global targets	WHO tools
3	<p>Tobacco use^ç</p> <p>Implement FCTC</p> <ul style="list-style-type: none"> – Reduce affordability of tobacco products by increasing tobacco excise taxes⁺⁺⁺ – Create by law completely smoke-free environments in all indoor workplaces, public places and public transport⁺⁺⁺ – Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns⁺⁺⁺ – Ban all forms of tobacco advertising, promotion and sponsorship⁺⁺⁺ <p>Harmful alcohol use</p> <ul style="list-style-type: none"> – Excise tax increases on alcoholic beverages⁺⁺⁺ – Comprehensive restrictions and bans on alcohol advertising and promotion⁺⁺⁺ – Restrictions on the availability of retailed alcohol⁺⁺⁺ – Implement the WHO global strategy to reduce harmful use of alcohol (see objective 2) <p>Unhealthy diet and physical inactivity</p> <ul style="list-style-type: none"> – Salt reduction through mass media campaigns/reduced salt content in processed foods⁺⁺⁺ – Replacement of trans-fats with polyunsaturated fats⁺⁺⁺ – Public awareness programme about diet and physical activity⁺⁺⁺ <p>Implement other policy options in objective 3 to reduce risk factors:</p> <ul style="list-style-type: none"> – Implement the WHO global strategy to reduce harmful use of alcohol (see objective 2) – Implement the WHO Global Strategy on Diet, Physical Activity and Health (see objective 2) – Implement recommendations on the marketing of foods and non-alcoholic beverages to children (see objective 2) 	<p>A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years</p> <p>At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context.</p> <p>A 10% relative reduction in prevalence of insufficient physical activity</p> <p>A 30% relative reduction in mean population intake of salt/sodium intake</p> <p>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances</p> <p>Halt the rise in diabetes and obesity</p>	<p>The WHO Framework Convention on Tobacco Control (FCTC) and its Guidelines</p> <p>MPOWER capacity building modules to reduce demand for tobacco, in line with the WHO FCTC</p> <p>Recommendations on the marketing of foods and non-alcoholic beverages to children (WHA63.14)</p> <p>Global Strategy on Diet, Physical Activity and Health, (WHA57.17)</p> <p>Global recommendations on physical activity for health</p> <p>Global strategy to reduce the harmful use of alcohol (WHA63.13)</p> <p>Toolkit in support of the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol</p> <p>WHO Global Status Reports on Alcohol and Health 2011, 2013</p> <p>WHO Guideline on dietary salt and potassium</p> <p>Existing regional and national tools</p>
4	<ul style="list-style-type: none"> – Integrate highly cost effective noncommunicable disease interventions into the basic primary health care package to advance the universal health coverage agenda – Explore viable health financing mechanisms and innovative financing approaches, like tobacco and alcohol taxation, to generate resources to expand health coverage – Improve availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities – Scale-up early detection and coverage starting with very cost effective high impact interventions – Implement other policy options in objective 4, to strengthen and reorient health systems to address noncommunicable diseases and risk factors through people centered primary health care and universal health coverage. 	<p>An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.</p>	<p>WHO World Health Reports 2010, 2011</p> <p>WHO Package of Essential Noncommunicable Disease interventions (WHO PEN) for primary health care including costing tool</p> <p>Scaling-up NCD interventions, WHO 2011</p> <p>Guidelines: Primary health care</p> <p>Prevention of Cardiovascular Disease</p>

Obj.	Menu of options	Voluntary global targets	WHO tools
	<p>Cardiovascular disease and diabetes:</p> <ul style="list-style-type: none"> – Multi-drug therapy (including glycaemic control for diabetes mellitus and control of hypertension through total risk approach) to individuals who have had a heart attack or stroke, and to persons with high risk ($\geq 30\%$) of a fatal and nonfatal cardiovascular event in the next 10 years⁺⁺⁺ – Acetylsalicylic acid for acute myocardial infarction⁺⁺⁺ – Multi-drug therapy (including glycaemic control for diabetes mellitus and control of hypertension through total risk approach) to individuals who have had a heart attack or stroke, and to persons with moderate risk ($\geq 20\%$) of a fatal and nonfatal cardiovascular event in the next 10 years* – Acetylsalicylic acid, atenolol and thrombolytic therapy (streptokinase) for acute myocardial infarction – Treat congestive cardiac failure with ACE inhibitor, beta-blocker and diuretic – Cardiac rehabilitation post myocardial infarction – Secondary prevention of rheumatic fever and rheumatic heart disease* – Anticoagulation for medium- and high-risk non-valvular atrial fibrillation and for mitral stenosis and atrial fibrillation – Low dose acetylsalicylic acid for ischemic stroke – Care of acute stroke and rehabilitation in stroke units – Interventions for foot care; educational programs, access to appropriate footwear; and multidisciplinary clinics. <p>Diabetes:</p> <ul style="list-style-type: none"> – Lifestyle interventions for preventing type 2 diabetes** – Influenza vaccination** – Preconception care among women of reproductive age includes patient education and intensive glucose management** – The detection diabetic retinopathy by dilated eye examination followed by appropriate laser photocoagulation therapy to prevent blindness** – Enalapril to prevent progression of renal disease** <p>Cancer:</p> <ul style="list-style-type: none"> – Prevention of liver cancer through hepatitis B immunization⁺⁺⁺ – Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA]) linked with timely treatment of pre-cancerous lesions⁺⁺⁺ – Vaccination against human papillomavirus, as appropriate if cost effective and affordable, according to national programmes and policies – Population based cervical cancer screening linked with timely treatment * – Population based breast cancer , mammography screening (50-70 years) linked with timely treatment* – Population based colorectal cancer-screening at age >50, linked with timely treatment* 	<p>At least 50% of eligible people receive drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes</p> <p>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</p> <p>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances</p> <p>Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities</p>	<p>Management of diabetes mellitus</p> <p>Management of asthma and chronic respiratory disease</p> <p>Cervical cancer</p> <p>Use of cryotherapy for cervical intraepithelial neoplasia</p> <p>Pharmacological treatment of persisting pain in children with medical illnesses</p> <p>Indoor air quality</p> <p>Other implementation tools</p> <p>Modules cancer prevention and control</p> <p>Integrated clinical protocols for primary health care and WHO ISH cardiovascular risk prediction charts</p> <p>Affordable technologies; blood pressure measurement devices</p> <p>Essential medicines list (2011)</p> <p>OneHealth tool</p> <p>Existing regional and national tools</p>

Obj.	Menu of options	Voluntary global targets	WHO tools
	<ul style="list-style-type: none"> – Oral cancer-screening in high risk groups (e.g.tobacco users) linked with timely treatment* – Palliative care; using cost effective treatment modalities including opioid analgesics for pain relief & <p>Chronic respiratory disease:</p> <ul style="list-style-type: none"> – Access to improved stoves and cleaner fuels to reduce indoor air pollution* – Cost effective interventions to prevent occupational lung diseases i.e. exposure to silica, asbestos – Treatment of asthma based on WHO guidelines* – Influenza vaccination for patients with chronic obstructive pulmonary disease 		
5	<ul style="list-style-type: none"> – Develop and implement a prioritized national research agenda for NCDs – Strengthen research capacity through cooperation with research institutes – Implement other policy options in objective 5, to promote and support national capacity for high quality research and development 	Contributes to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by generating evidence on effectiveness and impact	<p>Prioritized research agenda for the prevention and control of noncommunicable diseases 2011</p> <p>World Health Report 2013</p> <p>Global strategy and plan of action on public health innovation and intellectual property (WHA 61.21)</p> <p>Existing regional and national tools</p>
6	<ul style="list-style-type: none"> – Develop national targets and indicators based on global monitoring framework – Establish/strengthen a comprehensive NCD surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors, and monitoring national response, – Integrate NCD surveillance/monitoring into national health information systems – Implement other policy options in objective 6, to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control 	Contributes to all 9 voluntary global targets.	<p>Global monitoring framework</p> <p>Verbal autopsy instrument</p> <p>STEP-wise approach to surveillance, Global Tobacco Surveillance System, Global Information System on Alcohol and Health, Global school based student health survey, ICD-10 Training Tool</p> <p>Service Availability and Readiness (SARA) assessment tool</p> <p>IARC GLOBOCAN 2008</p> <p>Existing regional and national tools</p>

Explanatory notes:

[‡] Tobacco use: "Each of these measures reflects one or more provisions of the WHO Framework Convention on Tobacco Control (FCTC). Parties to the WHO FCTC are required to implement all obligations under the treaty in full, and in accord with paragraph 35 of the action plan, all Member States that are not Parties are encouraged to look to the WHO FCTC as the foundational instrument in global tobacco control. The measures included in this Appendix are not intended to suggest a prioritization of obligations under the WHO FCTC. Instead, these measures have been proven to be feasible, affordable and cost-effective and are intended to fulfill the criteria established in the chapeau paragraph of Appendix 3 for assisting countries to meet the agreed targets as quickly as possible. The WHO FCTC includes a number of other important provisions, including supply reduction measures and those to support multi-sectoral action, which are part of any comprehensive tobacco control program."

§This list is non-exhaustive. Interventions listed under objective 4 are based on available data on cost-effectiveness. Some interventions for management of noncommunicable diseases that are cost effective in high income settings, which assume a cost-effective infrastructure for diagnosis and referral and an adequate volume of cases, are not listed under objective 4 , i.e. pacemaker implants for atrioventricular heart block, defibrillators in emergency vehicles, coronary revascularization procedures, and carotid endarterectomy.

For more information, please refer to (i) "Scaling up action against NCDs: How much will it cost?" (available at http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf); (ii)WHO-CHOICE (<http://www.who.int/choice/en/>) and (iii) Disease Control Priorities in Developing Countries (<http://www.dcp2.org/pubs/DCP>).

Appendix 4³⁶

Initial division of labor for United Nations Funds, Programmes and Agencies besides WHO³⁷

UNDP	<ul style="list-style-type: none"> • Support non-health governmental departments in their efforts to engage in a multisectoral national whole-of-government approach to noncommunicable diseases • Support the ministry of planning in integrating noncommunicable diseases in the development agenda of each Member State • Support ministries of planning to integrate noncommunicable diseases explicitly into poverty-reduction strategies • Support the national AIDS commissions to integrate interventions to address the harmful use of alcohol into existing national HIV programme
UNECE	<ul style="list-style-type: none"> • Support the Transport, Health and Environment Pan-European Programme
UN-ENERGY	<ul style="list-style-type: none"> • Support global tracking of access to clean energy and its health impacts for the United Nations' Sustainable Energy for All Initiative • Support the Global Alliance for Clean Cook stoves and the dissemination/tracking of clean energy solutions to households
UNEP	<ul style="list-style-type: none"> • Support the implementation of international environmental conventions
UNFPA	<ul style="list-style-type: none"> • Support health ministries in integrating noncommunicable diseases into existing reproductive health programmes, with a particular focus on (1) cervical cancer and (2) promoting healthy lifestyles among adolescents
UNICEF	<ul style="list-style-type: none"> • Strengthen the capacities of health ministries to reduce risk factors for noncommunicable diseases among children and adolescents • Strengthen the capacities of health ministries to tackle malnutrition and childhood obesity
UNWOMEN	<ul style="list-style-type: none"> • Support ministries of women or social affairs to promote gender-based approaches for the prevention and control of noncommunicable diseases
UNAIDS	<ul style="list-style-type: none"> • Support national AIDS commissions to integrate interventions for noncommunicable diseases into existing national HIV programmes • Support health ministries to strengthen chronic care for HIV and noncommunicable diseases (within the context of overall health system strengthening) • Support health ministries to integrate HIV and noncommunicable disease health system services, with a particular focus on primary health care
UNSCN	<ul style="list-style-type: none"> • Facilitate United Nations harmonization of action at country and global levels for the reduction of dietary risk of noncommunicable diseases • Disseminate data, information and good practices on the reduction of dietary risk of noncommunicable diseases • Integration of the action plan into food and nutrition-related plans, programmes and initiatives (for example, UNSCN's Scaling Up Nutrition, FAO's Committee on World Food Security, and the Maternal, Infant and Young Child Health programme of the Global Alliance for Improved Nutrition)
IAEA	<ul style="list-style-type: none"> • Support health ministries to strengthen their capacities to evaluate interventions on physical activity and healthy lifestyle by using nuclear technology • Expand support to health ministries to strengthen treatment components within national cancer control strategies, alongside reviews and projects of IAEA's Programme of Action for Cancer Therapy that promote comprehensive cancer control approaches when implementing

³⁶ * This information will be updated periodically.

³⁷ Concerns a provisional list only. A division of labour is being developed by UN Funds, Programmes and Agencies.

	radiation medicine programmes
ILO	<ul style="list-style-type: none"> • Support WHO's action plan on workers' health, Global Occupational Health Network and the Workplace Wellness Alliance of the World Economic Forum • Promote the implementation of international labour standards for occupational safety and health, particularly those regarding occupational cancer, asbestos, respiratory diseases and occupational health services
UNRWA	<ul style="list-style-type: none"> • Strengthen preventive measures, screening, treatment and care for Palestine refugees living with noncommunicable diseases • Improve access to affordable essential medicines for noncommunicable diseases through partnerships with pharmaceutical companies
WFP	<ul style="list-style-type: none"> • Prevent nutrition-related noncommunicable diseases, including in crisis situations
ITU	<ul style="list-style-type: none"> • Support ministries of information to include noncommunicable diseases in initiatives on information communications and technology and girls and women's initiatives • Support ministries of information to use mobile phones to encourage healthy choices and warn people about tobacco use
FAO	<ul style="list-style-type: none"> • Strengthen the capacity of ministries of agriculture to redress food insecurity, malnutrition and obesity • Support ministries of agriculture to align agricultural, trade and health policies
WTO	<ul style="list-style-type: none"> • Operating within the scope of its mandate, support ministries of trade in coordination with other competent government departments (especially those concerned with public health), to address the interface between trade policies and public health issues in the area of noncommunicable diseases."
UN-HABITAT	<ul style="list-style-type: none"> • Support ministries of housing to address noncommunicable diseases in a context of rapid urbanization

Appendix 5

Examples of cross-sectoral government engagement to reduce risk factors and potential health effects of multisectoral action*

Sector	Tobacco	Physical inactivity	Harmful use of alcohol	Unhealthy diet
Agriculture	✓		✓	✓
Communication	✓	✓	✓	✓
Education	✓	✓	✓	✓
Energy		✓	✓	✓
Environment	✓	✓	✓	✓
Finance	✓	✓	✓	✓
Food	✓		✓	✓
Health	✓	✓	✓	✓
Housing	✓	✓		✓
Industry		✓	✓	✓
Justice/Security	✓	✓	✓	✓
Legislature	✓	✓	✓	✓
Transport	✓	✓	✓	✓
Social/Welfare	✓	✓	✓	✓
Sports	✓	✓	✓	✓
Trade	✓	✓	✓	✓
Urban planning	✓	✓	✓	✓

Examples of multisectoral action**

	Tobacco	Physical inactivity	Harmful use of alcohol	Unhealthy diet
Sectors involved (examples)	<ul style="list-style-type: none"> • Legislature • Stakeholder ministries across government, including ministries of agriculture, customs /revenue, economy, education, finance, health, foreign affairs, labour, planning, social welfare, state media, statistics, and trade 	<ul style="list-style-type: none"> • Ministries of education, finance, labour, planning, transport, urban planning, sports, and youth • Local government 	<ul style="list-style-type: none"> • Legislature • Ministries of trade, industry, education, finance, justice • Local government 	<ul style="list-style-type: none"> • Legislature • Ministries of trade agriculture, industry, education, urban planning, energy, transport, social welfare, environment
Examples of multisectoral action	<ul style="list-style-type: none"> • Full implementation of WHO Framework Convention on Tobacco Control obligations through coordination committees at the national and subnational levels 	<ul style="list-style-type: none"> • Urban planning /re-engineering for active transport and walkable cities • School-based programmes to support physical activity • Incentives for work site healthy-lifestyle programmes • Increased availability of safe environments recreational spaces • Mass media campaigns • Economic interventions to promote physical activity (taxes on motorized transport, subsidies on bicycles and sports equipment) 	<ul style="list-style-type: none"> • Tax increases • Restrictions and bans on alcohol advertising • Restricted access to retailed alcohol • Reduced drunk driving 	<ul style="list-style-type: none"> • Reduced amounts of salt, saturated fat and sugars in processed foods • Eliminate industrially produced trans-fats in foods • Controlled advertising of unhealthy food to children • Increase availability and affordability of fruit and vegetables to promote intake • Offer of healthy food in schools and other public institutions and through social support programmes • Economic interventions to drive food consumption (taxes, subsidies) • Food security
Desired outcome	<ul style="list-style-type: none"> • Reduced tobacco use and 	<ul style="list-style-type: none"> • Decreased physical inactivity 	<ul style="list-style-type: none"> • Reduced harmful use of 	<ul style="list-style-type: none"> • Reduced use of salt, saturated fat and

	consumption, including secondhand smoke exposure and reduced production of tobacco and tobacco products		alcohol	sugars <ul style="list-style-type: none"> • Substitution of healthy foods for energy-dense micronutrient-poor food
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Recommended steps to implement sustainable multisectoral action***

- i. Self-assessment of Ministry of Health
- ii. Assessment of other sectors
- iii. Analyze the area of concern
- iv. Develop engagement plans
- v. Use a framework to foster common understanding between sectors
- vi. Strengthen governance structures, political will and accountability mechanisms
- vii. Enhance community participation
- viii. Choose other good practices to foster intersectoral action
- ix. Monitor and evaluate

Explanatory notes:

* Adapted from A/67/373

(available at <http://www.who.int/nmh/events/2012/20121128.pdf>)

** With the involvement of civil society and the private sector, as appropriate

*** Annex 6 of the WHO Global Status Report on NCDs 2010 for more information

(http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf).

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