1. We, Heads of State and Government, Ministers and representatives of State and Government participating in this Conference, have come together to restate our firm commitment to take bold action and accelerate progress to, by 2030, reduce by one third the premature mortality from noncommunicable diseases (NCDs) in line with the 2030 Agenda for Sustainable Development. We continue to be inspired by the action catalysed by the 2011 UN Political Declaration on NCDs, and WHO Global Action Plan for the prevention and control of NCDs. We reaffirm our commitment to their implementation.

2. We acknowledge (Too weak. Should read ‘We are concerned that’ or similar) that premature mortality from NCDs continues to constitute one of the major challenges for development in the 21st century, driven by economic, environmental and social determinants of health. Despite the remarkable progress achieved in some countries or regions, this has been insufficient and highly uneven. Each year, 15 million people die from an NCD between the ages of 30 and 69 years; over 80% of these “premature” deaths occur in developing countries, disproportionately affecting the poorest and those furthest behind (delighted to delete). Important: WHO documents continue to use this misleading statistic: 80% of deaths occur in LMICs because 80% of the world’s population live in LMICs. A much more transparent metric is that the risk of premature death is 1.5 times higher for individuals from LMICs vs HICs. (Reference is Allen L, Cobiac L, Townsend N. Quantifying the global distribution of premature mortality from non-communicable diseases. Journal of Public Health. 2017 Feb 10:1-6.) and risk of “premature” death is 1.5 times higher for individuals living the world’s poorest countries compared with those in the richest. Implementing coherent policies and ensuring that cost-effective, affordable and evidenced-based NCD interventions are available to all countries, according to national context and priorities, can reduce inequities and premature deaths from NCDs.

3. We recognize that there are obstacles that countries must overcome to achieving SDG target 3.4. Addressing the complexity of the determinants and main risk factors of NCDs, namely, tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets, and developing necessary multisectoral responses is challenging, particularly when robust monitoring of NCD risk factors is absent. Commercial vested interests and globalisation of unhealthy products and environments are a major driver that should be mentioned up top here. There is little appetite to take on multinationals. There are also continuing ‘behind the border’ intellectual property skirmishes in the vein of Philip Morris/Australia. Consequently, there is limited political leadership, strategic action across sectors and policy coherence for the prevention and control of NCDs in line with approaches such as whole-of-government and health in all policies. One of the main obstacles at country level is the lack of capacity in addressing the conflicting public health goals and private sector objectives and drivers in order to adequately leverage the role of the diverse range of private sector entities in combatting NCDs. (Clumsy sentence needs rewording. Split into two to aid clarity). In addition, policies to prevent and control NCDs, such as regulatory and fiscal measures, are not effectively used and can be hampered by industry interference, including through legal disputes (good but so what? This sentence needs a recommendation. Also note that some countries have led the way with food and beverage taxes). Health systems must improve their work in recognizing and managing NCDs and in providing preventive services in the context of efforts to achieve universal health coverage. Reducing NCDs remain a low priority across the UN Agencies, NGOs, philanthropic foundations and academic institutions. The epidemiological transition resulting in an increasing disease burden from NCDs should be taken fully into account in international cooperation and development policies with a view to address the unmet demand for technical cooperation to strengthen national capacities.

5. Despite the complexity and challenging nature of developing coherent policies across government sectors through a health in all policies approach to addressing NCDs, we will continue doing so to achieve improved outcomes from the perspectives of health, health equity and health system functioning. (Consider rewording aid clarity. ‘We will continue to pursue X because Y despite Z’).

6. We will prioritize the most cost-effective, affordable and evidenced-based interventions that will bring the highest public health return on investment, in accordance with national context and priorities. We will emphasize health as a political priority, which must be reflected in regulation, standard setting and fiscal policies that address the impact of the four common NCD risk factors.

7. We will act across relevant government sectors to create health-conducive environments and opportunities to establish concrete sectoral commitments based on co-benefits and to reduce negative impacts on health, including through health impact assessments. We will encourage NCDs implementation research to enhance the
Enable health systems to respond more effectively to NCDs (This section is missing a para on the central role of investing in strong primary care as the bedrock of any sustainable and equitable health system. Primary care should be prevention-oriented, and the main vehicle for medical NCD prevention and control. Primary care is the means by which vertical health programmes can be reconciled and existing resources directed towards NCDs).

8. We will strengthen, as necessary, essential population level, people-centred public health functions and institutions to effectively prevent and control NCDs and to promote mental health and wellbeing. (One of the more important actions. Easy to assess by reviewing MoH line items.)

9. We will continue investing in health workers as an essential part of strengthening health systems and social protection. We will ensure a highly skilled, well-trained and well-resourced health workforce to lead actions in the field of prevention and promotion of health (Nice but should not be so far up the list).

10. We commit to improve health promotion and disease prevention, early detection, treatment, health surveillance, promoting reduced exposure to environmental risk factors, sustained management of people with or at high risk for cardiovascular disease, cancer, chronic respiratory disease, diabetes, or mental health conditions (Excellent – core work for countries. Consider adding a sentence committing to measuring success with objective and transparent metrics).

12. We will ensure the availability of resources and the capacity needed to respond more effectively and equitably to NCDs as part of Universal Health Coverage, including through strengthened community level prevention and health services delivery and equitable access to essential NCD medicines and technologies. We will ensure that our national health systems provide equal access to basic and specialised health services with financial risk protection (Move higher up)

14. We acknowledge that national NCDs responses – through domestic, bilateral and multilateral channels – require adequate, predictable and sustained financing, commensurate with the global health and socioeconomic burden they impose. We will start by prioritizing domestic budgetary allocations for addressing NCDs, where possible (justify this – under which circumstances would it not be possible?) Is it possible to add another clause/metric e.g. MoH annual spending? This will make it easier to hold member states to account.

15. Where needed, we will work on national investments cases for the prevention and control of NCDs, their risk factors and determinants, to create the fiscal space for action (Assumes that investment cases are all that is required free up domestic funds – possibly naive and continues to demonstrate the lack of political adroitness of NCD community. Policymakers and politicians need good narratives, an open policy window, and consideration of opportunity costs – not just RoI figures). Many countries will have to manage blends of innovative and traditional funding sources. Where appropriate, we will consider using interventions that have the capacity to generate revenues such as taxation of tobacco, alcohol, sugar-sweetened beverages as well as impact investment (LMICs will need technical support in managing increasingly complex portfolios of funding).

16. We call upon, UN agencies and other global health actors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, International Fund for Agricultural Development (IFAD), GAVI Alliance, regional development banks, and philanthropic foundations, to scale up support to governments in developing and implementing the national responses for the prevention and control of NCDs, aligned with national priorities. We call on WHO to consider establishing platform to bring together offer and demand for international cooperation on NCDs (Good. Important that there are unified requirements/accounting systems to reduce onerous bureaucratic elements and potential duplication).

17. NCDs can perpetuate poverty (And poverty predisposes to NCDs). For the poor and near poor, chronic illness and disability can be an economic catastrophe. Hard fought economic gains can be quickly wiped out. Women face a double NCD burden, often assuming gender-based roles as unpaid carers of the sick. We will take action on the impacts of NCDs on poverty and development and we strongly encourage the inclusion of NCDs in the Official Development Assistance.

18. We acknowledge that influencing public policies in sectors beyond health is essential in achieving health gains to reduce premature deaths from NCDs. In addition, we recognize the interconnectedness between the prevention and...
control of NCDs and the achievement of the SDGs beyond 3.4, including targets related to poverty, substance abuse, nutrition, death related environmental exposure, sustainable cities and others. Coordinated upstream action across sectors, including agriculture, environment, industry, trade and finance, education and urban planning will help to create a healthy and enabling environment that promotes policy coherence and supports healthy behaviours and lifestyles. It is the role of the health sector to advocate for these actions, present evidence-based information, support health impact assessments and provide policy reviews and analyses on how decisions impact health, including implementation research. We therefore commit to strong leadership and to ensure collaboration among sectors to implement policies to achieve shared goals.

19. WHO has a key role in providing sound advice about the interaction between the legal environment and NCDs. We will promote policy expertise to develop NCDs responses in order to achieve the SDGs. We call upon WHO with other relevant actors to scale up and broaden work integrating legal issues into country support, including supporting NCD interventions by providing evidence, tracking legal challenges, comparing laws and legal claims across jurisdictions, developing model laws and assisting countries in responding to legal challenges, including through support in implementing model laws, data and evidence gathering and tracking impact. We therefore encourage the UN Inter-Agency Task Force on NCDs to explore the possibility of establishing a UN Commission on NCDs and the Law.

22. We are concerned that the increased production of energy-dense, nutrient poor foods has contributed to diets high in saturated fats, sugars and salts. We will work towards advancing the implementation of global strategies and recommendations that make progress towards strengthening national food and nutrition policies, including by developing guidelines and recommendations that support and encourage healthy and sustainable diets throughout the lifecourse of our citizens, increasing the availability and affordability of healthy, nutritious food, including fruits and vegetables, while enabling healthier food choices, and ensuring access to clean and safe drinking water. We call on WHO to fully leverage the UN Decade of Action on Nutrition to reduce diet-related NCDs and contribute to ensure healthy and sustainable diets for all.

23. We call on WHO to conduct a review of international experience of intersectoral policies to achieve SDG target 3.4 on NCDs, and update its guidance on multisectoral and multi-stakeholder action for the prevention and control of NCDs and to consider establishing a web portal with case studies on multisectoral NCD responses to be updated on a continuing basis.

Seek measures to address the negative impact of products and environmental factors harmful for health and strengthen the contribution and accountability of the private sector.

24. One of the main challenges for the prevention and control of NCDs is that public health objectives and private sector interests can, in many cases, conflict. We commit to enhancing the national capacity to engage constructively with the private sector for NCDs prevention and control in a way that maximizes health gains.

25. We acknowledge that we need to develop coordinated and coherent policies and strengthen evidenced-based regulatory frameworks and align private sector incentives with public health goals, to make health conducive choices available and affordable, and in particular, to promote healthy environments and lifestyles.

26. We further encourage the private sector to produce and promote more food products consistent with a healthy diet, including by reformulation products to provide healthier options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content; to take measures to implement WHO set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, while taking into account existing national legislation and policies.

27. We acknowledge the importance of environmental risk factors and the inter linkage of SDG targets 3.4 and 3.92. We will promote actions that are mutually reinforcing and support achievement of both of these targets.
28. We will take steps, where needed, to implement reliable national accountability systems to monitor the implementation of private sector commitments and their contribution to national NCDs responses. We call on WHO to support countries with expertise and tools to address these gaps. These metrics should be agreed with business input. More important are metrics to monitor national and international legislation.

29. We call upon all countries to accelerate the implementation of the WHO Framework Convention on Tobacco Control, as appropriate, as one of the cornerstone of the global response to NCDs. Recognizing the fundamental and irreconcilable conflict of interest between the tobacco industry and public health, we will continue to implement tobacco control measures without any tobacco industry interference. Yes. An issue here national addiction to tobacco tax revenues. Do we need to think about monitoring closely unfolding evidence around the impact of e-cigarettes?

38. Acting in unity to address NCDs demands a renewed and strengthened commitment to show that we can be effective in shaping a world free of the avoidable burden of NCDs. In so doing, we will continue to listen to and involve the peoples of the world – those exposed to NCD risk factors, and those with health care needs for NCDs and mental health. We will continue to build a future that ensures present and future generations enjoy the highest attainable standard of health. (I'm happy to provide further comments and expand upon those written if needed. Thanks.).