

A draft comprehensive global monitoring framework: report summarizing the results of the discussions in the regional committees and inputs from stakeholders

Report by the Director-General

In line with the provisions of World Health Assembly decision WHA65(8) on the prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, subparagraph (8)(4); in view of the leadership role assigned to WHO by the General Assembly, and the requirement to conclude the work on the draft comprehensive global monitoring framework, and to prepare recommendations, before the end of 2012, for a set of voluntary global targets for the prevention and control of noncommunicable diseases;¹ the Director-General has the honour to present a report that includes summaries of the results of the discussions by each of the regional committees and other relevant regional processes, and a brief account prepared by the Secretariat of input drawn from dialogue with stakeholders (see Annex).

¹ See United Nations General Assembly resolution 66/2.

ANNEX

**RESULTS OF DISCUSSION BY THE REGIONAL COMMITTEES
AND OTHER RELEVANT REGIONAL PROCESSES****WHO African Region (Technical meeting, Nairobi, 8–9 September 2012)**

1. Countries expressed full support for the overall target of noncommunicable diseases mortality reduction: 25% by 2025. Countries supported the global monitoring framework and voluntary global targets to focus attention and track progress on preventing and reducing noncommunicable diseases. Most of the indicators in the global monitoring framework were considered a high priority for monitoring at global and national levels. Member States unanimously supported giving high priority to indicators for mortality, cancer incidence, blood pressure, blood glucose, essential medicines to treat noncommunicable diseases, and vaccination against cancer-causing infections. Most countries agreed that the indicators proposed were measurable and feasible. Concerns were raised about the measurability and availability of baseline data for the indicators related to alcohol, fat intake, salt, essential noncommunicable disease medicines, elimination of *trans*-fats, marketing to children, and vaccinations against human papillomavirus. Additional indicators were suggested that related to specialized treatment (radiotherapy), psychosocial care and sickle-cell disease. All proposed target areas were considered useful and of a high priority. The proposed targets related to mortality, physical inactivity, fat intake, alcohol, cholesterol, essential medicines for noncommunicable diseases, and drug therapy were all supported in their current formulation. Revisions were proposed to targets related to blood pressure, tobacco, salt/sodium, and obesity. Countries suggested replacing tobacco smoking by tobacco use (all forms). Countries indicated that technical and financial support was needed to strengthen surveillance of the global monitoring framework indicators in order to enable countries to report on those indicators.

**WHO Regional Committee for the Americas (Washington, 17–21 September 2012) and
Technical Consultation (9 August 2012)**

2. Countries agreed on the value of a global monitoring framework for the purposes of accountability, communication and resource mobilization, and in order to be public health action-oriented. There was agreement on the “25% by 2025” premature mortality reduction target. There was general agreement on targets for tobacco, salt/sodium, physical inactivity, and blood pressure; and questions about alcohol, obesity, diabetes, cholesterol, and health system response. Concerns were expressed on the need to strengthen country capacity, given that most indicators rely on surveys, as well as on how some indicators were developed. It was recognized that the United Nations General Assembly High-level Meeting on Non-communicable Diseases placed noncommunicable diseases on the development agenda; however, some aspects were felt to be missing from the indicators and targets such as: development and economic investment indicators; equity; social determinants of health; access to medications and health services; interventions targeting children and adolescents; regulatory capacity and concrete multisectoral actions. It was also considered important to have short-term and medium-term targets (for example, with respect to structure, process and results) in order to assess progress. Agreed regional, subregional and national targets were seen as having the potential to complement global ones.

WHO Regional Committee for South-East Asia (Yogyakarta, Indonesia, 4–7 September 2012)

3. The Regional Committee supported the “4 by 4 model” (four risks and four diseases) for the prevention and control of noncommunicable diseases and called for inclusion of indicators and targets within the scope of this model. The Committee suggested inclusion of a sufficient number of global targets (for example, 10), to cover major risk behaviours, namely, tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, as well as targets relating to health outcomes and health system response. The Committee expressed concern with regard to the achievability of some of the proposed targets as well as the lack of availability of baseline data for those targets, for example, “population salt intake”. The Committee urged Member States to strengthen their respective capacity for surveillance, including the measurement of baseline data to monitor and evaluate the prevention and control of noncommunicable diseases. Further, it requested Member States to participate fully and actively in all steps of the noncommunicable disease follow-up processes, including consultations and meetings of the WHO governing bodies on the global monitoring framework and setting up of global targets. The Committee requested the Secretariat to provide technical support to Member States in developing a national monitoring framework, including indicators and targets for prevention and control of noncommunicable diseases.

WHO Regional Committee for Europe (Valleta, 10–13 September 2012) and Technical Consultation (9–31 August 2012)

4. A web-based consultation was organized during August 2012 and the results were presented to the Regional Committee. The main findings fall under the following headings: mortality, behavioural risk factors, intermediate risk factors, disaggregation and process. There is universal capacity to report on mortality, and thus set baselines for and monitor progress towards the global target of reducing premature mortality from noncommunicable diseases. Countries have a high capacity for monitoring four behavioural risk factors (from highest to lowest capacity): tobacco use, alcohol intake, diet and physical inactivity. The question on diet did not distinguish between different components of the diet (such as salt, saturated fat, and *trans*-fats), but countries reported a high capacity to monitor unhealthy diets in general. On average, a capacity to monitor intermediate risk factors was low. Blood lipids were the only risk factor monitored in less than half of EUR-B+C countries.¹ In addition, the low capacity for measuring some intermediate risk factors was cited as a cost issue. The capacity to disaggregate data on noncommunicable diseases is rare in the European Region, despite multiple statements on the importance of indicators to assess inequity and measure social determinants. The Committee indicated a strong preference for the reuse of existing data, consistency with existing data sets, the adoption of a minimal number of indicators and little or no collection of new data.

5. The Regional Committee adopted a decision on noncommunicable diseases welcoming the global target of a 25% relative reduction of premature mortality from noncommunicable diseases by the year 2025, as had been agreed by the World Health Assembly. In addition, the decision referred to the outcomes of the web-based consultation and emphasized the need, in the selection of indicators, to take into account the existing monitoring capacity in Member States in order not to increase unnecessarily the reporting burden of the Member States. The decision also stressed the need to take

¹ Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

into account the availability of feasible interventions, called for a systematic and science-based approach and for the selection of a limited number of scientifically sound indicators that are feasible for the current monitoring systems, emphasized the need to have additional health system indicators, and called for attention to be paid to health inequities and their determinants.

WHO Regional Committee for the Eastern Mediterranean (Cairo, 1–4 October 2012)

6. Participants fully agreed with the overall mortality reduction target of “25 by 2025”, which had been endorsed by the Sixty-fifth World Health Assembly in May 2012. There was general support for the adoption of four other targets to address tobacco smoking, raised blood pressure, salt/sodium intake, and physical inactivity. On tobacco, there was a suggestion to replace tobacco smoking by tobacco use to include smokeless tobacco, which is a significant problem in many countries. Another proposal was to add a further target for diabetes to the four others proposed, preferably focusing on early detection and treatment, owing to the high burden of this disease in the Eastern Mediterranean Region. Several country representatives raised questions and views related to the other targets proposed in the discussion paper but there was no general support for their inclusion. Participants emphasized the importance of integrating the monitoring framework in the national health information system and the importance of enhancing national capacities to implement the framework.

WHO Regional Committee for the Western Pacific (Hanoi, 24–28 September 2012)

7. In general, Member States supported the idea of global targets and indicators; however, concerns were raised about there being too many. The suitability, measurability and achievability of “all targets and indicators for all countries” were questioned. Member States preferred to select targets and indicators of relevance to their needs and capacity. An overarching concern was the cost of data collection. There was agreement on the target on premature mortality reduction as well as on the targets and indicators on raised blood pressure and tobacco use. There was less consensus and support for the targets involving alcohol, salt intake, raised total cholesterol levels, fat intake, obesity and drug therapy.

INPUT FROM OTHER STAKEHOLDERS

8. Input from an entity within the United Nations system¹ suggested that greater emphasis be given to the need for action across governments and civil society, and beyond the health system.

9. Input from a number of relevant nongovernmental organizations² indicated broad support for the draft global monitoring framework, including indicators, and a set of voluntary global targets for the

¹ The entity is UNAIDS.

² The relevant nongovernmental organizations are: Action on Smoking and Health (Scotland), Active - sobriety, friendship and peace (Sweden), Addiction Commission of the French Medical Academy, American Cancer Society & American Diabetes Association & American Heart Association, American Heart Association & American Stroke Association, Center for Health and Development Intelligence & NCD-Forum (Bangladesh), EuroCare - European Alcohol Policy Alliance, European Association for the Study of the Liver, European Heart Network, European Respiratory Society, Framework Convention Alliance, German Obesity Association, Global Alcohol Policy Alliance, Global Asthma Network, Health Promotion Watch & Cameroonian Coalition against Tobacco, International Alliance of Patient's Organizations, International Association for Hospice and Palliative Care, International Association for the Study of Obesity, International Diabetes Federation, International Society of Pediatric Oncology, IOGT International, IOGT-NTO (Sweden), National Heart Forum (UK), NCD Alliance, NCD Child, Pioneer Foundation for Youth Development Uganda, Union for International Cancer Control, World Action on Salt and Health, World Association of Clubs of Alcoholics in Treatment, World Cancer Research Fund, World Dental Federation, World Health Professional Alliance, and Worldwide Palliative Care Alliance.

prevention and control of noncommunicable diseases. Comments were generally supportive of the number and type of indicator and target, with some concerns regarding the exclusion of younger age groups for some indicators. The need for balance was highlighted, in particular among targets on prevention, treatment and care, as was the importance of considering the global monitoring framework in relation to other WHO commitments.

10. The concept of a global monitoring framework, indicators and global voluntary targets was supported by several private sector entities.¹ Two private sector entities raised concerns about the alcohol indicator and target; a third entity supported the indicator and target. Concerns about dietary indicators that address only single nutrients were raised, as well as the importance of indicators on health system capacity, and a lack of aspiration in relation to achievement of increased levels of physical activity.

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¹ The private sector entities are: European Spirits Organization, Global Alcohol Producers Group, International Dairy Federation, International Federation of Pharmaceutical Manufacturers & Associations, International Food and Beverage Alliance, Korea Alcohol & Liquor Industry Association, Lundbeck, The Brewers of Europe, and World Federation of the Sporting Goods Industry.