

Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018

Report by the Director-General

1. This report is submitted in response to Health Assembly resolution WHA69.6 (2016) and provides an update on the preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018, including the responses to specific assignments given to the Secretariat.

2. In January 2017, the Executive Board, at its 140th session, noted an earlier version of this report¹ and adopted resolution EB140.R7, which it recommended to the Health Assembly for adoption. Since then, the report has been updated to take account of mortality estimates for 2015 and other recent developments. Annex 1 has been brought into line with the outcomes of WHO-CHOICE modelling.

NONCOMMUNICABLE DISEASES: CURRENT SITUATION

3. WHO estimates that in 2015, 15.0 million people between the ages of 30 and 69 died from noncommunicable diseases, as shown below:²

	Men	Women	Total	Percentage
Low-income countries	0.4 million	0.4 million	0.9 million	6%
Lower middle-income countries	3.6 million	2.6 million	6.1 million	41%
Upper middle-income countries	3.5 million	2.4 million	5.8 million	39%
High-income countries	1.4 million	0.8 million	2.2 million	15%
Total	8.9 million	6.2 million	15.0 million	100%

¹ See document EB140/27 and the summary records of the Executive Board at its 140th session, fifteenth meeting, section 1.

² Data available at http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html (accessed 2 May 2017).

	Men	Women	Total	Percentage
African Region	0.7 million	0.6 million	1.3 million	9%
Region of the Americas	1.1 million	0.8 million	1.9 million	13%
Eastern Mediterranean Region	0.6 million	0.5 million	1.0 million	7%
European Region	1.5 million	0.8 million	2.4 million	16%
South-East Asian Region	2.6 million	1.8 million	4.4 million	29%
Western Pacific Region	2.4 million	1.6 million	4.0 million	27%
Total	8.9 million	6.2 million	15.0 million	100%

4. Over 80% of these premature deaths, which occurred in people between the ages of 30 and 69, were the result of the four main noncommunicable diseases: cardiovascular disease, cancer, diabetes and chronic respiratory disease.

5. Globally, premature mortality from these four main noncommunicable diseases declined by 15% between 2000 and 2012. This rate of decline is insufficient to meet target 3.4 of the Sustainable Development Goals (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

6. In 2015, 138 Member States had shown very poor or no progress towards implementing the four time-bound national commitments for 2015 and 2016 set out in the Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases.^{1,2} The attainment of those commitments by Member States is currently being assessed³ using the indicators set out in WHO's technical note dated 1 May 2015.⁴ It appears that the pace of progress in 2015 and 2016 has been insufficient.

7. Although the number of countries which have an operational national noncommunicable disease policy with a budget for implementation increased from 32% in 2010 to 50% in 2013,⁵ many countries, in particular developing countries, continue to struggle to move from commitment to action. The main obstacles include: a lack of policy expertise to integrate measures to address noncommunicable diseases into national responses to the Sustainable Development Goals; unmet demands for technical assistance to be provided through bilateral and multilateral channels to strengthen national capacity, which would enable countries to develop their national multisectoral noncommunicable disease responses; a change in patterns of health financing (where more of the burden is placed on domestic budgets); insufficient analytical, legal and tax administrative capacity to

¹ See paragraphs 16–18 of document A69/10, based on data included in the Noncommunicable diseases progress monitor 2015, available at <http://www.who.int/nmh/publications/ncd-progress-monitor-2015/en/> (accessed 10 October 2016).

² Adopted by the United Nations General Assembly in resolution 68/300 (2014). See http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/68/300 (accessed 2 May 2017).

³ The assessment is based on the outcomes of the WHO's global noncommunicable disease country capacity survey, which is being conducted during the first half of 2017. See the question and answer document available at <http://www.who.int/nmh/events/2015/technical-note-qa-en.pdf?ua=1> (accessed 2 May 2017).

⁴ Available at <http://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1> (accessed 2 May 2017).

⁵ See paragraph 12 of United Nations General Assembly resolution 68/300 (2014).

increase domestic taxes on health-harming products in order to ensure the self-financing of national responses; and industry interference that blocks the implementation of certain measures.

8. In order to help Member States overcome these obstacles, the Secretariat has continued to scale up its technical assistance through the existing actions set out in programme area 2.1 (noncommunicable diseases) of the Programme budget 2016–2017. Outputs since May 2016 have included:

- the launch of the new Data for Health programme to support Member States in conducting household surveys on risk factors for noncommunicable diseases (June 2016);¹
- updated systematic reviews on the effect of saturated fatty acid and trans-fatty intake on blood lipids (June 2016);²
- the launch of the report of the 2015 global survey on assessing national capacity for the prevention and control of noncommunicable diseases (July 2016);³
- the launch of a global communications campaign on noncommunicable diseases (July 2016);⁴
- the release of a technical package for cardiovascular disease management in primary health care (September 2016);⁵
- the adoption of the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development⁶ at the Ninth Global Conference on Health Promotion (Shanghai, 21–24 November 2016), which sets out bold political choices for health that governments may wish to include in their ambitious national responses to the 2030 Agenda;
- the launch of the second phase of the ITU/WHO joint global programme, “Be He@lthy, be mobile” (November 2016);⁷
- the launch of the WHO Global Noncommunicable Disease Document Repository (December 2016);⁸

¹ See <http://www.who.int/nmh/events/2015/bloomberg-data-for-health/en/> (accessed 2 May 2017).

² See <http://www.who.int/nutrition/en/>, http://www.who.int/nutrition/publications/nutrientrequirements/sfa_systematic_review/en/ and http://www.who.int/nutrition/publications/nutrientrequirements/tfa_systematic_review/en/ (accessed 2 May 2017).

³ See <http://www.who.int/mediacentre/news/notes/2016/noncommunicable-diseases-global-commitments/en/> and <http://apps.who.int/iris/bitstream/10665/246223/1/9789241565363-eng.pdf?ua=1> (accessed 2 May 2017).

⁴ See <http://www.who.int/ncds/gcm/launch-of-WHO-GCC-at-UN-new-york/en/> (accessed 2 May 2017).

⁵ See http://www.who.int/cardiovascular_diseases/global-hearts/en/ (accessed 2 May 2017).

⁶ <http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration/en/> (accessed 2 May 2017).

⁷ http://www.itu.int/en/ITU-D/ICT-Applications/eHEALTH/Be_healthy/Pages/Be_Healthy.aspx (accessed 2 May 2017)

⁸ <https://extranet.who.int/ncdccs/documents/Db> (accessed 2 May 2017).

- the launch of three global joint programmes with other agencies of the United Nations system (September 2016);¹
- the launch of a report on fiscal policies for diet and the prevention of noncommunicable diseases (October 2016);²
- the launch of practice communities on noncommunicable disease governance, health care, prevention and surveillance, to facilitate the exchange of lessons learned between Member States (January 2017);³
- the Global Dialogue meeting on the role of non-State actors in supporting countries in their national efforts to attain Sustainable Development Goal target 3.4 on noncommunicable diseases (November 2016);⁴
- the publication of the National Cancer Institute Tobacco Control Monograph report, *The Economics of Tobacco and Tobacco Control*;⁵ and
- an annual progress report by the Secretary-General to the United Nations Economic and Social Council on the WHO-led United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases from June 2016 to March 2017.⁶

9. In addition, the Secretariat has been finalizing its work on a number of specific global assignments, as set out below, for consideration by Member States.

SPECIFIC GLOBAL ASSIGNMENTS

Draft updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020

10. In paragraph 3(10) of resolution WHA66.10 (2013), the Director-General was requested to propose an update of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020, in the light of new scientific evidence. Accordingly, an initial expert group meeting was held to advise the Secretariat on an appropriate methodology and a review of evidence was conducted in 2015.⁷

¹ See <http://www.who.int/ncds/un-task-force/events/unga-friends-meeting-2016/en/> (accessed 10 October 2016).

² See <http://www.who.int/dietphysicalactivity/publications/fiscal-policies-diet-prevention/en/> (accessed 3 November 2016).

³ <http://www.who.int/global-coordination-mechanism/news/communities-of-practice/en/> (accessed 2 May 2017).

⁴ <http://www.who.int/global-coordination-mechanism/dialogues/en/> (accessed 2 May 2017).

⁵ <http://www.who.int/mediacentre/news/releases/2017/tobacco-control-lives/en/> (accessed 2 May 2017).

⁶ The progress report will be published by ECOSOC for consideration by Member States during the Coordination and Management Meeting from 7 to 9 June 2017 in New York (see <https://www.un.org/ecosoc/en/about-the-cmm>).

⁷ See <http://www.who.int/nmh/events/meeting-report-consultation-on-appendix-3-final.pdf?ua=1> (accessed 3 May 2017).

11. In paragraph 5(1) of resolution WHA69.6, the Director-General was requested to submit a draft updated Appendix 3, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 2 to document A69/10.

12. In response to these resolutions, in May 2016 the Secretariat announced to the permanent missions in Geneva the process that the Secretariat is following to update Appendix 3. The process has included: a second expert group meeting (27 and 28 June 2016);¹ a web-based consultation on a WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3 (25 July–1 September 2016); an informal consultation of Member States (24 August 2016); and an informal hearing with non-State actors (25 August 2016). The process and its outcomes to date are described on WHO's website.²

13. Taking into account the feedback received during the process to date, the Secretariat has prepared a draft updated Appendix 3 for consideration by Member States, which is set out in Annex 1 to the present document. In revising the Annex since its presentation to the Executive Board in document EB140/27, the menu of policy options to reduce tobacco use has been updated to take into account up-to-date scientific knowledge, available evidence and a review of international experience.

14. The Secretariat convened an information session on 24 April 2017 to provide Member States with: additional information to explain the underlying analysis related to interventions included in Appendix 3; and additional technical briefings on the evidence underpinning the interventions presented in Appendix 3.²

Draft approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases³

15. In paragraph 37 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, the General Assembly called upon WHO, in consultation with Member States, in the context of the comprehensive global coordination mechanism for the prevention and control of noncommunicable diseases, while ensuring appropriate protection from vested interests, to develop, before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for noncommunicable diseases.

16. In response to this resolution, the Secretariat submitted a report to the Sixty-ninth World Health Assembly on the development of such an approach,⁴ outlining a conceptual framework that the Secretariat proposed to explore in 2016. The report also proposed an initial set of overarching principles and a preliminary analysis of potential risks. Member States adopted resolution WHA69.6,

¹ See <http://www.who.int/nmh/events/appendix3-2nd-technical-meeting-report-25july2016.pdf?ua=1> (accessed 3 May 2017).

² See <http://www.who.int/ncds/governance/appendix3-update/en/> (accessed 3 May 2017).

³ Paragraph 37 of United Nations General Assembly resolution 68/300 refers to “the private sector, philanthropic entities and civil society”. However, for the purpose of discussions at the World Health Assembly, it is assumed that all non-State actors identified in paragraph 8 of WHO's Framework of Engagement with Non-State Actors are included in the scope of this approach (i.e. nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions).

⁴ Document A69/10, Annex 4.

endorsing the process to further develop the approach in 2016 and requesting the Director-General to submit a report setting out the approach, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 4 to document A69/10.

17. In response to resolution WHA69.6, in September 2016 the Secretariat announced to the permanent missions in Geneva the process that the Secretariat is following to finalize its work on the development of the approach. The process is described on WHO's website¹ and has included a web-based consultation on a WHO discussion paper dated 26 September 2016 setting out a draft approach (26 September–14 October 2016). The feedback received through the web-based consultation has been given due consideration by the Secretariat and is reflected in the revised draft approach as set out in Annex 2 to the present document, which remains a work in progress.

Proposed workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019

18. In paragraph 15 of the terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases,² the Director-General is requested to submit draft workplans for the global coordination mechanism to the Health Assembly, through the Executive Board, setting out the activities of the global coordination mechanism.

19. In response to this request, the Secretariat has prepared a proposed workplan for the global coordination mechanism, covering the period 2018–2019, for consideration by Member States, which is set out in Annex 3 to the present document.

EVALUATIONS

20. In accordance with paragraph 60 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020,³ and in conformity with the evaluation workplan for 2016–2017,⁴ the Secretariat will convene a representative group of stakeholders, including Member States and international partners, that will work from the beginning of the second quarter of 2017 to the end of third quarter of 2017, in order to conduct a mid-point evaluation of progress on the implementation of the global action plan. The results will be reported to the Seventy-first Health Assembly, through the Executive Board.

21. In accordance with the modalities of the preliminary evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases,⁵ paragraph 19 of the terms of reference for the global coordination mechanism, and the evaluation workplan for 2016–2017, the Health Assembly will conduct a preliminary evaluation of the global coordination mechanism between May 2017 and January 2018, in order to assess its results and its added value. The results will be reported to the Seventy-first Health Assembly, through the Executive Board.

¹ See <http://www.who.int/ncds/governance/measure-non-state-contribution/en/> (accessed 3 May 2017).

² Document A67/14 Add.1, Annex, Appendix 1.

³ See resolution WHA66.10 (2013).

⁴ Document EB138/2016/REC/1, Annex 3.

⁵ Document A68/11, Annex 3, Appendix 2.

PREPARATORY PROCESS LEADING TO THE THIRD HIGH-LEVEL MEETING OF THE GENERAL ASSEMBLY ON THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES, TO BE HELD IN 2018

22. In response to paragraph 38 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, in September 2017 the Director-General will submit to the United Nations General Assembly a report on the progress achieved in the implementation of the Outcome document and of the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,¹ in preparation for a comprehensive review by the General Assembly, in 2018, of the progress achieved in the prevention and control of noncommunicable diseases. The contours of the report are described in Annex 7 to document A69/10.

23. As in the preparation for the first High-level Meeting of the General Assembly, in 2011, the Secretariat will hold global and regional multisectoral informal consultations of Member States between October 2017 and May 2018, as appropriate, which will serve to provide inputs to the preparation for the third High-level Meeting, as well as to the meeting itself. The results of these informal consultations will be reported to the Seventy-first Health Assembly, through the Executive Board.

24. The President of Uruguay will host the WHO Global Conference on Noncommunicable Diseases: enhancing policy coherence between different spheres of policy-making that have a bearing on attaining SDG target 3.4 on NCDs by 2030, which will take place from 18 to 20 October 2017 in Montevideo.² The mandate for the conference derives from action 1.3 of the workplan of the WHO Global Coordination Mechanism on the prevention and control of noncommunicable diseases covering the period 2016–2017,³ and the preparatory process for the third High-level Meeting of the United Nations General Assembly on Non-communicable Diseases, which will be held in 2018. The Global Conference is expected to result in a concise outcome document, to be endorsed by the conference participants, setting out a roadmap that Member States may consider implementing to attain SDG target 3.4.

ACTION BY THE HEALTH ASSEMBLY

25. The Health Assembly is invited to note the report and to adopt the draft resolution recommended by the Executive Board in resolution EB140.R7.

¹ Adopted by the United Nations General Assembly in resolution 66/2 (2011).

² More information will be posted at <http://www.who.int/montevideo2017>.

³ See Annex 3 of document A68/11.

ANNEX 1

DRAFT UPDATED APPENDIX 3 TO THE GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020**What is Appendix 3?**

1. Appendix 3 is a part of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. It consists of a menu of policy options and cost-effective interventions to assist Member States in implementing, as appropriate for national context (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets for the prevention and control of noncommunicable diseases. They are presented under the six objectives of the global action plan. The list of interventions is not exhaustive but is intended to provide information and guidance on the effectiveness and cost-effectiveness of population-based and individual interventions based on current evidence, and to serve as the basis for future work to develop and expand the evidence base. Countries are implementing the global action plan, as appropriate for the national context, and Appendix 3 has been used in the development and prioritization of national action plans.

Why update Appendix 3?

2. Appendix 3 has been updated at the request of Member States, to take into consideration the emergence of new evidence of cost-effectiveness and the issuance of new WHO recommendations since the adoption of the global action plan in 2013, and also to refine the existing formulation of some interventions based on lessons learned from the use of the first version. The global action plan ends in 2020, and any future updates will be considered as part of the development of any subsequent global strategies for noncommunicable diseases.

What has changed?

3. The menu of options listed for objectives 1 (raising the priority accorded to noncommunicable diseases), 2 (strengthening leadership and governance), 5 (research) and 6 (monitoring and evaluation) are process-related recommendations and have not changed. Within objectives 3 (risk factors) and 4 (health systems), in the updated Appendix 3, there are now a total of 86 interventions and overarching/enabling actions, representing an expansion from the original list of 62. This increase is due to the greater availability of scientific evidence and to the need to disaggregate some previous interventions (such as “reduce salt intake”) into more clearly defined and implementable actions.

4. As in the original Appendix 3, a select number of interventions, considered to be the most cost-effective and feasible for implementation, are identified in bold text. In the updated Appendix 3, 16 interventions are listed in bold,¹ as compared to 14 in the original version, and the method for

¹ With an average cost-effectiveness ratio of \leq \$100/disability-adjusted life-year averted in low and lower-middle income countries. The international dollar (\$) is a hypothetical unit of currency that has the same purchasing power parity that the United States dollar had in the United States at a given point in time.

identifying such interventions has been modified.¹ Other interventions, for which cost-effectiveness analysis by the WHO's Choosing interventions that are cost-effective (WHO-CHOICE) project could be completed, are listed in descending order of cost-effectiveness.² Interventions that are mentioned in WHO's guidelines and technical documents where WHO-CHOICE analysis has not been able to be conducted are also listed. Care needs to be taken when interpreting these lists; for example, the absence of WHO-CHOICE analysis does not necessarily mean that an intervention is not cost-effective, affordable or feasible – rather, there were methodological or capacity reasons for which the WHO-CHOICE analysis could not be completed. The economic analyses in the technical annex,³ upon which this list is based, give an assessment of cost-effectiveness ratio, health impact and the economic cost of implementation. These economic results present a set of parameters for consideration by Member States, but it must be emphasized that such global analyses should be accompanied by analyses in the local context. Other WHO tools, such as the OneHealth Tool,⁴ are available to help individual countries cost specific interventions in their national context.

The importance of non-financial considerations

5. Cost-effectiveness analysis is a useful tool but it has limitations and should not be used as the sole basis for decision-making. When selecting interventions for the prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

6. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3. Many of the interventions for the prevention and control of noncommunicable diseases involve multisectoral benefits and costs that need to be taken into account, and examples of the multisectoral aspects of these interventions are outlined in Appendix 5 to the global action plan. It was not possible to provide an equity rating for each intervention, given the importance of context, but, in general, population-based interventions, including fiscal policies and environmental changes, show the most potential to reduce inequalities in the prevention and control of noncommunicable diseases.⁵ Individual interventions, especially those involving education and awareness campaigns, are most likely to widen inequalities and should be accompanied by measures to assess and address other barriers to behaviour change. For any

¹ The listing of interventions in bold text in this updated Appendix 3 is based on economic analyses only. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3.

² Based on cost-effectiveness ratio in low and middle income settings.

³ The draft technical annex is available in the WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3, and information on the process to update the Appendix, are available at: <http://who.int/ncds/governance/appendix3-update-discussion-paper/en/> (accessed 3 May 2017).

⁴ <http://www.who.int/choice/onehealthtool/en/> (accessed 3 May 2017).

⁵ See for example: http://www.euro.who.int/__data/assets/pdf_file/0003/247638/obesity-090514.pdf; http://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf?ua=1; and http://www.euro.who.int/__data/assets/pdf_file/0003/247629/Alcohol-and-Inequities.pdf (accessed 3 May 2017).

intervention, the impact on health inequalities needs to be considered and evaluated, in order to ensure that policies are effective across all population groups.¹

Technical annex

7. Based on feedback from experts and Member States, this updated Appendix 3 is accompanied by a technical annex.² The annex provides more detailed information about the methodology used to identify and analyse interventions, and presents the results of the economic analysis separately for low and lower-middle income, and upper-middle and high income countries. The Secretariat will explore options to provide an interactive web-tool, to enable users to compare and rank the information according to their own needs. The detailed description of the WHO-CHOICE methods for these analyses, including the assumptions, strength of evidence and the individual studies used to inform the development of models for each intervention, will be published separately as peer-reviewed scientific papers, which will be publicly available through open access.

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
OBJECTIVE 1			
Overarching/enabling actions	<ul style="list-style-type: none"> • Raise public and political awareness, understanding and practice about prevention and control of NCDs • Integrate NCDs into the social and development agenda and poverty alleviation strategies • Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learned and best practices • Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels • Implement other policy options in objective 1 		<ul style="list-style-type: none"> – WHO global status report on NCDs 2014 – WHO fact sheets – Noncommunicable diseases country profiles (2014) – IARC GLOBOCAN 2008

¹ For example, accompanying tobacco price increases with smoking cessation support for the poor, and ensuring food product reformulation involves the entire product range and not just the more expensive options.

² The draft technical annex is available in the WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3, which is available at <http://who.int/ncds/governance/appendix3-update/en/> (accessed 10 October 2016). It will be updated after the 140th session of the Executive Board, before the Seventieth World Health Assembly.

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
OBJECTIVE 2		
Overarching/enabling actions	<ul style="list-style-type: none"> • Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies • Assess national capacity for prevention and control of NCDs • Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement • Implement other policy options in objective 2 to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases 	<ul style="list-style-type: none"> – United Nations Secretary-General’s Note A/67/373 – NCD country capacity survey tool – Online NCD MAP Tool for developing, implementing and monitoring national multisectoral action plans
OBJECTIVE 3		
TOBACCO USE		
Overarching/enabling actions	<p><i>For the Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC):</i></p> <ul style="list-style-type: none"> • Strengthen the effective implementation of the WHO FCTC and its protocols • Establish and operationalize national mechanisms for coordination of the WHO FCTC implementation as part of national strategy with specific mandate, responsibilities and resources <p><i>For the Member States that are not Parties to the WHO FCTC:</i></p> <ul style="list-style-type: none"> • Consider implementing the measures set out in the WHO FCTC and its protocols, as the foundational instrument in global tobacco control 	<ul style="list-style-type: none"> – The WHO FCTC, its guidelines and its Protocol to Eliminate Illicit Trade in Tobacco Products – MPOWER capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC (2011–2014) – MPOWER policy measures (2009) – WHO reports on the global tobacco epidemic (2008, 2009, 2011, 2012, 2015)
	<ul style="list-style-type: none"> • Increase excise taxes and prices on tobacco products 	<ul style="list-style-type: none"> – Assessing the national capacity to implement effective tobacco control policies (2011) – Technical resource for country implementation of the WHO Framework Convention on Tobacco Control Article 5.3 (2012)

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">WHO-CHOICE analysis available^c</p> <ul style="list-style-type: none"> • Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages • Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship • Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, public transport • Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke • Provide cost-covered, effective and population-wide support (including brief advice, national toll-free quit line services) for tobacco cessation to all those who want to quit 		<ul style="list-style-type: none"> – WHO tobacco tax simulation model (TaXSiM) (2014) – WHO technical manual on tobacco tax administration (2010) – IARC Handbook of Cancer Prevention/ Volume 12 (2008), Volume 13 (2009), Volume 14 (2011) – Plain packaging of tobacco products: evidence, design and implementation (2016) – Banning tobacco advertising, promotion and sponsorship – What you need to know (2013) – Making your city smoke-free: brochure (2011) and workshop package (2013) – Smoke-free movies: from evidence to action – third edition (2016) – Protect people from tobacco smoke: smoke-free environments (2011) – A guide to tobacco-free mega events (2009) – Policy recommendations on protection from exposure to second-hand tobacco smoke (2007) – Strengthening health systems for treating tobacco dependence in primary care (2013)

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
			<ul style="list-style-type: none"> – Training for tobacco quit line counsellors: telephone counselling (2014) – Developing and improving national toll-free tobacco quit line services (2011)
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Implement measures to minimize illicit trade in tobacco products • Ban cross-border advertising, including using modern means of communication • Provide cessation for tobacco cessation to all those who want to quit 		<ul style="list-style-type: none"> – Confronting the tobacco epidemic in a new era of trade and investment liberalization (2012)
HARMFUL USE OF ALCOHOL			
Overarching/enabling actions	<ul style="list-style-type: none"> • Implement the WHO global strategy to reduce harmful use of alcohol through multisectoral actions in the recommended target areas • Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol • Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems 		<ul style="list-style-type: none"> – Global strategy to reduce the harmful use of alcohol (2010) (WHA63.13) – WHO global status report on alcohol and health (2014) – WHO fact sheets and policy briefs on harmful use of alcohol
WHO-CHOICE analysis available ^c	<ul style="list-style-type: none"> • Increase excise taxes on alcoholic beverages • Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media) • Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale) 	<ul style="list-style-type: none"> – Requires an effective system for tax administration and should be combined with efforts to prevent tax avoidance and tax evasion – Requires capacity for implementing and enforcing regulations and legislation 	<ul style="list-style-type: none"> – WHO implementation toolkit for the global strategy to reduce the harmful use of alcohol (2017) – Resource book on alcohol taxation (2017)

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
WHO-CHOICE analysis available^c	<ul style="list-style-type: none"> • Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints • Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use 	<ul style="list-style-type: none"> – Formal controls on sale need to be complemented by actions addressing illicit or informally produced alcohol – Requires allocation of sufficient human resources and equipment – Requires trained providers at all levels of health care 	<ul style="list-style-type: none"> – Manuals for the alcohol, smoking and substance involvement screening test (ASSIST) and the ASSIST-linked brief interventions (2011) – Brief intervention for hazardous and harmful drinking: a manual for use in primary care (2001)
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Carry out regular reviews of prices in relation to level of inflation and income • Establish minimum prices for alcohol where applicable • Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets • Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people • Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services • Provide consumer information about, and label, alcoholic beverages to indicate, the harm related to alcohol 		<ul style="list-style-type: none"> – WHO implementation toolkit for the global strategy to reduce the harmful use of alcohol (2017) – mhGAP intervention guide 2.0 (2016)
UNHEALTHY DIET			
Overarching/enabling actions	<ul style="list-style-type: none"> • Implement the global strategy on diet, physical activity and health • Implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children 		<ul style="list-style-type: none"> – Global strategy on diet, physical activity and health (2004) – WHO Set of recommendations on the marketing of foods and non-alcoholic beverages to children (2010)

	Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
			<ul style="list-style-type: none"> – Framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children (2012)
WHO-CHOICE analysis available ^c	<ul style="list-style-type: none"> • Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals • Reduce salt intake through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided • Reduce salt intake through a behaviour change communication and mass media campaign • Reduce salt intake through the implementation of front-of-pack labelling • Eliminate industrial <i>trans</i>-fats through the development of legislation to ban their use in the food chain • Reduce sugar consumption through effective taxation on sugar-sweetened beverages 	<ul style="list-style-type: none"> – Requires multisectoral actions with relevant ministries and support by civil society – Regulatory capacity along with multisectoral action is needed 	<ul style="list-style-type: none"> – WHO nutrient profile model(s) for regulating marketing food and non-alcoholic beverages to children – Report of the Commission on Ending Childhood Obesity (2016) – WHO e-Library of Evidence for Nutrition Actions (eLENA) – Fact sheet on healthy diet – Interventions on diet and physical activity: what works: summary report (2009) – Guideline: sodium intake for adults and children (2012) – Guideline: potassium intake for adults and children (2012) – SHAKE the salt habit: technical package for salt reduction (2016) – Guideline: sugars intake for adults and children (2015) – Fiscal policies for diet and the prevention of noncommunicable diseases (2016)

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">WHO-CHOICE analysis not available</p> <ul style="list-style-type: none"> • Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding • Implement subsidies to increase the intake of fruits and vegetables • Replace <i>trans</i>-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal policies or agricultural policies • Limiting portion and package size to reduce energy intake and the risk of overweight/obesity • Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables • Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats 		<ul style="list-style-type: none"> – Global strategy for infant and young child feeding (2003) – International Code of Marketing of Breast-milk Substitutes (1981) – Evidence for the ten steps to successful breastfeeding (1998) – Marketing of breast-milk substitutes: national implementation of the international code: status report (2016) – Baby-friendly hospital initiative: revised, updated and expanded for integrated care (2009) – Five keys to a healthy diet (2016) – Fruit and vegetables for health (2004) – Population-based approaches to childhood obesity prevention (2012) – Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition (2013) – Planning guide for national implementation of the Global Strategy for Infant and Young Child Feeding (2007) – School policy framework: implementation of the WHO global strategy on diet, physical activity and health (2008)

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
	<ul style="list-style-type: none"> Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables 		<ul style="list-style-type: none"> Development of a framework on the nutrition-friendly schools initiative (2006) Prioritizing areas for action in the field of population-based prevention of childhood obesity (2012)
PHYSICAL INACTIVITY			
Overarching/enabling actions	<ul style="list-style-type: none"> Implement the global strategy on diet, physical activity and health 		<ul style="list-style-type: none"> Global recommendations on physical activity for health (2010) Report of the Commission on Ending Childhood Obesity (2016) Interventions on diet and physical activity: what works: summary report (2009) WHO global strategy on diet, physical activity and health: a framework to monitor and evaluate implementation (2008) Physical activity technical package (Draft)
WHO-CHOICE analysis available ^c	<ul style="list-style-type: none"> Provide physical activity counselling and referral as part of routine primary health care services through the use of a brief intervention Implement public awareness and motivational communications for physical activity, including mass media campaigns for physical activity behavioural change 	<ul style="list-style-type: none"> Requires sufficient, trained capacity in primary care 	

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Ensure that macro-level urban design incorporates the core elements of residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport • Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programs to support physical activity for all children • Provide convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling • Implement multi-component workplace physical activity programmes • Promotion of physical activity through organized sport groups and clubs, programmes and events 	<ul style="list-style-type: none"> – Requires involvement and capacity of other sectors apart from health 	<ul style="list-style-type: none"> – Guide for population-based approaches to increasing levels of physical activity (2007) – Prioritizing areas for action in the field of population-based prevention of childhood obesity (2012) – Population-based approaches to childhood obesity prevention (2012) – School policy framework (2008) – Promoting physical activity in schools: an important element of a health-promoting school (2007) – Quality physical education policy package (2014) – Preventing noncommunicable diseases in the workplace through diet and physical activity (2008)
OBJECTIVE 4			
	<ul style="list-style-type: none"> • Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda 		<ul style="list-style-type: none"> – Implementation tools: WHO package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings (2013)

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
<p style="text-align: center; transform: rotate(-90deg);">Overarching/enabling actions</p> <ul style="list-style-type: none"> • Explore viable health financing mechanisms and innovative economic tools supported by evidence • Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective interventions to address behavioural risk factors • Train the health workforce and strengthen the capacity of health systems, particularly at the primary care level, to address the prevention and control of noncommunicable diseases • Improve the availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities • Implement other cost-effective interventions and policy options in objective 4 to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred health care and universal health coverage • Develop and implement a palliative care policy, including access to opioids analgesics for pain relief, together with training for health workers • Expand the use of digital technologies to increase health service access and efficacy for NCD prevention, and to reduce the costs in health care delivery 		<ul style="list-style-type: none"> – WHO model list of essential medicines – Scaling-up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals – Scaling up action against noncommunicable diseases: How much will it cost? (2011) – Health systems financing: the path to universal coverage (2010)
CARDIOVASCULAR DISEASE AND DIABETES		
<ul style="list-style-type: none"> • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk¹ approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and non-fatal cardiovascular event in the next 10 years 	<ul style="list-style-type: none"> – Feasible in all resource settings, including by non-physician health workers 	<ul style="list-style-type: none"> – Global atlas on cardiovascular disease prevention and control (2011)

¹ Total risk is defined as the probability of an individual experiencing a cardiovascular disease event (for example, myocardial infarction or stroke) over a given period of time, for example 10 years.

Menu of policy options		Critical non-financial considerations ^a	WHO tools ^b
WHO-CHOICE analysis available^c	<ul style="list-style-type: none"> • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with moderate to high risk ($\geq 20\%$) of a fatal and non-fatal cardiovascular event in the next 10 years • Treatment of new cases of acute myocardial infarction¹ with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis, or primary percutaneous coronary interventions (PCI) • Treatment of acute ischemic stroke with intravenous thrombolytic therapy • Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level • Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin 	<ul style="list-style-type: none"> – Applying lower risk threshold increases health gain but also increases implementation cost – Selection of option depends on health system capacity – Needs capacity to diagnose ischaemic stroke – Depending on prevalence in specific countries or sub-populations 	<ul style="list-style-type: none"> – WHO ISH cardiovascular risk prediction charts – Guidelines for primary health care in low-resource settings (2012) – A global brief on hypertension (2013) – Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: what's new (2015) – HEARTS technical package for cardiovascular disease management in primary health care (2016)
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Treatment of congestive cardiac failure with angiotensin-converting-enzyme inhibitor, beta-blocker and diuretic • Cardiac rehabilitation post myocardial infarction • Anticoagulation for medium-and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation • Low-dose acetylsalicylic acid for ischemic stroke • Care of acute stroke and rehabilitation in stroke units 		

¹ Costing assumes hospital care in all scenarios.

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
DIABETES		
WHO-CHOICE analysis available ^c	<ul style="list-style-type: none"> • Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics) • Diabetic retinopathy screening for all diabetes patients and laser photocoagulation for prevention of blindness • Effective glycaemic control for people with diabetes, along with standard home glucose monitoring for people treated with insulin to reduce diabetes complications 	– Requires systems for patient recall
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Lifestyle interventions for preventing type 2 diabetes • Influenza vaccination for patients with diabetes • Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management • Screening of people with diabetes for proteinuria and treatment with angiotensin-converting-enzyme inhibitor for the prevention and delay of renal disease 	<ul style="list-style-type: none"> – Guidelines for primary health care in low-resource settings (2012) – Global report on diabetes (2016)
CANCER		
WHO-CHOICE analysis available ^c	<ul style="list-style-type: none"> • Vaccination against human papillomavirus (2 doses) of 9–13 year old girls • Prevention of cervical cancer by screening women aged 30–49, either through: <ul style="list-style-type: none"> • Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions • Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions • Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions 	<ul style="list-style-type: none"> – Visual inspection with acetic acid is feasible in low resource settings, including with non-physician health workers – Pap smear requires cytopathology capacity – Requires systems for organized, population-based screening and quality control
<ul style="list-style-type: none"> – National cancer control programmes core capacity self-assessment tool (2011) – Guidelines for primary health care in low-resource settings (2012) – Cancer control: knowledge into action, six modules (2008) 		

	Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
WHO-CHOICE analysis available^c	<ul style="list-style-type: none"> • Treatment of cervical cancer stages I and II with either surgery or radiotherapy +/- chemotherapy • Treatment of breast cancer stages I and II with surgery +/- systemic therapy • Screening with mammography (once every 2 years for women aged 50–69 years) linked with timely diagnosis and treatment of breast cancer • Treatment of colorectal cancer stages I and II with surgery +/- chemotherapy and radiotherapy • Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicines 	<ul style="list-style-type: none"> – Requires systems for organized, population-based screening and quality control – Requires access to controlled medicines for pain relief 	<ul style="list-style-type: none"> – Comprehensive cervical cancer control: A guide to essential practice – Second edition (2014) – WHO position paper on mammography screening (2014) – Cryosurgical equipment for the treatment of precancerous cervical lesions and prevention of cervical cancer (2012) – Monitoring national cervical cancer prevention and control programmes (2013) – Use of cryotherapy for cervical intraepithelial neoplasia (2011) – Global atlas of palliative care at the end of life (2014) – Planning and implementing palliative care services: a guide for programme managers (2016) – Guidelines on the pharmacological treatment of persisting pain in children with medical illnesses (2012)
WHO-CHOICE analysis not available	<ul style="list-style-type: none"> • Prevention of liver cancer through hepatitis B immunization • Oral cancer screening in high-risk groups (for example, tobacco users, betel-nut chewers) linked with timely treatment • Population-based colorectal cancer screening, including through a faecal occult blood test, as appropriate, at age >50, linked with timely treatment 		<ul style="list-style-type: none"> – Practices to improve coverage of the hepatitis B birth dose vaccine (2013)

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
CHRONIC RESPIRATORY DISEASE		
WHO-CHOICE analysis available^c	<ul style="list-style-type: none"> • Symptom relief for patients with asthma with inhaled salbutamol • Symptom relief for patients with chronic obstructive pulmonary disease with inhaled salbutamol • Treatment of asthma using low dose inhaled beclometasone and short acting beta agonist 	<ul style="list-style-type: none"> – Guidelines for primary health care in low-resource settings (2012) – Selected pollutants: WHO guideline for indoor air quality (2010) – WHO air quality guidelines for particular matter, ozone, nitrogen, dioxide and sulphur dioxide (2005)
WHO-CHOICE analysis not available	<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, for example, from exposure to silica, asbestos • Influenza vaccination for patients with chronic obstructive pulmonary disease 	<ul style="list-style-type: none"> – WHO guidelines for indoor air quality: Household fuel combustion (2014) – Outline for the development of national programmes for elimination of asbestos-related diseases (2014)
OBJECTIVE 5		
Overarching/enabling actions	<ul style="list-style-type: none"> • Develop and implement a prioritized national research agenda for noncommunicable diseases • Prioritize budgetary allocation for research on noncommunicable disease prevention and control • Strengthen human resources and institutional capacity for research • Strengthen research capacity through cooperation with foreign and domestic research institutes • Implement other policy options in objective 5 to promote and support national capacity for high-quality research, development and innovation 	<ul style="list-style-type: none"> – Prioritized research agenda for the prevention and control of noncommunicable diseases 2011 – Research for universal health coverage: World Health Report 2013 – Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21)

Menu of policy options	Critical non-financial considerations ^a	WHO tools ^b
OBJECTIVE 6		
<p style="text-align: center;">Overarching/enabling actions</p> <ul style="list-style-type: none"> • Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plans • Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation • Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response • Integrate noncommunicable disease surveillance and 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 		<ul style="list-style-type: none"> – Noncommunicable diseases progress monitor 2015 – Global monitoring framework – Verbal autopsy instrument – STEPwise approach to surveillance – Global Tobacco Surveillance System – Global Information System on Alcohol and Health – Global database on the Implementation of Nutrition Action (GINA) – Global school-based student health survey, ICD-10 training tool – Service Availability and Readiness (SARA) assessment tool – IARC GLOBOCAN 2008

^a Cost-effectiveness alone does not imply the feasibility of an intervention in all settings. This column highlights some of the critical non-financial aspects that should be taken into account when considering the suitability of interventions for specific contexts.

^b An up-to-date list of WHO tools and resources for each objective can be found at: <http://www.who.int/nmh/ncd-tools/en/> (accessed 10 October 2016).

^c Interventions in bold font are those with an average cost-effectiveness ratio of \leq \$100/DALY averted in low and lower-middle income countries.

ANNEX 2

DRAFT APPROACH THAT CAN BE USED TO REGISTER AND PUBLISH CONTRIBUTIONS OF NON-STATE ACTORS TO THE ACHIEVEMENT OF THE NINE VOLUNTARY TARGETS FOR NONCOMMUNICABLE DISEASES**PROCESS**

1. In paragraph 37 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases,¹ the General Assembly called upon WHO, in consultation with Member States, “in the context of the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases, while ensuring appropriate protection from vested interests, to develop before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for non-communicable diseases”.
2. In response to this resolution, the Secretariat submitted a report to the Sixty-ninth World Health Assembly on the development of such an approach,² outlining a conceptual framework that the Secretariat proposed to explore in 2016. The report also proposed an initial set of overarching principles and a preliminary analysis of potential risks.
3. Member States adopted resolution WHA69.6 (2016), endorsing the process to further develop the approach in 2016 and requesting the Director-General to submit a report setting out the approach, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 4 to document A69/10.
4. In response to resolution WHA69.6, the Secretariat prepared a WHO discussion paper (version dated 26 September 2016)³ setting out a draft approach, including a set of proposed output indicators, which was submitted for comments from Member States and non-State actors, through a web-based consultation, from 26 September 2016 to 14 October 2016. The Secretariat received comments from four Member States and two non-State actors. The feedback received has been given due consideration in developing the draft approach set out in the present document, which remains a work in progress.

CONTEXT

5. In paragraph 37 of the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases,⁴ the General Assembly acknowledged “the contribution of and important role played by all relevant stakeholders, including individuals, families and communities, intergovernmental organizations and religious institutions, civil

¹ Adopted by the United Nations General Assembly in resolution 68/300 (2014). See http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/68/300 (accessed 2 May 2017).

² Document A69/10, Annex 4.

³ See <http://www.who.int/ncds/governance/measure-non-state-contribution/en/> (accessed 4 November 2016).

⁴ Adopted by the United Nations General Assembly in resolution 66/2 (2011).

society, academia, the media, voluntary associations and, where and as appropriate, the private sector and industry, in support of national efforts for noncommunicable disease prevention and control”, and recognized “the need to further support the strengthening of coordination among these stakeholders in order to improve the effectiveness of these efforts”.

6. In addition, in paragraph 44 of the Political Declaration, the General Assembly called upon the private sector, with a view to strengthening its contribution to noncommunicable disease prevention and control, to: (a) take measures to implement the WHO’s set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children; (b) consider producing and promoting more food products consistent with a healthy diet; (c) promote and create an enabling environment for healthy behaviours among workers; (d) work towards reducing the use of salt in the food industry; and (e) contribute to efforts to improve access to and affordability of medicines and technologies in the prevention and control of noncommunicable diseases.

7. In paragraph 26 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases,¹ the General Assembly acknowledged that limited progress has been made in implementing paragraph 44 of the Political Declaration, and “although an increased number of private sector entities have started to produce and promote food products consistent with a healthy diet, such products are not always broadly affordable and available in all communities within countries”.

8. Although a global accountability framework on the prevention and control of noncommunicable diseases has been established for Member States,² no agreed set of predefined indicators exists to encourage non-State actors to register and publish their own contributions to the achievement of the nine voluntary targets for noncommunicable diseases in the most objective and independently verifiable manner.

SCOPE AND PURPOSE OF THE DRAFT APPROACH

9. In Annex 4 to document A69/10, the Secretariat highlighted some considerations to be taken into account when developing the approach, including alignment, impact and participation criteria and methodological options. Accordingly, the approach will consist of (a) a self-reporting tool for non-State actors and (b) a platform to publish the use of the tool by non-State actors.

10. In 2013, Member States adopted the global action plan for the prevention and control of noncommunicable diseases 2013–2020, which provides a comprehensive set of policy options for Member States and proposed actions for international partners and the private sector. The implementation of the global action plan would accelerate progress towards the achievement of the nine voluntary global targets by 2025 and provide the impetus for the attainment of noncommunicable disease-related targets of the Sustainable Development Goals.

11. The Secretariat considers that the actions for international partners as reflected in the global action plan are the cornerstone for developing an approach that ensures coordination among non-State actors and alignment with WHO’s technical support to Member States. Although the global action

¹ Adopted by the United Nations General Assembly in resolution 68/300 (2014).

² Summarized in Annex 8 to document A69/10.

plan is time-bound, its objectives remain relevant for addressing noncommunicable diseases and reaching the noncommunicable disease-related targets of the Sustainable Development Goals.

12. The six objectives of the global action plan are mutually reinforcing and it is likely that a non-State actor's activities may cover more than one objective. However, non-State actors are encouraged to register only those contributions related to activities within their core area of business, as defined in their strategy documents, that have the highest impact in reducing the burden of noncommunicable diseases.

13. The Secretariat does not have the capacity to quality assure all activities by non-State actors. The purpose of the draft approach is therefore to allow the Secretariat to give further guidance on the contributions that non-State actors can make to help accelerate the achievement of the nine targets, including a set of proposed output indicators for the different categories of non-State actors, and to enable aggregate reporting on the level of these activities by non-State actors to the Health Assembly.

PARTICIPATION

14. Given the multiplicity of actors currently working to advance the fight against noncommunicable diseases, and the wide range of activities engaged in, the participation of non-State actors in the implementation of the approach will serve a meaningful purpose only if the participation criteria are selective.

15. In paragraph 38 of the 2011 Political Declaration, the General Assembly recognized the fundamental conflict of interest between the tobacco industry and public health. This irreconcilable conflict is recognized in the guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control, which stress the inherent contradiction between the tobacco industry and social responsibility. Accordingly, the tobacco industry is excluded from participation. The arms industry is also excluded.

16. Overall eligibility for participation in the implementation of the approach is based on compliance by non-State actors with the provisions of United Nations General Assembly resolutions 66/2 (2011) and 68/300 (2014), WHO's framework of engagement with non-State actors¹ and the global action plan for the prevention and control of noncommunicable diseases 2013–2020.²

Proposed Platform to publish the use of the approach

17. The global coordination mechanism on the prevention and control of noncommunicable diseases will promote the use of the approach by non-State actors. When endorsed by the Health Assembly, however, the approach will be a self-reporting method. It is proposed that the process of publishing the use of the self-reporting tool would entail detailed guidelines from the Secretariat on ways in which non-State actors can contribute to the achievement of the nine voluntary global targets, including the development of quality criteria and quantifiable output indicators against which the achievement of the six agreed objectives of the global action plan can be measured. The process would also entail self-publishing by non-State actors of their contributions on their own websites, using the guidelines developed by the Secretariat.

¹ Adopted by the Sixty-ninth World Health Assembly in resolution WHA69.10 (2016).

² Endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10 (2013).

18. To develop the approach – consisting of a self-reporting tool for non-State actors and a platform to publish the use of the self-reporting tool by non-State actors – further, the Secretariat is seeking guidance from Member States on the level of ambition that is required from the Secretariat in order to:

- develop a concrete self-reporting tool for non-State actors, including related indicators; and
- develop an open Internet platform which non-State actors could access in order to upload their own reports for broad comparison and assessment.

ANNEX 3

**PROPOSED WORKPLAN FOR THE GLOBAL COORDINATION MECHANISM
ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE
DISEASES COVERING THE PERIOD 2018–2019**

1. This workplan sets out the activities of the global coordination mechanism on the prevention and control of noncommunicable diseases, including those of time-bound Working Groups, covering the period 2018–2019. The workplan takes into account the terms of reference for the global coordination mechanism,¹ the workplans covering the periods 2014–2015² and 2016–2017,³ the global action plan for the prevention and control of noncommunicable diseases 2013–2020,⁴ the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,⁵ the Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases,⁶ and the 2030 Agenda for Sustainable Development.
2. This workplan takes into consideration the 2030 Agenda for Sustainable Development and the need to enhance multisectoral and multistakeholder advocacy, engagement and action that supports whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in order to achieve the noncommunicable disease-related targets of the Sustainable Development Goals.
3. During the implementation of this workplan, account will be taken of: the evaluations mentioned in paragraphs 16 and 17 of document EB140/27; the Outcome document to be adopted at the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018; and outcomes adopted at other relevant high-level meetings, forums and events convened by the United Nations General Assembly as part of the systematic follow-up and review of the implementation of the 2030 Agenda for Sustainable Development at the global level.⁷
4. As with the previous two workplans, this workplan is organized around five objectives, in line with the five functions of the global coordination mechanism stated in its terms of reference. It will be implemented between January 2018 and December 2019 in line with the time frame of the Proposed programme budget 2018–2019 and the budgetary provisions related to the activities of the global coordination mechanism included in that programme budget. This workplan will be fully integrated into programme area 2.1 (noncommunicable diseases) of the Proposed programme budget 2018–2019,

¹ Document A67/14 Add.1, Annex, Appendix 1.

² Document A67/14 Add.3 Rev.1.

³ Document A68/11, Annex 3.

⁴ Endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10 (2013).

⁵ Adopted by the United Nations General Assembly in resolution 66/2 (2011).

⁶ Adopted by the United Nations General Assembly in resolution 68/300 (2014).

⁷ Adopted by the United Nations General Assembly in resolution 70/299 (2016).

which will be operationalized through Programme Area Network 2.1, in accordance with established operating procedures.

5. As with the workplan covering the period 2016–2017, and in line with the scope and purpose of the global coordination mechanism, the draft third workplan covering the period 2018–2019 aims to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.¹

OBJECTIVES AND ACTIONS

Objective 1. Advocate for and raise awareness of the urgency of implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and mainstream the prevention and control of noncommunicable diseases in the international development agenda.

Action 1.1: Continue the implementation and development of the global communications campaign launched in 2016, with a focus on achieving the noncommunicable disease-related targets of the Sustainable Development Goals and realizing the commitments to prevent and control noncommunicable diseases, as agreed by Member States.²

Action 1.2: Raise awareness of the need to accelerate action to strengthen national responses to noncommunicable diseases by facilitating and enhancing the coordination of activities, multistakeholder engagement and actions across sectors by participants in the global coordination mechanism at high-level political forums.

Action 1.3: Conduct at least one dialogue to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, to support Member States in realizing their commitments to address noncommunicable diseases.

Objective 2. Disseminate knowledge and share information based on scientific evidence and/or best practices regarding implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 2.1: Continue to facilitate the exchange of information on noncommunicable disease-related research and its translation, identify barriers to research generation and translation, and facilitate innovation in order to enhance the knowledge base for ongoing national, regional and global action.

¹ Document A67/14 Add.1, Annex, Appendix 1, paragraph 1.

² See United Nations General Assembly resolutions 66/2 (2011) and 68/300 (2014).

Action 2.2: Curate a resource library through the portal¹ of the global coordination mechanism by the end of 2018, which will include relevant and appropriate materials that promote multisectoral and multistakeholder action on noncommunicable diseases.

Action 2.3: Support knowledge dissemination and information sharing, including through communities of practice and webinars to support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 at the national, regional and global levels.

Action 2.4: Develop and disseminate an annual activity report describing progress made in the implementation of the workplan.

Objective 3. Provide a forum to identify barriers and share innovative solutions and actions for the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and to promote sustained actions across sectors.

Action 3.1: Establish at least one working group to recommend ways and means of encouraging Member States and non-State actors to realize the commitments made to prevent and control noncommunicable diseases through multisectoral and multistakeholder approaches.

Action 3.2: Conduct at least one meeting of participants in the global coordination mechanism to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels.

Objective 4. Advance multisectoral action by identifying and promoting sustained actions across sectors that can contribute to and support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 4.1: Establish strategic roundtables aimed at supporting governments in strengthening their whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in collaboration with relevant WHO technical units, the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, and other stakeholders, as appropriate.

Action 4.2: Work with relevant WHO technical units and the United Nations Inter-Agency Task Force in efforts to meet the requests by Member States to implement the recommendations of the WHO working groups of the global coordination mechanism.

Action 4.3: Continue to contribute to an integrated initiative, in collaboration with relevant WHO technical units and offices, the United Nations Inter-Agency Task Force and other stakeholders, that ensures an appropriate, coordinated and comprehensive response to provide support to Member States that are committed to making fast-track progress towards achieving the nine voluntary global targets for noncommunicable diseases by 2025, and the noncommunicable disease-related targets of the Sustainable Development Goals by 2030.

¹ See <http://www.gcmportal.org/> (accessed 2 May 2017).

Objective 5. Identify and share information on existing and potential sources of finance and cooperation mechanisms at the local, national, regional and global levels for implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 5.1: Continue to promote the implementation of the approach that WHO will have developed to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases.

Action 5.2: Map and publish the commitments made by participants in the global coordination mechanism to implement the global action plan for the prevention and control of noncommunicable diseases 2013–2020.¹

Action 5.3: Establish an ongoing dialogue to explore the feasibility of establishing voluntary innovative financing mechanisms and partnerships² to develop and implement national noncommunicable disease responses through multisectoral and multistakeholder approaches.

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¹ See document A67/14 Add.1, Annex, Appendix 1, paragraph 22.

² In accordance with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development).