
Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases in 2018

Report by the Director-General

1. In preparation for a comprehensive review at the United Nations General Assembly in 2018 of the progress achieved in the prevention and control of noncommunicable diseases, this report provides an update on responses to specific assignments given to the Secretariat in World Health Assembly resolution WHA66.10 (2013), United Nations General Assembly resolution 68/300 and United Nations Economic and Social Council resolution 2014/10.

2. In January 2016, the Executive Board, at its 138th session, noted an earlier version of this report¹ and adopted resolution EB138.R4, which recommended to the Health Assembly the adoption of a resolution. Paragraphs 3, 4, 5, 11, 16 and 17 in this report contain new text in response to comments from Member States. Annexes 1, 3, 5 and 6 have been updated to take account of recent developments. Annexes 8 and 9 have been added in response to requests from Member States.

HISTORIC DECISIONS

3. 2015 was a year of historic decisions when global leaders decided at two high-level international meetings to include noncommunicable diseases in the new global Sustainable Development Goals – a major health issue that the Millennium Development Goals did not address.

4. As part of the Addis Ababa Action Agenda² adopted at the Third United Nations International Conference on Financing for Development (Addis Ababa, 13–16 July 2015), Heads of State and Government noted the enormous burden that noncommunicable diseases place on developed and developing countries, and recognized, in particular, that, as part of a comprehensive strategy of prevention and control of noncommunicable diseases, price and tax measures on tobacco can be an

¹ See document EB138/10 and the summary record of the Executive Board at its 138th session, twelfth meeting, section 6 (document EB/138/2016/REC/2).

² United Nations General Assembly resolution 69/313.

effective and important means to reduce tobacco consumption and health-care costs and represent a revenue stream for financing for development in many countries.¹

5. The 2030 Agenda for Sustainable Development, adopted at the United Nations Summit on Sustainable Development (New York, 25–27 September 2015),² recognizes noncommunicable diseases as a major challenge for sustainable development.³ As part of the Agenda, Heads of State and Government made the commitment to develop ambitious national responses to the overall implementation of this Agenda,⁴ including the following targets:

- 3.4: by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being
- 3.5: strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 3.8: achieve universal health coverage, including financial risk protection, access to quality essential health-care services and across to safe, effective, quality and affordable essential medicines and vaccines for all
- 3.a: strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate
- 3.b: support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

SPECIFIC GLOBAL ASSIGNMENTS

6. A number of specific assignments are being pursued by the Secretariat in response to resolution WHA66.10 (2013), United Nations General Assembly resolution 68/300 and United Nations Economic and Social Council resolution 2014/10. These include the following:

- to submit reports on progress made in implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and in attaining the nine voluntary global targets for noncommunicable diseases;
- to propose an update of Appendix 3 of the global action plan;

¹ United Nations General Assembly resolution 69/313, paragraph 32.

² United Nations General Assembly resolution 70/1.

³ United Nations General Assembly resolution 70/1, paragraph 26.

⁴ United Nations General Assembly resolution 70/1, paragraph 78.

- to develop an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets;
- to develop a purpose code to track official development assistance for noncommunicable diseases;
- to report on progress made in carrying out the 2014–2015 workplan of the global coordination mechanism on the prevention and control of noncommunicable diseases;
- to report on progress made by the United Nations Inter-agency Task Force on the Prevention and Control of Noncommunicable Diseases;
- to present an outline of the report that the Director-General will submit to the Secretary-General of the United Nations in preparation for the comprehensive review by the United Nations General Assembly in 2018.

Global action plan for the prevention and control of noncommunicable diseases 2013–2020

7. In response to subparagraph 3(9) of resolution WHA66.10 (2013), the Director-General hereby submits the report on progress made in implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020 during the period from May 2013 to March 2016 (see Annex 1).

8. In response to subparagraph 3(10) of resolution WHA66.10, the Director-General hereby submits a proposal for a process to update, in 2016, Appendix 3 of the global action plan (see Annex 2).

WHO global monitoring mechanism on noncommunicable diseases

9. In response to the second request in subparagraph 3(9) of resolution WHA66.10, the Director-General hereby submits the report on progress made in 2015 towards attainment of the nine voluntary global targets for the prevention and control of noncommunicable diseases (see Annex 3).

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

10. In response to paragraph 37 of United Nations General Assembly resolution 68/300, the Director-General hereby describes the development, in 2016, of an 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, for the consideration of the Executive Board at its 140th session before transmission to the Seventieth World Health Assembly. The development of the approach is set out in Annex 4.

Tracking official development assistance for noncommunicable diseases

11. In support of paragraph 33 of United Nations General Assembly resolution 68/300, the Secretariat is engaging with the Development Assistance Committee of the Organisation for Economic Co-operation and Development on the development of a purpose code to track official development

assistance for noncommunicable diseases, which its members may wish to consider in 2016. The proposal for a code is set out in Annex 9.

Global coordination mechanism on the prevention and control of noncommunicable diseases

12. In accordance with paragraph 14 of the terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases, the Director-General hereby submits the report on progress made in carrying out actions in the global coordination mechanism's 2014–2015 workplan, for the consideration of the Executive Board before transmission to the Sixty-ninth World Health Assembly. The report is set out in Annex 5.

United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases

13. In resolution 2015/8, the United Nations Economic and Social Council took note of the report of the Director-General of WHO on the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases submitted pursuant to paragraph 3 of its resolution 2014/10 and requested the United Nations Secretary-General to report further progress at its 2016 session. The progress made by the Task Force between April and March 2016 is set out in Annex 6.

Report to the United Nations General Assembly

14. In paragraph 38 of its resolution 68/300, the United Nations General Assembly requested the Secretary-General of the United Nations, in collaboration with Member States, WHO and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2017, for consideration by Member States, a report on the progress achieved in the implementation of 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 diseases¹ and of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,² in preparation for a comprehensive review, in 2018, of the progress achieved in the prevention and control of noncommunicable diseases. The contours of the report that the Director-General will submit to the United Nations Secretary-General are set out in Annex 7.

WHO NONCOMMUNICABLE DISEASE PROGRESS MONITOR 2015

15. The road map for developing national responses to noncommunicable diseases was established in the Political Declaration of 2011 and the Outcome document of 2014. The latter includes four time-bound measures which Ministers have committed themselves to prioritize in 2015 and 2016, in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018:

¹ United Nations General Assembly resolution 68/300 (2014).

² United Nations General Assembly resolution 66/2 (2011).

- by 2015, consider setting national targets for 2025 and process indicators based on national situations, taking into account the nine voluntary global targets for noncommunicable diseases
- by 2015, consider developing or strengthening national multisectoral policies and plans to achieve the national targets by 2025, taking into account the global action plan for the prevention and control of noncommunicable diseases 2013–2020
- by 2016, as appropriate, reduce risk factors for noncommunicable diseases and underlying social determinants through the implementation of interventions and policy options to create health-promoting environments, building on guidance set out in Appendix 3 to the global action plan
- by 2016, as appropriate, strengthen and orient health systems to address the prevention and control of noncommunicable diseases and underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in Appendix 3 to the global action plan.

16. At a side event to the United Nations Summit on Sustainable Development (New York, 25–27 September 2015),¹ WHO launched its Noncommunicable Disease Progress Monitor 2015.² This monitoring tool tracks the extent to which 194 Member States are implementing the four time-bound commitments for 2015 and 2016 included in the United Nations General Assembly’s Outcome document on prevention and control of noncommunicable diseases, in accordance with a technical note³ published by the Director-General on 1 May 2015 pursuant to decision EB136(13) (2015).

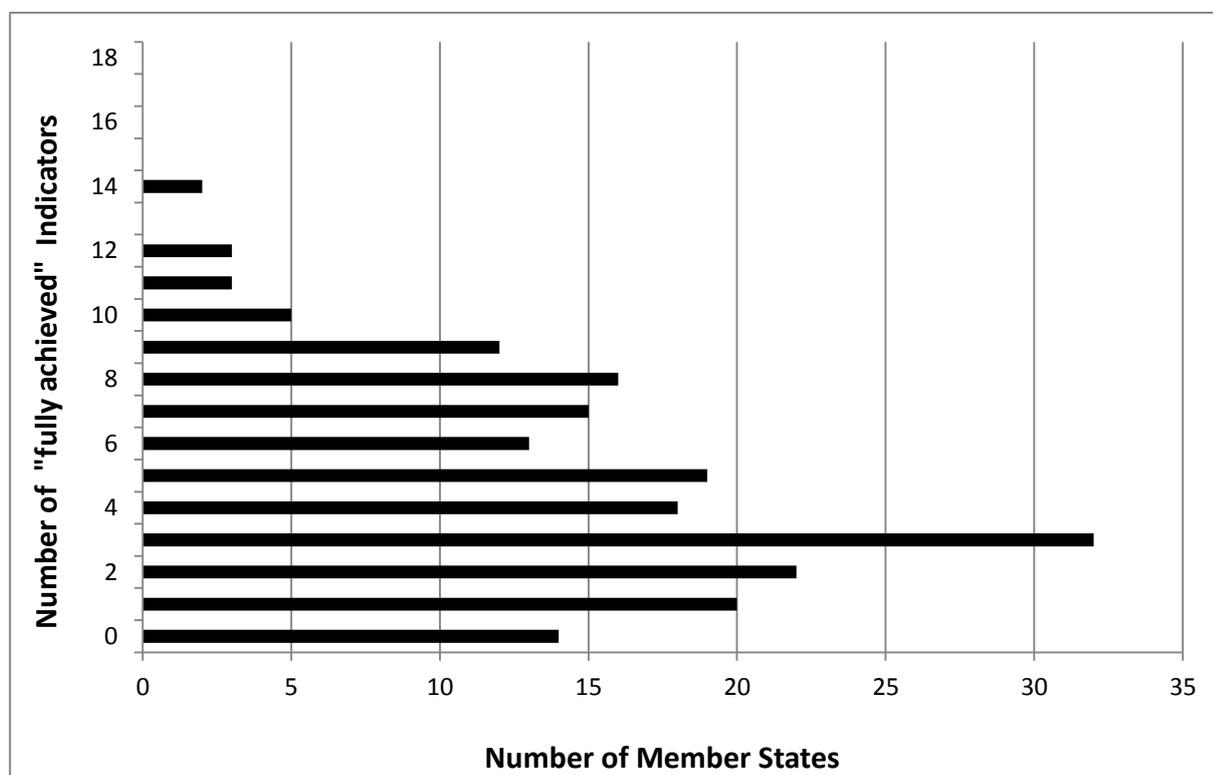
17. Two Member States score 14 out of a total of 18 fully achieved measures. However, a significant number of Member States show very poor or no progress towards achieving implementation of the commitments: 14 Member States progressed on not one single indicator, a further 124 Member States only fully achieved one to six of the measures, and 54 Member States fully achieving seven to twelve (see Figure 1).

¹ <http://www.who.int/nmh/25-September-2015-side-event-NCDs-update-2.pdf?ua=1> (accessed 21 April 2016).

² <http://www.who.int/nmh/publications/ncd-progress-monitor-2015/en/> (accessed 21 April 2016).

³ <http://www.who.int/nmh/events/2015/getting-to-2018/en/> (accessed 21 April 2016).

Figure 1. Number of Member States that have “fully achieved” 0 to 18 progress monitor indicators related to the four time-bound commitments for 2015 and 2016 included in the 2014 United Nations General Assembly’s Outcome document on prevention and control of noncommunicable diseases

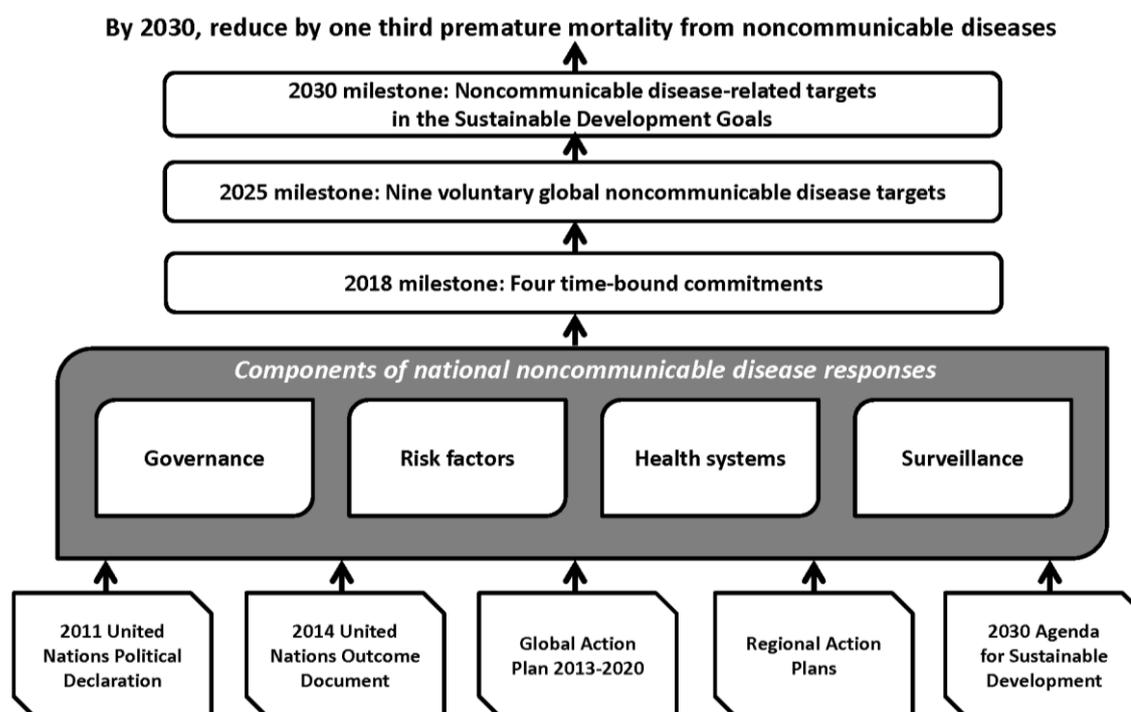


18. The global accountability framework for the prevention and control of noncommunicable diseases is summarized in Annex 8.

PRIORITY ACTIONS FOR MEMBER STATES

19. In preparation for the third High-level Meeting in 2018, Member States are encouraged to accelerate the implementation of these commitments. In the long term, they are encouraged to strengthen national responses that contribute to the global target in the Sustainable Development Goals of reducing premature mortality from noncommunicable diseases through prevention and treatment by one third by 2030 (Figure 2.).

Figure 2. Sustainable Development Goals and the nine voluntary global targets for noncommunicable disease prevention and control



ACTION BY THE HEALTH ASSEMBLY

20. The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB138.R4 (2015).

ANNEX 1

**PROGRESS MADE IN IMPLEMENTATION OF THE GLOBAL ACTION PLAN
FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES
2013–2020 DURING THE PERIOD FROM MAY 2013 TO MARCH 2016**

1. This report describes the progress made in implementation of the global action plan for the prevention of noncommunicable diseases 2013–2020 during the period from May 2013 to March 2016.

PROGRESS MADE BY MEMBER STATES

2. The Sixty-seventh World Health Assembly approved nine process indicators to inform reporting on progress made in implementing the global action plan 2013–2020 against a baseline in 2010.¹ As in 2010, the Secretariat conducted a global noncommunicable disease capacity survey in 2015, which captured data for most process indicators. For other process indicators, the data used were those already collected by WHO in routine reporting.

Table. Global noncommunicable disease capacity surveys

Number	Global action plan indicator ²	2010	2015	Trend
1	Number of countries with at least one operational multisectoral national policy, strategy or action plan that integrates several noncommunicable diseases and shared risk factors in conformity with the global/regional action plans 2013–2020.	30/166 (18%) ^a	61/166 (37%)	↑
2	Number of countries that have operational noncommunicable disease unit(s)/branch(es)/department(s) within the Ministry of Health, or equivalent.	88/166 (53%) ^b	110/166 (66%)	↑
3a	Number of countries with an operational policy, strategy or action plan to reduce the harmful use of alcohol, as appropriate, within the national context.	80/166 (48%)	111/166 (67%)	↑
3b	Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity.	91/166 (55%)	119/166 (72%)	↑

^a The questionnaire used in the 2010 capacity survey did not include the word “multisectoral”.

^b The 2010 questionnaire included funding for noncommunicable disease “treatment and control”, “prevention and health promotion” and “surveillance, monitoring and evaluation”, and the 2015 questionnaire included funding for noncommunicable disease “primary prevention”, “health promotion”, “early detection/screening”, “health care and treatment” and “surveillance, monitoring and evaluation”.

¹ See the summary records of the Sixty-seventh World Health Assembly, Committee A, seventh meeting, section 2 (document WHA67/2014/REC/3).

² See document A67/14, Annex 4, Appendix.

Number	Global action plan indicator ²	2010	2015	Trend
3c	Number of countries with an operational policy, strategy or action plan, in line with the WHO Framework Convention on Tobacco Control, to reduce the burden of tobacco use.	109/166 (66%)	135/166 (81%)	↑
3d	Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets.	99/166 (60%)	123/166 (74%)	↑
4	Number of countries that have evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities.	125/166 (75%)	61/166 (37%) ^a	N/A ^c
5	Number of countries that have an operational national policy and plan on noncommunicable disease-related research, including community-based research and evaluation of the impact of interventions and policies.	NO DATA	60/166 (36%)	N/A ^c
6	Number of countries with noncommunicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global noncommunicable disease targets.	60/166 (36%)	48/166 (29%) ^b	N/A ^c

^a The 2010 questionnaire only included guidelines on diabetes, while the 2015 questionnaire included guidelines for the four major noncommunicable diseases.

^b In the 2010 questionnaire, the wording of the mortality question was different: it simply asked whether cause-specific mortality related to noncommunicable diseases was included in the national health reporting system. In addition, salt was not included in risk factor surveillance.

^c Not applicable.

PROGRESS MADE BY INTERNATIONAL PARTNERS

3. At the multilateral level, the United Nations Economic and Social Council welcomed the two reports of the Secretary-General of the United Nations on the progress achieved by the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases,¹ recognizing WHO's leadership and coordination role in relation to the work of other organizations of the United Nations system in providing technical assistance for national responses to noncommunicable diseases. The initial successes among many United Nations Country Teams demonstrate that WHO can break new ground.

4. At the bilateral level, requests for technical assistance to strengthen the capacity of ministries of health to exercise a strategic leadership and coordination role in developing a policy on and national responses to noncommunicable diseases remain largely unanswered. The increase in the volume of official development assistance since the adoption of the Monterrey Consensus² in 2002 does not seem to translate into concrete efforts to raise the priority accorded to noncommunicable diseases in bilateral development cooperation. The call for the Development Assistance Committee of the Organisation for Economic Co-operation and Development to establish a purpose code to

¹ United Nations Economic and Social Council reports E/2014/55 and E/2015/53.

² United Nations General Assembly resolution 56/210 (2002).

track official development assistance for noncommunicable diseases underscores the urgent need to recognize and address this deficit.

5. At the level of non-State actors, partners from civil society, philanthropic foundations and academia have contributed greatly to implementation of the global action plan. A highly mobilized civil society (including through the NCD Alliance), philanthropic foundations such as the Bill & Melinda Gates Foundation and Bloomberg Philanthropies, and academia (including through *The Lancet* series on noncommunicable diseases) have proven to be a powerful engine in raising the priority accorded to the prevention and control of noncommunicable diseases in national and international agendas. Non-State actors have expressed intense interest in becoming participants in the global coordination mechanism on the prevention and control of noncommunicable diseases. While an increasing number of private sector entities have started to produce and promote more food products consistent with a healthy diet, these food products are unfortunately not affordable, accessible and available in most developing countries.

PROGRESS MADE BY THE SECRETARIAT

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

6. The Secretariat published the second global status report on noncommunicable diseases in 2014. The report provides the 2010 baseline estimates on noncommunicable disease mortality and risk factors against which progress towards the nine voluntary global targets will be measured. In addition, the report identifies bottlenecks as well as opportunities and priority actions for attaining the nine targets.

7. The Secretariat and the secretariat of the WHO Framework Convention on Tobacco Control launched a publication on the economic and health benefits of tobacco taxation¹ on the occasion of the Third International conference on Financing for Development (Addis Ababa, 13–16 July 2015). The report estimates that governments collect nearly US\$ 270 billion in tobacco excise tax revenues each year. The report estimates that a tripling of excise tax on tobacco in most low- and middle-income countries would double cigarette prices, reducing consumption by about 40%. To date, at least 30 Member States have chosen to earmark tobacco tax revenues for health purposes.

8. The Secretariat also published reports with recommendations emerging from the first and second dialogues on noncommunicable diseases and development cooperation convened by the global coordination mechanism for the prevention and control of noncommunicable diseases.²

9. The Secretariat dedicated World Health Day in April 2016 to diabetes,³ and used the event to launch the first-ever *WHO global report on diabetes*, accompanied by individual country profiles. A

¹ See <http://www.who.int/tobacco/publications/economics/post2015tobacco/en/> (accessed 21 April 2016).

² See Annex 5 of this report.

³ <http://www.who.int/diabetes/global-report/en/> (accessed 21 April 2016).

range of communication and advocacy materials was developed, along with a launch event in Geneva, to raise awareness and increase the priority given to diabetes prevention and management.¹

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

10. The Secretariat established a web page providing links to all WHO tools for the prevention and control of noncommunicable diseases.² The web page is designed to be the first reference for policy-makers when developing national responses to noncommunicable diseases.

11. In order to answer Member States' requests for technical support more rapidly, address gaps in skills, reduce costs and meet funding challenges, an internal steering group for the one-WHO workplan for the prevention and control of noncommunicable diseases was established in 2013. It includes all three levels of the Organization and meets every three months. Underpinned by stronger results-based management in the WHO Programme Budget 2014–2015, it has steadily built up a way of working within the Secretariat that is more effective, efficient, responsive, objective, transparent and accountable.

12. In a powerful sign of governments' determination to strengthen national capacity for the prevention and control of noncommunicable diseases, more than 200 delegates from 137 Member States met in Geneva from 15 to 17 February 2016 for the first WHO Global Meeting of National NCD Programme Directors and Managers.³ The meeting was organized jointly with the secretariat of the WHO Framework Convention on Tobacco Control. Delegates discussed how to reflect the new noncommunicable disease-related targets for 2030 included in the 2030 Agenda for Sustainable Development in national development plans and policies; shared their experiences in setting national noncommunicable disease targets for 2030; exchanged lessons learnt on how to build national noncommunicable disease action plans that involve all government departments; identified means to accelerate progress on reducing risk factors and scaling up noncommunicable disease detection, diagnosis, treatment and care; proposed new ways to make WHO's policy expertise on noncommunicable diseases available to governments at all stages of implementation; discussed the strengthening of implementation of the WHO Framework Convention on Tobacco Control, its contribution to noncommunicable disease prevention and control and promoted the entry into force of the Protocol to Eliminate the Illicit Trade in Tobacco Products; and started discussions on how to prepare for the third United Nations General Assembly's High-level Meeting on Noncommunicable Diseases.

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

¹ <http://www.who.int/campaigns/world-health-day/2016/en/> (accessed 21 April 2016).

² <http://www.who.int/nmh/ncd-tools/en/> (accessed 30 November 2015).

³ See <http://www.who.int/ncds/media/ncd-focal-points-report/en/> and <http://www.who.int/nmh/events/2016/ncd-focal-points/en/> (accessed 21 April 2016).

Tobacco control

13. As part of the preparatory process leading to the United Nations summit for the adoption of the post-2015 development agenda, WHO highlighted the potential to generate additional domestic public finance through taxation of tobacco products, in order to ensure attainment of the health-related targets in the SDGs. In this connection, the WHO Secretariat and the Convention Secretariat of the WHO Framework Convention on Tobacco Control jointly prepared the publication, *The economic and health benefits of tobacco taxation*. World No Tobacco Day in 2014 was devoted to underlining how raising taxes on tobacco is a win-win policy for all Member States, and in 2015 it focused on the need to eliminate illicit trade in tobacco. WHO has engaged with officials from ministries of finance from more than 70 Member States around the world to provide technical assistance on tobacco taxation.

14. The WHO report on the global tobacco epidemic is published every two years. The 2015 report focused on tobacco taxation and provided an in-depth analysis of tobacco taxes in all WHO Member States. Another key instrument for policy dialogue has been the WHO global report on trends in tobacco smoking 2000–2025. The results show that although 35 countries are on track to attain the target of a 30% relative reduction in the prevalence of current tobacco use by 2025, most countries will not reach the target unless they implement tobacco control measures at the highest level.

15. In the light of challenges under international trade and investment agreements to tobacco control measures such as plain packaging and large graphic health warnings, and in accordance with resolution WHA59.26, WHO provided training and technical support in 40 Member States. It also provided technical support to seven countries with developing national plans to counter tobacco industry interference. In partnership with ITU, WHO developed innovative, cost-effective, personalized and interactive mobile cessation tools to decrease tobacco use in four Member States.

16. WHO has supported the Conference of the Parties to the WHO Framework Convention on Tobacco Control, through the Convention Secretariat, in the development of guidelines for articles 6, 9 and 10 of the Convention. In addition, it produced the Global Adult Tobacco Survey Atlas (2015), the fifth Report on the scientific basis of tobacco product regulation, and tobacco use knowledge summaries on pregnancy and dementia.

Promoting a healthy diet and physical activity

17. WHO developed a salt reduction toolkit. A report of a technical meeting of experts on fiscal policies for diet, as well as a report and background review document of a technical meeting on nutrition labelling were published, to support Member States in implementing policies to promote a healthy diet. To support national responses, networks for salt reduction were established in several regions. Technical support was also provided to Member States to develop national plans for salt reduction. The Secretariat developed nutrient profile models to serve as a tool to support countries in implementing WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children. Capacity-building activities were also carried out. Many Member States received technical support with developing fiscal policy measures to address the marketing of foods and non-alcoholic beverages to children.

18. The Secretariat provided technical support in strengthening and updating national nutrition policies and action plans in a number of Member States. Tracking national progress was carried out through the WHO global database on the implementation of nutrition action, which now contains

approximately 4000 policy and action data. In March 2015, the Secretariat published WHO's updated guideline on sugar intake for adults and children, and released draft WHO guidelines on the intake of total fatty acids, saturated fatty acids and *trans*-fatty acids for public consultation in April 2016.

19. Tools were developed to guide Member States on the promotion of physical activity, including a quality physical education policy package for schools, in collaboration with UNESCO and others, an implementation toolkit for primary health care, sports and the workplace, and a policy audit tool. A regional action plan on physical activity was developed specifically in one region and as part of obesity prevention plans in others, while regional physical activity campaigns were carried out in two regions. Technical cooperation was undertaken with many Member States in the areas of planning physical activity programmes and capacity-building programmes for social marketing and mass media interventions.

Reducing the harmful use of alcohol

20. To strengthen the capacity of ministries of health to lead effective policy development and implementation to reduce the harmful use of alcohol, the Secretariat continued to support the network of WHO national counterparts, focusing on exchange of experience, collection of best practices and promotion of cost-effective interventions. Following the second meeting of the global network, WHO organized a capacity-building workshop on alcohol pricing policies in South Africa. Effective options for regulation of the marketing of alcoholic beverages, particularly to protect young people, were discussed at an expert meeting held at the headquarters of the Pan-American Health Organization in 2015. Following the presentation of the baseline for alcohol-related indicators in WHO's *Global status report on alcohol and health 2014*, the global alcohol policy progress survey was undertaken in 2015. A global United Nations thematic group on reducing the harmful use of alcohol was established in 2015, as part of the work of the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases.

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

21. To guide the Secretariat's priority activities in the area of management of noncommunicable diseases in the years to come, the Secretariat convened four global technical and strategic meetings during 2015 on the management of cancer, diabetes, chronic respiratory diseases and cardiovascular diseases. For each meeting, a set of priority actions were identified, including producing policy guidance on population cancer screening, preparing a global report on diabetes and updating the charts for cardiovascular risk assessment. A number of regional consultations were also convened on key noncommunicable disease management issues, including the integration of noncommunicable disease management into primary health care, palliative care, cancer care and the total risk approach to cardiovascular disease.

22. The Secretariat continued to promote an integrated approach to noncommunicable disease management, with emphasis on primary health care and universal health coverage. The WHO package of essential noncommunicable disease interventions for primary health care was updated in 2013 and complemented by additional guidance and tools. Components of the package have been adapted for use in specific WHO regions; for example, an electronic cardiovascular disease risk calculator, based on the WHO cardiovascular risk assessment chart, was developed in the Region of the Americas. With technical support provided by the Secretariat, the package has now been

implemented in 27 Member States. Country-specific cardiovascular risk charts were developed and are being validated in the first half of 2016.

23. The Secretariat also developed a number of new guidelines and tools to strengthen the implementation of cost-effective interventions for early detection, treatment, rehabilitation and palliative care. They include: comprehensive guidelines for cervical cancer control; a WHO position statement on mammography screening; diagnostic criteria and classification of hyperglycaemia first detected in pregnancy; a global brief on hypertension; guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection; updated fact sheets on palliative care, cardiovascular disease, cancer, diabetes, asthma, and chronic obstructive pulmonary disease; a toolbox for access to essential medicines and health technologies for noncommunicable diseases; and a tool for developing, implementing and monitoring national multisectoral noncommunicable disease action plans. WHO's recommendations for cervical cancer primary and secondary prevention (two-dose human papillomavirus vaccination and screen-and-treat approaches) have been published. An expert consultation on cancer early diagnosis and screening was organized in 2015 and work is progressing on developing a model list of equipment for cancer treatment.

24. The Secretariat provided Member States with technical support to strengthen their health system responses to specific noncommunicable disease challenges. Member States in the Region of the Americas were supported to improve diabetes management, with a focus on communities with vulnerable populations. Support was provided to establish Barbados as a demonstration site for the Global Standardized Hypertension Treatment project. Comprehensive national cancer control review and assessment missions were conducted jointly with IAEA and IARC to 59 countries. Additional country support was provided to develop cancer registries and strengthen cervical cancer control. A Joint Global Programme on Cervical Cancer Prevention and Control was established with eight organizations in the United Nations system, and will support participating countries in having in place a functioning and sustainable high-quality national comprehensive cervical cancer control programme with women able to accessing services equitably. The Secretariat convened the annual general meetings of the Global Alliance against Chronic Respiratory Diseases, attended by representatives of 25 countries and many professional and patient associations. The Secretariat also convened regional workshops on palliative care with Member States in four WHO regions between October and December 2015.

25. The 20th WHO Expert Committee on the Selection and Rational Use of Essential Medicines recommended in April 2015 the addition of 16 new cancer medicines to the WHO Model List of Essential Medicines and endorsed the use of 30 medicines listed currently as part of proven clinically effective treatment regimens for noncommunicable diseases. To enhance efforts to attain 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, the Secretariat engaged international partners in dialogue through a discussion paper and web-based consultation. In March 2016, the Secretariat conducted a survey of some 30 low- and middle-income countries to assess price and availability of essential medicines for diabetes and other noncommunicable diseases at different levels of the health system. Country surveys on prices, availability, affordability and price components of medicines to treat noncommunicable diseases were also conducted in three countries in the Eastern Mediterranean Region. In the Region of the Americas, more than 25 medications for cardiovascular diseases, diabetes, cancer and chronic respiratory diseases have been included in the PAHO Strategic Fund, with long-term agreements for a unique price for each medication with prequalified manufacturers. The medicines are now available for access by all Member States in the Region.

26. The Secretariat provided input into work with the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières,

UNICEF, UNFPA and UNHCR to update the Interagency Emergency Health Kit 2011 used in humanitarian emergencies and disaster relief, to ensure that noncommunicable diseases receive attention in the acute phase of disaster and emergency response. A policy brief for Member States was also developed on how Member States can incorporate the prevention and control of noncommunicable diseases into emergency responses. A situation analysis on the provision of noncommunicable disease care to Syrian refugees and internally displaced persons was conducted in Egypt, Jordan, Lebanon, Syrian Arab Republic and Turkey.

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

27. The Secretariat organized an ad hoc meeting of leading researchers, representatives of international nongovernmental organizations and WHO collaborating centres in May 2015, in order to identify strategic directions and key activities in noncommunicable disease research that WHO could implement, in collaboration with its partners, in the following three years. The outputs of the meeting will enable the Secretariat to prepare a workplan 2016–2018 to implement action 54 (research) in the global action plan for noncommunicable disease prevention and control 2013–2020, taking into account the research-related commitments in United Nations General Assembly resolutions 66/2 and 68/300.

28. A WHO practical guide to implementation research is being prepared in collaboration with international experts, with the aim of guiding countries in analysing health problems, generating new evidence and linking existing evidence and policy, setting priorities for action, and exploring innovative approaches to scaling up recommended interventions.

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

29. The Secretariat provided technical support and guidance to Member States in strengthening or developing their noncommunicable disease monitoring and surveillance systems covering mortality, behavioural risk factors and biological/metabolic risk factors. Technical missions and regional workshops were conducted to provide advice, support and training to Member States establishing or expanding their risk factor surveillance systems. Support was also provided to Member States in developing national targets and indicators for noncommunicable diseases based on the global standards: detailed indicator specifications and definitions were developed, and tools to help set appropriate targets based on national circumstances were disseminated.

30. Between May and August 2015, the Secretariat undertook an extensive mapping and assessment of Member States' national capacity to prevent and control noncommunicable diseases.

ANNEX 2

PROCESS TO UPDATE, IN 2016, APPENDIX 3 OF THE GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020

CONTEXT

1. Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 consists of a menu of policy options and interventions for each of the six objectives of the plan. These 81 policy recommendations include 14 policy interventions that are classified as “very cost-effective and affordable interventions for all Member States”¹ (also referred to as the “best buys”), as well as other cost-effective interventions (also referred to as the “good buys”).
2. An expert consultation was convened from 22 to 23 June 2015 to advise the Secretariat on a methodology to update Appendix 3.² Participants included experts in economic evaluation methodology, as well as topic experts. There was agreement among the experts in their recommendation to the Secretariat that Appendix 3 should be updated in light of new scientific evidence. Similarly, it was recommended to the Secretariat that the process of updating Appendix 3 should also be used to strengthen public trust and transparency by classifying cost-effective interventions across two categories.

OVERARCHING APPROACH

3. The Secretariat will update Appendix 3 using the following approach.
 - (a) The current Appendix 3 will be used as the starting point for the update.
 - (b) The process to update Appendix 3 will be transparent: a clear algorithm will show which interventions have been considered and how they are classified (including those interventions that do not proceed to the final text).
 - (c) Improvements will be made to the presentation of Appendix 3 to make it clearer and easier for Member States to assess interventions in relation to their national context (see section on “Presentation of the updated Appendix 3” below).
 - (d) Additional information and guidance will be developed to accompany the updated Appendix 3, to provide context regarding implementation, health system and equity considerations.
 - (e) The list of interventions will need to be updated on an ongoing basis.

¹ Generate an extra year of healthy life at a cost less than the average annual income or gross domestic product per person.

² <http://www.who.int/nmh/events/meeting-report-consultation-on-appendix-3-final.pdf?ua=1>.

- (f) Once the list of interventions has been finalized, the WHO web page on tools to prevent and control noncommunicable diseases will be updated with any additional resources.

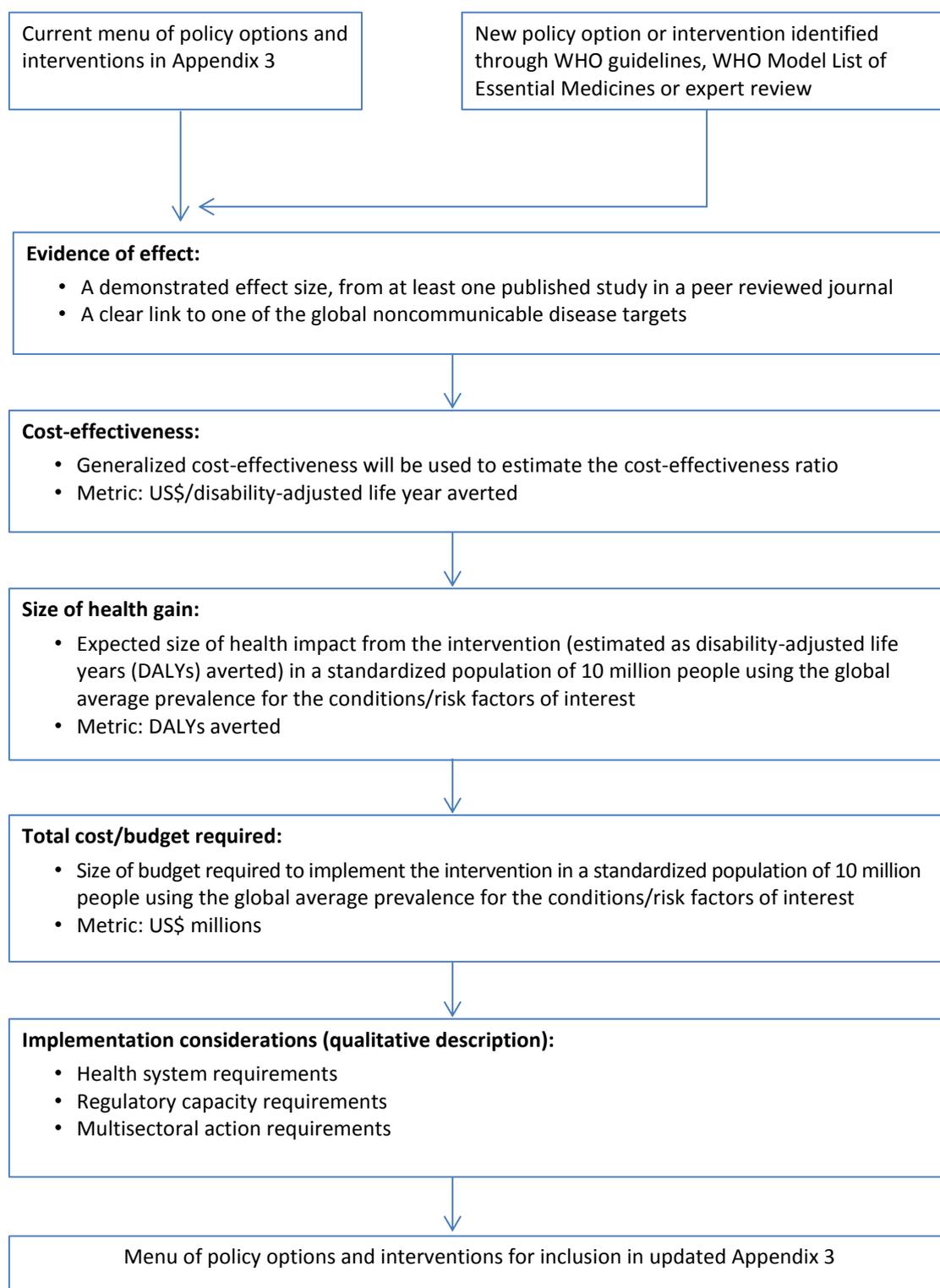
IDENTIFYING INTERVENTIONS FOR ANALYSIS

4. The following effectiveness criteria should be used to identify possible interventions for analysis:

- (a) Some interventions in the current Appendix 3 warrant a fresh cost-effectiveness analysis, because of new evidence or changing cost.
- (b) Some interventions in the current Appendix 3 can be replaced by more specific interventions.
- (c) Some new interventions that were not included in Appendix 3 should be analysed for inclusion.
- (d) The criteria for identifying new interventions to be analysed include:
 - action areas in the global action plan that are not reflected in the current Appendix 3;
 - areas covered by new WHO guidelines published since 2011;
 - other interventions proposed through WHO global expert consultation meetings and expert advisory panels.
- (e) To be considered for further analysis, all new interventions must meet the following effectiveness criteria:
 - a demonstrated and quantifiable effect size, from at least one published study in a peer-reviewed journal;
 - a clear link to one of the nine voluntary global targets.

ANALYSIS OF INTERVENTIONS

5. For interventions that meet the effectiveness criteria, the following parameters will be considered, according to the algorithm outline in Figure 1.

Figure 1. Algorithm for analysis of interventions

Cost-effectiveness

- (a) It is recognized that for some interventions, robust cost-effectiveness analysis is not possible. Robust cost-effectiveness analysis requires that:
- health impact can be measured for the range of likely health outcomes;
 - health impacts can be modelled over the life course;
 - the cost function of the intervention can be identified.
- (b) Interventions for which robust cost-effectiveness analysis is not considered possible at this time will proceed directly to consideration of implementation constraints.
- (c) For interventions where robust cost-effectiveness analysis is considered possible, they will be analysed using the generalized WHO CHOICE methodology.¹
- (d) Interventions will be listed in order of their cost-effectiveness ratio. No distinct threshold is considered to indicate if an intervention is “cost-effective” or “not cost-effective”. Recommendations can be made based on the relative cost-effectiveness of the different policy options or interventions.

Size of health gain

- (a) The expected size of the population health impact of each intervention will be calculated based on the total number of disability-adjusted life years (DALYs) averted in a standardized population of 10 million people.
- (b) The effect size for each intervention will be taken from published literature. Where feasible, a meta-analysis of trials will be used. The minimum requirement is one published study showing an impact of the intervention on a quantifiable health outcome.
- (c) Health gain will be measured using an epidemiological model that includes all of the health outcomes likely to be impacted by the intervention. Two scenarios, one in which the intervention is implemented and one where there is no intervention, will be compared. The difference in DALYs between the two scenarios represents the health gain.
- (d) The prevalence of the relevant conditions/risk factors, based on global averages or averages for each country income grouping (low, lower middle, upper middle, high), will be applied to the standardized population of 10 million people. The prevalence figures used will be listed to make it easier for Member States to assess how the estimate may compare to their national situation.

Total cost/budget required

- (a) The total cost required to implement each intervention will be estimated, based on the cost to implement in a standardized population of 10 million people.

¹ Available at <http://www.who.int/choice/cost-effectiveness/en/> (accessed 29 November 2015).

(b) Costs will be calculated using an “ingredients approach” whereby each item required to implement the intervention (such as drugs, syringes, police officer training, legislation drafting) is identified, a quantity (q) is estimated based on WHO guidelines or other country experience, and a price (p) for each is taken from the WHO CHOICE price database. The multiplication of q and p gives the total cost.

(c) The prevalence of the relevant conditions/risk factors, based on global averages or averages for each country income grouping (low, lower middle, upper middle, high), will be applied to the standardized population of 10 million people. The prevalence figures used will be listed to make it easier for Member States to assess how the estimate may compare to their national situation.

Feasibility/implementation constraints

(a) Feasibility will be defined in terms of non-financial implementation constraints. Rather than being the subject of an eliminatory judgement, this dimension will be addressed through qualitative comments in the table of interventions in Appendix 3, indicating the main implementation considerations that policy-makers should bear in mind (health system capacity requirements, regulatory capacity, etc).

(b) The additional dimensions of fairness and protection from financial risk, as well as a more detailed discussion of implementation constraints, will be provided in a qualitative addendum to Appendix 3.

PRESENTATION OF THE UPDATED APPENDIX 3

6. Once the analysis of interventions has been completed, the Secretariat will consider the most appropriate options for presenting the information to inform policy decisions. The current Appendix 3 lists interventions according to the six objectives of the global action plan. Other options for presenting the updated Appendix 3 include:

- (a) listing in order of cost-effectiveness;
- (b) grouping interventions by typology (regulatory/fiscal, clinical management, etc.).

ADDENDUM TO THE UPDATED APPENDIX 3

7. To address a number of other important considerations (implementation challenges in different resource/health system contexts, considerations of fairness, and the need for greater transparency about the methodology for deriving the list of interventions), an addendum to Appendix 3 is recommended. The title and format of this document would be finalized by the Secretariat, but the contents would include the issues summarized below.

Methodological issues

(a) Technical details would be given of the WHO CHOICE model and of how the cost-effectiveness analysis was done, including assumptions and methods, or a link to an online resource containing this information.

(b) The full list of interventions considered for inclusion would be given, including those which were found to be not cost-effective, and an algorithm would be included showing how the interventions progressed through to different stages of analysis (see Figure 1.).

(c) Explicit discussion is needed of multisectoral co-benefits of interventions that are likely to have broader social benefits through improved outcomes outside the health sector (such as increased economic productivity by reduced traffic congestion from improved public transport policy, increased government revenue from tobacco tax increases).

Implementation issues

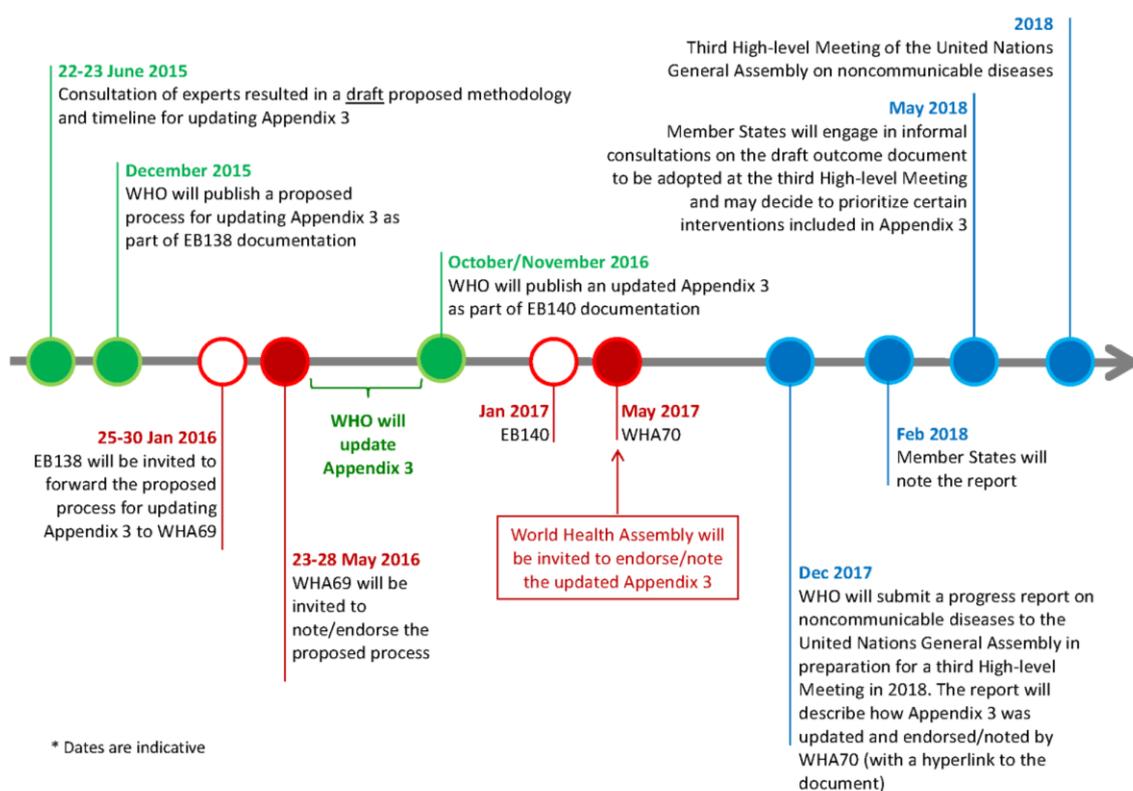
(a) The implications of fairness and protection against financial risk vary by country, so overall guidance on applying these principles will be given, rather than an application to each policy option or intervention.

(b) To support successful implementation of the policy options or interventions in Appendix 3, a programme managers' guide could be developed as a separate document, which could consider differences within populations.

TIMELINE

8. The timeline to update Appendix 3 is shown in Figure. 2.

Figure 2. Timeline to update Appendix 3



ANNEX 3

**REPORT ON PROGRESS MADE IN 2015 TOWARDS ATTAINMENT OF THE
NINE VOLUNTARY GLOBAL TARGETS FOR THE PREVENTION AND
CONTROL OF NONCOMMUNICABLE DISEASES**

1. This report describes the progress made in 2015 towards attainment of the nine voluntary global targets for the prevention and control of noncommunicable diseases.

PROGRESS MADE BY MEMBER STATES

2. By subparagraph 1(2) of resolution WHA66.10 the Health Assembly adopted the global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases. Taking account of the 15 “core” indicators, progress made by Member States towards attainment of the nine voluntary global targets for achievement by 2025 is summarized below.

Framework element	Target	Indicator	2010	2014
Mortality and morbidity				
Premature mortality from noncommunicable disease	(1) A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	(1) Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	20%	19% ¹
Risk factors				
Behavioural risk factors				
Harmful use of alcohol ²	(2) At least 10% relative reduction in the harmful use of alcohol, ³ as appropriate, within the national context	(3) Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context	6.4	6.3

¹ 2012 figure.

² Countries will select indicator(s) of harmful use as appropriate to their national context and in line with WHO’s global strategy to reduce the harmful use of alcohol. Such indicators may include prevalence of heavy episodic drinking, total per capita consumption of alcohol, and alcohol-related morbidity and mortality.

³ In WHO’s global strategy to reduce the harmful use of alcohol, the concept of “harmful use of alcohol” encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

Framework element	Target	Indicator	2010	2014
		(4) Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context <ul style="list-style-type: none"> • Among adolescents (15–19 years old) • Among adults (15+ years old) 	9.6%	9.3%
			7.8%	7.7%
		(5) Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context <ul style="list-style-type: none"> • Age-standardized prevalence of alcohol use disorders (as a percentage of population 15+ years old) 	4.1%	4.1%
Physical inactivity	(3) A 10% relative reduction in prevalence of insufficient physical activity	(6) Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily	81%	NO DATA ¹
		(7) Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)	23%	NO DATA ²
Salt/sodium intake	(4) A 30% relative reduction in mean population intake of salt/sodium ³	(8) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years	3.95 gram/day	NO DATA
Tobacco use	(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	(9) Prevalence of current tobacco use among adolescents	15% ⁴	NO DATA

¹ Country-comparable estimates of adult physical inactivity are currently under development, due for release in November 2016.

² Country-comparable estimates of adolescent physical inactivity are currently under development, due for release in November 2016.

³ WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per day.

⁴ Population-weighted average of global youth tobacco survey data from 67 countries, covering more than 50% of the global population. Surveys were carried out 2009–2011. Estimates refer to youths aged 13–15 years.

Framework element	Target	Indicator	2010	2014
		(10) Age-standardized prevalence of current tobacco use among persons aged 18+ years	Prevalence of smokeless tobacco use 6% ¹ Prevalence of tobacco smoking among adults aged 18+ years 23.1%	NO DATA Prevalence of tobacco smoking among adults aged 18+ years 21.8%
Biological risk factors				
Raised blood pressure	(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	(11) Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg) and mean systolic blood pressure	23%	22%
Diabetes and obesity ²	(7) Halt the rise in diabetes and obesity	(12) Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose) (13) Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex) (14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m ² for overweight and body mass index ≥ 30 kg/m ² for obesity)	7.9% NO DATA 11% (obesity) 37% (overweight)	8.5% NO DATA 13% (obesity) 39% (overweight)

¹ Population-weighted average of survey data from 86 countries, covering more than 50% of the global population. Surveys were carried out 2004–2014. Estimate based on available survey data for adults, covering varying age ranges.

² Countries will select indicator(s) appropriate to national context.

Framework element	Target	Indicator	2010	2014
National systems response				
Drug therapy to prevent heart attacks and strokes	(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	(18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk $\geq 30\%$, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	NO DATA	NO DATA ¹
Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases	(9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	(19) Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities	NO DATA	NO DATA ²

¹ Country-comparable estimates of adolescent obesity and overweight are currently under development and will be released in May 2016. Data to generate this indicator are currently available from a few countries that have undertaken STEPS surveys with biochemical measures. In order to generate a global estimate, data from more countries are needed.

² Data to generate this indicator are currently available from a few countries that have undertaken facility-based surveys to determine availability of medicines and technologies. In order to generate a global estimate, data from more countries are needed.

ANNEX 4

DEVELOPMENT OF AN 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

SCOPE AND PURPOSE

1. In paragraph 37 of United Nations General Assembly resolution 68/300, 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.
2. Bearing in mind the wide range of potential approaches to the assignment, this report outlines the preliminary avenues that the Secretariat proposes to explore in 2016, in full consultation with Member States. These include:
 - possible options for specifying what types of “contributions” by non-State actors might usefully be registered, and how to ensure that these would have the greatest impact on the attainment of the nine voluntary targets;
 - alternatives for defining which non-State actors could be eligible to participate and the potential modalities for their participation;
 - an initial exploration of the types of instruments that could be developed to register contributions in the most effective way.
3. This Annex proposes an initial set of overarching principles (paragraph 5) and considerations (paragraphs 6 to 10) that the Secretariat will take into account when identifying and developing a final draft approach. The report also provides a preliminary analysis of potential risks and mitigation measures (paragraph 11).
4. A proposed timeline to complete the work in 2016, for consideration by Member States in WHO’s governing bodies in 2017, is presented at the end of the Annex (paragraph 12).

OVERARCHING PRINCIPLES

5. The development of an approach for registering the contributions of non-State actors is envisaged as a multi-year process, which could be underpinned by specific overarching principles. An initial set of overarching principles is proposed below:
 - Support the achievement of the voluntary targets

- Comply with the principles of transparency, openness, inclusiveness, accountability and amenability to independent verification
- Ensure consistency with the WHO Framework of engagement with non-State actors (under development)
- Recognize the fundamental conflict of interest between the tobacco industry and public health.

CONSIDERATIONS IN DEVELOPING AN APPROACH FOR REGISTERING CONTRIBUTIONS

6. The following section provides a range of methodological options for the development of a final approach.

7. **Alignment criteria.** In developing the approach, the Secretariat proposes to take into account other existing international treaties, frameworks, agendas and initiatives. The approach could:

(a) align with relevant WHO treaties, frameworks, strategies, action plans and recommendations already agreed by Member States, including:

- WHO Framework Convention on Tobacco Control
- Global strategy on diet, physical activity and health
- Global strategy to reduce the harmful use of alcohol
- Recommendations on the marketing of foods and non-alcoholic beverages to children
- Global recommendations on physical activity for health
- global action plan for the prevention and control of noncommunicable diseases 2013–2020
- draft WHO framework of engagement with non-State actors;

(b) take into account lessons learnt from other similar initiatives and frameworks engaging various types of non-State actors (such as the UN Global Compact, Access to Medicines Index, Initiative on Public–Private Partnerships for Health and G-Finder), while recognizing the specificity of this effort;

(c) build on the 2030 Agenda for Sustainable Development, including the target in the Sustainable Development Goals to reduce premature mortality from noncommunicable diseases by one third by 2030, and the Addis Ababa Action Agenda, which invites the private sector to engage as partners in the development process and to invest in areas critical to sustainable development.

8. **Impact criteria.** The Secretariat proposes to explore the following options in guiding non-State actors to register contributions that are likely to have the greatest impact on achievement of the nine voluntary targets:

(a) Non-State actors could be encouraged to focus primarily on those policy options and interventions identified in Appendix 3 of the global action plan as “very effective and affordable for all countries”. This could secure greatest visibility to those contributions with the highest impact.

(b) With regard to the different types of contributions that non-State actors could be encouraged to register, some options which the Secretariat may propose could include, but are not limited to, the following:

- non-State actors could exclusively register contributions related to activities that directly minimize the potential impact of their core business on the global burden of noncommunicable diseases;
- non-State actors could register contributions related to two areas: (1) activities that directly minimize the impact of their core business on the global burden of noncommunicable diseases; and (2) initiatives that help prevent their employees’ likelihood of developing noncommunicable diseases;
- non-State actors could register contributions related to three areas: (1) activities that directly minimize the impact of their core business on the global burden of noncommunicable diseases; (2) initiatives that help prevent their employees’ likelihood of developing noncommunicable diseases; (3) other initiatives of a philanthropic nature proven to have a direct and significant impact on noncommunicable diseases (such as providing financial or in kind support to the implementation of interventions included in the list of “very cost-effective and affordable interventions for all countries”).

9. **Participation criteria.** Non-State actors at global, regional and national levels represent a wide range of stakeholders that could be grouped by market size, coverage, sector and geographical context. The diversity of non-State actors should be taken into consideration when defining the most effective approach to register their contributions. Different options for defining parameters for eligibility and modalities of participation which the Secretariat will explore are described below.

(a) Overall eligibility for the initiative could be based on compliance by non-State actors with the definition and principles of the WHO framework of engagement with non-State actors (under development), the provisions of United Nations General Assembly resolutions 66/2 and 68/300, and the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

(b) Different options could then be considered to determine the modality of participation by eligible non-State actors. These could take into account typology and context-specific differences and might include the following:

- All eligible actors who wished to participate could be allowed to register their contributions, regardless of their geographical context and coverage, sector and size.
- Specific parameters based on geographical context and coverage, sector, and size could be developed, in order to limit participation to selected eligible actors (for instance, only those with a global presence or a minimum market size/coverage might be invited to participate).

- All eligible actors could be encouraged to participate, but participation could be “streamed” by size, typology or sector, allowing for the development of different reporting parameters and guidelines for specific groups of actors.

(c) Finally, the Secretariat may consider phasing in the registration process. For instance, a selected group of non-State actors (such as global actors whose core business is directly related to the nine voluntary targets) could be encouraged to participate in a first phase. Participation could then be broadened to a wider constituency later in the process.

10. **Methodological options.** The approach could be operationalized through a range of possible mechanisms, to encourage voluntary participation by non-State actors, who would be invited to register their contributions. These could enable all relevant actors to report their own contributions in the most objective and independently verifiable way possible, perhaps by allowing them to assess their individual contributions against a set of predefined parameters and indicators. To ensure broad uptake and support by all types of actors, it would be key that any reporting tools developed were perceived as being relevant and easy to use. The options to be considered include the following:

(a) a universal web-based “reporting tool” comprising predefined fields aligned with clear standardized parameters, criteria and offering potential indicators. This predefined form, to be completed online, could guide non-State actors to register contributions with the greatest impact on noncommunicable diseases prevention and control. This could ensure the highest level of transparency, consistency and accuracy. It would also enable non-State actors to participate using very limited resources, thus making it highly inclusive for a broad range of actors across typologies, sectors and contexts;

(b) an overarching assessment framework including minimum requirements, parameters and guidelines. This template could be available via the Internet to non-State actors who wished to participate. The approach could provide more flexibility to such actors while supporting them to focus their individual reporting on key areas of impact. This, however, would ensure a more limited level of transparency and consistency. Moreover, comparing different contributions across a variety of sectors, typologies and contexts could be challenging;

(c) an open Internet platform, or portal, which non-State actors could access to upload their own reports for broad assessment and comparison. Predefined parameters and indicators could be listed as examples of guidelines to be followed. This approach would enable such actors to publish their own assessment of what contributions they deemed most relevant to noncommunicable disease prevention and control. Despite allowing greater freedom of interpretation to non-State actors, published data might be less comparable and the relevance of registered contributions more difficult to ascertain in the absence of a comprehensive pre-set assessment framework.

POTENTIAL RISKS AND MITIGATION MEASURES

11. The Secretariat will consider a number of challenges and risks in further defining an approach for registering contributions by non-State actors.

(a) Participation by non-State actors will be on a voluntary basis. Any approach developed should therefore be perceived as a tool that:

- can genuinely facilitate the registration of contributions by non-State actors, guiding them in assessing the real impact of their contributions and consequently enabling them to progress further in their engagement in the prevention and control of noncommunicable diseases;
 - can foster better coordination between different categories of non-State actors.
- (b) Potential reporting tools should be perceived not as unilateral but as participative instruments.
- (c) The registration of contributions by individual non-State actors should not be used to serve their interests or to promote their brand, product, views or activity with limited or no benefits for the prevention and control of noncommunicable diseases. This could be avoided by clearly defining the parameters of what constitutes a contribution and what does not. Participation in the initiative and registration of contributions could be improperly presented by some actors as an endorsement by WHO. The role of WHO should therefore be clearly defined.
- (d) Participation in the initiative by some non-State actors could potentially be used to divert attention from their core business to activities that have no proven direct impact on the prevention and control of noncommunicable diseases. This could be addressed by developing clear parameters and guidelines for registering contributions.

PROPOSED TIMELINE

12. The proposed timeline for consideration and implementation of the approach is set out below.

January 2016 to January 2017: In full consultation with Member States, the Secretariat will complete its work on the development of an approach. This will include proposing a concrete reporting method or mechanism, and related specific parameters and indicators.

January 2017 to May 2017: The Seventieth World Health Assembly, through the Executive Board, will be invited to endorse the proposed final approach.

September 2017: Once endorsed by the Seventieth World Health Assembly, the Director-General will include a reference to the developed approach in the 2017 report to the United Nations General Assembly on the progress achieved in the implementation of United Nations General Assembly resolution 68/300, in preparation for the third United Nations High-level Meeting on prevention and control of noncommunicable diseases in 2018.

May 2017 and beyond: Once endorsed by the Seventieth World Health Assembly, and in accordance with action 4.2 of its workplan for 2016–2017,¹ the global coordination mechanism for the prevention and control of noncommunicable diseases will start implementing the approach that the Secretariat will have developed.

¹ See document A68/11, Annex 3.

ANNEX 5

REPORT ON PROGRESS MADE IN CARRYING OUT ACTIONS INCLUDED IN THE 2014–2015 WORKPLAN OF THE GLOBAL COORDINATION MECHANISM ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES DURING THE PERIOD FROM MAY 2014 TO MARCH 2016

1. This report describes the progress made by the Secretariat of the global coordination mechanism on the prevention and control of noncommunicable diseases in carrying out the actions included in its 2014–2015 workplan.¹

PROGRESS MADE BY THE SECRETARIAT

2. The Sixty-seventh World Health Assembly noted the global coordination mechanism's 2014–2015 workplan. The progress made by the Secretariat on the actions contained in that workplan is summarized below.

Action	Activity	Progress achieved in 2014 and 2015
Action 1.1	Conduct a dialogue in 2014 on how to encourage the continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies. The dialogue will result in a report with recommendations.	A dialogue on noncommunicable diseases and development cooperation was held on 20–21 April 2015 and a report was issued. ²
Action 1.2	Conduct a dialogue in 2015 on how to strengthen international cooperation on the prevention and control of noncommunicable diseases within the framework of North–South, South–South and triangular cooperation. The dialogue will result in a report with recommendations.	A dialogue on noncommunicable diseases and international cooperation was held from 30 November to 1 December 2015 and a report will be issued during the first half of May 2016. ³
Action 2.1	Establish a web-based platform in 2014 that builds and disseminates information about the necessary evidence base to inform policy-makers about the relationship between noncommunicable diseases, poverty and development.	A web-based platform was established in 2015. ⁴

¹ See document A67/14 Add.3 Rev.1.

² Available at http://www.who.int/global-coordination-mechanism/final_meeting_report_dialogue_ncd_development_april15_en.pdf?ua=1 (accessed 30 November 2015).

³ To be made available at <http://www.who.int/global-coordination-mechanism/dialogues/dialogue-international-partnership/en/> (accessed 6 May 2016).

⁴ See <http://www.who.int/ncds/gcm/en/> and <http://www.gcmportal.org> (accessed 21 April 2016).

Action	Activity	Progress achieved in 2014 and 2015
Action 2.2	Establish a web-based platform in 2015 that promotes and facilitates international and intercountry collaboration for exchange of best practices in the areas of health-in-all policies, whole-of-government and whole-of-society approaches, legislation, regulation, health system strengthening and training of health personnel, so as to disseminate learning from the experiences of Member States in meeting the challenges.	Web-based platform established in 2015 under Action 2.1 ¹
Action 2.3	Establish a series of webinars starting in 2014 to support the coordinating role of WHO in areas where stakeholders can contribute to and take concerted action against noncommunicable diseases.	A series of webinars were organized. ²
Action 3.1	Establish a working group in 2014 to recommend ways and means of encouraging Member States and non-State actors to realize the commitment included in paragraph 44 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.	The working group was established in March 2015 and met three times before completing its work. An interim report was published in July 2015. ³ A final report with recommendations was submitted to the Director-General in April 2016 and made available to Member States. ⁴
Action 4.1	Establish a community of practice where participants can contribute to and take concerted action against noncommunicable diseases.	Communities of practice have been developed around the relevant thematic work of WHO, as well as a follow-up to the first WHO Global Meeting of National NCD Programme Directors and Managers.
Action 5.1	Establish a working group in 2014 to recommend ways and means of encouraging Member States and non-State actors to realize the commitment included in paragraph 45(d) of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.	The working group was established in March 2015 and met three times before completing its work. An interim report was published in July 2015. ³ A final report with recommendations was submitted to the Director-General in April 2016 and made available to Member States. ⁵

¹ See <http://www.who.int/ncds/gcm/en/> and <http://www.gcmportal.org> (accessed 29 April 2016).

² See <http://www.who.int/global-coordination-mechanism/news/webinars/en/> (accessed 29 April 2016).

³ Available at <http://www.who.int/global-coordination-mechanism/working-groups/wg-interim-report-comments/en/> (accessed 30 November 2015).

⁴ Available at http://www.who.int/global-coordination-mechanism/working-groups/final_3_1report_with_annexes_apr16_fin.pdf?ua=1 (accessed 29 April 2016).

⁵ Available at http://www.who.int/global-coordination-mechanism/working-groups/final_5_1report_with_annexes_apr16_fin.pdf?ua=1 (accessed 29 April 2016).

3. The Sixty-eighth World Health Assembly noted the global coordination mechanism's workplan for 2016–2017 contained in Annex 3 of document A68/11.¹ Paragraph 11 of this workplan, recalling paragraph 12 of the terms of reference of the global coordination mechanism, mandates its participants to meet face-to-face in 2017 in order to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors at all levels, as well as to promote WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and to assess progress made so far by the global coordination mechanism. The Secretariat has started to define the details for convening this general meeting in 2017 in accordance with the proposed modalities set out in Appendix 1 of Annex 3 of document A68/11.

¹ Available at http://www.who.int/global-coordination-mechanism/working-groups/whaa68_gcm_workplan_2016_17a.pdf?ua=1 (accessed 29 April 2016).

ANNEX 6

**REPORT ON PROGRESS MADE BETWEEN APRIL 2015 AND MARCH 2016 BY
THE UNITED NATIONS INTER-AGENCY TASK FORCE ON THE PREVENTION
AND CONTROL OF NON-COMMUNICABLE DISEASES**

1. This report describes the progress made by the Secretariat since March 2015, when the Secretary-General of the United Nations transmitted to the United Nations Economic and Social Council the report of the Director-General of WHO on the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases.¹
2. During the first week of March 2016, and pursuant to resolution 2015/8 of the United Nations Economic and Social Council, the Secretariat of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases submitted the report of the Director-General of WHO on the Inter-Agency Task Force to the Office for ECOSOC Support and Coordination, United Nations Department of Economic and Social Affairs for onward transmittal to the Economic and Social Council. The report is currently being edited and translated and will be published on the website of the Economic and Social Council;² it will be considered by Member States during the Council's Coordination and Management Meeting (New York, 1–3 June 2016).³

PROGRESS MADE BY THE SECRETARIAT**Joint country programming missions**

3. Under WHO's leadership, and with the participation of interested organizations of the United Nations system, joint country programming missions were undertaken to Barbados (13–17 April 2015), the Democratic Republic of the Congo (13–17 July 2015), Mongolia (7–11 September 2015), Sri Lanka (5–9 October 2015), Mozambique (2–7 November 2015), Paraguay (22–26 February 2016), Kyrgyzstan (14–18 March 2016) and Oman (10–14 April 2016). The objectives of the missions were to support country teams in their efforts to support countries in their efforts to build and share solutions for the prevention and control of noncommunicable diseases, and to establish a United Nations thematic group on noncommunicable diseases, or other appropriate arrangements, to serve as platforms for coordinated support to national noncommunicable disease responses that contribute to attaining target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being) of Sustainable Development Goal 3. Efforts include integrating noncommunicable diseases into the common country assessment and United Nations Development Assistance Framework, identifying opportunities for country team cooperation, including joint programming, and monitoring progress on the implementation of the activities of the country teams relevant to addressing noncommunicable diseases. Members of the missions included the Asian Development Bank, FAO, IOM, ILO, UNAIDS, UNDP, the United Nations Economic and Social Commission for Asia and the Pacific,

¹ Document E/2015/53.

² <https://www.un.org/ecosoc/en/documents/reports> (accessed 21 April 2016).

³ <https://www.un.org/ecosoc/en/events/2016/ecosoc-coordination-and-management-meeting-0> (accessed 21 April 2016).

UNFPA, UNICEF, UNESCO, the United Nations Volunteers programme, the United Nations Entity for Gender Equality and the Empowerment of Women, the World Bank, WFP and WHO.

Development of global joint programmes

4. When the United Nations Economic and Social Council adopted resolution 2015/8 on the work of the Task Force in June 2015, the WHO Secretariat shared plans with Member States for the development of three global joint programmes with other organizations of the United Nations system. The three programmes are: (i) the UNDP/WHO global joint programme to catalyse multisectoral action for noncommunicable diseases; (ii) the IAEA/IARC/WHO global joint programme to strengthen national cancer control responses; and (iii) the IAEA/IARC/UNAIDS/UNFPA/UNICEF/United Nations Office on Drugs and Crime/UN Women/World Bank/WHO global joint programme to strengthen national cervical cancer responses. The participating organizations are finalizing legal and operational arrangements and have started to jointly mobilize resources. The ITU/WHO global joint programme “Be He@lthy, Be Mobile”, to promote the use of mobile technologies in addressing noncommunicable diseases, has been expanded to include India.

Development of the 2016–2017 workplan

5. At its fifth meeting in October 2015, the Task Force discussed a draft workplan for 2016–2017.¹ It agreed to focus on a small set of high-level strategic priorities, including the implementation of global joint programmes, the development of a fast-track country initiative, and the design of a global strategic communication campaign to promote the work of the Task Force and the work of its members. The final version of the workplan for 2016–2017 is available on the website of the Task Force.²

Tobacco control

6. Members of the Task Force continue to acknowledge the special focus on tobacco control within the mandate of the Task Force and remain committed to ensuring that tobacco control continues to be duly addressed and prioritized.

Conflicts of interest

7. The Terms of Reference of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases stipulates that “public health policies for the prevention and control of non-communicable diseases must be protected from undue influence by any form of vested interest”. There have, however, been examples of the tobacco industry associating itself with some members of the Task Force, sometimes without the knowledge of members themselves. At the fifth meeting of the Task Force, the secretariat of the WHO Framework Convention on Tobacco Control and WHO presented a paper³ to highlight good practices of agencies including IAEA, UNDP, UNESCO, WHO, the secretariat of the WHO Framework Convention, and the World Bank to prevent

¹ A report on the outcomes of the fifth meeting is available at <http://www.who.int/ncds/un-task-force/events/oct-2015-uniatf-fifth-meeting/en/> (accessed 21 April 2016).

² <http://www.who.int/ncds/un-task-force/en/> (accessed 21 April 2016).

³ <http://apps.who.int/ftc/implementation/database/groups/un-agencies-and-tobacco-industry-interference-examples-good-practices-un-agencies-document> (accessed 21 April 2016).

tobacco industry interference. During both the fifth and sixth meetings of the Task Force, information was shared with members on specific examples where the industry continues to associate itself with individual organizations in the United Nations system.

8. The Task Force is now developing a “Model policy for agencies of the United Nations system on preventing tobacco industry interference” containing measures based on Article 5.3 of the WHO Framework Convention and the relevant guidelines adopted by the Conference of the Parties, with the expectation that is adopted by Task Force members by the end of the year.

9. The Task Force is also aware that the alcohol industry has lobbied at least one Member State ahead of Task Force meetings.

ANNEX 7

**CONTOURS OF THE REPORT TO THE
UNITED NATIONS GENERAL ASSEMBLY**

1. This report sets out the contours of the report that the Director-General will submit to the United Nations General Assembly towards the end of 2017 on the progress achieved in the implementation of the 2011 Political Declaration and the 2014 Outcome document.

FORMAT OF THE REPORT

2. The format of the Note of the United Nations Secretary-General transmitting the report of the Director-General of the World Health Organization on the prevention and control of noncommunicable diseases, which will be submitted to the United Nations General Assembly for the consideration of Member States towards the end of 2017, will be similar to the format used in 2013,¹ as shown below.

Chapter	Scope
1	Introduction
2	Where do we stand? (outcomes, progress and process, including links to the 2030 Agenda for Sustainable Development)
3	Progress made in realizing global commitments and assignments
4	Progress made in realizing the four time-bound national commitments for 2015 and 2016
5	International cooperation
6	Recommendations
Annex	WHO Noncommunicable Disease Progress Monitor 2017

3. Unlike the 2013 report, the report in 2017 will include an annex with individual county data on the 10 progress indicators set out in the technical note published by WHO on 1 May 2015.²

¹ Document A/68/650.

² Available at <http://www.who.int/nmh/events/2015/getting-to-2018/en/> (accessed 21 April 2016).

ANNEX 8

GLOBAL ACCOUNTABILITY FRAMEWORK ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

Existing agreements

1. In resolution WHA66.10 (2013), the Health Assembly adopted the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases.¹
2. In the same resolution, the Health Assembly adopted the set of nine voluntary global targets for achievement by 2025 for the prevention and control of noncommunicable diseases, noting that the target related to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases concerns premature mortality from noncommunicable diseases between the ages of 30 and 70, in accordance with the corresponding indicator.²
3. Furthermore, the Health Assembly requested the Director-General to submit reports on progress made in implementing the action plan, through the Executive Board, to the Health Assembly in 2016, 2018 and 2021, and reports on progress achieving in attaining the nine voluntary global targets in 2016, 2021 and 2026.³
4. In 2014, the Health Assembly approved nine indicators for the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020.⁴
5. In March 2016, the United Nations Statistical Commission on the global indicators for the 2030 Agenda for Sustainable Development agreed at its 47th session of, as a practical starting point, with the proposed global indicator framework for the goals and targets of the 2030 Agenda for Sustainable Development as reflected in the list of indicators presented in annex IV of report E/CN.3/2016/2/Rev.1, subject to future technical refinement.⁵ This list includes the indicators for noncommunicable disease-related targets set out in table 1:

¹ As contained in Annex 4, Appendix 2 of WHA66/2013/REC/1 (http://apps.who.int/gb/ebwha/pdf_files/WHA66-REC1/WHA66_2013_REC1_complete.pdf, accessed 21 April 2016).

² As contained in Annex 4, Appendix 3 of WHA66/2013/REC/1 (http://apps.who.int/gb/ebwha/pdf_files/WHA66-REC1/WHA66_2013_REC1_complete.pdf, accessed 21 April 2016).

³ Resolution WHA66.10, paragraph 3(9).

⁴ See document A67/14, Annex 4 and its Appendix, and document WHA67/2014/REC/3, p. 118.

⁵ Decision 1 of the UN Statistical Commission at its 47th session.

Table 1. Final list of noncommunicable disease-related sustainable development indicators (as included in Annex IV of document E/CN.3/2016/2/Rev.1, Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators).

Noncommunicable disease-related goals and targets (from the 2030 Agenda)	Indicators
3.4 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population) 3.8.2 Number of people covered by health insurance or a public health system per 1000 population
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis 3.b.2 Total net official development assistance to medical research and basic health sectors

Global accountability framework

6. When these agreements are taken into account, the WHO-related aspects of the global accountability framework for the prevention and control of noncommunicable disease include the components set out in Table 2.

Table 2. WHO's actions and functions in the global accountability framework.

Which reports does WHO prepare?	Which indicators does WHO use?	Where does the data go to?	When does WHO report?	When does WHO collect data for this report?
Progress report on progress towards nine global noncommunicable disease targets to be reached by 2025	25 outcome indicators	WHO's governing bodies	2016, 2021 and 2026	WHO Country Capacity Survey on Noncommunicable Diseases in 2015 and 2017
Report on progress towards implementing the WHO's global noncommunicable diseases action plan 2013–2020	9 action plan indicators	WHO's governing bodies	2016, 2018 and 2021	WHO Country Capacity Survey on Noncommunicable Diseases in 2015 and 2017
Report on progress made towards implementing the 2011 United Nations Political Declaration on NCDs and 2014 United Nations Outcome Document on Noncommunicable Diseases	10 progress monitor indicators published on 1 May 2015	United Nations General Assembly	2017	WHO Country Capacity Survey on Noncommunicable Diseases in 2015 and 2017
Report on progress made towards the noncommunicable disease-related targets in the Sustainable Development Goals to be reached by 2030	See Table 1	United Nations General Assembly	Yearly	To be determined

ANNEX 9

PROPOSED CODE FOR NONCOMMUNICABLE DISEASES

1. In support of paragraph 33 of United Nations General Assembly resolution 68/300, the Secretariat is engaging with the Development Assistance Committee of the Organisation for Economic Co-operation and Development to explore options for the development of a purpose code to track official development assistance for noncommunicable diseases.

2. Options currently being explored include:

Code: 123 – I.3 – Noncommunicable diseases (Total)

Possible subcodes:

- 12311 – Tobacco use
- 12312 – Exposure to physical inactivity
- 12313 – Exposure to harmful use of alcohol
- 12314 – Exposure to unhealthy diet
- 12321 – Cardiovascular disease control
- 12322 – Cancer control
- 12323 – Chronic respiratory disease control
- 12324 – Diabetes control
- 12325 – Research for the prevention and control of noncommunicable diseases
- 12326 – Surveillance for the prevention and control of noncommunicable diseases

= = =