

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.

SPECIFIC GLOBAL ASSIGNMENTS

2. The specific assignments given to WHO are:

- 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;
- 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

3. In response to paragraph 3(9) of resolution WHA66.10, 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 October 2015, for the consideration of the Executive Board before transmission to the Sixty-ninth World Health Assembly. The report is set out in Annex 1.

4. In response to paragraph 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. The proposal is set out in Annex 2.

WHO global monitoring mechanism on noncommunicable diseases

5. In response to paragraph 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 noncommunicable diseases, for the consideration of the Executive Board before transmission to the Sixty-ninth World Health Assembly. The report is set out in 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

6. 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

7. In support of paragraph 33 of United Nations General Assembly resolution 68/300, the Secretariat is currently developing a draft technical paper on a purpose code to track official development assistance for noncommunicable diseases, which members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development may wish to consider in 2016. The Secretariat envisages conducting a web-based consultation during the first quarter of 2016 with a view to seeking comments on a preliminary draft from Member States, bodies of the United Nations system and other international organizations, civil society, academia, the private sector and philanthropic foundations. The outcomes of the consultation will serve as input to the work of the Secretariat on completing a draft technical paper for consideration by the Sixty-ninth Health Assembly.

Global coordination mechanism on the prevention and control of noncommunicable diseases

8. 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

9. By 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 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 November 2015 is set out in Annex 6.

Report to the United Nations General Assembly

10. By 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 which the Director-General will submit to the United Nations Secretary-General are set out in Annex 7.

WHO NONCOMMUNICABLE DISEASE PROGRESS MONITOR 2015

11. The road map for developing national responses to noncommunicable diseases was established in the 2011 Political Declaration and the 2014 Outcome document. 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.

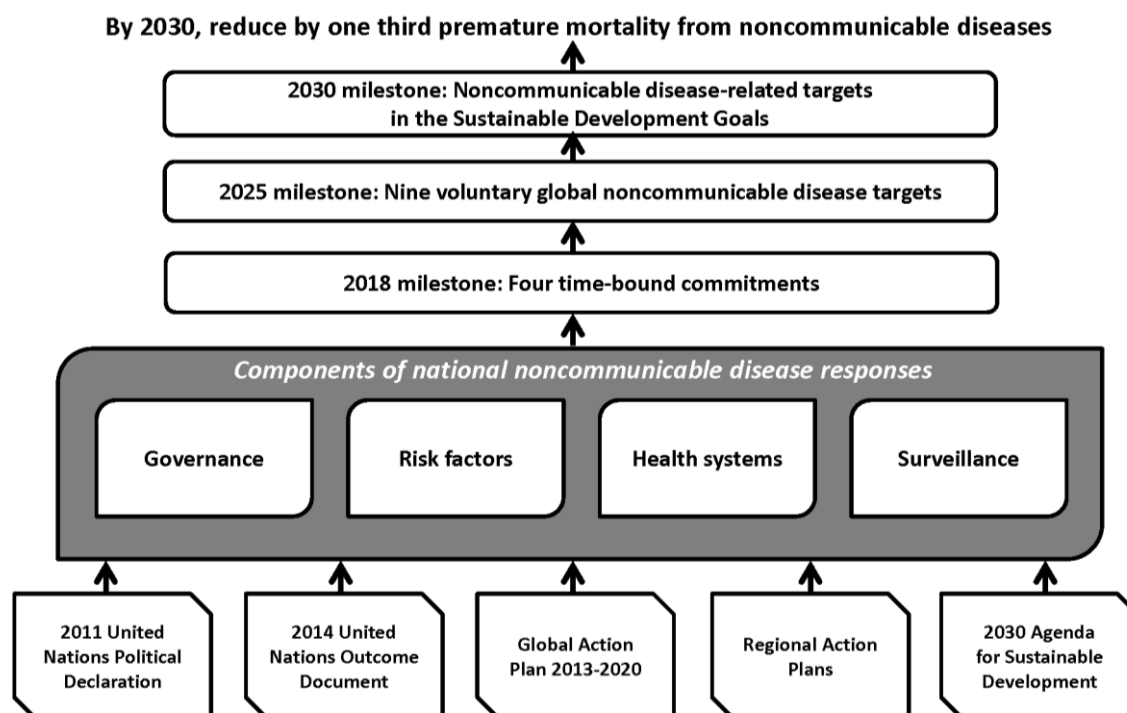
12. WHO launched the WHO Noncommunicable Disease Progress Monitor 2015 at the United Nations Summit on Sustainable Development in New York on 25 September 2015. The Monitor shows the extent to which 194 Member States are meeting those four time-bound commitments, in accordance with a technical note published by the Director-General on 1 May 2015.¹

PRIORITY ACTIONS FOR MEMBER STATES

13. 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 1.).

¹ <http://www.who.int/nmh/events/2015/getting-to-2018/en/>.

Figure 1. –Sustainable Development Goals and the nine voluntary global targets for noncommunicable disease prevention and control



ACTION BY THE EXECUTIVE BOARD

14. The Board is invited to consider the following draft resolution.

The Executive Board,

Having considered the report on 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 Noncommunicable Diseases in 2018,¹

RECOMMENDS to the Sixty-ninth World Health Assembly, the adoption of the following resolution:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level

¹ Document EB138/10.

Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases in 2018;

PP2 Recalling resolution WHA66.10, United Nations General Assembly resolutions 66/2, 68/300, 69/313 and 70/1, and United Nations Economic and Social Council resolutions 2013/12, 2014/10 and 2015/8,

OP1. NOTES the process to update, in 2016, Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

OP2. ENDORSES the process to further develop, in 2016, an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases;

OP3. URGES Member States to continue to implement the road map of national commitments included in United Nations General Assembly resolutions 66/2 and 68/300, including the four time-bound national commitments for 2015 and 2016, in preparation for a third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases in 2018, taking into account the technical note published by WHO on 1 May 2015, which sets out the progress monitor indicators that the Director-General will use to report to the United Nations General Assembly in 2017 on the progress achieved in the implementation of national commitments;

OP4. REQUESTS the Director-General:

OP4.1 to submit an updated Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, through the Executive Board, to the Health Assembly in 2017, in accordance with the timelines contained in Annex 2 of the report;

OP4.2 to submit an approach that can be used to register and publish contributions of non-State actors, through the Executive Board, to the Health Assembly in 2017, in accordance with the timelines contained in Annex 4 of the report.

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 OCTOBER 2015**

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 October 2015.

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
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”, while 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
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
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%)
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
^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.			

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

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

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

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. The Secretariat also published a report with recommendations emerging from the first Dialogue on noncommunicable diseases and development cooperation (Geneva, 20–21 April 2015) 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 was convened by the global coordination mechanism.

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

7. The Secretariat established a web page providing links to all WHO tools for the prevention and control of noncommunicable diseases.¹ The web page is designed to be the first reference for policy-makers when developing national responses to noncommunicable diseases.

8. 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.

¹ <http://www.who.int/nmh/ncd-tools/en/>, accessed 30 November 2015.

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

Tobacco control

9. 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 connexion, 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.

10. 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.

11. 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.

12. 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

13. WHO developed a salt reduction toolkit. A report of a technical meeting of experts on fiscal policies for diet was published, to assist 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.

14. 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 4 000 policy and action data. In March 2015, the Secretariat published the updated WHO guideline on sugar intake in adults and children, and in June 2015 it finalized the recommendations related to the intake of total fatty acids, saturated fatty acids and *trans*-fatty acids.

15. 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

16. 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 the second WHO Global status report on alcohol and health (2014), the global alcohol policy 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

17. 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, cancer care and the total risk approach to cardiovascular disease.

18. 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.

19. 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.

20. 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. 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.

21. 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. Country surveys on prices, availability, affordability and price components of medicines to treat noncommunicable diseases were conducted in three countries in the Eastern Mediterranean Region. In the Region of the Americas, over 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.

22. 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

23. 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.

24. 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

25. 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.

26. 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.

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>.

- (e) The list of interventions will need to be updated on an ongoing basis.
- (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.

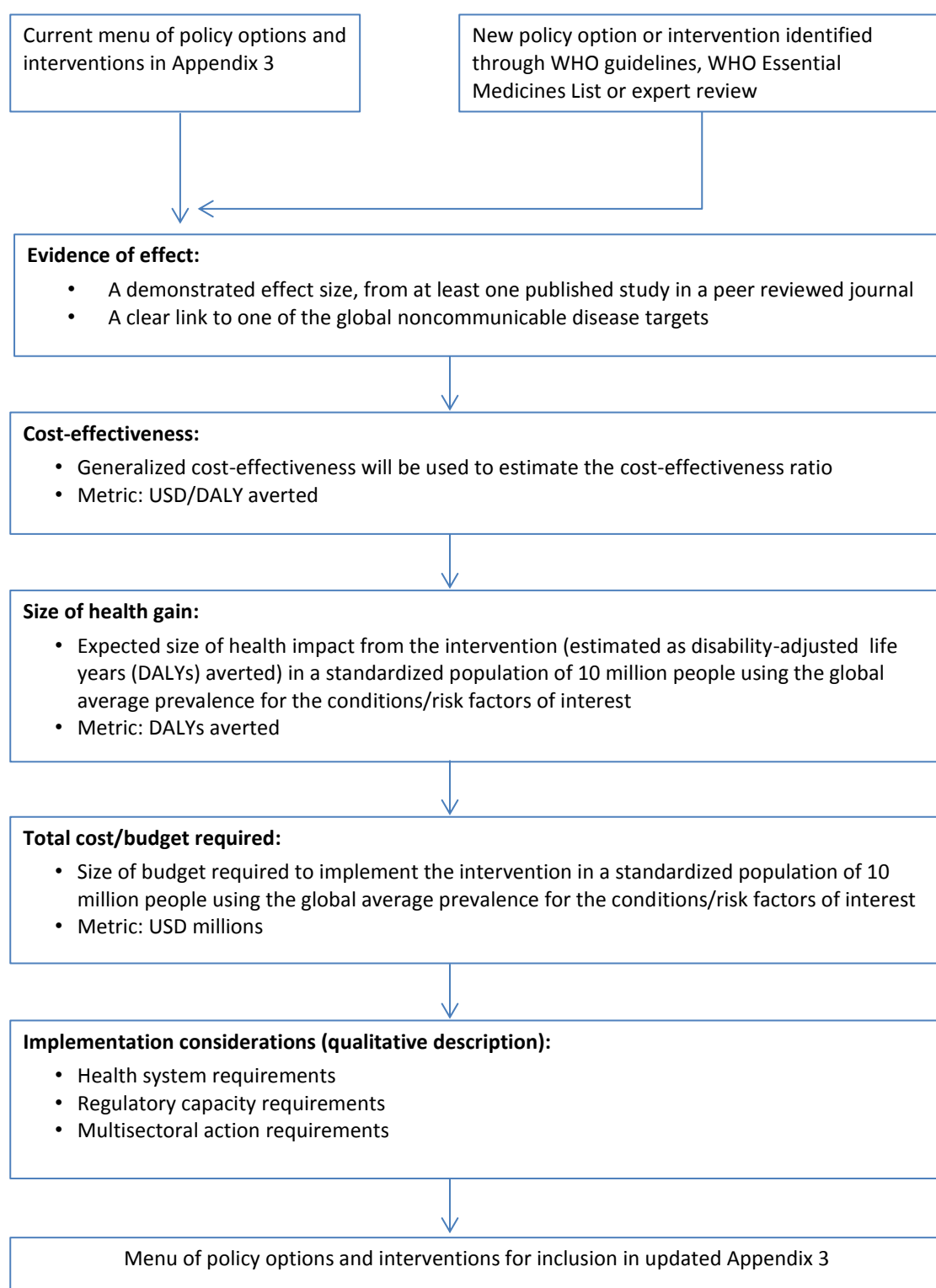
IDENTIFYING INTERVENTIONS FOR ANALYSIS

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).

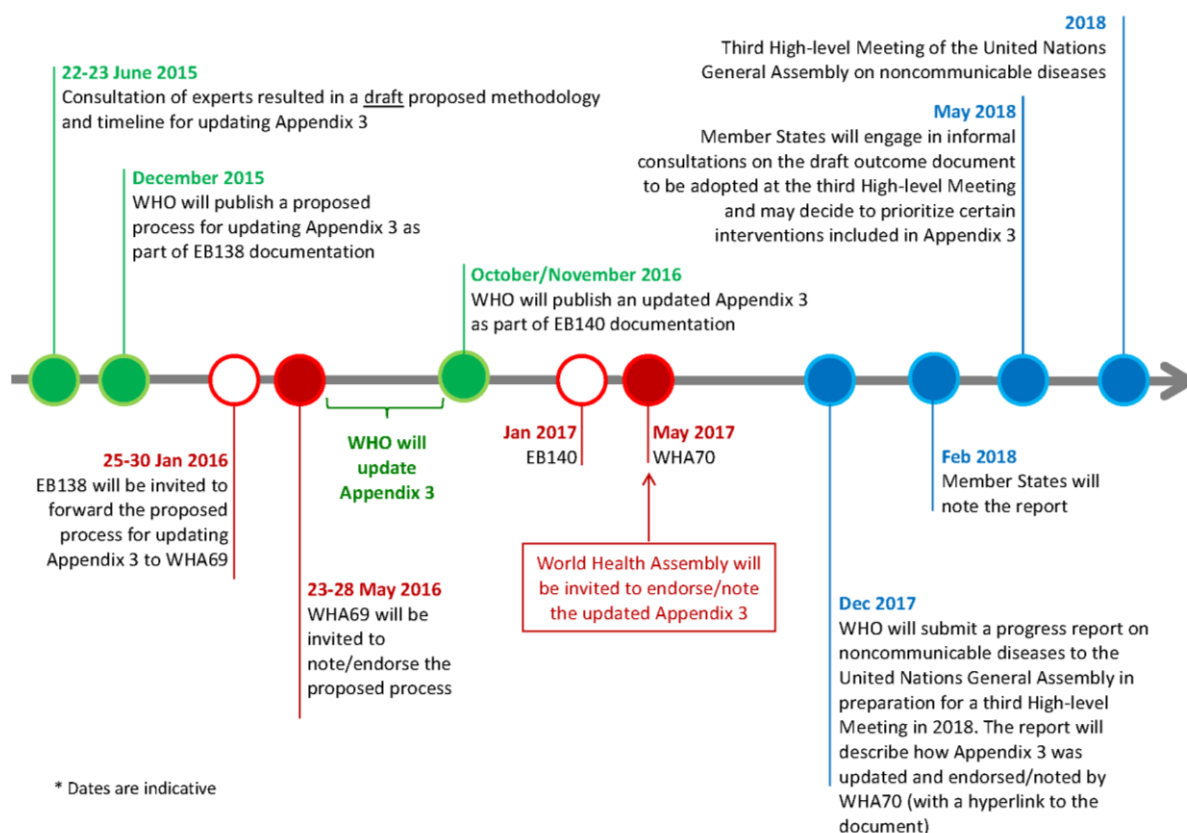
Implementation issues

- (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 paragraph 1(2) of resolution WHA66.10 the World 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	6% (adults)	6% (adults)
		(5) Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context	NO DATA	NO DATA
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
		(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
Salt/sodium intake	(4) A 30% relative reduction in mean population intake of salt/sodium ¹	(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% ²	NO DATA
		(10) Age-standardized prevalence of current tobacco use among persons aged 18+ years	Prevalence of smokeless tobacco use 6% Prevalence of tobacco smoking among adults aged 18+ years 23.1%	Prevalence of smokeless tobacco use not available Prevalence of tobacco smoking among adults aged 18+ years 21.8%

¹ WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per day.

² Based on data from 67 countries that undertook a global youth tobacco survey in 2009, 2010 and 2011.

Framework element	Target	Indicator	2010	2014
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 ¹	(7) Halt the rise in diabetes and obesity	<p>(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)</p> <p>(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)</p> <p>(14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m² for overweight and body mass index ≥ 30 kg/m² for obesity)</p>	<p>8%</p> <p>NO DATA</p> <p>11% (obesity)</p> <p>37% (overweight)</p>	<p>9%</p> <p>NO DATA</p> <p>13% (obesity)</p> <p>39% (overweight)</p>
National systems response				
Drug therapy to prevent heart attacks and strokes	(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	(18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk $\geq 30\%$, including those with existing cardiovascular disease) receiving drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes	NO DATA	NO DATA

¹ Countries will select indicator(s) appropriate to national context.

Framework element	Target	Indicator	2010	2014
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

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 report 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 report (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 frameworks, agendas and initiatives. The approach could:

(a) align with relevant WHO 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
- 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 Health Assembly, through the Executive Board, will be invited to endorse the proposed final approach.

September 2017: Once endorsed by the Seventieth 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 noncommunicable diseases in 2018.

May 2017 and beyond: Once endorsed by the Seventieth Health Assembly, and in accordance with action 4.2 of its workplan for 2016–2017¹, 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 NOVEMBER 2015**

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.
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. ³

¹ See 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 See <http://www.who.int/ncds/gcm/en/>.

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.	Under development.
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.
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. ¹ A final report will be submitted to the Director-General towards the end of 2015.
Action 4.1	Establish a community of practice where participants can contribute to and take concerted action against noncommunicable diseases.	A first community of practice has been organized around the work of the WHO Internal Steering Group on the implementation of a One-WHO workplan on Monitoring and Surveillance of noncommunicable diseases.
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. ¹ A final report will be submitted to the Director-General towards the end of 2015.

¹ Available at <http://www.who.int/global-coordination-mechanism/working-groups/wg-interim-report-comments/en/> (accessed 30 November 2015).

ANNEX 6

**REPORT ON PROGRESS MADE BETWEEN APRIL AND NOVEMBER 2015 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

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

2. Under the leadership of WHO, and with the participation of interested organizations of the United Nations system, joint country programming missions were undertaken to Tonga (March 2015), Barbados (April 2015), the Democratic Republic of the Congo (July 2015), Mongolia (September 2015), Sri Lanka (October 2015) and Mozambique (November 2015). The objective of the missions was to support United Nations Country Teams in their efforts to help Member States strengthen national responses to noncommunicable diseases and to establish resident United Nations Thematic Groups to serve as platforms from which to scale up the provision of coordinated technical assistance. United Nations Country Teams which received missions in 2014 and 2015 reported on progress at the fifth meeting of the Task Force in October 2015. A joint UNDP/WHO follow-up mission to Barbados was undertaken in August 2015 to support the government in building the business case for investing in the prevention and control of noncommunicable diseases.

Development of global joint programmes

3. When the United Nations Economic and Social Council adopted resolution 2015/8 on the work of the Task Force in June 2015, WHO 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.

¹ Document E/2015/53.

Development of the 2016–2017 workplan

4. 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 will be published towards the end of 2015 on the website of the Task Force.²

Conflicts of interest

5. In accordance with paragraphs 22–24 of the terms of reference of the Task Force, WHO acts as a repository of information concerning incidents of conflicts of interest. In this respect, WHO has been made aware that certain members of the Task Force continue to undertake activities in collaboration with the tobacco industry, and to receive funds from it. In addition, WHO has been made aware of a case where the tobacco industry has associated itself with some members of the Task Force without their knowledge or consent. A number of members of the Task Force now have policies that explicitly exclude any form of collaboration with the tobacco industry. WHO will continue to encourage other members of the Task Force to develop robust policies that preclude any form of engagement with the tobacco industry.

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/>.

² <http://www.who.int/ncds/un-task-force/en/>.

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 country data on the 10 progress indicators set out in the technical note published by WHO on 1 May 2015.²

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¹ Document A/68/650.

² Available at <http://www.who.int/nmh/events/2015/getting-to-2018/en/>.