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Follow-up to the high-level meetings of the United Nations General Assembly on health-related issues

Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

Report by the Director-General

1. This report is submitted pursuant to decision WHA72(11) (2019), in which the Health Assembly requests the Director-General: to prepare and update menus of policy options and cost-effective interventions to support Member States in implementing the commitments made in the political declaration of the third high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases, both to promote mental health and well-being and to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution; and to report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of the global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward.

2. Annexes 1 and 2 to this document set out the menus of policy options and cost-effective interventions related to the first two requests. In response to the reporting request, Annex 3 describes the implementation of the global strategy to reduce the harmful use of alcohol.

3. At a meeting in November 2019 on the provisional agenda of the Executive Board at its 146th session,[1] the Officers of the Board agreed to the request of Member States for a discussion of the early detection of noncommunicable diseases and strengthening the control of harmful use of alcohol.[2] Annex 4 to this document sets out the challenges to and opportunities for promoting access to affordable diagnostics, screening and early diagnosis as part of a comprehensive approach to the prevention and control of noncommunicable diseases.

ACTION BY THE EXECUTIVE BOARD

4. The Board is invited to note the report and to provide guidance on the way forward to (1) consider the menu of policy options and cost-effective interventions in Annex 1 to promote mental health and well-being; (2) finalize the work of the Secretariat described in Annex 2 to prepare a menu of policy options and cost-effective interventions to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution; and (3) strengthen the implementation of the global strategy to reduce the harmful use of alcohol.

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[1] See document EB146/1 (annotated).

[2] See document EB146/7 Add.1.

ANNEX 1

MENU OF POLICY OPTIONS AND COST-EFFECTIVE INTERVENTIONS TO PROMOTE MENTAL HEALTH AND WELL-BEING

1. The Sixty-sixth World Health Assembly in resolution WHA66.8 (2013) adopted the comprehensive mental health action plan 2013–2020. In decision WHA72(11) (2019) the Health Assembly confirmed the objectives of the action plan and extended the implementation period to 2030, thereby ensuring alignment with the 2030 Agenda for Sustainable Development. In the decision it requested the Director-General to propose updates to the appendices to the action plan, as appropriate, in consultation with Member States and taking into account the views of other stakeholders, ensuring that the action plan remains based on scientific evidence for the achievement of previous commitments for the prevention and control of noncommunicable diseases, including target 3.4 of Sustainable Development Goal 3, by 2030. Appendices 1 and 2 to the action plan list indicators for measuring progress towards targets and options for implementation, respectively.

2. Pursuant to decision WHA72(11) (paragraph (3)(b)) the Secretariat has prepared a menu of cost-effective interventions (see Appendix 1 below). Since 2001, it has used the WHO-CHOICE method to estimate the cost–effectiveness of a range of mental health interventions implemented since 2001; this work, which focused primarily on assessing individual-level interventions for clinical management of psychosis, bipolar disorder and depression, has been published in peer-reviewed literature and widely disseminated. As part of the preparations of the menu of cost-effective interventions, key data parameters used to analyse the interventions have been updated and new cost–effectiveness estimates have been generated.

3. To expand the menu of options beyond clinical management, the Secretariat conducted economic analyses of three population-level interventions: universal school-based socioemotional learning programmes to improve mental health and prevent suicide in adolescents; indicated, school-based socioemotional learning programmes to improve mental health and prevent suicide in adolescents; and regulatory bans on the use of highly hazardous pesticides in order to reduce cases of suicide. These analyses were revised following a technical consultation (Geneva, 20 and 21 August 2019) to review the epidemiologically-based population models, the selected parameters and the estimated cost–effectiveness and cost–effectiveness for these three interventions. The results of the three analyses are being prepared for publication in a peer-reviewed academic journal.

4. In September 2019 a discussion paper presenting the draft menu of cost–effectiveness interventions was opened to Member States, organizations in the United Nations system, other international organizations and non-State actors for a web-based consultation. The discussion paper and feedback from the consultation have been published on the WHO website.[1]

5. The list of cost-effective interventions is intended to provide information and guidance on the relative costs and health impacts of a preliminary set of evidence-based interventions, and to serve as a basis for developing and broadening the menu. The absence of an intervention from the menu does not

[1] WHO website. Development of a menu of policy options and cost-effective interventions to support Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs diseases to promote mental health and well-being (https://www.who.int/mental_health/cost-effectiveness_consultation_2019/en/, accessed 5 November 2019).

necessarily mean that it is not cost-effective but rather that there were methodological or capacity reasons for not completing a WHO-CHOICE analysis.

6. In the second half of 2020, the Secretariat will prepare updated appendices to the comprehensive mental health action plan 2013–2030, in consultation with Member States and considering the views of other stakeholders. The update to Appendix 2 of the action plan will be informed by the menu of cost-effective interventions for mental health. The text will cover a broad range of interventions, including many for which a WHO-CHOICE analysis could not be conducted. These lists should therefore be interpreted with care; the list in Appendix 2 to the action plan is neither comprehensive nor prescriptive but rather provides illustrative or indicative options.

Appendix 1

DRAFT MENU OF COST-EFFECTIVE INTERVENTIONS FOR MENTAL HEALTH

What is the menu of cost-effective interventions for mental health?

1. The menu is a list of interventions for which information on cost–effectiveness is available for use by Member States when selecting interventions, as appropriate for their national context. It is not exhaustive; the menu is a preliminary list of population- and individual-level interventions based on current evidence (see Table 1), which will serve as a basis for subsequently developing and broadening the evidence base.

How was the menu of cost-effective interventions for mental health developed?

2. The menu was developed using the WHO-CHOICE methodology to prepare and update, as appropriate, estimates of the cost–effectiveness of a range of interventions, in line with the development of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

3. WHO-CHOICE is a programme that helps countries to identify priorities on the basis of impact and cost–effectiveness. It can include any activities that may be considered relevant to policies affecting health outcomes. All options are compared to a common comparator, a null scenario in which the impacts of currently implemented interventions are removed, thereby enabling comparison of interventions across geographical areas and aspects of health.

4. The menu has been compiled from the results of economic analyses, which are available on the WHO website.[1] These analyses assess cost–effectiveness ratios, health impact and the economic costs of implementation. The results translate into a set of parameters for consideration by Member States. Global analyses should, however, be accompanied by local context analyses; other WHO tools, such as the OneHealth Tool,[2] are available to help individual countries to cost specific interventions in their national context.

SCOPE

5. Identifying a list of core interventions with cost–effectiveness information that are sufficiently comprehensive to meet the needs of Member States is inherently challenging. The menu as currently proposed consists largely of individual-level clinical management interventions for adults; most of the available mental health analyses based on WHO-CHOICE were for those types of intervention as they are amenable to cost–effectiveness analysis. Over time, the menu will need to be expanded to include recovery interventions, clinical interventions for a wider range of conditions across the life course, interventions for comorbidities, and a broader list of public mental health interventions, including interventions that address deinstitutionalization and known determinants of mental health.

[1] See discussion document, Annex 1. Available at: https://www.who.int/mental_health/cost-effectiveness_consultation_2019/en/ (accessed 5 November 2019).

[2] WHO website. Cost effectiveness and strategic planning (WHO-CHOICE) – OneHealth Tool (https://www.who.int/choice/onehealthtool/en/, accessed 12 November 2019).

The importance of non-financial considerations

6. Although cost–effectiveness analysis provides pertinent information, it has limitations and should not be used as the sole basis for decision-making and resource allocation. Beyond cost–effectiveness and affordability, full consideration should be given to: human rights and health equity; balance of potential benefits and harm of interventions; values and preferences related to interventions and their outcomes; and implementation capacity, acceptability and the need to implement a combination of population-wide and individual-level interventions.

7 Progressive expansion of service coverage is a key aspect of universal health coverage. Scaling up interventions for mental health conditions should proceed through community-based mental health and social care services. As recommended in the comprehensive mental health action plan 2013–2030, the locus of care should be systematically shifted away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including use of stepped care principles, as appropriate) and deployment of a network of linked community-based mental health services, including short-stay inpatient care and outpatient care in general hospitals, primary care facilities, community mental health centres and day care centres, support for people with mental health conditions living with their families, and supported housing.

8. Mental health services must adhere to human rights principles, which include the respect of individual preferences, based on communication of potential benefits and harms of any proposed care, including any potential short- and long-term adverse effects of psychotropic treatment.

Table 1. Menu of population-based and individual-level interventions

POPULATION-BASED INTERVENTIONS		
	Intervention	**Significant non-financial considerations[1]**
P1	Universal school-based socioemotional learning programmes to improve mental health and prevent suicide in adolescents	Intervention involves implementation by education sector. It reaches only adolescents who attend school.
P2	Indicated school-based socioemotional learning programmes[2] to improve mental health and prevent suicide in adolescents	Intervention involves implementation by education sector. It reaches only adolescents who attend school. Intervention requires an identification system for adolescents for whom the intervention is indicated. Possible social stigmatization associated with identification should be taken into account.

[1] Cost–effectiveness alone does not imply the feasibility of an intervention in all settings. This column highlights some of the critical non-financial aspects that should be taken into account by countries when deciding on the suitability of interventions.

[2] Indicated school-based socioemotional learning programmes target students with subthreshold mental health conditions.

P3	Regulatory bans on the use of highly hazardous pesticides[1] to prevent suicide[2]	Intervention involves engagement with agricultural sector. Intervention is especially relevant to low-income, rural populations.
INDIVIDUAL-LEVEL INTERVENTIONS[3]		
	Intervention	**Significant non-financial considerations**
	Psychosis (adults)[4]	
I1	Basic psychosocial support and older antipsychotic medication	Persons with psychosis are frequently subjected to stigmatization, discrimination and human rights violations. Health care providers must adhere to the United Nations Convention on the Rights of Persons with Disabilities.
I2	Basic psychosocial support and newer antipsychotic medication	
I3	Psychological treatment[5] and older antipsychotic medication	
I4	Psychological treatment and newer antipsychotic medication	
	Bipolar disorder (adults)	
I5	Basic psychosocial support and mood stabilizing medication (lithium)	Persons with bipolar disorder are frequently subjected to stigmatization, discrimination and human rights violations. Health care providers must adhere to the United Nations Convention on the Rights of Persons with Disabilities.
I6	Psychological treatment[6] and mood stabilizing medication (lithium)	
I7	Basic psychosocial support and mood stabilizing medication (valproate[7])	
I8	Psychological treatment and mood stabilizing medication (valproate)	

[1] For the definition of "highly hazardous pesticides", see International Code of Conduct on Pesticide Management, available at: http://www.fao.org/fileadmin/templates/agphome/documents/Pests_Pesticides/Code/Code_ENG_2017 updated.pdf (accessed 5 November 2019) and Guidelines on Pesticide Management, available at: http://www.fao.org/3/a-i5566e.pdf (accessed 5 November 2019).

[2] Preventing suicide: a resource for pesticide registrars and regulators. Geneva: World Health Organization and Food and Agriculture Organization of the United Nations; 2019 (https://apps.who.int/iris/handle/10665/326947, accessed 5 November 2019).

[3] For an example of a relevant WHO clinical tool, see mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0. Geneva: World Health Organization; 2016. Available at: https://apps.who.int/iris/handle/10665/250239 (accessed 5 November 2019).

[4] Estimates of the cost–effectiveness of older and newer antipsychotic medication were based, respectively, on the estimated costs and effectiveness of haloperidol and risperidone.

[5] Cognitive behavioural therapy and family therapy are examples of effective psychological treatments for people with psychosis.

[6] Cognitive behavioural therapy and interpersonal therapy are examples of effective psychological treatments for depressive episodes in bipolar disorder.

[7] Valproate should be avoided in women of childbearing age owing to association with birth defects.

	Depression (adults)	
I9	Basic psychosocial support for mild cases	Health care providers must adhere to the United Nations Convention on the Rights of Persons with Disabilities. Psychological interventions can also be feasibly offered through the social and educational sector.
I10	Basic psychosocial support and antidepressant medication for first episode moderate–severe cases	
I11	Psychological treatment[1] of first episode moderate–severe cases	
I12	Psychological treatment and antidepressant medication of first episode moderate–severe cases	
I13	Basic psychosocial support and antidepressant medication for recurrent moderate–severe cases on an episodic basis	
I14	Psychological treatment of recurrent moderate–severe cases on an episodic basis	
I15	Psychological treatment and antidepressant medication for recurrent moderate–severe cases on an episodic basis	
I16	Basic psychosocial support and antidepressant medication for moderate–severe cases on a maintenance basis	
I17	Psychological treatment of recurrent moderate–severe cases on a maintenance basis	

[1] Cognitive behavioural therapy, behavioural activation and interpersonal psychotherapy are examples of effective psychological treatments for moderate–severe depression. For examples of relevant WHO tools, see: Thinking healthy: a manual for psychosocial management of perinatal depression. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/152936, accessed 5 November 2019),
Group interpersonal therapy (IPT) for depression. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250219/WHO-MSD-MER-16.4-eng.pdf?sequence=1&isAllowed=y, accessed 5 November 2019) and Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/206417, accessed 5 November 2019).

ANNEX 2

MENU OF POLICY OPTIONS AND COST-EFFECTIVE INTERVENTIONS TO REDUCE THE NUMBER OF PREMATURE DEATHS FROM NONCOMMUNICABLE DISEASES ATTRIBUTED TO AIR POLLUTION

1 In May 2015, Member States took a significant step towards tackling air pollution by adopting resolution WHA68.8 on health and the environment: addressing the health impact of air pollution, which identified reduction of air pollution as an integral element of global sustainable development and that health impacts related to air pollution can be a relevant health indicator for sustainable development policies.

2 As requested in the resolution, the Director-General submitted to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the adverse health effects of air pollution, which the Health Assembly welcomed in decision WHA69(11) (2016).

3 The integration of strategies to mitigate air pollution into wider public health prevention and health care delivery strategies is fundamental to an effective health sector response to air pollution. Strategies to mitigate air pollution will be linked to strategies and activities for the prevention of noncommunicable diseases, such as the global action plans for the prevention and control of noncommunicable diseases 2013–2020 and for the prevention of communicable diseases such as pneumonia (as set out in the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030), and other relevant existing health strategies, processes and instruments (such as the WHO Framework Convention on Tobacco Control).

4 Some 91% of the global population is exposed to pollutant levels exceeding those recommended by WHO for fine particulate matter, with people living in low- and middle-income countries bearing most of the associated burden. Likewise, around three billion people still cook with solid fuels (such as wood, crop wastes, charcoal, coal and dung) or kerosene using open fires and inefficient stoves, exposing themselves to unsafe levels of household air pollution; these sources are a major cause of ambient air pollution in many parts of the world.

5. In 2016, WHO estimated that seven million premature deaths from acute lower respiratory infections, chronic obstructive pulmonary disease, ischaemic heart disease, lung cancer and stroke had been the result of exposure to air pollution in the outdoor and indoor environments.

6. The main areas in which measures will be taken to reduce air pollution will likely be: energy production, energy efficiency, and access to clean energy; shipping and transport; agriculture; and land-use planning.

7. With regard to ambient air pollution, policy options that will contribute to the achievement of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 are being compiled. At the outset, existing WHO and United Nations guidance on tackling air pollution and related health effects will be collated.

8. With regard to household air pollution, WHO guidelines for indoor air quality: household fuel combustion and the WHO's Clean Household Energy Solutions Toolkit provide specific evidence-based policy recommendations and resources to support Member States in selecting household energy interventions that reduce exposure to air pollution and protect health.

9. The Secretariat will conduct an in-depth analysis of the effectiveness of existing interventions and prepare guidance on how to select population-level policy options and interventions, taking into account the evidence included in the WHO air quality guidelines and comprehensive reviews of other evidence. The guidance will be subject to external expert peer review. The resulting guidance will stress the need to take account of local context and will provide the necessary tools for Member States to select interventions that are effective in reducing source emissions, have co-benefits, and be are likely to be cost-effective.

ANNEX 3

IMPLEMENTATION OF THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL DURING THE FIRST DECADE SINCE ITS ENDORSEMENT, AND THE WAY FORWARD

1. In 2010, the Health Assembly, in resolution WHA63.13, endorsed the global strategy to reduce the harmful use of alcohol. It urged Member States to adopt and implement the global strategy and requested the Director-General inter alia to collaborate with and provide support to Member States in doing so and in strengthening national responses to public health problems caused by the harmful use of alcohol, and to monitor progress in implementing the global strategy. In May 2013, the Sixty-sixth World Health Assembly noted the progress in implementing the global strategy to reduce the harmful use of alcohol. In May 2019, the Seventy-second World Health Assembly, in decision WHA72(11) on follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, requested the Director-General to report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward.

2. Since the endorsement of the global strategy in 2010, Member States' commitment to reducing the harmful use of alcohol has been further strengthened by the adoption of the political declarations emanating from the high-level meetings of the United Nations General Assembly on noncommunicable diseases, in particular the declaration in 2011, and by the adoption and implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. The global action plan lists harmful use of alcohol as one of the four key risk factors for major noncommunicable diseases and has enabled Member States and other stakeholders to identify and use opportunities for synergies to tackle more than one risk factor at the same time, strengthen coordination and coherence between measures to reduce the harmful use of alcohol and activities for the prevention and control of noncommunicable diseases, and set voluntary targets for reducing the harmful use of alcohol and other risk factors for noncommunicable diseases. Furthermore, target 3.5 of Sustainable Development Goal 3 includes the objective of strengthening the prevention and treatment of substance abuse, including harmful use of alcohol, which reflects the broader impact of the latter on health beyond noncommunicable diseases, in areas such as mental health, violence, road traffic injuries and infectious diseases.

3. Evidence on the cost–effectiveness of policy options and interventions was updated in a revision of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases, which the Health Assembly endorsed in resolution WHA70.11 (2017). This resulted in a new set of enabling and recommended actions to reduce the harmful use of alcohol. The most cost-effective actions, or "best buys", include increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol.

4. By prioritizing the most cost-effective policy measures, the Secretariat, with partners, launched the SAFER initiative,[1] whose primary objective is to support Member States in reducing the harmful use of alcohol by enhancing ongoing implementation of the global strategy to reduce the harmful use of

[1] WHO launches SAFER, a new alcohol control initiative (see https://www.who.int/substance_abuse/safer/en/, accessed 5 November 2019).

alcohol and other WHO and United Nations strategies. Equally important, it aims to protect public health-oriented policy-making against interference from commercial interests and establish strong monitoring systems to ensure accountability and track progress in the implementation of SAFER policy options and interventions.

5. Since the endorsement of the global strategy, the pace of development and implementation of policies on alcohol has been uneven between the WHO regions. The number of countries with a written national alcohol policy has steadily increased, and many countries have revised their alcohol policies. In 2016, 80 countries reported having written national alcohol policies in place, while a further eight had subnational policies and 11 others imposed a total ban on alcohol. The presence of written national alcohol policies continues to be most common in high-income countries (67%) and least common among low-income countries (15%); most countries in the Africa Region and the Region of the Americas did not have written national alcohol policies. The disproportionate prevalence of effective alcohol policies in higher-income countries raises questions of global health equity and underscores the need for more resources and greater priority to be given to supporting development and implementation of effective actions in low- and middle-income countries.

6. Between 2010 and 2016, no progress was made in reducing the total alcohol consumption per capita in the world; the figures for people aged 15 years and over rose from 5.5 litres of pure alcohol in 2005 to 6.4 litres in 2010 and remained at 6.4 litres in 2016. The highest levels of consumption per capita were observed in countries of the European Region. Although consumption per capita remained stable between 2010 and 2016 in countries in the Region of the Americas and the African and Eastern Mediterranean regions, it decreased in those in the European Region from 11.2 litres in 2010 to 9.8 litres in 2016 (a 12.5% relative reduction, surpassing the target set in the global monitoring framework for noncommunicable diseases). Consumption per capita increased in the South-East Asia and Western Pacific regions.

7. In 2016, more than half (57%, or 3.1 billion people) of the global population aged 15 years and older reported having abstained from drinking alcohol during the previous 12 months. Some 2.3 billion people were current drinkers. Alcohol was consumed by more than half the population in only three WHO regions: the Americas, European and the Western Pacific. The number of drinkers declined across all WHO regions between 2010 and 2016. Age-standardized prevalence of heavy episodic drinking (defined as 60 or more grams of pure alcohol on at least one occasion at least once per month) decreased globally from 20.6% in 2010 to 18.5% in 2016 among the total population but remained high among drinkers particularly in parts of eastern Europe and in some sub-Saharan African countries (more than 60% among current drinkers). In all WHO regions higher alcohol consumption rates and higher prevalence of current drinkers are associated with the economic wealth of countries, but the prevalence of heavy episodic drinking is fairly equally distributed between higher- and lower-income countries in most regions. The two exceptions to this are the African Region where rates of heavy episodic drinking are higher in lower-income countries than in higher-income countries and the European Region where, conversely, heavy episodic drinking is less frequent in low-income countries than in high-income ones.

8. Although there have been some improvements in the number of age-standardized alcohol-attributable deaths and disability-adjusted life years (DALY) in all regions except South-East Asia, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, the harmful use of alcohol resulted in some 3 million deaths (5.3% of all deaths) worldwide and 132.6 million DALYs (5.1% of all DALYs). Mortality from alcohol consumption is higher than from diseases such as tuberculosis, HIV infection/AIDS and diabetes. In 2016, an estimated 2.3 million deaths and 106.5 million DALYs among men were attributable to alcohol consumption. For women, those figures were 0.7 million and 26.1 million, respectively. Worldwide in 2016 alcohol was responsible for

7.2% of all premature mortality (persons aged 69 years or less). Younger people were disproportionately affected by alcohol; 13.5% of all deaths among 20–39-year-olds in 2016 were attributed to alcohol.

9. The age-standardized alcohol-attributable burden of disease and injury was highest in the African Region, whereas the proportions of all deaths and DALYs attributable to alcohol consumption were highest in the European Region (10.1% of all deaths and 10.8% of all DALYs) followed by the Region of the Americas (5.5% of deaths and 6.7% of DALYs). About 49% of alcohol-attributable DALYs are due to noncommunicable diseases and mental health conditions, and about 40% are due to injury.

10. Projections until 2025 show that total alcohol consumption per capita in people aged 15 years and older is likely to increase in countries in the Region of the Americas and the South-East Asia and Western Pacific regions. This rise is unlikely to be offset by substantial declines in consumption in the other regions. If these trends persist, total alcohol consumption per capita in the world will be 6.6 litres in 2020, rising to 7.0 litres by 2025. Unless projected increases in alcohol consumption in the three mentioned regions can be halted and reversed, the consequence will be an increase in alcohol-attributable disease and social burden.

11. Addressing the harmful use of alcohol needs whole-of-government and whole-of-society approaches, with appropriate engagement of non-State actors, including public health-oriented nongovernmental organizations, professional associations and civil society groups. At the international level, the broad scope and magnitude of health and social problems caused by the harmful use of alcohol need coordinated and concerted actions across organizations in the United Nations system and regional intergovernmental organizations in the context of the 2030 Agenda for Sustainable Development. New partnerships and appropriate engagement of all relevant stakeholders are needed to support the implementation of practical and focused technical packages based on evidence of effectiveness and cost–effectiveness of alcohol-control measures that can ensure returns on investment by reducing the harmful use of alcohol. The magnitude of alcohol-attributable disease and its social burden and the availability of a range of effective and cost-effective policy options and interventions continue to be in sharp contrast with the resources available at all levels to reduce the harmful use of alcohol.

12. In response to the request of the Health Assembly to the Director-General in decision WHA72(11) (2019) to report on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement and the way forward, and in line with the Director-General's commitment to prepare the report in full consultation and engagement with Member States, the Secretariat has embarked on a broad consultative process, including regional technical consultations with Member States, a web-based consultation with all stakeholders, and informal consultations with Member States on a discussion paper developed subsequently. The summary of the findings of the consultation process are submitted as an addendum to this report.[1]

[1] See document EB146/7 Add.1.

ANNEX 4

PROMOTING EARLY DETECTION OF NONCOMMUNICABLE DISEASES AND RISK FACTORS AS PART OF A COMPREHENSIVE APPROACH TO THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

1. Globally, the probability of dying from cardiovascular disease, cancer, diabetes and chronic lung disease between the ages of 30 and 70 years fell from 22% in 2000 to 18% in 2016.

2. The political declaration adopted at the third high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases in 2018[1] recognizes, in paragraph 4, that "action to realize the commitments made [in 2011 and 2014] for the prevention and control of non-communicable diseases is inadequate and that the level of progress and investment to date is insufficient to meet target 3.4 of the Sustainable Development Goals and that the world has yet to fulfil its promise of implementing, at all levels, measures to reduce the risk of premature death and disability from non-communicable diseases".

3. WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 highlights the need to prioritize early detection, stating that "a strengthened health system directed towards addressing noncommunicable diseases should aim to improve prevention, early detection, treatment and sustained management of people with or at high risk for cardiovascular disease, cancer, chronic respiratory disease, diabetes and other noncommunicable diseases, in order to prevent complications, reduce the need for hospitalization and costly high-technology interventions and premature deaths".

CHALLENGES

4. Strengthening capacity for early diagnosis, screening and appropriate treatment is crucial if premature mortality from noncommunicable diseases is to be rapidly reduced. However, countries' health systems already face significant and diverse challenges in their existing capacities: lack of access to affordable, safe, effective and good quality essential medicines, vaccines and other health products and medical devices for noncommunicable diseases; insufficiently trained or ill-equipped workforce; service-delivery models that are not patient-centred; inadequate investment in primary health care; and limited progress in implementing evidence-based programmes. Late diagnosis of major noncommunicable diseases can result in higher costs of treatment, catastrophic health expenditures and impoverishment.

5. WHO has highlighted the importance of early diagnosis and screening. Early diagnosis is defined as the early identification of a disease in patients who have symptoms or signs of that disease. This contrasts with screening, which seeks to identify unrecognized (preclinical) lesions in an apparently healthy target population and subsequently to provide clinical management of all those who test positive on screening.[2]

[1] United Nations General Assembly resolution A/73/2 (2018).

[2] WHO Guide to cancer early diagnosis. Geneva: World Health Organization; 2017. Available at: https://www.who.int/cancer/publications/cancer_early_diagnosis/en/ (accessed 30 October 2019).

6. WHO's global country capacity survey for the prevention and control of noncommunicable diseases conducted in 2017[1] reported that 76% and 73% of countries had national screening programmes for cervical cancer and breast cancer, respectively, and that just over a third of the cervical cancer screening programmes reached 10–50% of the target population.

7. Metabolic and physiological risk factors, such as raised blood pressure and raised blood concentrations of glucose and selected lipids, can be detected and managed in primary care. The country capacity survey showed that many basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases were generally available in primary care facilities (that is, available in 50% of facilities or more) in the public health sector: 97% of responding Member States had generally available equipment for blood pressure measurement; 89% for height and weight measurement; and 83% for measurement of blood glucose concentration. Strips for measurement of glucose and ketone in urine, albumin assay, and total cholesterol measurement were also reported by most countries as being generally available (71%, 62% and 59%, respectively). Less than half of the responding countries, however, reported that the remainder of basic technologies were generally available: tests for measuring haemoglobin A1c levels (45% of responding Member States); dilated fundus examination (41%); foot vibration perception by tuning fork (41%); peak flow measurement spirometry (39%); and determination of foot vascular status by Doppler ultrasound procedure (24%).

OPPORTUNITIES

8. Several WHO publications highlight the appropriateness of screening for cancer in countries with different health system capacities. These include WHO's guide to cancer early diagnosis,[2] PAHO's guidance on early diagnosis of childhood cancer,[3] the WHO position paper on mammography screening,[4] the WHO guidelines for screening and treatment of precancerous lesions for cervical cancer prevention,[5] and guidance on national control programmes. WHO's initiative to eliminate cervical cancer as a public health problem will boost the momentum for cervical cancer screening and treatment.

9. WHO's guidance on cardiovascular disease risk assessment is provided through its Package of Essential Noncommunicable Disease Interventions. WHO's guidance on screening for diabetes was published in 2003.[6] WHO's HEARTS technical package,[7] offers guidance on hypertension and diabetes

[1] WHO. Assessing national capacity for the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/276609/9789241514781-eng.pdf?ua=1, accessed 6 November 2019).

[2] WHO. Guide to cancer early diagnosis. Geneva: World Health Organization; 2017 (available at: https://apps.who.int/iris/handle/10665/254500 (accessed 6 November 2019).

[3] Early diagnosis of childhood cancer. Washington, DC: Pan American Health Organization; 2014. Available at: http://iris.paho.org/xmlui/bitstream/handle/123456789/34850/9789275118467-eng.pdf?sequence=1&isAllowed=y (accessed 6 November 2019).

[4] WHO position paper on mammography screening. Geneva: World Health Organization; 2014 (available at : https://apps.who.int/iris/bitstream/handle/10665/137339/9789241507936_eng.pdf?sequence=1 (accessed 6 November 2019).

[5] WHO guidelines for screening and treatment of precancerous lesions for cervical cancer prevention. Geneva: World Health Organization; 2013 (available at: https://apps.who.int/iris/handle/10665/94830, accessed 6 November 2019).

[6] WHO. Screening for type 2 diabetes: report of a World Health Organization and International Diabetes Federation meeting. Geneva: World Health Organization; 2003 (https://apps.who.int/iris/handle/10665/68614, accessed 12 November 2019).

[7] WHO, PAHO, World Heart Federation, World Stroke Organization, International Society of Hypertension, World Hypertension League, Centers for Disease Control and Prevention. Hearts: technical package for cardiovascular disease

diagnosis and management in primary care. Total cardiovascular risk prediction charts, which include metabolic and physiological risk factors and body mass index, are being updated as laboratory-based and non-laboratory-based charts.

10. The Second WHO Model List of Essential In Vitro Diagnostics (2019)[1] provides a comprehensive reference for programme managers on the necessary in vitro diagnostics required for the prevention and early detection of noncommunicable diseases and builds on the WHO list of priority medical devices required for cancer management.[2]

11. In 2018–2019, the Secretariat provided support for implementation of cardiovascular disease and cancer programmes, including early diagnosis, screening and treatment, in more than 30 Member States. Consultations on cancer screening were conducted in the European and Eastern Mediterranean regions. Discussions on early detection in the context of the prevention and control of noncommunicable diseases took place in other regions.

THE SECRETARIAT'S RESPONSE

12. The Secretariat will generate technical packages and service delivery models as global public health goods that support the scaling up of early diagnosis and screening, through technical consultations and a global policy dialogue starting in 2020. Regional offices will further advance this work by providing guidance and support to Member States for implementing these packages and models.

13. To support Member States in fulfilling their commitments to the early detection of noncommunicable diseases, the Secretariat is producing a guide for cancer screening, taking account of a variety of perspectives and the potential harms and benefits. The capacity of the OneHealth Tool[3] is being enhanced to help health planners to understand the financial costs, health system requirements and potential impacts of early detection programmes for cancers, including the necessary diagnostic tools, medicines, vaccines and technologies, and the palliative care required for such programmes.

14. The Secretariat will also update its guidance on screening for metabolic and physiological risk factors (hypertension, diabetes and an unfavourable blood lipid profile) and selected cancers. There is much to consider before embarking on population-based organized screening programmes; global evidence must be taken into account, but local capacity and feasibility must also be tested.

15. Strengthened information systems are required for safe and effective implementation of early detection programmes for noncommunicable diseases. Improvements may include, for example, creation of a registry to monitor the status of individuals participating in a given screening programme. WHO has produced guidance on the indicators that should be used to monitor programme performance

management in primary health care. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/252661, accessed 6 November 2019).

[1] Second WHO model list of essential in vitro diagnostics. Geneva: World Health Organization; 2019 (https://www.who.int/medical_devices/publications/Standalone_document_v8.pdf?ua=1, accessed 6 November 2019).

[2] WHO list of priority medical devices required for cancer management. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/255262, accessed 6 November 2019).

[3] WHO website. Cost effectiveness and strategic planning (WHO-CHOICE) – OneHealth Tool (https://www.who.int/choice/onehealthtool/en/, accessed 12 November 2019).

in cervical cancer in its toolkit for cervical cancer prevention and control programmes.[1] WHO is also working on a clinic-based register of noncommunicable diseases, which can track the detection, screening, diagnosis, treatment and follow-up information on noncommunicable diseases in primary care.

ROLE OF INTERNATIONAL PARTNERS

16. Organizations in the United Nations system are supporting the work in this area. IARC produces handbooks on cancer screening that summarize the best evidence on the efficacy of screening programmes.[2] IAEA supports comprehensive country assessments of cancer prevention and control through its imPACT missions.[3] IAEA, IARC, UNAIDS, UNFPA, UNICEF and UN Women, together with WHO, form the United Nations Joint Global Programme on Cervical Cancer Prevention and Control,[4] which provides support to Member States.

17. Professional societies have a major role in promoting a standardized approach but should consider resource constraints. Development partners and non-State actors, including civil society and other stakeholders seeking to support implementation of early detection programmes should consider both the guidance of intergovernmental agencies and the feasibility of screening for noncommunicable diseases, giving due recognition to the potential harm of diverting resources towards programmes that have high costs and minimal population benefit. To support monitoring, reporting and accountability, all partners should consider using an agreed set of performance indicators and report on progress on closing the gap on early treatment to the appropriate public health authorities.

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[1] WHO, Centers for Disease Control and Prevention, CDC Foundation, George W. Bush Institute. Improving data for decision-making: a toolkit for cervical cancer prevention and control programmes. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/279420, accessed 6 November 2019).

[2] International Agency for Research on Cancer. IARC handbooks of cancer protection (http://handbooks.iarc.fr/, accessed 6 November 2019).

[3] IAEA. imPACT review (https://www.iaea.org/services/review-missions/impact-review, accessed 6 November 2019).

[4] United Nations joint global programme on cervical cancer prevention and control (https://www.who.int/ncds/un-task-force/un-joint-action-cervical-cancer-leaflet.pdf, accessed 6 November 2019).