World Health Organization

SEVENTY-SECOND WORLD HEALTH ASSEMBLY **A72/19**
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Follow-up to the high-level meetings of the United Nations General Assembly on health-related issues

Prevention and control of noncommunicable diseases

Report by the Director-General

1. The report is submitted in response to resolution WHA71.2 (2018), which "requests the Director-General to report to the Seventy-second World Health Assembly, through the Executive Board, on the outcomes of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up".

2. In January 2019, the Executive Board, at its 144th session, noted an earlier version of this report.[1] This updated report contains additional text (in paragraphs 8–11, 14–16, 19, and 25–26), additional text in Annex 1 (all paragraphs), Annex 2 (paragraphs 1–2, 5–13, 20 and 25) and Annex 5 (paragraphs 4 and 5), and two new annexes (Annex 6 and 7) in response to comments received from Member States. Document EB144/20 Add.1 has been integrated into this document as Annex 4.

PREPARATORY PROCESS

3. The preparatory process that led to the third high-level meeting included the elements set out in Table 1.

Table 1. Preparatory process for the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases, by date, auspice, meeting or document, and outcome or source

Dates	Auspices	Meeting/document	Outcome/source
19–21 October 2016	WHO, hosted by Government of Mauritius	WHO Global Dialogue meeting on the role of non-State actors in their national efforts to tackle noncommunicable diseases (NCDs) as part of the 2030 Agenda for Sustainable Development	Co-Chairs statement

[1] See document EB144/20 and the summary records of the Executive Board at its 144th session, tenth and eleventh meetings.

Dates	Auspices	Meeting/document	Outcome/source
8 and 9 June 2017	WHO, in collaboration with Graduate Institute in Geneva	Informal meeting on the theme "The NCD challenge: current status and priorities for sustained action"	Meeting report
18–20 October 2017	WHO, hosted by Government of Uruguay; co-chaired by Governments of Finland and Russian Federation	WHO Global Conference on NCDs	Montevideo road map 2018–2030 on NCDs as a sustainable development priority (see resolution WHA71.2, Annex)
Established in October 2017	WHO	WHO Independent High-level Commission on NCDs	Report of the Commission
Established in October 2017	WHO, co-chaired with NCD Alliance	WHO Civil Society Working Group on the third high-level meeting on the prevention and control of NCDs	Report of the Working Group
21 December 2017	United Nations Secretary-General, in collaboration with WHO and relevant funds, programmes and specialized agencies of the United Nations system	Report of the Secretary-General on progress on the prevention and control of NCDs	United Nations General Assembly document A/72/662
9–11 April 2018	WHO and the Government of Denmark, supported by the OECD, the World Diabetes Foundation, the International Federation of Pharmaceutical Manufacturers and Associations, the World Economic Forum and the NCD Alliance	WHO Global dialogue on financing for prevention and control of NCDs	Report of the meeting
12 April 2018	United Nations General Assembly	Scope, modalities, format and organization of the third high-level meeting on the prevention and control of NCDs	General Assembly resolution 72/274
20 May 2018	WHO	Saving lives, spending less: a strategic response to NCDs	WHO publication (Geneva, 2018)
21–26 May 2018	WHO	Reports of the Director-General to the Seventy-first World Health Assembly on the preparation for the third high-level meeting on the prevention and control of NCDs	WHO documents A71/14 and A71/14 Add.1

Dates	Auspices	Meeting/document	Outcome/source
19 and 20 June 2018[1]	WHO	Consultation with representatives of economic operators in alcohol production and trade on ways they could contribute to reducing the harmful use of alcohol	Report[2]
26 June 2018	WHO, in collaboration with Chatham House in London	Round table with food and non-alcoholic beverage industry	Report[3]
26 June 2018	WHO, in collaboration with Chatham House in London	Round table with pharmaceutical industry	Report[3]
5 July 2018	President of the United Nations General Assembly	United Nations interactive hearing on NCDs	Statements and summary by President of United Nations General Assembly[4]
27 September 2018	United Nations General Assembly	Political Declaration of the third high-level meeting on the prevention and control of NCDs	General Assembly resolution 73/2

OUTCOMES

4. The Political Declaration of the third high-level meeting, entitled "Time to deliver: accelerating our response to address NCDs for the health and well-being of present and future generations", was accepted in the opening segment of the high-level meeting and adopted by the General Assembly on 10 October 2018. The Political Declaration:

(a) in paragraph 4, recognizes "that action to realize the commitments made 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";

(b) includes 14 new commitments by Heads of State and Government and representatives of States and Governments (see Annex 1);

[1] This meeting was organized in line with the guidance provided by WHO's Global strategy to reduce the harmful use of alcohol.

[2] Available at: http://www.who.int/substance_abuse/activities/dialogue_economic_operators_alcohol_production/en/ (accessed 26 February 2019).

[3] Available at: http://www.who.int/ncds/governance/private-sector (accessed 26 February 2019).

[4] Available at: https://www.un.org/pga/72/wp-content/uploads/sites/51/2018/08/NCD-9-August.pdf (accessed 26 February 2019).

(c) broadens the scope of the commitments from the four major NCDs and four main risk factors (the so-called "4 x 4 NCD agenda") to include commitments to reduce air pollution and promote mental health and well-being (the so-called "5 x 5 NCD agenda");

(d) in paragraph 50, requests "the Secretary-General, in consultation with Member States, and in collaboration with the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2024, for consideration by Member States, a report on the progress achieved", in preparation for a fourth high-level meeting to be held in 2025.

5. The overall theme of the high-level meeting was "Scaling up multi-stakeholder and multisectoral responses for the prevention and control of non-communicable diseases in the context of the 2030 Agenda for Sustainable Development". The plenary segment of the third high-level meeting was addressed by 11 Heads of State, 12 Heads of Government, 55 ministers, four vice-ministers and two senior representatives of Member States, representing a total of 84 Member States. The opening segment included statements by the President of the United Nations General Assembly, the Deputy Secretary-General of the United Nations, the Director-General of WHO, the President of Uruguay (in his capacity as Co-Chair of the WHO Independent High-level Commission on NCDs) and Her Royal Highness Princess Dina of Jordan (in her capacity as an eminent person). The first multistakeholder panel was co-chaired by the President of Zambia and the Prime Minister of Saint Kitts and Nevis. The second multistakeholder panel was co-chaired by the ministers of health of Canada and Jamaica. Keynote addresses were given by Mr Michael Bloomberg, WHO Global Ambassador for Noncommunicable Diseases and Injuries, and by the Executive Director of UNFPA. The multistakeholder panels included six speakers from nongovernmental organizations, two speakers from the private sector and three speakers from organizations in the United Nations system. During the closing segment, the Minister of Health of Portugal summarized the proceedings.

6. On the margins of the third high-level meeting, the WHO Secretariat sponsored 12 side events and released the following global goods:

- WHO's noncommunicable diseases country profiles 2018;
- WHO's Global status report on alcohol and health;
- WHO's SAFER alcohol control initiative;
- the WHO Global Initiative for Childhood Cancer;
- a WHO tool to highlight investment opportunities for preventing and treating NCDs;
- the WHO/World Obesity report on taking action on childhood obesity;
- the description and composition of the accountability consortium of institutions to measure the contribution of the food and non-alcoholic beverage industries towards target 3.4 of the Sustainable Development Goals (see Annex 2);
- a presentation on the worldwide trends in insufficient physical activity from 2001 to 2016 (published in a medical journal);

- policy briefs from the WHO-led United Nations Inter-Agency Task Force on NCDs setting out what government ministries need to know about NCDs.

7. The Director-General also reappointed Mr Michael Bloomberg, Founder of Bloomberg Philanthropies, as WHO Global Ambassador for Noncommunicable Diseases and Injuries for a second term until September 2020. Projects under the ambassadorship are listed on WHO's website.[1]

WHERE DO WE STAND TODAY?

8. WHO estimates that, in 2016, 15.2 million people between the ages of 30 and 70 years died from noncommunicable diseases (see Table 2).[2] The total number of these premature deaths is increasing owing to population growth.

Table 2. Breakdown of deaths from noncommunicable diseases in 2016 by WHO region

Region	Men	Women	Total	Percentage
African	682 328	644 046	1 326 374	9
Americas	1 156 268	826 342	1 982 610	13
South-East Asia	2 644 348	1 810 929	4 455 277	29
European	1 508 617	824 265	2 332 882	16
Eastern Mediterranean	609 982	465 189	1 075 171	7
Western Pacific	2 385 249	1 621 549	4 006 798	26
Total	**8 986 792**	**6 192 320**	**15 179 112**	**100**

9. Globally, the probability of dying from cardiovascular disease, cancer, diabetes and chronic lung disease between the ages of 30 and 70 years continues to decline from 22% in 2000 to 18% in 2016.[3] However, this rate of decline is insufficient to meet Sustainable Development Goal target 3.4.[4]

10. There is slow progress towards most of the voluntary global targets for 2025 for the prevention and control of noncommunicable diseases, with the exception of the prevalence of obesity and diabetes, as shown in Table 3.

[1] See https://www.who.int/tobacco/about/partners/bloomberg/en/ (accessed 1 March 2019).

[2] Data available at https://www.who.int/healthinfo/global_burden_disease/estimates/en/ (accessed 26 February 2019).

[3] World Health Statistics 2018: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2018.

[4] World Health Statistics 2016; monitoring health for the SDGs. Geneva: World Health Organization; 2016.

Table 3. Progress towards the targets of the Global action plan for the prevention and control of noncommunicable diseases 2013-2020 between 2010 and 2016

Target for 2025	Indicator	2010	2014	2016
A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	Unconditional probability of dying between ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	22%	19%	18%
At least 10% relative reduction in the harmful use of alcohol[1,2]	Total alcohol per capita (aged ≥15 years old) consumption within a calendar year in litres of pure alcohol[2] Age-standardized prevalence of heavy episodic drinking:[2] • among adolescents (15–19 years old) • among adults (≥15 years old) Age-standardized prevalence of alcohol use disorders (as a percentage of population ≥15 years old)[2]	6.4 litres 15.6% 20.6% 5.1%	No data	6.4 litres 13.6% 18.5% 5.1%
A 10% relative reduction in prevalence of insufficient physical activity	Prevalence of insufficiently physically active adolescents[3] Age-standardized prevalence of insufficiently physically active persons aged ≥18 years[4]	82% 28%	81% 28%	81% 28%
A 30% relative reduction in mean population intake of salt/sodium	Age-standardized mean population intake of salt[5] per day in grams in persons aged ≥18 years	10 gram/ day	No data	No data
A 30% relative reduction in prevalence of current tobacco use in persons aged ≥15 years	Prevalence of cigarette smoking in 13–15-year-olds Age-standardized prevalence of tobacco smoking among adults aged ≥15 years	No data 22.1%	No data 20.6%	6.8% (2017) 19.9%
A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure	Age-standardized prevalence of raised blood pressure among persons aged ≥18 years[6] and mean systolic blood pressure	23%	22%	22% (2015)

[1] In WHO's Global strategy to reduce the harmful use of alcohol, the concept of "harmful use of alcohol" encompasses 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.

[2] As appropriate, within the national context.

[3] Defined as less than 60 minutes of moderate-to-vigorous intensity activity daily.

[4] Defined as less than 150 minutes of moderate-intensity activity per week, or equivalent.

[5] Sodium chloride.

[6] Defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.

Target for 2025	Indicator	2010	2014	2016
Halt the rise in diabetes and obesity	Age-standardized prevalence of raised blood glucose/diabetes among persons aged ≥18 years[1]	7.9%	8.5%	No data
	Prevalence of overweight and obesity in adolescents[2]	14%	16%	17%
	Age-standardized prevalence of overweight and obesity in persons aged ≥18 years[3]	36%	38%	39%
At least 50% of eligible people receive drug therapy and counselling to prevent heart attacks and strokes	Proportion of eligible persons[4] receiving drug therapy and counselling[5] to prevent heart attacks and strokes	No data	No data	No data[6]
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	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	No data

11. Table 4 shows the steady progress in strengthening national capacities for the prevention and control of noncommunicable diseases.

[1] Defined as fasting plasma glucose concentration ≥7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose concentration.

[2] 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.

[3] Defined as body mass index ≥25 kg/m² for overweight and body mass index ≥30 kg/m² for obesity.

[4] Defined as aged 40 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease.

[5] Including control of glycaemia

[6] The proportion of eligible people at high risk of cardiovascular disease receiving drug treatment can be obtained only through nationally representative surveys where parameters of cardiovascular disease risk assessment are available along with those for medicine intake. These data area not available yet in all countries and hence the indicator cannot be reported as a global indicator at this time.

Table 4. Progress in strengthening national capacities for the prevention and control of noncommunicable diseases between 2010 and 2017

Indicator	2010	2015	2017
Number of countries with at least one operational multisectoral national policy, strategy or action plan.[1]	32/169 (19%)	69/169 (41%)	89/169 (53%)
Number of countries that have operational noncommunicable disease unit(s)/branch(es)/ department(s) within the health ministry.	90/169 (53%)	113/169 (67%)	116/169 (69%)
Number of countries with an operational policy, strategy or action plan to reduce the harmful use of alcohol, as appropriate, within the national context.	82/169 (49%)	114/169 (67%)	127/169 (75%)
Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity.	93/169 (55%)	120/169 (71%)	137/169 (81%)
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.	112/169 (66%)	138/169 (82%)	146/169 (86%)
Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets.	101/169 (60%)	124/169 (73%)	139/169 (82%)
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.	No data	74/169 (42%)	84/169 (50%)
Number of countries with noncommunicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global noncommunicable disease targets.	67/169 (39%)	51/169 (30%)	70/169 (41%)
Number of countries with an operational national coordination mechanism in place for the prevention and control of noncommunicable diseases.	No data	57/169 (34%)	65/169 (38%)

FOLLOW-UP

12. To provide support to governments in fulfilling the commitments they made last year in the Political Declaration on the prevention and control of NCDs, the Secretariat is developing a delivery plan to meet the rapidly increasing demand for technical assistance requested by Member States and to ensure optimal delivery of the Thirteenth General Programme of Work, 2019–2023.

[1] A policy, strategy or action plan that integrates several noncommunicable diseases and shared risk factors in conformity with the global/regional action plans 2013–2020.

13. To provide support to Member States in realizing their commitment to accelerate their response over the next 3–5 years to address NCDs and attain Sustainable Development Goal target 3.4 by 2030, the Secretariat is working to identify a specific subset of "NCD accelerators" within the overall set of interventions included in the WHO list of best buys and other recommended interventions for the prevention and control of NCDs.[1] The subset of NCD accelerators will be published on WHO's website.

14. To fast-track health outcomes in specific areas in selected countries, the Secretariat will scale up four special initiatives launched in 2018: (a) Bringing mental health out of the shadows (London, 2 May 2018); (b) the Global Hearts Initiative to prevent premature deaths from noncommunicable diseases, including the global initiative to eliminate industrially-produced *trans*-fat from the global food supply (Geneva, 14 May 2018); (c) cervical cancer elimination (Geneva, 20 May 2018); and (d) the Global Initiative on Childhood Cancer (New York, 27 September 2018). These initiatives provide opportunities for synergy, as do existing mechanisms to forge multistakeholder partnerships and alliances with civil society and the private sector.

15. In order to help Member States to realize their commitment to strengthen health systems and reorient them towards the achievement of universal health coverage, the Secretariat will scale up its support to countries for integrating the prevention and control of NCDs and the promotion of mental health within primary and specialized health services. This support includes the development of relevant workforces and access to safe, affordable, effective and quality essential diagnostics, medicines, vaccines and technologies, and palliative care.

16. As a support to Member States in realizing their commitment (paragraph 21 of the Political Declaration) to promote, inter alia, fiscal measures, as appropriate, aiming at minimizing the impact of the main risk factors for NCDs, and promote healthy diets and lifestyles, the Secretariat provides a note on current scientific knowledge, available evidence and a review of international experience regarding fiscal measures for the prevention and control of NCDs (Annex 2).

17. In response to paragraph 37 of United Nations General Assembly resolution 68/300 (2014),[2] the Secretariat will continue its work on the development of 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 by 2025 and Sustainable Development Goal target 3.4 by 2030 (see Annex 3).

18. In preparation for the fourth high-level meeting on the prevention and control of noncommunicable diseases in 2025, the Secretariat will convene global meetings of national NCD directors and programme managers on a regular basis.

19. To provide support to Member States in their efforts to implement paragraph 44 of the Political Declaration, the Secretariat will convene the following dialogues: every six months with representatives from international business associations representing the food and non-alcoholic beverage industries, pharmaceutical industries, and sport industries; and every 12 months with representatives of the

[1] Endorsed as the updated Appendix 3 to the Global Action Plan for the Prevention and Control of NCDs 2013–2020; see resolution WHA70.11, paragraph 1 and Annex 3 of document WHA70/2017/REC/1, and http://www.who.int/ncds/management/best-buys/en/ (accessed 26 February 2019).

[2] Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/68/300, accessed 26 February 2019).

economic operators in the area of alcohol production and trade. The dialogues will focus on specific "asks" from the Secretariat to relevant private sector entities.

20. In accordance with paragraph 1 of its terms of reference, the WHO Independent High-level Commission on NCDs will continue its role until October 2019 to advise the Director-General on "bold and at the same time practical recommendations on how to transform new opportunities to enable countries to accelerate progress towards Sustainable Development Goal target 3.4". The implementation of the workplan of the Commission covering the second phase (October 2018–October 2019) is under way.

21. Political championing at the highest levels of government to address noncommunicable diseases and mental health is viewed as invaluable in advancing policies on these matters. In that regard, several Heads of State and Government have emphasized the value of promoting informal collaboration among interested counterparts in order to intensify their efforts over the next three to five years to put their countries on a sustainable path to reaching Sustainable Development Goal target 3.4 by 2030. To this end, strategic opportunities to leverage political championing are being explored.

22. Pursuant to paragraph 50 of the 2018 Political Declaration on NCDs and building on decision EB136(13) (2015), the Secretariat has set out in Annexes 4 and 6 how WHO will report in 2024 to the United Nations General Assembly on the national commitments included in the 2011 Political Declaration on NCDs, the 2014 outcome document on NCDs and the 2018 Political Declaration on NCDs, using existing survey tools and taking into account existing indicators at the global and regional levels. The Secretariat has set out in Annex 7 an analysis of which Member States have implemented the WHO framework for national noncommunicable disease surveillance, what are lessons learned, and how the Secretariat will provide support to countries.

23. Pursuant to paragraph 31 of the 2018 Political Declaration on NCDs, WHO and partners convened the first Global Conference on Air Pollution and Health (Geneva, 29 October–1 November 2018) in order to raise awareness and to share information and tools.

24. Pursuant to paragraph 8 of resolution 2018/13 of the United Nations Economic and Social Council, WHO will, through the WHO-led United Nations Inter-Agency Task Force for the Prevention and Control of Noncommunicable Diseases, develop new partnerships to achieve Sustainable Development Goals target 3.4 on NCDs and mental health with governments, nongovernmental organizations, relevant private-sector entities, academic institutions and philanthropic foundations.

STATUTORY REPORTING REQUIREMENTS

25. In response to paragraph 15 of the terms of reference of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases,[1] the proposed workplan for the Mechanism, covering the period until the end of its lifespan, is submitted (Annex 5) for consideration by Member States. The proposed workplan takes into account the recommendations of the preliminary evaluation of the Global Coordination Mechanism,[2] as well as the outcomes of its general meeting held in Geneva on 5 and 6 November 2018.

[1] Document A67/14 Add.1.

[2] Document A71/14 Add.1.

EVALUATIONS

26. In accordance with paragraph 60 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and in conformity with the evaluation workplan for 2018–2019, the Secretariat will convene a representative group of stakeholders, including Member States and international partners, that will work during the second quarter of 2019 to conduct a mid-point evaluation of progress on the implementation of the Global Action Plan. The results will be reported to the Seventy-third World Health Assembly, through the Executive Board. The evaluation has been delayed due to financial constraints.

ACTION BY THE HEALTH ASSEMBLY

27. The Health Assembly is invited to note the report.

ANNEX 1

MEMBER STATE COMMITMENTS ON NCDS: CONCORDANCE BETWEEN THE 2018 POLITICAL DECLARATION AND THE 2014 OUTCOME DOCUMENT, THE 2011 POLITICAL DECLARATION AND OTHER RELEVANT INSTRUMENTS

Member States made 14 new commitments on NCDs in the 2018 Political Declaration (United Nations General Assembly resolution 73/2) and reiterated 19 existing commitments, as follows:

Paragraph	Status	New commitments/source of reiterated commitments
17	New	Strengthen our commitment, as Heads of State and Government, to provide strategic leadership for the prevention and control of noncommunicable diseases by promoting greater policy coherence and coordination through whole-of-government and health-in-all-policies approaches and by engaging stakeholders in an appropriate, coordinated, comprehensive and integrated, bold whole-of-society action and response.
18	–	Based on United Nations General Assembly resolutions 66/2, 68/300 and 70/1.
19	–	Ibid.
20	–	Ibid.
21	New	Promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for noncommunicable diseases, and promote healthy diets and lifestyles.
22	–	Based on United Nations General Assembly resolutions 66/2, 68/300 and 70/1.
23	New	Implement cost-effective and evidence-based interventions to halt the rise of overweight and obesity, in particular childhood obesity, taking into account World Health Organization recommendations and national priorities.[1]
24	New	Develop, as appropriate, a national investment case on the prevention and control of noncommunicable diseases to raise awareness about the national public health burden caused by noncommunicable diseases, health inequities, the relationship between noncommunicable diseases, poverty and social and economic development, the number of lives that could be saved and the return on investment.
25	–	Based on United Nations General Assembly resolution 68/300, paragraph 30(a)(vi).
26	–	Based on United Nations General Assembly resolutions 66/2, 68/300 and 70/1.
27	–	Based on United Nations General Assembly resolution 66/2, paragraphs 57–59.
28	–	Based on WHO's Constitution.
29	New	Take measures to better prepare the health systems to respond to the needs of the rapidly ageing population, including the need for preventive, curative, palliative and specialized care for older persons, taking into account the disproportionate burden of noncommunicable diseases on older persons, and that population ageing is a contributing factor in the rising incidence and prevalence of noncommunicable diseases.
30	–	Based on United Nations General Assembly resolutions 66/2, paragraph 59, and 70/1.

[1] Although paragraph15 of the 2014 outcome document includes a commitment to reverse the rising trends in overweight and obesity, it is made by ministers and representatives of FAO and WHO, not by Member States at the highest level as in the 2018 Political Declaration on NCDs.

Paragraph	Status	New commitments/source of reiterated commitments
31	New	Increase global awareness, action and international cooperation on environmental risk factors, to address the high number of premature deaths from noncommunicable diseases attributed to human exposure to indoor and outdoor air pollution, underscoring the particular importance of cross-sectoral cooperation in addressing these public health risks.
32	New	Promote healthy communities by addressing the impact of environmental determinants on noncommunicable diseases, including air, water and soil pollution, exposure to chemicals, climate change and extreme weather events, as well as the ways in which cities and human settlements are planned and developed, including sustainable transportation and urban safety, to promote physical activity, social integration and connectivity.
33	New	Encourage the adoption of holistic approaches to health and well-being through regular physical activity, including sports, recreation and yoga, to prevent and control noncommunicable diseases and promote healthy lifestyles, including through physical education.
34	–	Based on United Nations General Assembly resolutions 68/300, paragraph 30(a)(iii); and 66/2, paragraph 43(b).
35	–	Based on United Nations General Assembly resolutions 66/2, paragraph 45(n), and 68/300, paragraphs 23 and 30(c).
36	–	Based on United Nations General Assembly resolution 66/2, paragraphs 45(p) and 52.
37	New	Implement measures to improve mental health and well-being, including by developing comprehensive services and treatment for people living with mental disorders and other mental health conditions and integrating them into national responses for noncommunicable diseases, and addressing their social determinants and other health needs, fully respecting their human rights.
38	New	Promote access to affordable diagnostics, screening, treatment and care, as well as vaccines that lower the risk of cancer, as part of the comprehensive approach to its prevention and control, including cervical and breast cancers.
39	–	Based on United Nations General Assembly resolutions 66/2, 68/300 and 70/1.
40	New	Strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure to treat people living with noncommunicable diseases and prevent and control their risk factors in humanitarian emergencies, including before, during and after natural disasters, with a particular focus on countries most vulnerable to the impact of climate change and extreme weather events.
41	–	Based on United Nations General Assembly resolutions 66/2, paragraphs 27 and 45(r), and 68/300, paragraph 30(d).
42	New	Promote meaningful civil society engagement to encourage Governments to develop ambitious national multisectoral responses for the prevention and control of noncommunicable diseases, and to contribute to their implementation, forge multistakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and amplify the voices of and raise awareness about people living with and affected by noncommunicable diseases.
43	–	Based on United Nations General Assembly resolutions 66/2, paragraphs 37 and 44, and 68/300, paragraphs 26, 28 and 30.

Paragraph	Status	New commitments/source of reiterated commitments
44	New	Invite the private sector to strengthen its commitment and contribution to the implementation of national responses to prevent, control and treat noncommunicable diseases to reach health and development objectives by: (a) Promoting and creating safe and healthy working environments, by implementing occupational health measures, including by establishing tobacco-free workplaces, and through good corporate practices, workplace wellness programmes and health insurance plans, as appropriate; (b) Encouraging economic operators in the area of alcohol production and trade, as appropriate, to contribute to reducing harmful use of alcohol in their core areas, taking into account national religious and cultural contexts; (c) Taking concrete steps, where relevant, towards eliminating the marketing, advertising and sale of alcoholic products to minors; (d) Further producing and promoting food products consistent with a healthy diet, making further efforts to reformulate them in order to provide healthy and nutritious options, reducing the excessive use of salt, sugars and fats, in particular saturated fats and trans-fats, as well as providing appropriate content information of those nutrients, bearing in mind international guidelines on nutrition labelling; (e) Committing to further reduce the exposure of children to and impact on them of the marketing of foods and beverages high in fats, in particular saturated fats and trans-fats, sugars or salt, consistent with national legislation, where applicable; (f) Contributing to further improving access to and the affordability of safe, effective and quality medicines and technologies in the prevention and control of noncommunicable diseases.
45	New	Establish or strengthen transparent national accountability mechanisms for the prevention and control of noncommunicable diseases, taking into account government efforts in developing, implementing and monitoring national responses for addressing noncommunicable diseases and existing global accountability mechanisms.
46	–	Based on United Nations General Assembly resolutions 66/2, paragraph 45(d) and 68/300, paragraph 32.
47	–	Based on United Nations General Assembly resolution 66/2.
48	–	Based on United Nations General Assembly resolutions 66/2 and various resolutions of the United Nations Economic and Social Council.
49	–	Based on United Nations General Assembly resolution 68/300.
50	Next steps	We request the Secretary-General, in consultation with Member States, and in collaboration with the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2024, for consideration by Member States, a report on the progress achieved in the implementation of the present political declaration, in preparation for a high-level meeting on a comprehensive review, in 2025, of the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health and well-being.

ANNEX 2

NOTE ON CURRENT SCIENTIFIC KNOWLEDGE, AVAILABLE EVIDENCE AND INTERNATIONAL EXPERIENCE REGARDING FISCAL MEASURES FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

1. In resolution WHA70.11 (2017) on Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Health Assembly endorsed the updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020, containing the WHO set of best buys and other recommended interventions for the prevention and control of noncommunicable diseases.[1]

2. In paragraph 21 of United Nations General Assembly resolution 73/2, Heads of State and Government and representatives of States and Governments committed themselves to scaling up efforts and further implementing the following action: "Promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for non-communicable diseases, and promote healthy diets and lifestyles".

3. In relation to paragraph 21 of the 2018 Political Declaration on NCDs, the three main fiscal measures included in the WHO list of best buys and other recommended interventions on the prevention and control of NCDs endorsed by the Seventieth World Health Assembly are:

(a) increase excise taxes and prices on tobacco products;

(b) increase excise taxes on alcoholic beverages;

(c) reduce sugar consumption through effective taxation on sugar-sweetened beverages.

4. The scientific knowledge, available evidence and a review of international experience regarding these interventions were published by the Secretariat on 12 April 2017.[2]

5. In order to support Member States in their efforts to promote fiscal measures, as appropriate, in accordance with paragraph 21 of the 2018 Political Declaration on NCDs, this note sets out the current scientific knowledge, available evidence and a review of international experience regarding the three fiscal measures included in the WHO list of best buys and other recommended interventions on the prevention and control of NCDs.

[1] Italy and the United States of America dissociated themselves from paragraph 1 of resolution WHA70.11 and did not endorse the updated set of best buys and other recommended interventions for the prevention and control of noncommunicable diseases. They stated, inter alia, that they believe that the evidence underlying certain interventions was not yet sufficient to justify their inclusion. They considered that the proposed interventions should also reflect the view that all foods could be part of an overall healthy diet.

[2] Available at http://www.who.int/ncds/governance/appendix3-update/en/ (accessed 26 February 2019).

Increase excise taxes and prices on tobacco products

6. The scientific knowledge and evidence base for the increase of excise taxes and prices on tobacco products remains largely similar to the evidence base published by the Secretariat in 2017.[1] It clearly demonstrates that higher tobacco product taxes and prices lead to reductions in tobacco use, and recent studies just reaffirm this conclusion.

7. As noted in the Addis Ababa Action Agenda of the Third International Conference on Financing for Development (adopted in 2015), "price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and health-care costs, and represent a revenue stream for financing for development in many countries".[2] Increasing excise taxes and prices on tobacco products will contribute to not only Sustainable Development Goals targets 3.4 and 3.a but Goals 1, 3, 5, 10, 12 and 17 as well.

8. The Secretariat is currently updating its country analysis and preliminary results show that, between 2016 and 2018, 94 countries increased their tobacco excise on cigarettes. The definitions, type and level of tax and range of tobacco products covered by tobacco taxes vary by country.

Increase excise taxes on alcoholic beverages

9. Studies published since 2017 continue to repeatedly find that increasing the price of alcohol is associated with reductions in harmful use of alcohol and alcohol-related morbidity and mortality. Price increases have low implementation costs, a moderate-to-high level of health impact, and a highly favourable ratio of costs to effects. Increasing excise taxes is the most cost-effective of the intervention strategy to reduce the harmful use of alcohol.[3]

10. To date, 155 countries reported the use of excise tax on alcohol. The definitions, type and level of tax and range of alcoholic beverages covered by alcohol taxes vary. Of reporting countries 59% indicated that they had established or increased an excise tax on alcohol since 2010, but only 38 responding countries adjust these excise taxes for inflation. The Secretariat is updating its implementation guide on alcohol tax administration.

Reduce sugar consumption through effective taxation on sugar-sweetened beverages

11. Reducing sugar consumption through effective taxation on sugar-sweetened beverages was identified as an effective intervention with a cost-effectiveness analysis (>INT$ 100 per disability-adjusted life years averted in low- and middle-income countries).

12. Reduction in sugar intake is associated with reduced body weight in both adults and children;[4] reduced sugar consumption will therefore contribute to the attainment of the global nutrition target and voluntary global target set by the Health Assembly to halt, by 2025, childhood overweight and halt the

[1] Available at https://www.who.int/ncds/governance/appendix3-update/en/ (accessed 26 February 2019).

[2] Paragraph 32 of United Nations General Assembly resolution 69/313.

[3] Chisholm D, Moro D, Bertram M, Pretorius C, Gmel G, Shield K, Rehm J. Are the "Best Buys" for Alcohol Control Still Valid? An Update on the Comparative Cost-Effectiveness of Alcohol Control Strategies at the Global Level. J Stud Alcohol Drugs, 2018. 79(4): p. 514–522.

[4] Te Morenga L, Mallard S, Mann J. Dietary sugars and body weight: systematic review and meta analyses of randomised controlled trials and cohort studies. BMJ. 2013; 346:e7492

rise in obesity and diabetes; it will also contribute to the achievement of Sustainable Development Goal target 3.4 to reduce, by 2030, premature mortality from NCDs by one third.

13. In appraising evidence from 2016 to September 2018, nine peer-reviewed papers assessed the impact of reducing sugar consumption through effective taxation of sugar-sweetened beverages (post-implementation). This body of evidence comes from Chile, Mexico and the United States of America (Berkeley, California, and Philadelphia, Pennsylvania). Overall, the studies consistently demonstrate that following the introduction of effective taxation on sugar-sweetened beverages:

(a) the purchases, sales and consumption of taxed sugar-sweetened beverages decreased;

(b) the purchases, sales and consumption of untaxed beverages, particularly bottled water, increased.

14. Four studies provide consistent evidence that the introduction of the 1 peso/L tax in Mexico on sugar-sweetened beverages in 2014 was associated with a decline in their sales or purchases. The reported impact included an approximate decline of 6% in sales or purchases of sugar-sweetened beverages in the first year, which was sustained with slightly larger (8–10%) reductions in the second year following tax implementation,[1,2] suggesting potential habit-forming effects. The studies also show that the impact of the tax was larger for households of lower socioeconomic status, with sales or purchases of sugar-sweetened beverages falling by 9–10%.[3,4]

15. Evaluation of changes to an effective taxation of sugar-sweetened beverages in Chile shows that the increase in the tax rate from 13% to 18% on high-sugar sugar-sweetened beverages (>6.25 g of sugar/100 mL), combined with a reduction in the rate from 13% to 10% on low-sugar sugar-sweetened beverages (<6.25 g of sugar/100 mL), showed significantly lower purchases of high-sugar sugar-sweetened beverages following the tax rate change.[5,6] One of the studies reported a large effect of –21.6% despite not using a counter-factual in its analysis.

16. Published evidence also exists from implementation of sugar-sweetened beverages taxes at the subnational level. For example, the US$ 0.01/ounce tax in Berkeley, California, in 2015, led to a significant reduction in consumption of sugar-sweetened beverages (by 21%) among adults in

[1] Colchero MA, Guerrero-López CM, Molina M, Rivera JA. 2016. Beverages sales in Mexico before and after implementation of a sugar sweetened beverage tax. PLoS One. 11(9): e0163463.

[2] Colchero MA, Rivera-Dommarco J, Popkin BM, Ng SW. 2017. In Mexico, evidence of sustained consumer response two years after implementing. Health Aff. (Millwood). 36(3):564–71.

[3] Colchero MA, Popkin BM, Rivera JA, Ng SW. 2016. Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study. BMJ. 22 352:h6704.

[4] Colchero MA, Molina M, Guerrero-Lopez CM. 2017. After Mexico implemented a tax, purchases of sugar-sweetened beverages decreased and water increased: difference by place of residence, household composition, and income level. J. Nutr. 147(8):1552–1557.

[5] Caro JC, Corvalán C, Reyes M, Silva A, Popkin B, Taillie LS. Chile's 2014 sugar-sweetened beverage tax and changes in prices and purchases of sugar-sweetened beverages: an observational study in an urban environment. PLoS Med. 2018 Jul 3;15(7): e1002597.

[6] Nakamura R, Mirelman AJ, Cuadrado C, Silva-Illanes N, Dunstan J, Suhrcke M. Evaluating the 2014 sugar-sweetened beverage tax in Chile: an observational study in urban areas. PLoS Med. 2018 Jul 3;15(7): e1002596.

low-income neighbourhoods 4–8 months after the introduction of the tax[1] and an overall impact on sales of sugar-sweetened beverages was sustained, with a 10% reduction in sales one year later.[2] A beverage excise tax of US$ 0.015/ounce on both sugar- and artificially-sweetened beverages introduced in Philadelphia, Pennsylvania, in 2016, showed that two months after introduction of the tax the likelihood of daily soda and energy drink consumption was lower by 40% and 64%, respectively. In addition, the consumption of sodas over 30 days was 38% lower, although there were no reported significant differences in consumption of other taxed beverages.[3]

17. This recent body of evidence based on evaluations of actual excise taxes on sugar-sweetened beverages builds on a larger body of literature that has previously shown that the demand for sugar-sweetened beverages is price-sensitive.[4,5] In addition, it also demonstrates the presence of significant cross-tax beverage effects (i.e., the impact on untaxed substitute beverages), particularly on bottled water. In Mexico, for example, sales of untaxed beverages increased by 2–4% and evidence revealed that bottled water purchases increased by 5–16%, with higher increases of about 20% for low- and middle-income households. Evidence from Chile shows that purchases of reduced-tax low-sugar-sweetened beverages increased by 10.7% in one study,[6] but no statistically significant change was observed in another study.[7] Evaluation studies of taxation of sugar-sweetened beverages in Berkeley, California, found significant increases in bottled water consumption (+63% among adults in low-income communities and +15.6% in sales in supermarkets).[2] Two months after the introduction of the beverage tax in Philadelphia, the odds of bottled water consumption were found to be 58% higher.[3]

18. In addition to peer-reviewed literature, results from the introduction of effective taxation of sugar-sweetened beverages in the United Kingdom of Great Britain and Northern Ireland have shown an impact on product reformulation in the short term. Since the announcement of the tax in 2015, the average sugar concentrations per 100 mL fell by 11% in those products subject to the taxation that came into force in April 2018 (£0.18 and £0.24/L for the two sugar bands of 5 g/100 mL and 8 g/100 mL respectively). Also, there was a significant shift in volume sales towards products with sugar levels below 5 g/100 mL.[8]

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[1] Falbe J, Thompson HR, Becker CM, Rojas N, McCulloch CE, Madsen KA. 2016. Impact of the Berkeley excise tax on sugar-sweetened beverage consumption. Am. J. Public Health. 106(10):1865–1871.

[2] Silver LD, Ng SW, Ryan-Ibarra S, Taillie LS, Induni M, et al. 2017. Changes in prices, sales, consumer spending, and beverage consumption one year after a tax on sugar sweetened beverages in Berkeley, California, United States: a before-and-after study. PLoS Med. 14(4):e1002283.

[3] Zhong Y, Auchincloss AH, Lee BK, Kanter GP. The short-term impacts of the Philadelphia beverage tax on beverage consumption. Am J Prev Med. 2018 Jul;55(1):26–34.

[4] Andreyeva T, Long MW, Brownell KD. The impact of food prices on consumption: a systematic review of research on the price elasticity of demand for food. Am J Public Health. 2010:100:216–22.

[5] Powell LM, Chriqui JF, Khan T, Wada R, Chaloupka FJ. 2013. Assessing the potential effectiveness of food and beverage taxes and subsidies for improving public health: a systematic review of prices, demand and body weight outcomes. Obes. Rev. 14(2):110–128.

[6] Caro JC, Corvalán C, Reyes M, Silva A, Popkin B, Taillie LS. Chile's 2014 sugar-sweetened beverage tax and changes in prices and purchases of sugar-sweetened beverages: an observational study in an urban environment. PLoS Med. 2018 Jul 3;15(7): e1002597.

[7] Nakamura R, Mirelman AJ, Cuadrado C, Silva-Illanes N, Dunstan J, Suhrcke M. Evaluating the 2014 sugar-sweetened beverage tax in Chile: an observational study in urban areas. PLoS Med. 2018 Jul 3;15(7):e1002596.

[8] Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/709008/Sugar_reduction_progress_report.pdf (accessed 26 February 2019).

19. In summary, the new evidence shows consistent results of a reduction in sugar consumption through effective taxation on sugar-sweetened beverages. Substitution to increased bottled water consumption is indicative that the effective taxation on sugar-sweetened beverages will lead to a decrease in overall sugar intake and, hence, improvement in weight and health outcomes. However, such health impact needs to be duly documented by follow-up studies.

20. Country-level implementation of the WHO set of best buys and other recommended interventions is monitored through the WHO NCD Country Capacity Survey and the WHO Global Nutrition Policy Review. To date, 43 of 194 Member States self-reported that they have implemented a tax on sugar-sweetened beverages according to the survey and an additional 16 countries have been subsequently identified as part of WHO's ongoing tracking of policy implementation, with data for all 59 countries available in the Global database on the Implementation of Nutrition Action. Countries with an effective taxation on sugar-sweetened beverages cover all WHO regions; 21 of them are high-income, 17 are upper-middle-income; 15 are lower-middle income and five are low-income, and one country is not classified by income by the World Bank.

21. The definitions, type and level of tax and range of products covered by sugar-sweetened beverages taxes vary. Several Member States impose a differential tax across products, for example, with different tax rates for sugary drinks with added sugars and drinks with non-caloric sweeteners, and for drinks with a higher versus a lower sugar content. On the other hand, several Member States exclude fruit juices (100%) or fruit drinks (<100%) from the tax base. Similarly, few Member States include sugar-sweetened beverages other than sodas, such as sweetened and/or flavoured milk or dairy drinks or flavoured mineral water.

22. Of the 59 Member States whose taxation of sugar-sweetened beverages is covered in the Global Database for Information on Nutrition Action, 23 implemented an ad valorem excise tax (i.e., a tax applied as percentage of the product value), 29 have a specific excise tax (i.e., a tax applied as a specific amount per volume litre of drink or grams of sugar), six use a combination of ad valorem and a specific excise tax and one does not make available this information. The tax rate applied varies considerably. Member States with an ad valorem tax are applying tax rates as low as 4% and as high as 100%.

23. The Secretariat is developing implementation guides to support and strengthen Member States' implementation of policy measures, including fiscal measures, to reduce unhealthy diets. All countries implementing fiscal measures to promote healthy diets are encouraged to include robust evaluations to contribute to the evidence and further analysis of impact and cost effectiveness.

24. Based on current scientific knowledge, available evidence and a review of international experience:

(a) Member States can continue to consider effective taxation on sugar-sweetened beverages, including soft drinks, sweetened milk-based drinks and fruit juices, as a means to reduce sugar consumption;

(b) Member States intending to reduce sugar consumption through effective taxation on sugar-sweetened beverages are encouraged to undertake the evaluation of their effectiveness and impact and share their implementation experiences, so as to contribute to the evidence and knowledge base.

ANNEX 3

NOTE ON THE APPROACH THAT CAN BE USED TO REGISTER AND PUBLISH CONTRIBUTIONS OF NON-STATE ACTORS TO THE ACHIEVEMENT OF SUSTAINABLE DEVELOPMENT GOAL TARGET 3.4

1. Pursuant to paragraph 37 of United Nations General Assembly resolution 68/300, calling for development of 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, the Health Assembly noted documents A69/10 (including its Annex 4) and A70/27 (with its Annex 2) on the development of such an approach, outlining the conceptual framework that the Secretariat proposed to explore.[1]

2. In his document A/72/662, the United Nations Secretary-General noted in paragraph 43 that "While the contours of such an approach were noted by the World Health Assembly in 2016 and 2017, WHO has not been able to finalize a concrete self-reporting tool, including related indicators, that non-State actors could use to publish their own contributions on their own websites for independent comparison and assessment. WHO envisages finalizing this work before the end of 2018, in close consultation with other organizations of the United Nations system."

3. This assignment given by the General Assembly to WHO has been difficult to complete, in particular because, although a global accountability framework for the prevention and control of NCDs has been established for Member States (see document A69/10, Annex 8), no agreed set of predefined indicators exists to encourage non-State actors to register and publish their own contributions to the achievement of the nine voluntary targets for NCDs in the most objective and independently verifiable way possible to enable comparison of different contributions.

4. Unhealthy diet is one of the risk factors that can be addressed by the combined action of government regulatory approaches and private-sector voluntary commitments. Parts of the global food industry have made commitments to enhance the healthiness of packaged and restaurant foods; however, such products are not always broadly affordable and available in all communities within countries. WHO is developing an approach to register and publish the contributions of the global food industry as a test case for the overall contribution of the private sector to the achievement of the nine voluntary targets for NCDs and Sustainable Development Goal target 3.4. This test case will also provide guidance on developing a comprehensive approach that can also be used to register and publish contributions of philanthropic entities and civil society.

5. The Secretariat is also developing a mechanism to assess the progress of food and beverage sector companies on meeting global nutrition targets at global and country levels that will monitor:

(a) the progress of food and non-alcoholic beverage manufacturers towards meeting a set of food composition targets, which WHO will establish in consultation with government and nongovernment actors. Annual product-level data will be collected and updated for packaged and restaurant foods using the FoodSwitch system, which comprises data collection, processing and dissemination tools. Surveys of the national packaged and restaurant food supply will be updated

[1] See documents WHA69/2016/REC/3, summary records of the Sixty-ninth World Health Assembly, Committee A, eleventh meeting, and WHA70/2017/REC/3, summary records of the Seventieth World Health Assembly, Committee B, fourth meeting, section 4, fifth meeting, section 3 and seventh meeting, section 2.

each year, including detailed information on every product (product name, brand, manufacturer, package size, serving size, energy density, nutrient composition, ingredients list, labelling and health claims). Data will be provided to diverse user groups (ingredients manufacturers, manufacturing, retail, advertising, insurance, government, advocacy groups, media and consumers), as appropriate, in formats tailored to the needs of each;

(b) company policies and commitments on nutrition-labelling, promotion to children and adolescents, and product accessibility, relative to WHO-set benchmarks derived from WHO recommendations.

6. A publicly accessible database will be established that includes, for food and beverage companies that can be reached by the monitoring mechanism, a statement of each company's expressed commitment and of its compliance with (a) its own commitment and (b) WHO-set targets or benchmarks.

7. The monitoring mechanism will rely on a WHO-convened consortium of institutions, independent from the food and beverage manufacturers. A first group of institutions will include the Access to Nutrition Foundation, the George Institute for Global Health and the International Network for Food and Obesity/Non-communicable Diseases (NCDs) Research, Monitoring and Action Support (INFORMAS). The WHO-convened consortium will be open to other independent actors that may contribute. A key part of the process is engagement with company representatives to understand their policies and commitments. Funding that would not raise conflicts of interest will be sought from donors.

8. The WHO-convened consortium will develop a common protocol to monitor policies and practices of food companies. Monitoring of policies and practices will later be extended to other segments, such as fast-food restaurants and retailers. The process will begin with a market assessment, analysis of existing standards and a consultation process, as an input to methodology development by the consortium.

9. The monitoring of data will be used to implement standardized global food composition targets through policy development and industry action. Enhancing compliance with local labelling regulations will also be a prime objective. The data will enable objective quantification of programme impact and transparent dissemination of the findings.

10. Timelines and deliverables are currently under development.

ANNEX 4

NOTE ON WHO PREPARATION OF THE 2024 REPORT OF THE UNITED NATIONS SECRETARY-GENERAL ON THE PROGRESS ACHIEVED IN THE IMPLEMENTATION OF THE COMMITMENTS ON NCDS INCLUDED IN THE 2011 POLITICAL DECLARATION, THE 2014 OUTCOME DOCUMENT AND 2018 POLITICAL DECLARATION

CONTEXT

1. This note outlines how WHO, pursuant to paragraph 50 of the 2018 Political Declaration on NCDs, will prepare the 2024 report of the United Nations Secretary-General on the progress achieved in the implementation of the commitments included in the 2011 Political Declaration, the 2014 outcome document and the 2018 Political Declaration.

2. Document A/72/662 of the United Nations Secretary-General on progress on the prevention and control of NCDs reported, in paragraphs 12–14, progress measured against a scorecard for each Member State. Tracked against 10 indicators, the overall score for each Member State is also given in the WHO Noncommunicable Diseases Progress Monitor 2017, with a full explanation of the methodology used, using data collected in the first half of 2017. The 10 indicators included in the scorecard were first published by the Secretariat in a WHO technical note (version dated 1 May 2015)[1] in response to decision EB136(13) (2015). An updated WHO technical note (version dated 4 September 2017)[2] took into account the list of best buys and other recommended interventions for the prevention and control of NCDs endorsed by the Seventieth World Health Assembly.

Reporting framework for 2024

3. The methodology WHO will use to develop the reporting framework for 2024 takes into account the following:

(a) national commitments included in the 2011 Political Declaration, the 2014 outcome document and the 2018 Political Declaration on NCDs;

(b) existing indicators for monitoring NCDs at global and regional levels, including the comprehensive global monitoring framework for the prevention and control of NCDs,[3] the Thirteenth General Programme of Work, 2019–2023 and the global indicator framework for the Sustainable Development Goals and targets for the 2030 Agenda for Sustainable Development;[4]

(c) existing survey tools and data collection mechanisms.

[1] Available at http://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1 (accessed 26 February 2019).

[2] Available at http://www.who.int/nmh/events/2015/Updated-WHO-Technical-Note-NCD-Progress-Monitor-September-2017.pdf?ua=1 (accessed 26 February 2019).

[3] Adopted by the Health Assembly in 2013 in resolution WHA66.10, paragraph 1(2).

[4] Adopted by the United Nations General Assembly in resolution 71/313, paragraph 1.

4. Using existing survey tools and taking into account existing indicators at the global and regional levels so as not to create any additional reporting burden for Member States, WHO will identify and publish a new set of indicators, which will be used to produce a scorecard for each Member State to be included in the 2024 report to the United Nations General Assembly. The scorecard will track progress against indicators related to the implementation of the national commitments included in the 2011 Political Declaration, the 2014 outcome document and the 2018 Political Declaration on NCDs. It will include an updated and enhanced set of progress monitoring indicators, along with indicators that will highlight outcome indicators related to NCD mortality, risk factor exposures and key health system performance indicators, which together will form a comprehensive picture of country-level progress and achievement.

Survey tools and data collection mechanisms

5. Using the established NCD Country Capacity Assessment Survey mechanisms in operation since 2000, WHO will conduct periodic global surveys in 2019, 2021 and 2023 to continue to assess national capacity for, and progress being made in implementing, NCD prevention and control. The aim of these periodic surveys is to support countries in their efforts to assess their strengths and weaknesses related to NCD governance and infrastructure, policy response, surveillance and health systems response to address NCDs at the national level, as well as to provide data for reporting to the Health Assembly and/or WHO regional committees against existing outcome and process indicators at global and national levels, according to agreed timelines. In line with practices established since 2000, the questionnaire is reviewed during each round of the survey to ensure it takes into account any new national commitments included in the 2018 Political Declaration. Extensive validation of a number of survey item responses will be done to enhance the accuracy of reporting.

6. Other existing global tools relevant to the prevention and control of NCDs include the WHO Report on the Global Tobacco Epidemic, the WHO Global Information System on Alcohol and Health, the WHO Global Database on the Implementation of Nutrition Action, the WHO STEPwise Approach to NCD Risk Factor Surveillance, the Global Tobacco Surveillance System and the tools used to report on the outcome indicators for the Thirteenth General Programme of Work.

Next steps

7. Annex 6 sets out the indicators that will be used to produce a scorecard for each Member State to measure, on a yearly basis, the implementation of the commitments included in the 2011 Political Declaration, the 2014 outcome document and the 2018 Political Declaration on NCDs. The scorecards produced in 2024 will be submitted as part of the report of the Secretary-General.

ANNEX 5

PROPOSED WORKPLAN FOR THE GLOBAL COORDINATION MECHANISM ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES FOR 2020

CONTEXT

1. In response to paragraph 15 of the terms of reference of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases (the Mechanism),[1] the present document outlines the proposed workplan of the Mechanism for 2020.

2. The workplan takes into account the terms of reference of the Mechanism, its workplans for 2014–2015, 2016–2017 and 2018–2019[2] and the global action plan for the prevention and control of noncommunicable diseases 2013–2020.[3] In addition, it takes into account the Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,[4] the outcome document of the high-level meeting of the United Nations General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases,[5] the Political Declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases[6] and the 2030 Agenda for Sustainable Development.[7]

3. The workplan further takes into account the preliminary evaluation of the Mechanism[8] and the outcomes of its general meeting, mandated in paragraph 12 of its terms of reference and convened in Geneva on 5 and 6 November 2018. The outcomes of the general meeting include an update of the strategic priorities of the Mechanism in the light of the findings of the preliminary evaluation.[9]

WORKPLAN FOR 2020

Strategic priorities

4. The workplan for 2020 is organized around three strategic priorities, in accordance with the five functions of the Mechanism stated in its terms of reference, as follows:

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

[2] Documents A67/14 Add.3 Rev.1; A68/11, Annex 3; and A70/27, Annex 3, respectively.

[3] Endorsed by the World Health Assembly in resolution WHA66.10 (2013).

[4] See United Nations General Assembly resolution 66/2 (2011).

[5] See United Nations General Assembly resolution 68/300 (2014).

[6] See United Nations General Assembly resolution 73/2 (2018).

[7] See United Nations General Assembly resolution 70/1 (2015).

[8] Document A71/14 Add.1.

[9] See https://www.who.int/global-coordination-mechanism/publications/2018-general-meeting-report/en/ (accessed 1 March 2019).

Strategic priority 1. Foster multistakeholder collaboration, partnerships and accountability by means of online platforms that consolidate and disseminate current scientific knowledge and available evidence and that provide the basis for a review of national experience of engagement with non-State actors in order to assess the significance and effectiveness of that engagement in implementing national strategies to achieve Sustainable Development Goal target 3.4 on noncommunicable diseases;

Strategic priority 2. Promote a better understanding of the challenges identified at the national level to the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and achievement of Sustainable Development Goal target 3.4 on noncommunicable diseases, as well as the preliminary lessons learned and successful approaches to overcoming the challenges identified;

Strategic priority 3. Pilot capacity-building approaches with a view to developing a technical package on how to establish or strengthen national multistakeholder dialogue mechanisms for noncommunicable diseases[1] while giving due regard to managing conflicts of interest, including by supporting WHO programmes for implementing the multisectoral and multistakeholder components of the technical packages to reduce risk factors for noncommunicable diseases contained in WHO's draft Proposed programme budget 2020–2021.

Actions

5. The following actions will be undertaken in close collaboration with the relevant WHO technical programmes and the WHO-led United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, in consultation with participants in the Mechanism, as appropriate.

Strategic priority 1

- Strengthen the Mechanism's knowledge action portal on noncommunicable diseases[2] by, inter alia, conducting a continuous global stocktaking exercise on the engagement of governments with non-State actors, including public–private partnerships, in order to accelerate ambitious action to achieve Sustainable Development Goal target 3.4 by 2030.

- Develop an approach to register, publish and track the commitments and contributions of civil society, philanthropic foundations and academic institutions to achieving Sustainable Development Goal target 3.4.[3]

- Promote meaningful civil society engagement, including through the WHO Civil Society Working Group on the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, in order to encourage governments to develop ambitious national multisectoral responses for the prevention and control of noncommunicable diseases and to contribute to their implementation.[4]

[1] In accordance with paragraph 25 of General Assembly resolution 73/2.

[2] https://www.who.int/global-coordination-mechanism/news/launch-new-online-community-driven-platform/en/ (accessed 1 March 2019).

[3] This will complement the approach that can be used to register and publish the contributions of the food and non-alcoholic beverage industry, as described in document EB144/20, Annex 3.

[4] In accordance with paragraph 42 of United Nations General Assembly resolution 73/2.

Strategic priority 2

- Convene Mechanism participants in order to develop a policy brief providing recommendations on how to raise the priority assigned by national agendas to, and strengthen political choices on, jointly providing noncommunicable diseases and mental health and social care services, including primary health care, in community-based settings.

- Convene Mechanism participants in order to develop a policy brief providing recommendations on how to raise the priority assigned by national agendas to, and strengthen political choices on, jointly reducing air pollution and the risk of dying prematurely from noncommunicable diseases.

- Convene Mechanism participants in order to develop a policy brief providing recommendations on how to overcome challenges at the national level to addressing the impact of economic, market and commercial factors on the prevention and control of noncommunicable diseases.

- Convene Mechanism participants in order to promote investments in implementation research in low- and middle-income countries.

Strategic priority 3

- Develop a technical package to support governments in their domestic efforts to establish or strengthen: (a) multistakeholder dialogue mechanisms, as appropriate, to support the implementation of national multisectoral action plans for the prevention and control of noncommunicable diseases in order to attain national targets;[1] and (b) a national multisectoral mechanism, such as a high-level commission, agency or task force, to oversee the engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on noncommunicable diseases, in order to advance the implementation of health-in-all-policies, whole-of-government and whole-of-society approaches, as well as to advance action on, and monitoring of, the determinants of noncommunicable diseases, including social, environmental and gender determinants.[2]

- Pilot the above-mentioned technical package in a small group of up to six countries, including the convening of national multistakeholder dialogues.

- Provide for the stocktaking and dissemination of advocacy campaigns and develop communication packages, in forms suitable for replication and adaptation by countries, that educate the public about the harms of smoking and/or tobacco use and second-hand smoke, the harmful use of alcohol and the risks of excessive intake of fats (in particular saturated fats), *trans*-fats, sugars and salt; and that promote the consumption of fruits and vegetables, the choice of healthy, balanced and sustainable diets and the reduction of sedentary behaviour.[3]

[1] In accordance with paragraph 25 of United Nations General Assembly resolution 73/2.

[2] In accordance with paragraph 30(a)(vi) of United Nations General Assembly resolution 68/300.

[3] In accordance with paragraph 34 of United Nations General Assembly resolution 73/2.

ANNEX 6

TECHNICAL NOTE ON HOW THE DIRECTOR-GENERAL WILL REPORT IN 2024 TO THE UNITED NATIONS GENERAL ASSEMBLY ON THE NATIONAL COMMITMENTS INCLUDED IN RESOLUTIONS 73/2 (2018) USING EXISTING SURVEY TOOLS AND TAKING INTO ACCOUNT EXISTING INDICATORS

1. In response to a request from a member of the Executive Board at its 144th session in January 2019, this annex sets out how the Director-General will report in 2024 to the United Nations General Assembly on the national commitments included in the 2018 Political Declaration on NCDs,[1] using existing survey tools and taking into account existing indicators.

CONTEXT

2. Paragraph 50 of resolution 73/2 requests "the Secretary-General, in consultation with Member States, and in collaboration with the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2024, for consideration by Member States, a report on the progress achieved in the implementation of the present political declaration, in preparation for a high-level meeting on a comprehensive review, in 2025, of the progress achieved in the prevention and control of non-communicable diseases and the promotion of mental health and well-being".

3. Taking into account that a similar request was included in paragraph 38 of resolution 68/300 in preparation for the third high-level meeting on the prevention and control of non-communicable diseases, the Secretariat will follow a similar process in preparing the report for the United Nations Secretary-General in 2024 as was done in 2017.

4. The report of the United Nations Secretary-General in 2017 on the progress on the prevention and control of non-communicable diseases[2] was prepared by the Secretariat based on the WHO technical notes published on 1 May 2015[3] and 4 September 2017[4] setting out how the Director-General would report in 2017 to the United Nations General Assembly on national commitments included in the 2014 Outcome document and the 2011 Political Declaration, using existing survey tools and taking into account existing indicators at the global and regional levels.

[1] United Nations General Assembly resolution 73/2 (2018). Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases.

[2] Document A/72/662, distributed at the United Nations General Assembly on 21 December 2017

[3] Available at https://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1https://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1 (accessed 26 February 2019).

[4] Available at https://www.who.int/nmh/events/2015/Updated-WHO-Technical-Note-NCD-Progress-Monitor-September-2017.pdf?ua=1 (accessed 26 February 2019).

REPORTING FRAMEWORK FOR 2024

5. Using existing survey tools and taking into account existing indicators at the global and regional levels so as not to create any additional reporting burden for Member States, the Secretariat will focus its report to the United Nations General Assembly in 2024 on the progress achieved in implementing key commitments linked to the WHO best buys using the following 10 (19) progress indicators along with key NCD health outcome and risk factor exposure indicators.

Commitment	**Indicator**
Consider setting national NCD targets for 2025	Member State has set time-bound national targets and indicators based on WHO guidance. Member State has a functioning system for generating reliable cause-specific mortality data on a routine basis. Member State has undertaken a survey under the WHO STEPwise approach to surveillance or a comprehensive health examination survey every five years.
Consider developing national multisectoral policies and plans to achieve the national targets by 2025	Member State has an operational multisectoral national strategy or action plan that integrates the prevention and control of major NCDs and reduction of their shared risk factors.
Reduce risk factors for NCDs, building on guidance set out in WHO's Global action plan for prevention and control of noncommunicable diseases	Member State has implemented the following four demand-reduction measures of the WHO Framework Convention on Tobacco Control at the highest level of achievement: (a) reduce affordability by increasing excise taxes and prices on tobacco products; (b) eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport; (c) implement plain or standardized packaging and/or large graphic health warnings on all tobacco packages; (d) enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship; (e) implement effective mass media campaigns that educate the public about the harms of smoking and tobacco use and of second-hand smoke. Member State has implemented, as appropriate according to national circumstances, the following three measures to reduce the harmful use of alcohol as set out in WHO's Global strategy to reduce the harmful use of alcohol: (a) enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale); (b) enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media); (c) increase excise taxes on alcoholic beverages. Member State has implemented the following four measures to reduce unhealthy diets:

	(a) adopted national policies to reduce population salt/sodium consumption; (b) adopted national policies that limit saturated fatty acids and virtually eliminate industrially-produced *trans* fatty acids in the food supply; (c) implemented WHO's set of recommendations on marketing of foods and non-alcoholic beverages to children; (d) adopted legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes. Member State has implemented at least one recent national public awareness and motivational communication for physical activity, including mass media campaigns for physical activity behavioural change.
Strengthen health systems to address NCDs through people-centred primary health care and universal health coverage, building on guidance set out in WHO's Global action plan for prevention and control of noncommunicable diseases	Member State has evidence-based national guidelines, protocols or standards for the management of major NCDs through a primary care approach, recognized or approved by government or competent authorities. Member State has provision of drug therapy, including medications for control of glycaemia, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level.

ANNEX 7

ANALYSIS OF WHICH MEMBER STATES HAVE IMPLEMENTED THE WHO FRAMEWORK FOR NATIONAL NONCOMMUNICABLE DISEASE SURVEILLANCE, WHAT ARE THE LESSONS LEARNED, AND HOW WILL THE SECRETARIAT PROVIDE SUPPORT TO COUNTRIES

1. In response to a request from a member of the Executive Board at its 144th session in January 2019, this annex provides an analysis of the status of implementation of the WHO Framework for National Noncommunicable Disease Surveillance, the lessons learned, and how the Secretariat will support national efforts to strengthen the implementation of this framework.

CONTEXT

2. Chapter 3 of WHO's first Global status report on noncommunicable diseases (2010)[1] sets out the framework for national noncommunicable disease surveillance. Noncommunicable disease surveillance systems need to be integrated into national health information systems. Three major components of noncommunicable disease surveillance are: (a) monitoring exposures (risk factors); (b) monitoring outcomes (morbidity and disease-specific mortality); and (c) assessing health systems capacity and response, which also includes national capacity to prevent noncommunicable diseases (in terms of policies and plans, infrastructure, human resources and access to essential health care, including medicines).

SITUATION ANALYSIS: WHERE DO WE STAND TODAY?

3. The current capacities for NCD surveillance remain inadequate in many countries and require strengthening. The Secretariat believes that an NCD surveillance framework that monitors exposures (risk factors and determinants), outcomes (morbidity and mortality) and health-system responses (interventions and capacity) is essential in all countries to help to drive action and track progress. Sustainable NCD surveillance systems need to be integrated into national health information systems and supported with adequate resources.

4. Data on country level implementation on national NCD surveillance systems were systematically collected from all Member States in 2017 through the NCD Country Capacity Survey. A update for 2019 is currently under way. This survey revealed that governance for NCD surveillance has been established in most countries and is overseen either within or across departments in the health ministry of nearly all countries. Some 84% of countries had cancer registries, yet only two thirds of these were population-based. Diabetes registries existed in less than half the countries (46%) and only a third of these were population-based. Service availability and readiness assessments, an important means for Member States to monitor and evaluate their health systems, have only been implemented in less than a quarter of countries.

5. As part of the time-bound commitment to set national NCD targets for 2025, Member States are expected to undertake a survey under the WHO STEPwise approach to surveillance or a comprehensive health examination survey every five years, the regular collection of data being necessary not only to set targets but to track a country's progress towards those targets. There has been considerable overall

[1] Available at https://www.who.int/nmh/publications/ncd_report2010/en/ (accessed 26 February 2019).

progress in NCD surveillance since 2010, but only 19% of Member States had fully achieved this level of systematic and regular risk factor surveillance. Surveillance of adolescent NCD risk factors is also an important component, but a significant number of countries (around one in five) reported no surveys among adolescents.

OPPORTUNITIES FOR ENHANCEMENT

6. Accurate data from countries are vital to reverse the global rise in death and disability from NCDs. Although increasingly few countries are completely inactive in the area of NCD risk factor surveillance, many struggle to maintain a robust system, with sufficient resources to regularly collect and report data. Additionally, NCD relevant data are often not integrated into national health information systems. Improving country-level surveillance and monitoring must be a top priority in the fight against NCDs. In low-resource settings with limited capacity, viable and sustainable systems can be simple and still produce valuable data, at least every five years.

7. Key opportunities for enhancement include: strengthening and integration of NCD surveillance activities into existing national health information systems; adoption and use of standardized core indicators for each of the three components of the global NCD monitoring framework, including key indicators linked to universal health coverage; strengthening of vital registration and reporting of cause-specific mortality; and giving highest priority in low-resource settings to monitoring and surveillance of behavioural and metabolic risk factors. Financial and technical support is needed to encourage significant acceleration of efforts.

HOW THE SECRETARIAT WILL SUPPORT NATONAL EFFORTS

8. The Secretariat has prepared a range of technical materials to help to guide countries in national target setting and strengthening national NCD surveillance systems. These include: guidance on indicator definitions and specifications that provides details of how targets and indicators should be calculated and reported; simple spreadsheet-based tools to calculate national level targets based on global targets; and tools for strengthening national NCD surveillance systems – guidance on civil registration and vital statistics with information on causes of death, cancer registry establishment, adult and youth risk factor surveillance using the WHO STEPwise approach to surveillance and the global school-based student health survey; and topic-specific surveillance initiatives, such as tobacco surveillance work including global adult tobacco surveys and global youth tobacco surveys.

9. The Secretariat will provide technical assistance to Member States for considering the development of national NCD targets, and to strengthen and expand their NCD surveillance systems, ideally within the context of national multisectoral NCD plans.

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