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SIXTY-SIXTH WORLD HEALTH ASSEMBLY
Agenda item 13

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Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

Draft resolution proposed by the delegations of Australia, Bahrain, Barbados, Belgium, Brazil, Canada, Chile, China, Colombia, Costa Rica, Cote d'Ivoire, Denmark, Djibouti, Finland, Ghana, Iraq, Libya, Malaysia, Mexico, Monaco, Mongolia, Nigeria, Norway, Pakistan, Panama, Russian Federation, Singapore, South Africa, Spain, Suriname, Sweden, Switzerland, Thailand, United Republic of Tanzania, United Kingdom of Great Britain and Northern Ireland, Uruguay, United States of America and Zimbabwe

CORRIGENDUM

Appendix 3

Menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases, to assist Member States in implementing, as appropriate, for national context, (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets **(***Note: This appendix needs to be updated as evidence and cost-effectiveness of interventions evolve with time)*.

The list is not exhaustive but is intended to provide information and guidance on effectiveness and cost-effectiveness.[1,2,3] of interventions based on current evidence and to act as the basis for future work to develop and expand the evidence base on policy measures and individual interventions. According to WHO estimates, policy interventions in objective 3 and individual interventions to be implemented in primary care settings in objective 4, listed in bold, are very cost-effective* and affordable for all countries.[1-3] However, they have not been assessed for specific contexts of individual countries. When selecting interventions for prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost–effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

*very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person

Menu of policy options	Voluntary global targets	WHO tools
Objective 1 • Raise public and political awareness, understanding and practice about prevention and control of NCDs • Integrate NCDs into the social and development agenda and poverty alleviation strategies • Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learnt and best practices • Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels • Implement other policy options in objective 1 (see paragraph 21)	Contribute to all 9 voluntary global targets	– WHO Global status report on NCDs 2010 – WHO Fact Sheets – Global Atlas on cardiovascular disease prevention and control 2011 – IARC GLOBOCAN 2008 – Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees

[1] Scaling up action against noncommunicable diseases: How much will it cost?" (http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf).

[2] WHO-CHOICE (http://www.who.int/choice/en/).

[3] Disease Control Priorities in Developing Countries (http://www.dcp2.org/pubs/DCP).

Menu of policy options	Voluntary global targets	WHO tools
Objective 2 • Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies • Assess national capacity for prevention and control of NCDs • Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement • Implement other policy options in objective 2 (see paragraph 30) to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases	Contribute to all 9 voluntary global targets	– UN Secretary-General's Note A/67/373 – NCD country capacity survey tool – NCCP Core Capacity Assessment tool – Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees
Objective 3[4] **Tobacco use**[a] • Implement WHO FCTC (see paragraph 36). Parties to the WHO FCTC are required to implement all obligations under the treaty in full; all Member States that are not Parties are encouraged to look to the WHO FCTC as the foundational instrument in global tobacco control • **Reduce affordability of tobacco products by increasing tobacco excise taxes*** • **Create by law completely smoke-free environments in all indoor workplaces, public places and public transport*** • **Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns*** • **Ban all forms of tobacco advertising, promotion and sponsorship*** **Harmful use of alcohol** • Implement the WHO global strategy to reduce harmful use of alcohol (see objective 3, paragraph 42) through actions in the recommended target areas including: • Strengthening awareness of alcohol-attributable burden; leadership and political commitment to reduce the harmful use of alcohol • Providing prevention and treatment interventions for those at risk of or affected by alcohol use disorders and associated conditions	A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context A 10% relative reduction in prevalence of insufficient physical activity A 30% relative reduction in mean population intake of salt/sodium intake A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure	– The WHO FCTC and its Guidelines – MPOWER capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC – WHO reports on the global tobacco epidemic – Recommendations on the marketing of foods and non-alcoholic beverages to children (WHA63.14) – Global Strategy on diet, physical activity and health, (WHA57.17) – Global recommendations on physical activity for health – Global strategy to reduce the harmful use of alcohol (WHA63.13) – WHO Global Status Reports on Alcohol and Health 2011, 2013 – WHO Guidance on dietary salt and potassium

[4] In addressing each risk factor, Member States should not rely on one single intervention, but should have a comprehensive approach to achieve desired results.

Menu of policy options	Voluntary global targets	WHO tools
• Supporting communities in adopting effective approaches and interventions to prevent and reduce the harmful use of alcohol • Implementing effective drink–driving policies and countermeasures • **Regulating commercial and public availability of alcohol*** • **Restricting or banning alcohol advertising and promotions*** • **Using pricing policies such as excise tax increases on alcoholic beverages*** • Reducing the negative consequences of drinking and alcohol intoxication, including by regulating the drinking context and providing consumer information • Reducing the public health impact of illicit alcohol and informally produced alcohol by implementing efficient control and enforcement systems • Developing sustainable national monitoring and surveillance systems using indicators, definitions and data collection procedures compatible with WHO's global and regional information systems on alcohol and health **Unhealthy diet and physical inactivity** • Implement the WHO Global Strategy on Diet, Physical Activity and Health (see objective 3, paragraphs 40-41) • Increase consumption of fruit and vegetables • To provide more convenient, safe and health-oriented environments for physical activity • Implement recommendations on the marketing of foods and non-alcoholic beverages to children (see objective 3, paragraph 38-39) • Implement the WHO global strategy for infant and young child feeding • **Reduce salt intake***[5] • **Replace trans fats with unsaturated fats*** • **Implement public awareness programmes on diet and physical activity*** • Replace saturated fat with unsaturated fat • Manage food taxes and subsidies to promote healthy diet • Implement other policy options listed in objective 3 for addressing unhealthy diet and physical inactivity	according to national circumstances Halt the rise in diabetes and obesity	– Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees

[5] And adjust the iodine content of iodized salt, when relevant.

Menu of policy options	Voluntary global targets	WHO tools
Objective 4 • Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda • Explore viable health financing mechanisms and innovative economic tools supported by evidence • Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective interventions to address behavioural risk factors • Train health workforce and strengthen capacity of health system particularly at primary care level to address the prevention and control of noncommunicable diseases • Improve availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities • Implement other cost-effective interventions and policy options in objective 4 (see paragraph 47) to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred primary health care and universal health coverage • Develop and implement a palliative care policy using cost-effective treatment modalities, including opioids analgesics for pain relief and training health workers **Cardiovascular disease and diabetes**[b] • **Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and nonfatal cardiovascular event in the next 10 years*** • **Acetylsalicylic acid for acute myocardial infarction*** • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke, and to persons with moderate risk (≥ 20%) of a fatal and nonfatal cardiovascular event in the next 10 years • Detection, treatment and control of hypertension and diabetes, using a total risk approach • Secondary prevention of rheumatic fever and rheumatic heart disease • Acetylsalicylic acid, atenolol and thrombolytic therapy (streptokinase) for acute myocardial infarction • Treatment of congestive cardiac failure with ACE inhibitor, beta-blocker and diuretic	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 At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities	– WHO World Health Reports 2010, 2011 – Prevention and control of noncommunicable diseases: Guidelines for primary health care in low-resource settings; diagnosis and management of type 2 diabetes and Management of asthma and chronic obstructive pulmonary disease 2012 – Guideline for cervical cancer: Use of cryotherapy for cervical intraepithelial neoplasia – Guideline for pharmacological treatment of persisting pain in children with medical illnesses – Scaling up NCD interventions, WHO 2011 – WHO CHOICE database – WHO Package of essential noncommunicable (PEN) disease interventions for primary health care including costing tool 2011 – Prevention of Cardiovascular Disease. Guidelines for assessment and management of cardiovascular risk 2007 – Integrated clinical protocols for primary health care and WHO ISH cardiovascular risk prediction charts 2012 – Affordable Technology: Blood pressure measurement devices for low-resource settings 2007

Menu of policy options	Voluntary global targets	WHO tools
• Cardiac rehabilitation post myocardial infarction • Anticoagulation for medium- and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation • Low-dose acetylsalicylic acid for ischemic stroke **Diabetes[b]** • Lifestyle interventions for preventing type 2 diabetes • Influenza vaccination for patients with diabetes • Preconception care among women of reproductive age including patient education and intensive glucose management • Detection of diabetic retinopathy by dilated eye examination followed by appropriate laser photocoagulation therapy to prevent blindness • Effective angiotensin-converting enzyme inhibitor drug therapy to prevent progression of renal disease • Care of acute stroke and rehabilitation in stroke units • Interventions for foot care: educational programmes, access to appropriate footwear; multidisciplinary clinics **Cancer[b]** • **Prevention of liver cancer through hepatitis B immunization*** • **Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] (or Pap smear (cervical cytology), if very cost-effective)[6] linked with timely treatment of pre-cancerous lesions*** • Vaccination against human papillomavirus, as appropriate if cost-effective and affordable, according to national programmes and policies • Population-based cervical cancer screening linked with timely treatment[7] • Population-based breast cancer and mammography screening (50-70 years) linked with timely treatment[7] • Population-based colorectal cancer screening, including through fecal occult blood testing**,** as appropriate, at age >50, linked with timely treatment[7]		Indoor Air Quality guidelines WHO Air quality guidelines for particular matter, ozone, nitrogen, dioxide and sulphur dioxide, 2005 – Cancer control: Modules on Prevention and Palliative care – Essential Medicines List (2011) – OneHealth tool – Enhancing nursing and midwifery capacity to contribute to the prevention, treatment and management of noncommunicable diseases – Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees

[6] Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

[7] Screening is meaningful only if associated with capacity for diagnosis, referral and treatment.

Menu of policy options	Voluntary global targets	WHO tools
• Oral cancer screening in high-risk groups (e.g. tobacco users, betel-nut chewers) linked with timely treatment[7] **Chronic respiratory disease**[b] • Access to improved stoves and cleaner fuels to reduce indoor air pollution • Cost-effective interventions to prevent occupational lung diseases, e.g. from exposure to silica, asbestos • Treatment of asthma based on WHO guidelines • Influenza vaccination for patients with chronic obstructive pulmonary disease		
Objective 5 • Develop and implement a prioritized national research agenda for noncommunicable diseases • Prioritize budgetary allocation for research on noncommunicable disease prevention and control • Strengthen human resources and institutional capacity for research • Strengthen research capacity through cooperation with foreign and domestic research institutes • Implement other policy options in objective 5 (see paragraph 52) to promote and support national capacity for high-quality research, development and innovation	Contributes to all 9 voluntary global targets	– Prioritized research agenda for the prevention and control of noncommunicable diseases 2011 – World Health Report 2013 – Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21) – Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees
Objective 6 • Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plan • Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation • Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors, and monitoring national response • Integrate noncommunicable disease surveillance and monitoring into national health information systems	Contributes to all 9 voluntary global targets	– Global monitoring framework – Verbal autopsy instrument – STEPwise approach to surveillance – Global Tobacco Surveillance System – Global Information System on Alcohol and Health

Menu of policy options	Voluntary global targets	WHO tools
• Implement other policy options in objective 6 (see paragraph 58) to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control		– Global school-based student health survey, ICD-10 training tool – Service Availability and Readiness (SARA) assessment tool – IARC GLOBOCAN 2008 – Existing regional and national tools – Other relevant tools on WHO web site including resolutions and documents of WHO governing bodies and Regional Committees

Explanatory notes:

a. Tobacco use: Each of these measures reflects one or more provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). The measures included in this Appendix are not intended to suggest a prioritization of obligations under the WHO FCTC. Rather, these measures have been proven to be feasible, affordable and cost-effective and are intended to fulfil the criteria established in the chapeau paragraph of Appendix 3 for assisting countries to meet the agreed targets as quickly as possible. The WHO FCTC includes a number of other important provisions, including supply-reduction measures and those to support multisectoral action, which are part of any comprehensive tobacco control programme.

Some interventions for management of noncommunicable diseases that are cost-effective in high-income settings, which assume a cost-effective infrastructure for diagnosis and referral and an adequate volume of cases, are not listed under objective 4, e.g. pacemaker implants for atrioventricular heart block, defibrillators in emergency vehicles, coronary revascularization procedures, and carotid endarterectomy.

b. Policy actions for prevention of major noncommunicable diseases are listed under objective 3.

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