20 May, 2011

Excellency,

We have the honour to refer to the letter of 21 January, 2011 from the President of the General Assembly informing you of our reappointment as Co-Facilitators to conduct the informal consultations on the concise action-oriented outcome document to be adopted at the High-level Meeting of the General Assembly on the prevention and control of non-communicable diseases, to be held in the General Assembly on 19 and 20 September, 2011.

In this regard, we are pleased to convene a first informal meeting on 31 May, 2011 at 3.00 pm in the ECOSOC room.

The purpose of the meeting is twofold.

It will be an occasion to hear briefings concerning the various regional preparatory meetings held these last months as well as to listen to a presentation of the report of the Secretary-General on the global status of non-communicable diseases; an unedited English version of the report is annexed to this letter. It will furthermore be an opportunity to share views on how we envisage the outcome document, including its format and substance, and to receive first inputs by Member States.

Further inputs by Member States should be submitted in written form no later than 6 June 2011. On the basis of these inputs as well as inputs from the preparatory process and evidence-based inputs, where relevant, the Co-Faciliators will then prepare a first draft outcome document to be presented to Member States in the latter half of June, for consideration and agreement by Member States.

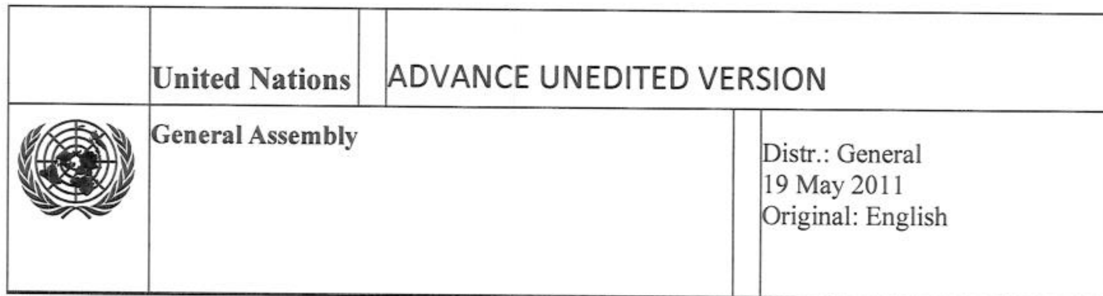
We look forward to working with you on this important issue.

Please accept, Excellency, the assurances of our highest consideration.

H.E. Mr. Raymond Wolfe
Co-Facilitator
Permanent Representative of Jamaica
to the United Nations

H.E. Ms. Sylvie Lucas
Co-Facilitator
Permanent Representative of Luxembourg
to the United Nations

All Permanent Representatives
and Permanent Observers to the United Nations



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Follow-up to the outcome of the Millennium Summit

Report of the Secretary-General on the Prevention and Control of Non-communicable Diseases

Executive Summary

Non-communicable diseases (NCDs), comprise a new frontier in the fight to improve global health. Worldwide, deaths related to NCDs have soared to astronomical rates and are responsible for more deaths than all other causes combined.
Commonly known as chronic or lifestyle-related diseases, the main NCDs are defined as cardiovascular diseases, diabetes, cancers and chronic respiratory diseases.[1] While the international community has focused on communicable diseases such as HIV/AIDS, malaria and tuberculosis, these four NCDs have emerged relatively unnoticed in the developing world and are now becoming a truly global epidemic. Yet, NCDs could be significantly reduced and prevented, with millions of lives saved and untold suffering avoided, through proven and affordable measures, many of which are complementary to global health efforts already underway. The knowledge and technology to fight the onset

[1] The primary focus of this report is on the four groups of diseases covered by the Global Strategy for the Prevention and Control of Noncommunicable Diseases: cardiovascular diseases, cancers, diabetes and chronic lung diseases, which are largely caused by four shared behavioral risk factors. The same focus is given by the UNGA Resolution 64/265. The broader scope of NCDs also includes conditions like gastrointestinal diseases, renal diseases, neurological and mental health disorders. These conditions account for a substantial portion of the global burden of disease. Although they are not specifically addressed by the content and focus of this report, many of the approaches and opportunities for tackling NCDs described are also directly relevant to these conditions.

and effects of NCDs already exists. Now is the time to act to save future generations from the health and socioeconomic harm of NCDs.

36 million people died from NCDs in 2008. This incredible number reflects 63% of the 57 million global deaths that year.[2] In the year 2030, NCDs are projected to claim the lives of 52 million people.[1] However, the demographic of lives lost is not readily apparent; people with NCDs often die young with 9 million annual deaths occurring in persons below the age of 60. The epidemic is fueled by a deadly combination of rising risk factors including tobacco use, unhealthy diet, lack of physical activity and harmful alcohol use. The four main NCDs sharing these risk factors cause almost 80% of all NCD deaths.

NCDs strike hardest at the developing world and lower income populations. Strong evidence links poverty, lack of education and other social determinants to NCDs and their risk factors. A vicious cycle is created by the epidemic, whereby NCDs and their risk factors worsen poverty, while poverty results in rising rates of NCDs. Prevention of NCDs will reduce poverty, particularly as the majority of NCD treatment costs in low- and middle-income countries occur in expensive private and out-of-pocket health care systems. At the same time, because of the enormous magnitude of illness, disabilities and premature deaths they cause, as well as long term care required, NCDs reduce productivity and increase health care costs, thereby weakening national economic development.

While traditionally NCDs have afflicted mostly high-income populations, current evidence shows that the spread of NCDs is associated with increasing levels of development. Death and disease from NCDs now outstrip communicable diseases in every region, except Africa. Even in Africa, the rate of NCDs is quickly rising. By 2030,

[2] Alwan A et al. Monitoring and surveillance of chronic non-communicable diseases: progress and capacity in high-burden countries. *The Lancet*, 2010, 376:1861–1868.

NCDs are projected to cause nearly five times as many deaths as communicable diseases worldwide, including in low- and middle-income countries.

The high burden of NCDs in low- and middle-income countries goes beyond the obvious fact that these countries are home to the world's largest populations. Unplanned urbanization, ageing populations and globalization of trade and product marketing, particularly for tobacco, alcohol and food, have led to a rise in NCD risk factors. The lack of health care capacity and social protection systems in lower income countries mean that people with NCDs are more likely to sicken and die at earlier ages from them.

Lastly, the health and socioeconomic toll of the NCD epidemic is impeding the UN Millennium Development Goals (MDG), which are falling short of targets set in many countries, especially MDGs 4 and 5 on women's and children's health. Women's and children's health is intricately linked with NCDs, specifically as poor nutrition during pregnancy and early life predisposes one to high blood pressure, heart disease and diabetes later in life.

However, the impacts of NCDs can be prevented with an approach that incorporates cost-effective population-wide and health care interventions, known as public health "best buys," to address risk factors, and primary health care measures to treat those who have or are at high-risk of contracting NCDs. Widespread implementation of such interventions requiring modest investment can lead to quick gains in counteracting the effects of NCDs.

The best buys for population-wide interventions include tobacco control measures like raising taxes and bans on advertising and smoking in public places; raising taxes on alcohol and enforcing bans on alcohol advertising; reducing salt intake; replacing trans-

fat in food with polyunsaturated fat; promoting public awareness about diet and physical activity; and delivering Hepatitis B vaccinations. Primary health care interventions include counselling, multi-drug therapy and screening and early treatment for cervical and breast cancers.

The obstacles are many yet the moral, social and economic imperative is clear. This year presents us with an unprecedented ability to critically analyse our weaknesses and opportunities in the emerging battle to prevent and control NCDs. Throughout the debate over best policy and programme action it must be remembered that the health and socioeconomic impacts of NCDs are largely preventable and the public health foundation of research and technical skill needed for progress is strong.

Five Recommendations for Progress:

1. The greatest reductions in NCDs will come from a whole-of-government approach to adopting population-wide interventions which address risk factors. These interventions can be achieved through modest and cost effective investment.

2. Sustained primary health care measures, including prioritized packages of essential interventions, along with palliative and long-term care must be implemented for those who already have NCDs or who are at high-risk of contracting them. Many of these health care interventions can, at low cost, be supported through healthy public policies.

3. Addressing NCDs requires strengthening Member States capacity for surveillance and monitoring of NCDs their risk factors and determinants, especially in lower income countries and including social disaggregated data such as gender.

4. Lessons learned from national HIV/AIDS, tuberculosis and malaria programmes in low- and middle-income countries must be harnessed for effective integration of

communicable and non-communicable disease initiatives.

5. NCD prevention and control must be given priority and commitment at the highest levels of government, the private sector, civil society and the United Nations and international organizations working together.

1. Introduction

1. This report has been developed in response to resolutions 64/265 and 65/238, adopted by the United Nations General Assembly on 13 May and 24 December 2010. It reviews the current status of NCDs, outlines the burden they impose on global health and socioeconomic development and presents recommendations to counteract NCDs by monitoring their trends, scaling up measures to reduce risk factors, strengthening health systems and services, and improving access to health care. Data on the NCD burden and on prevention and control strategies are based on the WHO Global Status Report 2010.[3]

2. Global initiatives to address NCDs started in 2000 with the adoption, by the World Health Assembly (WHA), of resolution WHA53.17 which endorsed the global strategy for the prevention and control of NCDs.[4] This strategy rests on three pillars: surveillance, primary prevention and strengthened health care. Since 2000, several WHA resolutions have been adopted in support of specific tools for the global strategy: the *Framework Convention on Tobacco Control (FCTC)* in 2003; the *Global Strategy on Diet, Physical Activity and Health* in 2004; and the *Global Strategy to Reduce the Harmful Use of Alcohol* in 2010. In 2008, the World Health Assembly endorsed the

[3] WHO. Global Status Report on Noncommunicable diseases 2010.

[4] Global strategy for the prevention and control of noncommunicable diseases (WHA A53/14). Geneva, World Health Organization, 2000.

2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. The action plan has six objectives, with a particular focus on low- and middle-income countries and vulnerable populations. It comprises a set of actions that, when performed collectively by Member States, international partners and the Secretariat, will address the growing public-health burden imposed by NCDs. Its six objectives include raising the priority accorded to NCDs in development work at global and national levels and integrating prevention and control of such diseases into policies across all government departments; establishing and strengthening national policies and plans; promoting interventions to reduce risk factors, mainly tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol; promoting research; strengthening partnerships; and monitoring NCDs and their determinants and evaluating progress at the national, regional and global levels.

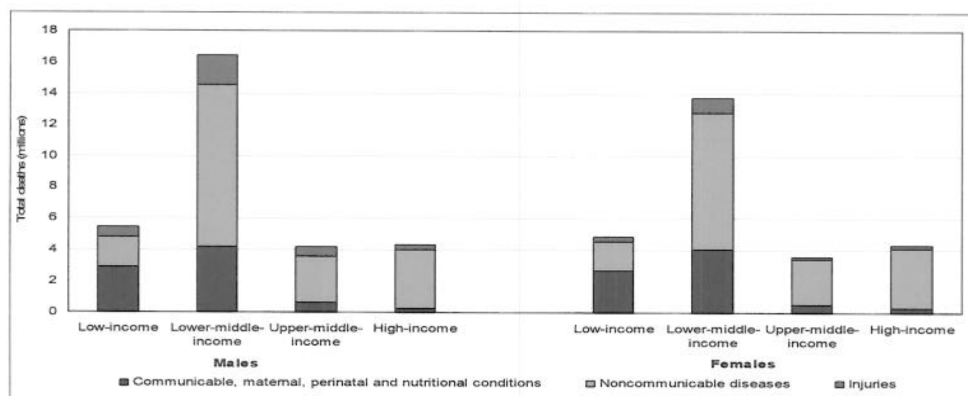
2. A rising epidemic

3. Of the 57 million global deaths in 2008, 36 million, or 63%, were due to NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. Total NCD deaths are projected to rise to 52 million in 2030. The rapidly growing magnitude of NCDs is driven in part by population ageing, the negative impact of urbanization and globalization of trade and marketing. It is fueled by the persistent increase in NCD risk factors, namely tobacco use, unhealthy diet, lack of physical activity and harmful alcohol use, particularly in low- and middle-income countries (LMICs).

2.1 Hidden, misunderstood and under-recorded

4. As the international community has intensified efforts to combat the global burden of communicable diseases such as HIV/AIDS, malaria and tuberculosis, a growing burden of non-communicable diseases has emerged relatively unnoticed in the developing world. Today, the burden of NCDs in low- and middle-income countries exceeds that in high-income countries. While popular belief holds that NCDs afflict mostly high-income populations, nearly 80% of NCD deaths occur in developing countries. NCDs are the most frequent causes of death in all regions of the world, except in Africa. Even in Africa, NCDs are rising rapidly and are projected to cause almost three quarters as many deaths as communicable, maternal, perinatal and nutritional diseases by 2020 and to exceed them as the most common causes of death by 2030.

Figure 1. Total deaths by broad cause group by World Bank income group and by sex, 2008.



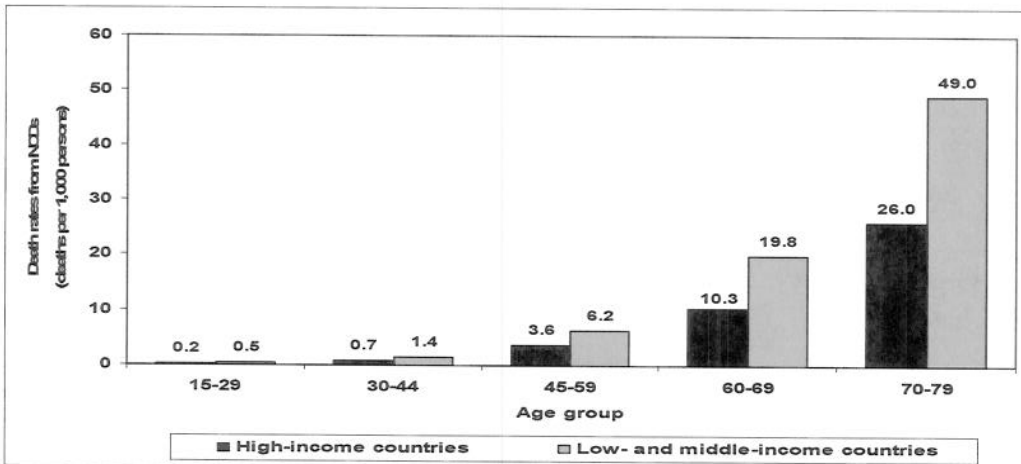
Source: *The Global Status Report on Noncommunicable Diseases 2010*

5. In low-and middle-income countries, NCDs will be responsible for nearly five times as many deaths as communicable diseases by 2030. Over 80% of cardiovascular and diabetes deaths, and almost 90% of deaths from chronic obstructive pulmonary disease, occur in low- and middle-income countries. More than two thirds of all cancer deaths occur in low- and middle-income countries. The estimated percentage increase in cancer incidence by 2030, compared with 2008, will be greater in low- (82%) and lower-middle-income countries (70%) than in upper-middle- (58%) and high-income countries (40%).

6. The large proportion of NCD deaths in low- and middle-income countries is not only the result of the fact that these countries have the largest populations. Urbanization and globalization of trade and product marketing, particularly for tobacco, food and alcohol, have led to a rise in NCD risk factors in the developing world. The lack of health care capacity and social protections in lower income countries mean that those who contract NCDs are more likely to sicken and die from them at younger ages.

7. As seen in Figure 2, death rates from NCDs are higher in low- and middle-income countries than in high-income countries across all age groups.

Figure 2. Death rates from NCDs in high-income and low- and middle-income countries, both sexes, 2008.



Source: *The global burden of disease: 2004 update***Error! Bookmark not defined.**

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8. Lower-middle and upper-middle income countries have higher rates of childhood overweight than high-income countries. The highest smoking rate among men is found in lower-middle income countries. The highest rates of raised blood pressure are seen in Africa. The percentage of global cancer burden attributable to a few treatable chronic infections is substantially larger in low-income countries than in high-income countries.

9. Despite abundant evidence of a global epidemic, NCDs are still not regarded by policy-makers or the public as a global health priority. Because the diseases are common and their risk factors ubiquitous, many fail to understand the profound burden these conditions exact on populations of the developing world. Perhaps because NCD risk factors and diseases are so much a part of everyday life, many people fail to see the epidemic in their midst or recognize that it is largely preventable.

2.2 Current and future health risks

10. Cardiovascular diseases were responsible for the largest proportion of NCD deaths under the age of 70 (39%), followed by cancers (27%). Together with chronic respiratory disease and diabetes they are responsible for almost 80% of deaths caused by NCDs.

11. Premature death is a major consideration when evaluating the impact of NCDs on a given population, with approximately 44% of all NCD deaths occurring before the age of 70. In low- and middle-income countries, a higher proportion (48%) of all NCD deaths are estimated to occur in people under the age of 70, compared with high-income countries (26%). The difference is even more marked in younger age ranges: in low- and middle-income countries, 29% of NCD deaths occur among people under the age of 60, compared to only 13% in high-income countries.

12. Although cardiovascular mortality has declined in some developed countries due to preventive and treatment measures, in all low- and middle-income countries where no such measures have occurred, cardiovascular diseases will continue to increase steeply in the next few decades, resulting in premature heart attacks and strokes that affect people in their economically productive years.

13. Cancer is predicted to be an increasingly important cause of death and disease in the next few decades in all regions of the world. Forecasted changes in population demographics in the next two decades mean that the estimated incidence of 12.7 million

new cancer cases in 2008 will rise to 21.4 million by 2030, with nearly two thirds of all cancer diagnoses in low- and middle-income countries.

14. Based on WHO's Global Status report 2010, the overall prevalence of raised blood pressure in adults aged 25 and over was approximately 40% in 2008, with higher rates seen in lower income countries. Unless urgent action is taken, more than 80% of the world's tobacco-related deaths will be in low- and middle-income countries by 2030. Annual tobacco-related deaths are projected to increase from about 6 million today to 8 million in 2030, accounting for 10% of all deaths in that year. As automation increases in the workplace and home, the lack of physical activity is also expected to increase. In some regions, more than 40% of adults, particularly women, are insufficiently active.

15. Furthermore, the growing globalization and industrialization of the food chain is leading to increased consumption of processed food, resulting in an upsurge in saturated fat, trans fat, salt and refined sugars in the diet. Prevalence of overweight infants and young children has been rising steadily in recent decades and is expected to continue to rise. While the highest prevalence of overweight among infants and young children is found in the upper-middle-income group, the fastest growth is in the lower-middle-income group. In 2008, 35% of adults were overweight. Worldwide, an estimated 2.8 million people die each year as a result of being overweight. The worldwide prevalence of obesity has nearly doubled between 1980 and 2008. In some regions like Europe, the Eastern Mediterranean and the Americas, over 50% of women are overweight.

16. Harmful use of alcohol takes an exceptionally high toll in the growing number of middle-income countries. In some regions, one in five male deaths is attributed to alcohol, and nearly half of all alcohol-attributable deaths occur from NCDs.

17. Regarding occupational risk, the International Labour Organization attributes about 1.4 million NCD fatalities to factors including exposure to chemical, physical, biological, ergonomic and psychological hazards at work.

2.3. NCDs in other contexts

18. A gender perspective is critical to understanding differences in men's and women's risks of morbidity and mortality from NCDs. In 2008, NCDs killed 4.9 million men and 3.3 million women between the ages of 15 and 59 worldwide. More women aged 15 to 59 years die due to NCDs in Africa than in high-income countries.

19. Men's risk of dying from NCDs exceeds that of women in all age groups, a phenomenon that has been attributed to men's greater exposure to risk factors such as tobacco and harmful use of alcohol, as well as their lower utilization of preventive health care and weaker social ties relative to women. Trends in other risk factors, however, portend a growing burden of NCDs among women as well. Women tend to be less physically active than men, are more likely to be obese and, in some populations, are taking up smoking at alarming rates. In several developed countries, lung cancer death rates have been rising faster among women than among men, reflecting women's later uptake of tobacco use relative to men. This suggests that the gender-gap in mortality from

NCDs may narrow in the future. In this regard more attention is needed for a gender-based approach founded on accurate gender-disaggregated data.

20. NCDs and risk factors also have a significant impact on maternal and child health. Under-nutrition in utero and low birth weights, particularly prevalent among low-income populations, increase the risks of cardiovascular diseases and diabetes. The rising prevalence of high blood pressure, diabetes and gestational diabetes is increasing adverse outcomes in pregnancy and maternal health. Improving maternal health and nutrition plays an important role in reducing future development of NCDs in offspring.

3. Socioeconomic impacts

21. The NCD epidemic creates serious socioeconomic consequences by increasing individual and household impoverishment and thwarting human and economic development. As shown before, the distribution and impact of NCDs and their risk factors are highly inequitable and impose a disproportionately large burden on low- and middle-income countries and populations. Because poverty is closely linked with NCDs, the expanding NCD epidemic is predicted to impede poverty reduction initiatives in low-income countries and communities.

3.1 Impacts on social and human development

22. Strong evidence links poverty, lack of education and other social inequities to NCDs and their risk factors. In high income countries, for example:

- Prevalence of physical inactivity, daily smoking and regular alcohol consumption was found to be consistently highest among men and women with the least education. An additional four years of schooling was associated with a decreased risk of heart disease and diabetes.
- Blue-collar workers have significantly higher levels of cancer, and female blue-collar workers have a higher incidence of metabolic syndrome, compared to female white-collar workers.
- Obesity is higher among women with lower income levels.
- Heart diseases and diabetes are more prevalent among immigrants and indigenous peoples in certain countries.

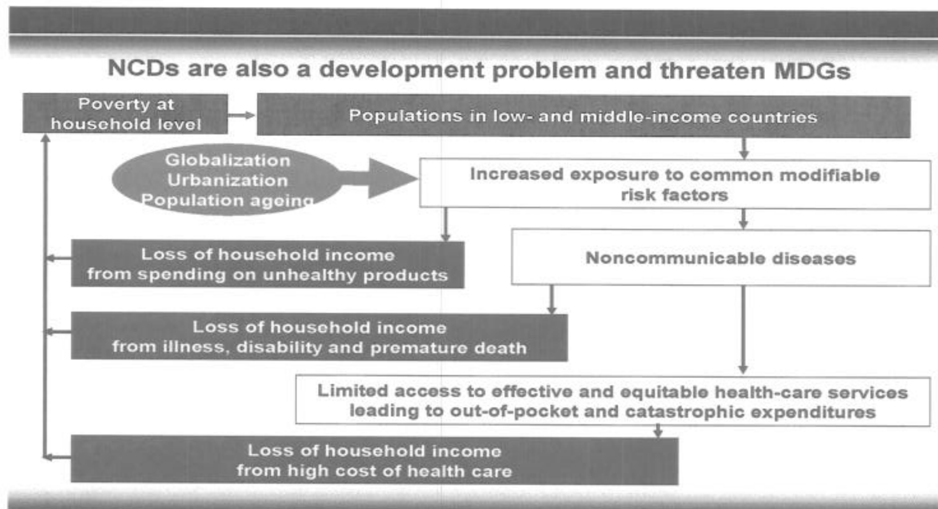
Similarly, in low- and middle-income countries, an increasing number of studies show associations between NCDs and social determinants:

- Tobacco use, hypertension, physical inactivity and alcohol use are far more common among people with lower educational achievement.
- Likewise, lower education levels and urban residency are strongly associated with an increased risk of diabetes.
- Cardiovascular mortality rates decreased among educated people compared to those without formal education.
- Poor people are more likely to smoke and are at greater risk of being exposed to a number of NCD risk factors, including second-hand smoke and harmful alcohol use, as well as suffering from asthma.

3.2 Impacts on household income

23. NCDs lead to loss of household income from unhealthy behaviours, poor physical capacity, long term treatment and high cost of health care.

Figure 3: A vicious circle: poverty contributes to NCDs and NCDs contribute to poverty



24. From a risk factor perspective, tobacco is a particular problem. People in many low-income households spend a significantly higher portion of their household budgets on tobacco compared with high-income households. This causes reduction of household spending on other important needs, most notably education and medical care. Alcohol can significantly drain family expenditures as well.

25. Poor physical capacity as a result of NCDs often prevents people from working or seeking employment, thus reducing household income. Annual income loss from NCDs,

from days spent ill and in care-giving efforts, amounted to an estimated US$ 23 billion (0.7% GDP) in India in 2004.

26. Treatment for cardiovascular diseases, cancer, diabetes and chronic respiratory diseases can quickly drain household resources, driving families into impoverishment. *The World Health Report 2010* states that each year, 100 million people are pushed into poverty because they had to pay directly for health services. The report indicates that out-of-pocket payments represent more than 50% of total health expenditures in a large number of low- and middle-income countries. A multi-country review of drug costs showed that it costs an average of two- to eight-days' wages to purchase a one-month supply of at least one cardiovascular medicine. Paying for care associated with diabetes, heart diseases and cancer can cost low-income households up to a third of their incomes, and can lead to distress borrowing and selling of assets. Catastrophic hospitalization expenditures are higher with NCDs compared to communicable diseases.

3.3 Impacts on economic development

27. NCDs have become a major component of health care system expenditures in developed countries as well as in the developing world. Estimated losses in national income from heart disease, stroke and diabetes in 2005 were estimated at US$ 18 billion in China, US$ 11 billion in the Russian Federation, US$ 9 billion in India and US$ 3 billion in Brazil. Costs for health care and productivity loss, are increasing in most countries, developing and developed, irrespective of population sizes, and consume growing portions of budgets. For the Latin America and Caribbean region, diabetes

health care costs were estimated at US$ 65 billion annually, or between 2% and 4% of gross domestic product and 8% to 15% of national healthcare budgets. Oman has experienced a 64% increase in health-care expenditures from 1995 to 2005, largely due to NCDs.

3.4 Impacts on MDGs

28. The socioeconomic impacts of NCDs are also affecting the Millennium Development Goals (MDG), which are falling short of the targets set in many countries.

29. Preventing NCDs is important for MDG 1 (eliminating poverty) because these diseases have a negative impact on productivity and family income, and also because a substantial proportion of household income is spent on health care in low-income countries.

30. Regarding MDG 1c (hunger and nutrition), improper nutrition in pregnancy is associated with stillbirths and preterm births, and also increases the risk of gestational diabetes. There is also a significant relationship between maternal nutrition, foetal health and vulnerability to cardiovascular disease and diabetes later in life.

31. NCD prevention and control may also contribute to the achievement of MDG 2 (universal primary education), since costs for NCD health care, medicines and tobacco and alcohol consumption displace household resources that otherwise might be available

for education. This problem is particularly acute in very poor families, which have the most to gain from education of their children.

32. There are also strong links with MDGs 4 and 5 (maternal health and child mortality). The rising prevalence of high blood pressure and gestational diabetes is increasing the adverse outcomes of pregnancy and maternal health. Diabetes during pregnancy presents serious risks to both the woman and baby. The prevalence of gestational diabetes may be as high as 20% among high-risk populations. The reported incidence of maternal mortality of pregnant women with type 1 diabetes is 5-20 times higher compared to women without diabetes. Smoking is an additional risk factor for foetal growth and development. Furthermore, mothers who smoke are likely to breastfeed for shorter periods of time and have lower quantities and less nutritious milk. Exposure to second-hand tobacco smoke increases the risks of childhood respiratory infections, sudden infant death and asthma.

33. The increasing NCD burden also threatens MDG 6 (tuberculosis), by interfering with the effective TB control. In an analysis of the 22 high TB-burden countries that account for 80% of the global TB burden, diabetes was associated with 10% of adult TB cases, smoking with 21% and harmful alcohol use 13%. Smoking is implicated in over 50% of tuberculosis deaths in India.

34. MDG Target 8 aspires to provide access to affordable essential drugs in developing countries. However, international efforts to provide access to essential drugs

are often focused on AIDS, tuberculosis and malaria. At a time when most ill-health and deaths are caused by NCDs, it is important that essential health care for NCDs be considered as part of health needs and development initiatives.

4. **A preventable epidemic**

35. The ability to counteract the NCD epidemic, thus saving millions of lives, preventing untold suffering and reducing enormous costs, already exists. Knowing how to reduce NCDs is not the problem. The problem is lack of action.

36. The greatest reductions in NCDs will come from population-wide interventions to address the risk factors of tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol. These interventions are low-cost, cost-effective and even revenue generating in some cases; they are especially inexpensive when compared to procedures necessary for patients with advanced stages of disease. But effective interventions are not implemented on a wide scale for a variety of factors, including inadequate political commitment, insufficient engagement of non-health sectors, lack of resources, vested interests of critical constituencies and limited engagement of key stakeholders.

37. Appropriate health care for people with NCDs will reduce complications, disability and premature death. However, such health care remains lacking or grossly inadequate in many settings, and access to essential technologies and life-saving medicines is limited, particularly in low- and middle-income countries.

38. The close links with child and maternal health and the importance of early-life origins of NCDs require that NCD preventive and health care interventions are integrated into reproductive, maternal and child health programmes, especially at the primary health care level.

4.1 Preventing causative factors and addressing determinants: A multisectoral challenge and response

39. Quick gains against the NCD epidemic can be achieved through modest investments in interventions. What is needed for widespread implementation of these interventions is active engagement of non-health sectors and a whole-of-government approach which includes sectors such as education, trade, agriculture, food security, and environment.

40. Among actions that should be taken immediately are "best buys" and "good buys." A best buy is an intervention that is not only highly cost-effective but also cheap, feasible and culturally acceptable to implement. Good buys are other interventions that may cost somewhat more or generate somewhat less health gain but still provide good value for money.[5] Best buys to reduce major risk factors for NCDs include:

- Smoke-free workplaces and public places
- Warnings about the dangers of tobacco
- Comprehensive bans on tobacco advertising, promotion and sponsorship
- Raising excise taxes on tobacco and alcohol
- Restricting access to retail alcohol

[5] For further information on best buys and good buys, please refer to *The Global Status Report on Noncommunicable Diseases 2010*

- Enforcing bans on alcohol advertising
- Reducing salt and sugar content in packaged and prepared foods and drinks
- Replacing trans fat with unsaturated fat in food
- Promoting public awareness about diet and physical activity through education and consumer information, including through mass media
- Delivering Hepatitis B vaccine immunization

41. In addition to best buys, there are many other cost-effective and low-cost population-wide interventions that can reduce risk factors for NCDs. These include nicotine dependence treatment; enforcing drink-driving laws; promoting adequate breastfeeding and complementary feeding; restrictions on marketing of foods and beverages high in salt, fats and sugar, especially to children; and food taxes and subsidies to promote healthy diet.

42. There are other population-wide interventions that focus on cancer prevention. Almost 70% of cervical cancer is preventable and vaccinations for human papillomavirus (HPV), the main cause of cervical cancer, are particularly effective Prevention through early detection, such as screening for breast and cervical cancer, can also be effective in reducing the cancer burden and death.

43. Most population-wide interventions must originate outside of a country's health sector, requiring multisectoral partnerships and a health-in-all-policies approach by

government. For example, the best buys of raising excise taxes on tobacco and alcohol must be accomplished by governmental agencies and policy makers outside the health sector. Similarly, education campaigns focusing on healthier diets and increased physical activity cannot be developed by the health sector alone. Such efforts need support from civil society, academia, nongovernmental organizations and others to achieve success.

44. Industry and the private sector must be engaged. Their role is critical in population-wide behavioral interventions. For example, initiatives by the food industry in reformulation to healthier products and in exercising responsible marketing are crucial. Food operators and suppliers can improve the availability of healthy food products, including fruits and vegetables and foods with lower levels of saturated fats, added sugars and salt. Marketers can comply with recommendations against marketing food and non-alcoholic beverages to children.

4.2 Providing essential health care: strengthening health system capacity and response

45. The long-term nature of many NCDs demands a comprehensive health system response that brings together a trained workforce with appropriate skills, affordable technologies, reliable supplies of medicines, referral systems and empowerment of people for self-care, all over a sustained period of time.

46. If rising NCD trends in low- and middle-income countries are to be reversed, current approaches to addressing NCDs need to be changed. At present, the main focus of

health care for NCDs in many low-and middle-income countries is hospital-centered. In the case of cardiovascular disease and diabetes, a large proportion of people with high risk remain undiagnosed and even those diagnosed have insufficient access to essential health care at the primary health care level to prevent complications.

47. When NCD diagnosis is made, it is often at a late stage of the disease, when people become symptomatic and are admitted to hospitals with acute events or long-term complications and disabilities. Treatment for advanced stage diseases is expensive as high-technology interventions are required.

48. At the present time, in many countries, cancer patients have limited or no access to care due to delayed diagnosis, lack of trained oncologists and specialized nursing staff, as well as lack of diagnostic facilities like pathology services, specialist equipment and drugs. Radiotherapy facilities in developing countries are grossly deficient, with some 36 countries lacking any radiotherapy services. The availability of oral morphine and staff trained in palliative care are limited in many low- and middle-income countries, even though these services can be made available at very low cost.

49. While strengthening health care systems must be the ultimate goal, short- and medium-term measures are necessary for people who either already have NCDs or who are at high-risk of contracting them. These measures should create prioritized packages of low-cost, high-impact essential interventions at the primary health care level. NCD

treatment programmes can further benefit from greater community engagement, acceptance and personal self-care.

4.3 Assessing the capacity of countries to address NCDs

50. The capacity of Member States to prevent and control NCDs is uneven with advancement mostly in high-income countries according to WHO surveys conducted in 2000 and 2010. Many countries do have at least one policy, plan or strategy to address NCDs or their risk factors, showing widespread recognition of the need to address NCDs and their risk factors. However, most of these policies and plans are for individual risk factors or diseases rather than an integrated and multisectoral approach, and a large percentage of them are not operational or sufficiently funded.

51. Improving country-level surveillance and monitoring systems which are integrated into existing national health information systems must be a top priority in the fight against NCDs. Three necessary components of all NCD surveillance are: a) monitoring exposures to risk factors); b) monitoring outcomes, ie morbidity and disease-specific mortality; and c) surveying health system responses, including national capacity to prevent NCDs through, for example, policies and plans, infrastructure, human resources and access to essential health care and medicines.

52. The availability to treat NCDs in low-income countries is one fourth of that in high-income countries. Even in hospital settings in low-income countries, availability of basic technologies and treatment for NCDs is often severely lacking. A study conducted

in some low-income countries revealed that up to two thirds of generic medicines were not freely available in the public sector and almost 50% were not available in the private sector.

5. The way forward

53. The global NCD epidemic can be countered through population-wide and individual health care interventions that are proven, evidence-based, and within the grasp of nearly all countries. However, there are many barriers to success due to the wide scope of actions required on national and global levels, the various sectors that must be involved in interventions and the many vested interests that may try to block or weaken them. To succeed, NCD prevention and control must be given priority and political commitment at the highest levels of governments. The way forward should include the following considerations:

- **Multisectoral action and health-in-all-policies:** Addressing risk factors and social determinants are beyond the capability of the health sector alone as international experience demonstrates the need for strong engagement of non-health sectors. Effective multisectoral action requires adopting health-in-all-policies, meaning that sectors outside the health sector must consider health issues when formulating policies, strategies and standards. Examples of guidelines that promote multisectoral action can be found in the WHO *Global Status Report on Noncommunicable Diseases 2010*.
- **A life-course approach:** NCDs and their risk factors are best addressed throughout the life course, through healthy behaviours and early diagnosis and

treatment that begin in pre-pregnancy and continue through childhood and adult life. Fostering meaningful community participation and engagement along with active partnerships among multiple stakeholders is imperative.

- **Surveillance and monitoring:** A standardized framework of measurable core indicators must be adopted to monitor trends and progress.
- **Reduced risk factors:** Multisectoral action must immediately address NCD risk factors through population-wide interventions that are affordable, cost effective and can even be revenue generating for governments.
- **Health-system strengthening:** People with NCDs must receive improved basic health care, which can be attained by addressing gaps in all six health system components: finance, governance, health workforce, health information, essential medicines and technologies and service delivery. Above all, a strong primary care system is critical -- especially where resources are limited. Health care services models should be transformed from acute emergency care to chronic life-long care. A first pragmatic step is to develop a realistic set of high-impact and cost-effective interventions to prevent, detect and treat NCDs.
- **NCD risk factors and trade, marketing and production of food:** Government and private sector entities involved in food supply can dramatically improve diet on global and country levels through regulations, incentives and voluntary efforts. Reformulation of processed food can reduce salt, saturated and trans fat, and changes in trade, taxation and subsidy policy can increase availability of fruit, vegetables and other healthy foods. The supply of fruits and vegetables can also be improved by support for local sustainable production and building up an

efficient local supply chain. In this regard, policies aimed at scaling up livestock production need to be reconsidered, while at the same time ensuring adequate marine and terrestrial sources of unsaturated fat. Standards for the marketing of food and non-alcoholic beverages can be developed and implemented based on recommendations endorsed by the World Health Assembly and others.

- **Essential medicines and technology:** Governments, in collaboration with the private sector, should give greater priority to treating chronic diseases and improving the accessibility of medicines to treat them. Important mechanisms for providing sustainable access to medicines include the development and use of evidence-based guidelines for the treatment of NCDs, efficient procurement and distribution of medicines in countries, establishment of viable financing options and promoting the use of generic medicines. Subsidies should be established to help the poorest segments of the population. In addition, the development of new medical treatments and technology is needed. Necessary policies regarding research and development, intellectual property and other areas can be modeled after successes that improved access to new medicines for HIV/AIDS and tuberculosis.
- **Social protections:** The ultimate protection for people at high risk or who already have NCDs is universal health insurance coverage. A significant factor in the unequal distribution of NCDs among low- and middle-income countries is the lack of public or private health insurance. Universal social protections must be the goal.

- **NCDs in emergency situations:** Crisis situations such as natural disasters and prolonged conflict can have a significant effect on NCD patients. Local communities and the international humanitarian community should develop the capacity to ensure continuity of health care during crises, while preparedness should include stores of essential NCD medications and technology.
- **NCDs and migration:** Conditions surrounding the 1 billion migrants worldwide can increase exposure and vulnerability to NCD risk factors. While the focus of migratory health initiatives has been on communicable diseases, governments must also integrate migrant health into NCD control and prevention policies.
- **NCDs and occupational health**: Part of the NCD burden is attributable to occupational risk factors including exposure to chemical, physical, biological, ergonomic and psychosocial hazards at work. Regulation to prevent exposure to such hazards must be implemented as necessary. Multisectoral action, including monitoring by concerned social partners is critical to reinforce implementation of national policies on health at work.
- **Advances in information and communications technology (ICT)**: Advances in ICTs have made access to information easier and cheaper and should be used to further expand the availability of health information. Mobile telephones and the Internet give remote communities an opportunity to be connected to health services, and these devices also facilitate the collection of clinical and public health data.

Conclusions

54. Member States and the international community have made the NCD epidemic a priority. Urgent action is now needed at all levels. The High-level Meeting on the prevention and control of noncommunicable diseases is an historic opportunity for Heads of State and Government to commit to concrete actions and to address impediments for success in the fight against NCDs. The following recommendations are proposed for Member States, the private sector, civil society and the United Nations and international organizations.

Recommended actions for:

Member States

- **Include prevention and control of NCDs among priorities in national health strategies and plans.**
- **Implement cost-effective population-wide interventions, including through regulatory and legislative actions, for NCD risk factors of tobacco use, unhealthy diet, lack of physical activity and harmful alcohol use.**
- **Strengthen national information systems by implementing a surveillance framework that monitors key risk factors and determinants, morbidity and mortality and health systems capacity. Set standardized national targets and indicators to assess progress made in addressing NCDs.**

- **Promote multisectoral and health-in-all policies to address the social determinants and risk factors of NCDs.**
- **Engage non-health sectors and key stakeholders, including the private sector and civil society, in collaborative partnerships to promote health and reduce NCD risk factors.**
- **Implement international agreements and strategies to reduce risk factors, including the *WHO Framework Convention on Tobacco Control (FCTC)*, the *Global Strategy on Diet, Physical Activity and Health* and the *Global Strategy to Reduce the Harmful Use of Alcohol.***
- **Revitalize primary health care and promote access to cost-effective interventions for NCDs, including access to essential medicines and technologies.**
- **Mobilize additional resources and support innovative approaches to financing essential NCD health care interventions within primary health care.**

Private sector

- **Promote healthy behaviours among workers, including occupational safety through good corporate practices, workplace wellness programmes and insurance plans.**
- **Contribute to improved access and affordability for NCD essential medicines and technologies.**
- **Ensure responsible and accountable marketing and advertising, especially to children.**

- **Ensure that foods needed for a healthy diet are accessible, including reformulating products to provide healthier options.**

Civil society

- **Mobilise political and community awareness in support of NCD prevention and control.**
- **Address shortcomings in NCD prevention and treatment services for marginalized populations and crisis situations. Build community capacity in promoting healthy diets and lifestyles.**
- **Mobilise additional resources and support innovative approaches to financing NCD prevention and control.**

United Nations agencies and international organizations

- **Acknowledge the threat of the NCD epidemic to sustainable development and integrate cost-effective preventive interventions into the development agenda and related investment programmes, including poverty reduction initiatives, in low- and middle-income countries.**
- **Develop, in collaboration with Member States, a global set of indicators to monitor NCD trends and assess the progress countries are making to reduce the NCD burden.**
- **Ensure the effective engagement of all non-health sectors in health and NCD policies.**

- **Ensure active engagement of United Nations Funds, Agencies and Programmes in global and regional initiatives to address the health and socioeconomic impacts of NCDs.**