# NON-PAPER SUMMARIZING THE OUTCOMES OF INFORMAL CONSULTATIONS HELD AMONG MEMBER STATES BETWEEN 7 AND 15 MAY 2013 CONCERNING DOCUMENT A66/9 (DRAFT ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020)

1. Following the publication of document A66/9 on 6 May 2013, a series of "informal informals" were convened by a group of Member States with a view to supporting discussions at the Sixty-sixth World Health Assembly on the draft action plan. These "informal informals" took place on 7, 13 and 15 May 2013 at the World Health Organization and were facilitated by Mr Colin L. McIff, Health Attaché, Permanent Mission of the United States of America to the United Nations (Geneva). The "informal informals" were attended by more than 30 Member States.

2. In order to assist Member States in their deliberations on the draft action plan, the results of the informal consultations described in paragraph 2 are included in Annex I of this non-paper.

## ANNEX I

## SUGGESTIONS IN RELATION TO DOCUMENT A66/9

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 6 | The main focus of this action plan is on four types of noncommunicable disease – cardiovascular diseases, cancer, chronic respiratory diseases and diabetes – which make the largest contribution to morbidity and mortality due to noncommunicable diseases, and on four shared behavioural risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. **[It recognizes that the conditions in which people live [and work] (France) and their lifestyles influence their health and quality of life.] (Canada)** There are many other conditions of public health importance that are closely associated with the four major noncommunicable diseases. They include: (i) other noncommunicable diseases (renal, endocrine, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and oral diseases, and genetic disorders); (ii) mental disorders; (iii) disabilities, including blindness and deafness; and (iv) violence and injuries (Appendix 1). Noncommunicable diseases and their risk factors also have strategic links to health systems and universal health coverage, environmental, occupational and social determinants of health, communicable diseases, maternal, child and adolescent health, reproductive health and ageing. Despite the close links, one action plan to address all of them in equal detail would be unwieldy. Further, some of these conditions are the subject of other WHO strategies and action plans or Health Assembly resolutions. Appendix 1 outlines potential synergies and linkages between major noncommunicable diseases and lists some of the interrelated conditions, to emphasize opportunities for collaboration so as to maximize efficiencies for mutual benefit. Linking the action plan in this manner also reflects WHO's responsiveness to the organization's reform agenda as it relates to working in a more cohesive and integrated manner. |
| 11 | Over the 2013–2020 time period other plans with close linkages to noncommunicable diseases (such as the action plan on disability called for in resolution EB132.R5) may be developed and will need to be synchronized with this action plan. Further, flexibility is required for updating Appendix 3 of this action plan periodically in light of new scientific evidence **[.] (Canada) and [Flexibility will also be needed for] (Canada) reorienting parts of the action plan, as appropriate, in response to the post-2015 development agenda [, in full consultation with Member States].** |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 12 | For all countries, the cost of inaction far outweighs the cost of taking action on noncommunicable diseases as recommended in this action plan. There are interventions for prevention and control of noncommunicable diseases which give a good return on investment, generating one year of healthy life for a cost that falls below the gross domestic product (GDP) per person and are affordable for all countries[1] (see Appendix 3). The total cost of implementing a combination of very cost-effective population-wide and individual interventions, in terms of current health spending, amounts to 4% in low-income countries, 2% in lower middle-income countries and less than 1% in upper middle-income and high-income countries. The cost of implementing the action plan by the Secretariat is estimated at US$ 940.26 million for the eight-year period 2013–2020. The above estimates for implementation of the action plan should be viewed against the cost of inaction. Continuing "business as usual" will result in loss of productivity and an escalation of health care costs in all countries. The cumulative output loss due to the four major noncommunicable diseases together with mental disorders is estimated to be US$ 47 trillion. This loss represents 75% of global GDP in 2010 (US$ 63 trillion).[2] This action plan should thus be seen as an investment prospect, because it provides direction and opportunities for all countries to (i) safeguard the health and productivity of populations and economies; **(ii) [to advise decisions related, inter alia, to] (Finland) / [create win-win situations that] / [influence the choice[s]] (Brazil) [of] [purchasing decisions] (Brazil) related [to] (Brazil) /** inter alia to food, media, information and communication technology, sports and health insurance; and (iii) identify the potential for new, replicable and scalable innovations that can be applied globally to reduce burgeoning health care costs in all countries |
| 13 | The framework provided in this action plan needs to be adapted at the regional and national levels, taking into account region-specific situations and in accordance with national legislation and priorities and specific national circumstances. There is no single formulation of an action plan that fits all countries, as they are at different points in their progress in the prevention and control of noncommunicable diseases and at different levels of socioeconomic development. However, all countries can benefit from the comprehensive response to the prevention and control of noncommunicable diseases presented in this action plan. There are cost-effective interventions and policy options across the six objectives (see Appendix 3), which, if implemented to scale, would enable all countries to make significant progress in attaining the nine voluntary global targets by 2025 (see Appendix 2). The exact manner in which sustainable national scale-up can be undertaken varies by country, being affected by each country's level of socioeconomic development, **[effects on the economy] (Honduras)** degree of enabling political and legal climate, characteristics of the noncommunicable disease burden, competing national public health priorities, budgetary allocations for prevention and control of noncommunicable diseases, degree of universality of health coverage and health system strengthening, type of health system (e.g. centralized or decentralized) and national capacity |

[1] Scaling up action against noncommunicable diseases: how much will it cost? Geneva, World Health Organization, 2011 http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf.

[2] *The global economic burden of noncommunicable diseases*. World Economic Forum and Harvard School of Public Health 2011.

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 15 | The purpose of the proposed global mechanism is to improve coordination of activities which address functional gaps that are barriers to the prevention and control of noncommunicable diseases, as outlined in the report of the Secretariat on options and a timeline (document A65/7) and the Note of the Secretary-General transmitting the report of the Director-General of the World Health Organization on options for facilitating and strengthening multisectoral action for the prevention and control of noncommunicable diseases through effective partnership (A/67/373). The global coordination mechanism is to be developed based on the following principles:<br>• The primary role and responsibility for preventing and controlling noncommunicable diseases lie with governments, while efforts and engagement of all sectors of society, international collaboration and cooperation are essential for success.<br>• The global coordination mechanism will advance WHO's role as the leading primary specialized agency for health, including with reference to its roles and functions concerning health policy in accordance with its mandate, and will be based on WHO's norms, values, treaties, strategies, instruments and commitments. **The main aim of the proposed global coordinating mechanism will be to engage with Member States, United Nations funds, programmes and agencies, and other international partners, including non-State actors[1], such as academia and relevant nongovernmental organizations as well as private sector entities, as appropriate, ~~[that are committed to promoting public health and implementing the action plan]~~ (Brazil), while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest; the engagement with non-State actors [FOOTNOTE C1] will follow the relevant rules currently being negotiated as part of WHO reform.** |
| 17 | To reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases by means of multisectoral collaboration and cooperation at national, regional and global levels, so that populations reach the highest attainable standards of health, **[quality of life] (Australia)** and productivity at every age and those diseases are no longer a barrier to well-being or socioeconomic development. |
| 18, second bullet point | Equity-based approach: **It should be recognized that the [high prevalence of NCDs] (Libya) / [unequal burden of noncommunicable diseases] is highly influenced by the social determinants of health, and that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies.** |

[1] **[FOOTNOTE C1: Without prejudice to ongoing discussions on WHO engagement with non-State actors] (Cuba), international partners are defined for this purpose as public health agencies with an international mandate, international development agencies, intergovernmental organizations (IGOs) including other UN organizations and Global Health Initiatives, international financial institutions (IFIs) including the World Bank, foundations, and nongovernmental organizations] (Facilitator)**

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 18, ninth bullet point | Management of real, perceived or potential conflicts of interest: Multiple actors, both State and non-State actors including civil society, academia, industry, nongovernmental and professional organizations, need to be engaged for noncommunicable diseases to be tackled effectively. Public health policies ~~[strategies and multisectoral action]~~ **(Finland)** for the prevention and control of noncommunicable diseases must be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed. |
| Objective 1, title above paragraph 23 | Proposed actions for international partners **[FOOTNOTE C1]** and the private sector |
| 23 chapeau | **[Without prejudice to ongoing discussions on WHO engagement with non-State actors] (Cuba) [international partners are defined for this purpose are defined as public health agencies with an international mandate, international development agencies, intergovernmental organizations (IGOs) including other UN organizations and Global Health Initiatives, International financial institutions (IFIs) including the World Bank, foundations, and nongovernmental organizations] (Facilitator)** ~~**International partners include relevant United Nations system agencies, funds and programmes, international financial institutions, development banks, academic institutions, professional organizations, civil society organizations and other relevant international organizations.**~~ **[ADD GLOSSARY: Monaco]** The private sector, excluding the tobacco industry, is to be engaged as appropriate. Proposed actions include: |
| 27 | Effective noncommunicable disease prevention and control require multisectoral approaches at the government level, including as appropriate, whole-of-government, whole-of-society, health-in-all policies approaches across such sectors as health, agriculture, communication, customs/revenue, education, employment/labour, energy, environment, finance, food, foreign affairs, housing, industry, justice/security, legislature, research social welfare, social and economic development, sports, trade, transport, urban planning and youth affairs (Appendix 5). **[One possible approach to implementing sustainable multisectoral action is] (Ireland, Finland)/[Actions to be considered to implement multisectoral action could include, inter alia,] (Australia, Brazil, France)** (i) self-assessment of Ministry of Health, (ii) assessment of other sectors required for multisectoral action, (iii) analyses of areas which require multisectoral action, (iv) development of engagement plans, (v) use of a framework to foster common understanding between sectors, (vi) strengthening of governance structures, political will and accountability mechanisms, (vii) enhancement of community participation, (viii) adoption of other good practices to foster intersectoral action and (ix) monitoring and evaluation. |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 28 | An effective national response for prevention and control of noncommunicable diseases requires multistakeholder engagement, to include individuals, families and communities, intergovernmental organizations, religious institutions, civil society, academia, the media, voluntary associations and, where appropriate, the private sector and industry. The active participation of civil society in efforts to address noncommunicable diseases, particularly the participation of grass-roots organizations representing people living with noncommunicable diseases and their carers, can empower society and improve accountability of public health policies, legislation and services, making them acceptable, responsive to needs and supportive in assisting individuals to reach the highest attainable standard of health and well-being. **Private sector involvement is multifaceted in nature and potentially includes workplace programmes to promote change [and] (Canada) sources of innovative thinking and resources ~~, and in some cases the involvement of actors whose behaviour has to change in order for progress to be made against noncommunicable diseases.~~ [Through constructive engagement with relevant private sector actors, the WHO can promote change to improve social and physical environments and enable progress against NCDs] (Canada)** |
| 30(b) title | Mobilize sustained resources: As appropriate to national context, and in coordination with the **[Ministry of Finance] (Secretariat) / [relevant Ministries] (Brazil)** |
| 30(i) | Forge partnerships: Lead collaborative partnerships to address implementation gaps (e.g. in the areas of training of health personnel, development of appropriate health care infrastructure, sustainable transfer of technology for the production of affordable, safe and quality diagnostics, essential medicines and vaccines, and for product access), as appropriate to national contexts, **on mutually agreed terms (EU).** |
| 33 | The Political Declaration recognizes the critical importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for noncommunicable diseases, while strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health. While deaths from noncommunicable diseases primarily occur in adulthood, exposure to risk factors begins in childhood and builds up throughout life, underpinning the importance of **[health promotion interventions that engage State and non-State actors [FOOTNOTE F1] from within and outside the health sectors, as well as] (Canada) [taking] (Canada)** legislative and regulatory measures, as appropriate, to protect children from adverse impacts of marketing and prevent childhood obesity, tobacco use, physical inactivity and **[unhealthy diet] (Finland)** harmful use of alcohol. |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 34 | **Governments should be the key stakeholders in the development of a national policy framework for [promoting health] (Finland) and reducing risk factors. ~~while at~~ (Canada) [At] (Canada) the same time, it must be recognized that [the] effectiveness of multisectoral action requires [engaging other stakeholders for] ~~allocation of defined roles to other stakeholders,~~ [while safeguarding WHO from undue influence by any form of real, perceived, or potential conflicts of interest] (Canada) ~~protection of the public interest and avoidance of conflicts of interest.~~ [FOOTNOTE F1]** Further, supportive environments that protect physical and mental health and promote healthy behaviour need to be created through multisectoral action (see Appendix 5), using incentives and disincentives, regulatory and fiscal measures, laws and other policy options, and health education, as appropriate within the national context, with a special focus on maternal health (including preconception, antenatal and postnatal care, and maternal nutrition), children, adolescents and youth, including prevention of childhood obesity (See Appendix 1). |
| 39(c) | Develop guidelines, recommendations or policy measures that engage different relevant sectors, such as food producers and processors and other relevant commercial operators, to:<br>• Reduce the level of **[added] (Finland)** salt/sodium in **~~[pre-packaged]~~ (Finland) / [manufactured] (Secretariat) / [in foods] (Finland) ~~[or prepared food[1]]~~ (Finland)**<br>• Increase consumption of fruit and vegetables<br>• **Reduce saturated fatty acids in food and replace them with unsaturated fatty acids[2] [ORDER WAS CHANGED: Finland]**<br>• **[Virtually eliminate *trans*-fatty acids in the food supply and replace them with unsaturated fatty acids[3] ]/[Replace trans fats with poly-unsaturated fats] (Secretariat) / [Replace trans fats with unsaturated fats] (Canada, Finland)**<br>• Reduce the content of free and added sugars in food and non-alcoholic beverages<br>• Reduce portion size and energy density of foods in order to limit excess calorie intake. |

~~[1] For example, by negotiating benchmarks for salt content by food category.~~

~~[2] For example, by providing incentives to manufacturers to use healthier vegetable oils or investing in oil crops with healthier fat profiles.~~

~~[3] For example, through regulatory approaches restricting the use of fat, oil, shortening or other ingredients used in food preparation containing industrially produced trans fatty acids (or partially hydrogenated vegetable oils) regulations limiting the sales of food products containing trans fatty acids in restaurants and food vending establishments; and voluntary approaches, based on negotiations with food manufacturers.~~

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 39(d) | Develop policy measures **[directed at] (Finland) / [that engage] (Canada, Ireland)** food retailers and caterers to improve the availability, affordability and acceptability of healthier food products (plant foods, including fruit and vegetables, and products with reduced content of salt/sodium, saturated fatty acids, trans fatty acids and free sugars).[1] |
| 39(f) | As appropriate to national context, consider economic tools that are justified by evidence, and may include taxes **~~[and subsidies]~~ (Brazil) / [and subsidies] (Finland),** that create incentives for behaviours associated with improved health outcomes, improve the affordability and encourage consumption of healthier food products and discourage the consumption of less healthy options.[2] |
| 39(g) | Develop policy measures in cooperation with the agricultural sector to reinforce the measures directed at food processors, retailers, caterers and public institutions, and provide greater opportunities for utilization of healthy **~~[local]~~ (USA)** agricultural products and foods. |
| 39(h) | Conduct public campaigns and social marketing initiatives to inform and encourage consumers about healthy dietary practices. **[Campaigns should be linked to supporting actions across the community and within specific settings for maximum benefit and impact] (Canada).** |
| 41(d), chapeau | **Develop [Secretariat, Finland, France, Norway, South Africa] / [Encourage] (Canada)** policy measures **[in cooperation with relevant sectors] (Secretariat)** to promote physical activity through activities of daily living, including through "active transport," recreation, leisure and sport, for example: |
| 48(c), first bullet point | Strengthen and organize services and referral systems around close-to-client and people-centred networks of primary health care that are fully integrated with the **[rest]/[secondary and tertiary care level] (Panama)** of the health care delivery system, including rehabilitation, palliative care and specialized ambulatory and inpatient care facilities. |
| 48(e), third bullet point | Promote procurement and use of safe, quality, efficacious and affordable **~~generic~~ medicines [, including generics,] (Canada)** for prevention and control of noncommunicable diseases, including access to medicines for alleviation of pain for palliative care and vaccinations against infection-associated cancers, through measures including quality assurance of generic products, preferential registration procedures, generic substitution, financial incentives where appropriate and education of prescribers and consumers. |

[1] ~~**For example, by providing incentives to the food distribution system and negotiating with caterers to offer food products with healthier fat profiles.**~~

[2] ~~**For example, taxation of categories of products to disincentivize consumption; taxation based on nutrient content; tax incentives to manufacturers undertaking product reformulation; price subsidies for healthier food products.**~~

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| 49(b), second bullet point | Encourage countries to improve access to cost-effective prevention, treatment and care including, inter alia, increased availability of affordable, safe, effective and quality medicines and diagnostics and other technologies **[, ~~and support the application and management of intellectual property and other relevant trade-related factors in a manner that maximizes health-related innovation, promotes access to health products and is consistent with the provisions of the TRIPS Agreement and related instruments, as well as other WTO agreements, and meets the specific research and development needs of Member States.~~] (Brazil) / [RETAIN ORIGINAL TEXT] (Canada, Switzerland)** |
| 50(c) | Contribute to efforts to improve access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights flexibilities **[and provisions] (EU) [, as appropriate] (Switzerland). [MOVE TO SECTION FOR MEMBER STATES] (EU, Switzerland) / [KEEP 50(c) HERE AS WELL AS UNDER SECTION FOR MEMBER STATES] (Brazil)** |
| 54(b) | **Technical cooperation:** Provide technical assistance upon request to strengthen national and regional capacity: (i) to incorporate research, development and innovation in national and regional policies and plans on noncommunicable diseases; (ii) to adopt and advance WHO's prioritized research agenda on the prevention and control of noncommunicable diseases, taking into consideration national needs and contexts; **and ~~[(iii) to formulate research and development plans, enhance innovation capacities to support the prevention and control of noncommunicable diseases, including, where appropriate, through the full use of flexibilities and policy options under the TRIPS agreement]~~. (EU)** |
| Appendix 1, 3rd paragraph | **~~In addition, air pollution with fumes from solid fuels, ozone, airborne dust and allergens, environmental pollution, climate change and psychological stress including chronic stress related to work or unemployment may contribute to morbidity and mortality from cancer, cardiovascular disease and chronic respiratory diseases.~~ [Air pollution, with fumes with ….] (Canada)** Exposure to carcinogens such as asbestos, diesel exhaust gases, and ionizing and ultraviolet radiation in the living and working environment increases the risk of cancer. Similarly, indiscriminate use of agrochemicals in agriculture and discharge of toxic products from unregulated chemical industries may cause cancer and other noncommunicable diseases such as kidney disease. These exposures have their greatest potential for noncommunicable disease influence early in life, and thus special attention must be paid to preventing exposure during pregnancy and childhood. |
| Appendix 2, target 1 | A 25% relative reduction **in the overall risk of premature (Secretariat)** mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| Appendix 3, first paragraph | **[Menu of] (France)** 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).* |
| Appendix 3, second paragraph | [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 and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.] **(MOVE TO A FOOTNOTE: South Africa)** |
| Appendix 3, table | **[DO NOT BOLD AND REMOVE * IN THE TABLE] (Brazil, Cuba, Finland)**<br>**OR**<br>**[RETAIN] (Switzerland)** |
| Appendix 3, title of first column in table | **[Menu of [policy] (Brazil) options] / [Policy options] (South Africa)** |
| Appendix 3, Objective 1, fifth bullet point | Implement other policy options in objective 1 **[~~(see pages 11–12)~~] (Secretariat) [see paragraph 21] (Secretariat)** |
| Appendix 3, Objective 2, fourth bullet point | Implement other policy options in objective 2 **[~~(see pages 15–17)~~] ~~(Secretariat)~~, [(see paragraph 30)] (Secretariat)** to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases |

[1] Scaling up action against noncommunicable diseases: How much will it cost?" (http://whqlibdoc.who.int/publications/2011/9789241507313_eng.pdf).

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

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

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| Appendix 3, Objective 3, tobacco use, first bullet point | Implement WHO FCTC **[~~(see objective 3 see pages 19–20)~~] (Secretariat) [(see paragraph 36-43)] (Secretariat).** 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. |
| Appendix 3, Objective 3, Harmful use of alcohol | Harmful use of alcohol<br>• Implement the WHO global strategy to reduce harmful use of alcohol (see objective 3) (see pages 23–24) through actions in the recommended target areas including:<br>• Strengthening awareness of alcohol-attributable burden; leadership and political commitment to reduce the harmful use of alcohol<br>• Providing prevention and treatment interventions for those at risk of or affected by alcohol use disorders and associated conditions<br>• Supporting communities in adopting effective approaches and interventions to prevent and reduce the harmful use of alcohol<br>• Implementing effective drink–driving policies and countermeasures<br>• Regulating commercial and public availability of alcohol***** **[UNBOLD AND REMOVE *] (Cuba)**<br>• Restricting or banning alcohol advertising and promotions***** **[UNBOLD AND REMOVE *] (Cuba)**<br>• Using pricing policies such as excise tax increases on alcoholic beverages***** **[UNBOLD AND REMOVE *] (Cuba)**<br>• Reducing the negative consequences of drinking and alcohol intoxication, including by regulating the drinking context and providing consumer information<br>• Reducing the public health impact of illicit alcohol and informally produced alcohol by implementing efficient control and enforcement systems<br>• 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 |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| Appendix 3, Objective 3, Unhealthy diet and physical inactivity | Unhealthy diet and physical inactivity<br>• Implement the WHO Global Strategy on Diet, Physical Activity and Health (see objective 3 see pages 20–23)<br>• Implement recommendations on the marketing of foods and non-alcoholic beverages to children (see objective 3 see pages 20–22)<br>• Implement the WHO global strategy for infant and young child feeding<br>• **Reduce salt intake***<br>• [Replace trans fats with polyunsaturated[2] fats*] **[UNBOLD AND REMOVE *] (Finland)**<br>• **Implement public awareness programmes on diet and physical activity***<br>• **[Replace saturated fat with unsaturated fat] [BOLD AND ADD *](Finland)**<br>• Manage food taxes and subsidies<br>• Implement other policy options listed in objective 3 for addressing unhealthy diet and physical inactivity |
| Appendix 3, Objective 4 | • Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package to advance the universal health coverage agenda<br>• Explore viable health financing mechanisms and innovative economic tools supported by evidence<br>• Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions **[including cost-effective interventions to address behavioural risk factors] (Secretariat)**<br>• Train health workforce and strengthen capacity of health system particularly at primary care level **[to address the prevention and control of noncommunicable diseases] (Secretariat)**<br>• Improve availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities<br>• Implement other cost-effective interventions and policy options in objective **[(see pages 27–29)] (Secretariat) [(see paragraph 48)] (Secretariat)** to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred primary health care and universal health coverage<br>• **Develop and implement a palliative care policy [Secretariat] / [Develop and implement a palliative care policy using cost- effective treatment modilities, including opiods analgesics for pain relief and training health workers] (Cuba, Mexico, Panama)** |
| Appendix 3, Objective 4, cardiovascular diseases and diabetes | **[ADD BULLET ON: Cost-effective lifestyle interventions] (Finland)** |

| Paragraph | Suggestions are indicated in **bold** *(clarifications are provided in italics)* |
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| Appendix 3, Objective 4, cancer | Cancer[3]<br>• **Prevention of liver cancer through hepatitis B immunization*** <br>• **Prevention of cervical cancer through screening ([such as] (USA) visual inspection with acetic acid [VIA][4] linked with timely treatment of pre-cancerous lesions***<br>• Vaccination against human papillomavirus, **[as appropriate,] (Brazil)** if cost-effective and affordable, according to national programmes and policies<br>• ~~**Note: Screening is meaningful only if the capacity for diagnosis, referral and treatment is simultaneously improved** **(Brazil, Cuba)~~**<br>• Population-based cervical cancer screening linked with timely treatment **[FOOTNOTE: Screening is meaningful only if the capacity for diagnosis, referral and treatment is simultaneously improved] (Secretariat, Finland) / [FOOTNOTE: Screening is meaningful only if associated with capacity for diagnosis, referral and treatment] (Brazil)**<br>• Population-based breast cancer and mammography screening (50-70 years) linked with timely treatment **[FOOTNOTE: SAME AS ABOVE] (Secretariat)**<br>• Population-based colorectal cancer screening at age >50, linked with timely treatment **[FOOTNOTE: SAME AS ABOVE] (Secretariat)**<br>• Oral cancer screening in high-risk groups (e.g. tobacco users, betel-nut chewers) linked with timely treatment **[FOOTNOTE: SAME AS ABOVE] (Secretariat)** |
| Appendix 3, Objective 5, fifth bullet point | Implement other policy options in objective 5 ~~**[(see pages 31–32)]**~~, **[(see paragraph 53)] (Secretariat)** to promote and support national capacity for high-quality research, development and innovation |
| Appendix 3, Objective 6, fifth bullet point | Implement other policy options in objective 6 ~~**[(see pages 33–34)]**~~ **(Secretariat) [(see paragraph 59)] (Secretariat)** to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control |
| Appendix 4, title | ~~**Initial division of labour for United Nations Funds, Programmes and Agencies besides WHO**~~[5] **[Illustrative actions of United Nations agencies, funds and programmes** [1] **] (Secretariat)** |
| Appendix 4 | *Add one additional bullet point*<br>**UNODC: [Promote the implementation of adequate regulations so that morfine is accessible for patients in need for palliative care] (Panama)** |
| Appendix 5, second table | *Please refer to next page* |

[1] Concerns a provisional list only. A division of labour is being developed by the UN Funds, Programmes and Agencies.

[2] A division of labour is under development, which will be formally agreed by all relevant United Nations agencies, funds and programmes.

**Appendix 5, second table**

Examples of potential health effects of multisectoral action**

| | Tobacco | Physical inactivity | Harmful use of alcohol | Unhealthy diet |
|---|---|---|---|---|
| Sectors involved (examples) | • Legislature<br>• Stakeholder ministries across government, including ministries of agriculture, customs/revenue, economy, education, finance, health, foreign affairs, labour, planning, social welfare, state media, statistics and trade | • Ministries of education, **[health] (USA)** finance, labour, planning, transport, urban planning, sports, and youth<br>• Local government | • Legislature<br>• Ministries of **[health] (USA)** trade, industry, education, finance and justice, **[revenue and customs] (USA)**<br>• Local government | • Legislature<br>• Ministries of **[health] (USA)** trade agriculture, industry, education, urban planning, energy, transport, social welfare and environment<br>• Local government |

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