EXECUTIVE BOARD
152nd session
Provisional agenda item 6

EB152/6
10 January 2023

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

Draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases

Report by the Director-General

1. This report is submitted by the Director-General pursuant to the request in decision WHA72(11) (2019) "to consolidate reporting on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health with an annual report to be submitted to the Health Assembly through the Executive Board, from 2021 to 2031, annexing reports on implementation of relevant resolutions, action plans and strategies, in line with existing reporting mandates and timelines".

2. In addition, decision WHA72(11) requested the Director-General, inter alia, to present, for consideration by the governing bodies, proposed updates to the menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases, as set out in Appendix 3 of WHO's global action plan for the prevention and control of noncommunicable diseases 2013-2030.[1] Such options would derive from consultation with Member States, entities of the United Nations system and non-State actors, ensuring that the proposed interventions are based on the latest scientific evidence as a WHO normative and standard setting product. This mandate received further support from the governing bodies in decision WHA75(11) (2022), in which the Health Assembly adopted the implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030. Paragraph 42(c) of the implementation plan[2] recommends that the Secretariat propose updates to Appendix 3 of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030.

[1] WHO. Global action plan for the prevention and control of noncommunicable diseases 2013-2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/handle/10665/94384, accessed 16 November 2022).

[2] See document A75/10 Add.8.

CONTEXT

3. This report presents an overview of the progress achieved in the prevention and control of noncommunicable diseases, the promotion of mental health and well-being, and the treatment and care of mental health conditions.

4. It is accompanied by a comprehensive overview[1] that details the status of the Secretariat's technical work to support Member States in implementing the global action plan for the prevention and control of noncommunicable diseases (NCDs) and to fulfil the relevant commitments made for such prevention and control and the promotion, protection and care of mental health by the United Nations General Assembly following the guidance provided by the Health Assembly to realize these commitments, including attention to follow up to decision WHA75(11).

SITUATIONAL ANALYSIS

Where we are today

5. Global attention and national action on NCDs over the past two decades have been insufficient to reduce their burden against the nine voluntary targets of the global action plan and target 3.4 of the Sustainable Development Goals (by 2030 reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being). No country is on track to achieve all nine voluntary global targets for 2025 set by the Health Assembly in 2013 against a baseline of 2010.[2] The failure of health system capacity to keep up with the needs for preventing and controlling NCDs is reflected in the lack of progress for NCDs of the universal health coverage service coverage index.[3] The pandemic of coronavirus disease (COVID-19) has highlighted the urgent need to strengthen health systems through a radical reorientation towards primary health care as the foundation for progress towards universal health coverage, as well as to ensure health security and achieve health and well-being for all. The prevention and control of NCDs and the promotion, protection and care of mental health are integral to this reorientation.

6. New data from WHO show that the NCD targets are not just aspirational but achievable.[4] The data broadly show that countries with policy, legislative and regulatory measures, including fiscal measures, for the prevention and control of NCDs, as well as strong and inclusive health systems, have had the best outcomes against NCDs. In those countries, people living with and affected by NCDs are more likely to have access to effective services, including protection against NCD risk factors, detection of hypertension and diabetes, treatment of NCDs, and consistent, high-quality follow-up and care.

7. Millions of people – especially in lower-income settings – cannot access the services for prevention, treatment and care that could prevent or delay NCDs, mental health conditions and their consequences. This huge inequity undermines the human right to the best available standard of health and drives poverty in all countries. Pathway analyses show that every country still has options for

[1] Available at https://www.who.int/teams/noncommunicable-diseases (accessed 19 December).

[2] The set of nine voluntary targets was adopted in res WHA66.10 in 2013. Steps to accelerate their implementation were set out in document EB150/7 para. 6 and the global action plan for the prevention and control of noncommunicable diseases.

[3] WHO. Tracking Universal Health Coverage: 2021 Global monitoring report. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240040618, accessed 16 November 2022).

[4] See document EB150/7.

achieving the global NCD mortality target.[1] Combinations of priority interventions for risk factors and diseases, specific to country context, along with domestic capacity for ensuring action across different sectors of government, can help to accelerate the NCD response. Collaborative, multisectoral policy approaches are required. It is paramount for health ministries and other health authorities to connect with other sectors about the broader imperatives and common, structural determinants of health that are influencing health equity. This requires strengthening governments' capacities to enable, lead and support coordinated, coherent multisectoral (whole-of-government) and multistakeholder (whole-of-society) engagement.

8. WHO has clearly outlined the economic argument for investing in the prevention and control of NCDs and the promotion, protection and care of mental health. The cost for implementing the menu of policy options and other recommended interventions for the prevention and control of NCDs in 76 low- and lower-middle income countries is less than US$ 1 per person per year; together these actions could save 7 million lives per country. Between now and 2030, the economic gains from implementing the cost-effective NCD interventions could amount to more than US$ 230 billion in lower-middle income countries when individual, economic and social benefits are factored in.[2]

9. It is estimated that the annual global burden of mental health conditions costs US$ 1000 billion in lost economic output.[3] Cost-effective mental health care and prevention can be delivered in community settings in low- and middle-income countries for US$ 3–4 per capita.[4]

The global burden of NCDs and risk factors

10. The global share of deaths due to NCDs among all deaths increased from 61% in 2000 to 74% in 2019.[5] At the global level, 7 of the 10 leading causes of death in 2019 were NCDs.[4] Oral diseases, even though they are largely preventable, affect half the world's population.[6] An estimated 2.4 billion people are living with a health condition that could benefit from rehabilitation.[7] Globally, the greatest decline in mortality between 2000 and 2019 was seen for chronic respiratory diseases (a 37% decline in age-standardized rates for all ages combined), followed by cardiovascular diseases (27%) and cancer

[1] NCD Countdown Collaborators. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. Lancet. 2020; 396:918–934. doi: 10.1016/S0140-6736(20)31761-X (https://pubmed.ncbi.nlm.nih.gov/32891217/, accessed 16 November 2022).

[2] WHO. Saving lives, spending less: the case for investing in noncommunicable diseases. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240041059, accessed 16 November 2022).

[3] The Lancet Global Health Editorial. Mental health matters Lancet Global Health, 2020; 8(11): E1352 (https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30432-0/fulltext, accessed 16 November 2022).

[4] WHO. Mental health investment case: a guidance note. Geneva: World Health Organization and the United Nations Development Programme, 2021 (https://www.who.int/publications/i/item/9789240019386, accessed 16 November 2022).

[5] WHO. Global health estimates 2019: deaths by cause, age, sex, by country and by region, 2000–2019. Geneva, World Health Organization; 2020. (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death, accessed 17 November 2022).

[6] WHO global oral health status report: towards universal health coverage for oral health by 2030. Geneva: World Health Organization; 2022.

[7] Cieza A, Causey K, Kamenov K, Hanssen SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet, 2020, 396(10267):2006-2017 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32340-0/fulltext, accessed 16 November 2022).

(16%), whereas deaths due to diabetes increased slightly (3%).[1] However, the overall progress is not comparable to that made for curbing communicable diseases and is unequal across regions and income groups.[2]

11. Of premature deaths from NCDs (deaths due to NCDs under the age of 70 years) in 2019 86% occurred in low- and middle-income countries.[4] Measuring the probability of dying between the ages of 30 and 70 years from any cardiovascular disease, cancer, diabetes or chronic respiratory disease (SDG indicator 3.4.1 against a 2015 baseline) is important to assess the extent of burden from mortality due to NCDs in a population; the global premature NCD mortality has declined more than one fifth, from 22.9% in 2000 to 17.8% in 2019.[3]

12. Premature mortality and morbidity from NCDs can partly be attributed to a lack of success in addressing many NCD risk factors. Existing data indicate that, although 60 countries are likely to achieve the tobacco use reduction target by 2025, there would be 1.27 billion people in the world still using tobacco by 2025.[4] Globally, in 2019, more than 14% of adults aged 18 years and over were projected to be obese, up from 9% in 2000 and 5% in 1975, with a figure of 8% for children and adolescents aged 5–19 years, more than double the percentage in 2000.[5] The pace of reduction in alcohol consumption has been slow and uneven globally while such consumption increased in the South-East Asia and Western Pacific regions between 2000 and 2015 (most notably among men) and then plateaued or subsequently declined by 2019.[6] In 2019, air pollution caused about 6.7 million deaths, of which 85% were from NCDs, mostly cardiovascular diseases. More than 9 in 10 people breathe air that is not healthy and 2.4 billion people still rely on polluting fuels and technologies for cooking.[7]

13. The results of the 2021 NCD country capacity survey[8] showed that there has been considerable progress in some areas in countries. With a survey response rate of 100%, the percentage of countries that have set national NCD targets based on the WHO Global Monitoring Framework has increased

[1] Global Health Estimates 2019: deaths by cause, age, sex, by country and by region, 2000-2019. Geneva: World Health Organization; 2020 (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death, accessed 17 November 2022).

[2] WHO. World health statistics 2021: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization. World Health Statistics 2022. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/342703, accessed 17 November 2022).

[3] WHO. World Health Statistics Report 2022 (https://apps.who.int/iris/handle/10665/356584, accessed 17 November 2022).

[4] WHO global report on trends in prevalence of tobacco use 2000-2025, fourth edition. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240039322, accessed 17 November 2022).

[5] WHO estimates were projected to 2019 as described here: WHO NCD Accountability Framework, including Global Monitoring Framework for NCD prevention and control (2021 update) in alignment with the extension of the NCD Global Action Plan to 2030 (https://cdn.who.int/media/docs/default-source/ncds/ncd-surveillance/who-ncd-accountability-framework-for-ncd-implementation-roadmap.pdf). WHO estimates are available at: Global Health Observatory. Noncommunicable diseases: risk factors. Geneva: World Health Organization; 2018 (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/ncd-risk-factors (both websites accessed 17 November 2022).

[6] WHO. World Health Statistics 2022: monitoring health for the SDGs. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/356584, accessed 17 November 2022).

[7] WHO. The Global Health Observatory: Air pollution data portal. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/air-pollution, accessed 17 November 2022).

[8] WHO. Noncommunicable disease surveillance, monitoring and reporting: NCD country capacity survey. Geneva: World Health Organization (https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs, accessed 17 November 2022).

from just under one in three (30%) in 2015 to well over half (56%) in 2020. Similar progress was seen in the percentage of countries that have operational integrated, multisectoral action plans on NCDs as well as management guidelines for the four main NCDs. However, other areas have not seen such marked progress: risk factor surveillance activities and public awareness campaigns to promote physical activity saw a decline in the last survey, no doubt due in part to the COVID-19 pandemic.

Mental health

14. Nearly 1 billion people globally lived with a mental disorder in 2019.[1] Depression and anxiety alone cost US$ 1 trillion annually.[2] People with severe mental disorders die 10 to 20 years earlier than the general population,[3] and more than one in every 100 deaths were due to suicide in 2019.[4] Neurological disorders are the leading cause of disability-adjusted life years and were the second leading cause of death in 2016.[5] There were 283 million people with alcohol use disorders in 2016[6] and 36 million with drug use disorders in 2019.[7] Yet, only 31% of Member States report mental health policies or that plans are being implemented and just 2% of health budgets goes to mental health. In low-income countries, there are fewer than one mental health worker per 100 000 population.[8]

15. Progress towards mental health-related Sustainable Development Goals is as follows:

(a) 3.4.2. global crude suicide rate: estimated at 9.2 per 100 000 population for 2019 (a 3.2% reduction in the crude rate of suicide since 2015);[4]

(b) 3.5.1. strengthen the prevention and treatment of substance abuse, including narcotic drug abuse: little progress made since 2010;

[1] GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/cb9c37d9454c80df77adaed394d7fc0f, accessed 17 November 2022).

[2] Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. Lancet Psychiatry. 2016;3(5):415–424. doi:10.1016/S2215-0366(16)30024-4.

[3] Chesney E, Goodwin GM, Fazel S. Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry. 2014;13(2):153–160. doi:10.1002/wps.20128.

[4] WHO. Suicide worldwide in 2019: Global health estimates. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/341728, accessed 17 November 2022).

[5] Feigin VL, Nichols E, Alam T, Bannick MS, Beghi E, Blake N et al. Global, regional, and national burden of neurological disorders, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet Neurology. 2019; 18:459–80. doi: https://doi.org/10.1016/S1474-4422(18)30499-X.

[6] WHO. Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/274603, accessed 17 November 2022).

[7] UNODC. World drug report 2021. New York: United Nations Office on Drugs and Crime; 2021 (https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html, accessed 10 January 2023).

[8] WHO. Mental Health Atlas 2020. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240036703, accessed 17 November 2022).

(c) 3.5.2. in 2019, the average level of alcohol consumption in the world, measured in litres of pure alcohol per person of 15 years of age or older, was 5.8 litres (a 5% relative decrease from 2010).[1]

The COVID-19 pandemic

16. The pandemic continues to be a major disrupter to progress against NCDs and on improving mental health by setting back advances on risk factor-reduction policies and interrupting services delivery, from early detection to management and control, and surveillance, all of which is expected to increase premature mortality in the near future. This reality further highlights the urgency to support countries with recommendations on how to reorient health systems towards primary health care, as the foundation of universal health coverage as well as health security and health and well-being for all, and to strengthen the design and implementation of policies to treat people living with NCDs and mental health conditions and to prevent and control their risk factors in humanitarian emergencies.

17. COVID-19 had broad and diverse negative effects on NCD service provision and caused an increase in excess mortality. The global excess mortality associated with COVID-19 was estimated to be 14.91 million between 1 January 2020 and 31 December 2021, representing 9.49 million more deaths than those globally reported as directly attributable to COVID-19.[2] Globally, in 2020, 58% and 62% of countries reported complete or partial disruptions, respectively, to services dealing with the management of hypertension or diabetes. Asthma services, cancer treatment and urgent dental care were each reported as disrupted in about 50% of countries. Services for cardiovascular emergencies were reported as disrupted in 48% of countries.[3] A systematic review identified 38 different categories of delays and disruption in aspects of cancer services, primarily affecting facility capacities (up to 78%), supply chain (up to 79%), and personnel availability (up to 60%).[4] Even though there have been limited measuring and reporting of mitigation strategies affecting patients' outcomes, and thus a scarcity of high-quality evidence to inform policy or programme development, some of the mitigation strategies used across countries reporting disruptions included improving community communications, enhanced triaging, task shifting, telemedicine, self-care and home-care interventions, redirecting patients, novel prescribing approaches and supply-chain management, and government removal of user fees.

18. NCDs and their risk factors also play a major role in the impact of COVID-19 outcomes. Studies have reported diverse findings in trends of alcohol consumption during the COVID-19 pandemic, with an increased use in some settings and decreased use in others.[5] Alcohol consumption and obesity

[1] WHO. The Global Health Observatory: SDG target 3.5 Substance abuse. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/sdg-target-3_5-substance-abuse, accessed 17 November 2022).

[2] WHO. Global excess deaths associated with COVID-19 January 2020 – December 2021: a comprehensive view of global deaths directly and indirectly associated with the COVID-19 pandemic. Geneva: World Health Organization; 2022 (https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021, accessed 17 November 2022).

[3] WHO. The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240010291, accessed 17 November 2022).

[4] Delays and disruptions in cancer health care due to COVID-19 pandemic: Systematic Review. JCO Glob Oncol. 2021 Feb; 7:311-323. doi: 10.1200/GO.20.00639. PMID: 33617304; PMCID: PMC8081532.

[5] WHO. World Health Statistics 2022. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/356584, accessed 17 November 2022).

increased the risk of complications and death for many NCDs following an infection with SARS-CoV-2.[1,2]

19. Major depressive disorder and anxiety disorders increased by an estimated 27.6% and 25.6%, respectively, in the first year of COVID-19,[3] coinciding with severe mental health service disruptions. Throughout much of the period 2020–2021, mental, neurological and substance use services were most disrupted among essential health services.[4]

20. Despite the evidence of serious disruption to health care services and less protection from risk factors due to the COVID-19 pandemic, leading to excess mortality, health system strengthening for the prevention and control of NCDs, and the promotion, protection and care of mental health are still not prominent in COVID-19 funding through international agencies.

Pending challenges and a road map for accelerated action at country level

21. Current investments in the implementation of the menu of policy options and cost-effective interventions for the prevention and control of NCDs and WHO packages, like the WHO package of essential noncommunicable (PEN) disease interventions for primary health care, continue to lack the scale needed to accelerate progress towards SDG target 3.4, particularly in low- and lower-middle-income countries.

22. The mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020[5] clearly describes the challenges impeding progress at the national and subnational levels across the six objectives, and additional cross-cutting issues, that underpin the action plan. It also provides recommendations for the Secretariat and Member States to meet these implementation challenges.

23. The Secretariat has described responses to these recommendations in the NCD implementation road map 2023–2030 for the global action plan,[6] which was adopted by the Health Assembly in decision WHA75(11). The heterogeneity in the epidemiology of NCDs across countries and regions, as well as local sociocultural, economic and political contexts, implies that countries need to take divergent domestic routes towards meeting SDG target 3.4 and the targets of the action plan. The purpose of the road map is to guide and support Member States to take urgent measures, in 2023 and beyond, to

[1] Patanavanich R, Siripoon T, Amponnavarat S, Glantz SA. Active smokers are at higher risk of COVID-19 death: A systematic review and meta-analysis. Nicotine Tob Res. 2022 Apr 1:ntac085. doi: 10.1093/ntr/ntac085. Epub ahead of print. PMID: 35363877.

[2] Cai Z, Yang Y, Zhang J. Obesity is associated with severe disease and mortality in patients with coronavirus disease 2019 (COVID-19): a meta-analysis. BMC Public Health 2021; 21(1)1505. doi: 10.1186/s12889-021-11546-6.

[3] WHO. Mental Health and COVID-19: Early evidence of the pandemics impact: Scientific brief, 2 March 2022. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Mental_health-2022.1, accessed 17 November 2022).

[4] WHO. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021: interim report, 7 February 2022. Geneva: World Health Organization; 2022. (https://apps.who.int/iris/handle/10665/351527, accessed 17 November 2022).

[5] WHO. Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 (NCD-GAP). Geneva: World Health Organization; 2020 (https://www.who.int/publications/m/item/mid-point-evaluation-of-the-implementation-of-the-who-global-action-plan-for-the-prevention-and-control-of-noncommunicable-diseases-2013-2020-(ncd-gap), accessed 17 November 2022).

[6] Document A75/10 Add.8.

accelerate progress and reorient and accelerate their domestic action plans with a view to placing themselves on a sustainable path to meeting the nine voluntary global NCD targets and SDG target 3.4. The road map, while focusing on the "4 by 4 NCD agenda" (four diseases – cardiovascular diseases, cancer, diabetes and chronic respiratory diseases – caused by four behavioural risk factors – tobacco use, the harmful use of alcohol, unhealthy diet and physical inactivity pursuant to the mandate, will have to be implemented in full alignment with the commitments to reduce air pollution and promote mental health and well-being (the latter being recognized in the "5 by 5 NCD").

WORK BY THE SECRETARIAT

24. WHO's Thirteenth General Programme of Work (2019–2025) is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier population. Effective and equitable responses for the prevention and control of NCDs and the promotion, protection and care of mental health are an integral part of the three interconnected strategic priorities.

25. The Secretariat's technical work is coordinated by a Technical Expert Network, convening the three levels of the Organization, so that the Secretariat's key actions, approaches, initiatives and global assignments demonstrate contributions across the triple billion targets of the General Programme of Work and support the three strategic shifts that guide the WHO's work in achieving these targets: stepping up leadership; driving public health impact in every country; and focusing global public goods on impact.

26. The full breadth of the Secretariat's technical work that supports Member States progressing towards implementing the WHO global action plan to prevent and control noncommunicable diseases 2013–2030 and achieving the nine voluntary global NCD targets by 2025 and SDG target 3.4, as well as other key targets, such as SDG 3.5, 3.8 and 3.A, is outlined in the complementary report[1] which showcases the key actions, approaches, initiatives and global assignments delivered by the three levels of WHO, across the three strategic shifts of the Thirteenth General Programme of Work, 2019–2025.

Stepping up leadership

27. The preparatory process for the fourth High-Level Meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, in 2025, builds on existing political commitments made by the General Assembly in 2011, 2014 and 2018 and will offer an opportunity to address evolving agendas and focus areas on the NCD agenda.[2] The Secretariat will facilitate strategic events as critical steps towards building and pursuing a collective vision for the next decades and course of action for accelerating progress towards SDG target 3.4 on NCDs and mental health, and SDG target 3.8 on universal health coverage, including their consideration in preparation for the second High-Level Meeting of the United Nations General Assembly on universal health coverage in 2023.[3]

[1] Available at https://www.who.int/teams/noncommunicable-diseases (accessed 19 December 2022).

[2] Document A75/10 Add.5 (https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add5-en.pdf, accessed 17 November 2022).

[3] WHO. Preparatory process leading to the fourth High-level meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases in 2025. Geneva: World Health Organization; 2022 (https://www.who.int/news-room/feature-stories/detail/preparatory-process-leading-to-the-fourth-high-level-meeting-of-the-general-assembly-on-theprevention-and-control-of-noncommunicable-diseases-in-2025, accessed 18 December 2022).

28. Member States should set inclusive, ambitious and integrated milestones in the preparatory process, that set the vision for the NCDs agenda from 2025 towards 2050 based on evidence, grounded in equity and human rights, placing countries on a sustainable path into the next decades linked to the well-being, environment and health security agenda.

29. The NCD implementation road map will aim to accelerate action at national level through three strategic directions to achieve SDG target 3.4 before 2025 and 2030:

(d) accelerate national response based on the understanding of NCDs epidemiology and risk factors and the identified barriers and enablers in countries;

(e) prioritize and scale up the implementation of feasible interventions with the most impact in the national context;

(f) ensure timely, reliable and sustained national data on NCD risk factors, and mortality for data-driven actions and to strengthen accountability.

30. The NCD implementation road map is expected to serve as an overarching guide for regions and countries, entities in the United Nations system and non-State actors in order to accelerate ongoing national NCD responses, by means such as strengthening and reorienting multisectoral action plans; scaling up health system capacity for NCDs through primary health care and universal health coverage; and strengthening national capacity, leadership, governance and partnerships.

31. The Secretariat published the *World mental health* report in 2022,[1] outlining latest evidence, providing examples of good practice and highlighting voices of people with lived experience. The report describes why and where change is needed, and how stakeholders can deepen commitment to mental health, reshape environments that influence mental health and strengthen mental health systems.

32. The Secretariat is supporting Member States in addressing the health effects of air pollution by expanding knowledge on and monitoring of exposure and impacts of air pollution and building capacity of health and other sectors with tools to engage in multisectoral action. The Secretariat is also supporting Member States to adapt the implementation of the new WHO global air quality guidelines to take account of the national context, by means of a series of activities to foster intersectoral dialogues and policies.

Focusing global public goods on impact[2]

33. The Secretariat is supporting Member States to operationalize the NCD implementation road map, with a comprehensive set of technical products across all programmatic areas, currently at different stages of development across headquarters and regional offices, that will empower Member States to

[1] WHO. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240049338, accessed 16 November 2022).

[2] WHO. WHO global public health goods for biennium 2020-2021 in WHO Results Report 2020-2021. Geneva: World Health Organization; 2022 (https://www.who.int/about/accountability/results/who-results-report-2020-2021#outcomes), and WHO. WHO Public Health Goods Technical Products: ongoing technical products for biennium 2022–2023. Geneva: World Health Organization; 2022 (https://www.who.int/our-work/technical-products, accessed 17 November 2022).

accelerate achievement of global NCD and mental health outcomes at country level, presented in the comprehensive overview.[1]

34. Support for the operationalization of the NCD implementation road map will be provided in full alignment with the development of technical products by the Secretariat to support Member States in the implementation of the Comprehensive Mental Health Action Plan 2013–2030 and in addressing the health effects of air pollution.

35. Through decision WHA75(11), the Health Assembly adopted, inter alia, the action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority.[2] In response, the Secretariat has worked with a focus on: (i) supporting Member States to implement the action plan and its high-impact strategies and interventions, by means that include WHO's SAFER initiative; and (ii) strengthening global advocacy, coordination, monitoring and capacity building activities on alcohol and health.

Driving public health impact in every country

36. The COVID-19 pandemic disclosed the need for radical reorientation and strengthening of health systems to respond to the prevention and control of NCDs and the promotion, protection and care of mental health as the foundation for universal health coverage, as well as health security and health and well-being for all. Despite the relevant commitments made at the United Nations General Assembly and the guidance provided by the Health Assembly to realize these commitments, requests are growing from countries for technical support in line with stronger guidance and recommendations to accelerate country responses, improve the integration of health services in primary health care, strengthen the design and implementation of policies to prevent and treat people living with NCDs and mental health conditions, and prevent and control their risk factors in humanitarian emergencies. In response, the Secretariat will develop technical guidance and recommendations to support Member States to reorient health systems towards including noncommunicable diseases into primary health care, as a component of universal health coverage and effective preparedness for and response to public health emergencies. There will be a need to measure health systems' responses to the prevention and control of NCDs and the promotion, protection and care of mental health by output measures. One tracer output for NCDs will be the improved diagnosis, treatment and control of hypertension that today contributes to 32% of all global deaths,[3] with only 54% of those with hypertension diagnosed, 42% treated and 21% under control.[4]

37. As the Secretariat lacks adequate financial and human resources to address all requests for technical support from countries, it will continue to build on the Operational Framework for Primary Health Care[5] and packages developed to address the prevention and control of NCDs and the promotion, protection and care of mental health by partnering at global, regional and national levels. Further

[1] Available at https://www.who.int/teams/noncommunicable-diseases (accessed 10 January 2023).

[2] Available at https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/our-activities/towards-and-action-plan-on-alcohol (accessed 10 January 2023).

[3] GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/cb9c37d9454c80df77adaed394d7fc0f, accessed 10 January 2023).

[4] NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants. The Lancet, S0140-6736(21)01330-1.

[5] WHO. Operational Framework for Primary Health Care. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 November 2022).

guidance still needs to be developed on new service delivery models including self-care, digital health solutions, NCD-ready health workforces, task-shifting, inclusion of NCDs in universal health care, and monitoring the coverage and response towards relevant health outcomes.

38. The ongoing work for strengthening NCD services through a primary health care approach is being undertaken with catalytic support in more than 120 countries through the UHC Partnership and more intensified support through the Pathway to Care Norway NCD Flagship project, hypertension control support through Resolve to Save Lives and cancer control support through St. Jude Children's Research Hospital (in Memphis, Tennessee, United States of America), among others, demonstrating what can be achieved through health system strengthening with an integrated primary health care approach, including more recently in the context of a pandemic and health emergencies.

39. In efforts to support countries to provide more people living with NCDs with high-quality essential health services and high-quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, and as part of the Global Diabetes Compact and the commitments identified through the dialogues with private sector entities, WHO has prequalified the first human insulins. In addition, updated storage conditions for the prequalified products will greatly facilitate the use of these essential medicines under challenging temperature conditions in locations with limited access to refrigeration in relevant low- and middle-income countries.[1]

40. In response to the requests in resolution WHA74.5 (2021) on oral health, the Secretariat developed a global oral health action plan,[2] including a framework for tracking progress with clear measurable targets to be achieved by 2030. This action plan is a crucial step in the implementation of both the resolution on oral health and the global strategy on oral health, adopted in decision WHA75(11). It translates the vision, goal and strategic objectives set out in the global strategy on oral health into action-oriented guidance on interventions for stronger and more coordinated action on oral health. The accompanying draft global monitoring framework provides two overarching global targets and nine global targets related to the strategic objectives, including a set of core indicators to assess implementation progress.

41. Launched in 2019, WHO's Special Initiative for Mental Health[3] aims to advance policy, advocacy and human rights for mental, neurological and substance use conditions and to scale up mental health services. Implementing countries include Argentina, Bangladesh, Ghana, Jordan, Nepal, Paraguay, Philippines, Ukraine and Zimbabwe. The initiative progressed well in 2022, yet success remains uncertain owing to constrained financial and human resources. Greater investment in this initiative will be critical for countries to provide adequate services and serve the most vulnerable.

42. The UNICEF and WHO Joint Programme on Mental Health and Psychosocial Well-being and Development of Children and Adolescents[4] aims to strengthen capacities to implement evidence-

[1] WHO. First human insulins prequalified [news item]. Geneva: World Health Organization; 2022 (https://extranet.who.int/pqweb/news/first-human-insulins-prequalified, accessed 17 November 2022).

[2] Global oral health action plan (2023-2030) (https://cdn.who.int/media/docs/default-source/ncds/mnd/oral-health/eb152-draft-global-oral-health-action-plan-2023-2030-en.pdf, accessed 18 December 2022).

[3] WHO Special Initiative for Mental health. Geneva: World Health Organization (https://www.who.int/initiatives/who-special-initiative-for-mental-health, accessed 17 November 2022).

[4] WHO mental health and substance abuse. UNICEF and WHO Joint Programme on Mental Health and Psychosocial Well-being and Development of Children and Adolescents. Geneva: World Health Organization (https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/unicef-and-who-joint-programme-on-mental-health-and-psychosocial-well-being-and-development-of-children-and-adolescents, accessed 17 November 2022).

informed multisectoral strategies to support children, adolescents and carers. To date, eight countries have been selected to join the programme: Bhutan, Colombia, Egypt, Guyana, Jordan, Maldives, Mozambique and Papua New Guinea. In 2022, UNICEF and WHO supported the development of country support cases, committed US$ 5 million to support implementation and are supporting development of multisectoral action plans tailored to countries.

43. Following the Health Assembly's adoption of the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 also in decision WHA75(11) (2022), the Secretariat will support Member States in providing services for people with epilepsy and other neurological disorders through implementation monitoring. The Secretariat published a position paper on optimizing brain health across the life course[1] and a technical brief on a public health approach to Parkinson's disease[2] to support the implementation.

44. The Annex to this report provides a draft updated menu of policy options and cost-effective interventions for the prevention and control of NCDs of the WHO global action plan 2013–2030 which will support countries in further prioritizing and scaling up the implementation of most efficacious and feasible interventions in their national context. The update is provided in response to requests in decisions WHA72(11) (2019) and WHA75(11) (2022).

ACTION BY THE EXECUTIVE BOARD

45. The Board is invited to note the report and its Annex and to consider the following draft decision:

> The Executive Board, having considered the report of the Director-General,[3]
>
> Decided to recommend that the Seventy-sixth World Health Assembly note the report by the Director-General and its Annex, and that it adopt the following decision:
>
> The Seventy-sixth World Health Assembly, having considered the report by the Director-General,
>
> Decided:
>
> (1) to endorse the draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases (2022 update of Appendix 3 of the WHO global action plan to prevent and control noncommunicable diseases);
>
> (2) to request the Director-General to submit a draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases for consideration by the Eightieth World Health Assembly through the Executive Board at its 160th session, and to incorporate revised interventions to Appendix 3 of the WHO global action plan on the prevention and control of noncommunicable diseases 2013–2030 on a continuous basis, when data are available.

[1] WHO. Optimizing brain health across the life course: WHO position paper. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240054561, accessed 17 November 2022).

[2] WHO. (2022). Parkinson's disease: a public health approach: technical brief. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240050983, accessed 17 November 2022).

[3] Document EB152/6.

ANNEX

DRAFT UPDATED APPENDIX 3 TO THE GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2030

What is Appendix 3?

1. The global action plan for the prevention and control of noncommunicable diseases 2013–2020[1] was endorsed by the Sixty-sixth World Health Assembly in 2013 with an Appendix containing a menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases (known as "Appendix 3"). The purpose of Appendix 3 is to support 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 for NCD prevention and control through the six objectives of the WHO global NCD action plan 2013–2030. The first update of Appendix 3 in 2017, endorsed by the Seventieth World Health Assembly,[2] contained very cost-effective and affordable interventions, as well as other cost-effective interventions for the prevention and control of NCDs. The list of interventions contained in Appendix 3 is not exhaustive but is intended to provide information and guidance on cost-effectiveness of population-based and individual interventions based on current evidence. It also aims to act as the basis for future work to develop and expand the evidence base, taking into consideration overarching/enabling policy actions as well as non-financial considerations.

SCOPE AND PURPOSE

Why update Appendix 3?

2. The current updates to Appendix 3, formulated in response to decisions WHA72(11) (2019) and WHA75(11) (2022), complement existing global strategies and action plans and reflect the introduction of several new technical products that support the implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030,[3] including the WHO menu of cost-effectiveness interventions for mental health,[4] the recommended interventions to address the health impact of air pollution[5,6] and the menu of cost-effective interventions for oral health.[7]

3. Appendix 3 has been updated in order to accelerate progress towards meeting the nine voluntary global NCD targets and Sustainable Development Goal 3 target 3.4 and to support the implementation

[1] See document WHA66/2013/REC/1, resolution WHA66.10.

[2] See document WHA70/2017/REC/1, resolution WHA70.11.

3 Document A75/10 Add.8; noted by the Health Assembly, see also document WHA75/REC/3, summary records of first meeting, section 3, fifth meeting, section 2, and sixth meeting of Committee A.

[4] WHO. WHO menu of cost-effective interventions for mental health. Geneva: World Health Organization; 2021 https://apps.who.int/iris/handle/10665/343074, accessed 1 December 2022).

[5] WHO. Compendium of WHO and other UN guidance on health and the environment, 2022 update. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/352844, accessed 1 December 2022).

[6] WHO. WHO global air quality guidelines: particulate matter (PM2.5 and PM10), ozone, nitrogen dioxide, sulfur dioxide and carbon monoxide. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/345329, accessed 1 December 2022).

[7] See document WHA74/2021/REC/1, resolution WHA74.5.

road map 2023–2030 with its new acceleration plan to support Member States in implementing the recommendations for the prevention and management of obesity over the life course[1], by:

(a) considering interventions that apply new WHO normative and standard-setting products developed since the adoption of the WHO global NCD action plan 2013–2020;

(b) refining the existing formulation of some interventions based on lessons learned from the use of the previous two versions and reflecting WHO's new guidance;

(c) updating and adding interventions on the basis of agreed criteria and new and available scientific evidence of impact.

What has changed?

4. There has been no change to the menu of options listed for four of the six objectives of the global NCD action plan – 1 (raising the priority of prevention and control of NCDs), 2 (strengthen national capacity, leadership, governance, multisectoral action and partnerships), 5 (promote research and development) and 6 (monitoring and evaluation) – which are process-related recommendations and are provided in the technical annex to this document.[2] Appendix 3 relates to objectives 3 (reduce risk factors and underlying social determinants) and 4 (strengthen and orient health systems).

5. The criteria used for identifying interventions for the current update were the same as those applied for the 2017 update:[3]

(a) an intervention must have a demonstrated and quantifiable effect, established in at least one published study in a peer-reviewed journal;

(b) an intervention must have a clear link to one of the global NCD targets.

6. The proposed menu of interventions for the newly updated Appendix 3 comprises the following (all the interventions presented in the 2017 update have been re-analysed):

(a) interventions that have been unchanged from the last updated version (2017);

(b) interventions from the 2017 update that have been reworded or revised to reflect updates in WHO policy or scientific evidence;

(c) interventions included in the 2017 update that had no analysis carried out at the time and for which cost-effectiveness analysis has now been done for the 2022 update;

[1] Document A75/10 Add.6, Annex 12; noted by the Health Assembly, see also document WHA75/REC/3, summary records of first meeting, section 3, fifth meeting, section 2, and sixth meeting of Committee A.

[2] WHO. Noncommunicable diseases: updating Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013-2030. Geneva: World Health Organization; 2022 (https://www.who.int/teams/noncommunicable-diseases/updating-appendix-3-of-the-who-global-ncd-action-plan-2013-2030/, accessed 9 December 2022).

[3] Available at https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf?sequence=1&isAllowed=y, page 3 'How were these interventions selected' (accessed 19 December 2022).

(d) new interventions deriving from WHO's new guidance and technical products.

7. The proposed updates are set out in the Table. Altogether 90 interventions and 22 overarching/enabling actions have been identified, representing an expansion from the 2017 list of 88 interventions (including overarching/enabling actions). Cost-effectiveness was examined for 58 of the 90 interventions using WHO's Choosing interventions that are cost-effective (WHO-CHOICE),[1] the methodology also used in the 2017 update. The increase in the number of interventions between the 2017 and 2022 updates is due to the availability of new scientific evidence or WHO recommendations as proposed by the Secretariat's technical units and/or expert groups linked to the global NCD action plan. Out of the 58 cost-effective interventions, 28 are considered to be the most cost-effective and feasible for implementation and are identified in **bold** text in the Table,[2] as compared to 16 interventions in the previous version.[3] The cost-effectiveness threshold is generally used to identify interventions that represent good value for money and will be different depending on the national context. For example, if the national cost-effectiveness threshold chosen by a low-income country is Int$ 1000 per healthy life year gained, then 82% of the proposed 58 interventions in the 2022 update would represent good value for money in that country. In addition, 32 interventions that are part of WHO's guidance were also included but without WHO-CHOICE analysis. The absence of cost-effectiveness does not mean that the intervention is not cost-effective, affordable or feasible but that the WHO-CHOICE analysis could not be completed in the 2022 update and further updates will continue.

Technical annex

8. The 2022 updates in this list are supported by the technical annex[4] which provides more detailed information about the methodology used to identify and analyse interventions, the assumptions used in the WHO-CHOICE economic modelling and an up-to-date list of WHO's tools and resources for each objective. It also contains more detailed economic analyses for each intervention, with summary tables of costs, health impacts and cost-effectiveness ratios in bands for all interventions, presented separately for the three income categories of countries. Detailed information on methods, the evidence and assumptions underlying different interventions by disease and risk factor area are provided in separate technical briefs.[5]

The importance of non-economic considerations

9. The economic analyses in the technical annex give an assessment of cost-effectiveness, based on the health impact and the economic cost of the intervention. Although the results provide a set of parameters for consideration by Member States, it must be emphasized that a global cost-effectiveness

[1] Available at https://www.who.int/teams/health-systems-governance-and-financing/economic-analysis/health-technology-assessment-and-benefit-package-design/generalized-cost-effectiveness-analysis (accessed 19 December 2022).

[2] With an average cost-effectiveness ratio of ≤Int$ 100 per healthy life year gained in low- and lower-middle-income countries. The international dollar (Int$) is a hypothetical unit of currency that has the same purchasing power parity that the United States dollar had in the United States of America at a given point in time.

[3] Based on cost-effectiveness ratio in low- and middle-income settings.

[4] WHO. Noncommunicable diseases: updating Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013-2030. Geneva: World Health Organization; 2022 (https://www.who.int/teams/noncommunicable-diseases/updating-appendix-3-of-the-who-global-ncd-action-plan-2013-2030/, accessed 9 December 2022).

[5] WHO. Updating Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030. Geneva: World Health Organization [website] (https://www.who.int/teams/noncommunicable-diseases/updating-appendix-3-of-the-who-global-ncd-action-plan-2013-2030/, accessed 2 December 2022).

analysis, such as this, should be accompanied by analyses further tailored to the local context. The OneHealth Tool[1] is available to help individual countries to cost specific interventions in their national context. The Secretariat will also consider the development of an interactive web-based tool for countries to visualize the impact on national NCD targets of prioritizing and scaling up the implementation of a set of cost-effective interventions of the updated Appendix 3 as part of the implementation road map for NCDs.

10. When considering interventions for prevention and management of any disease or condition, including noncommunicable diseases, emphasis should be given to both economic and non-economic criteria, as both will affect the implementation and impact of interventions. Non-economic aspects such as acceptability, feasibility or health system capacity, sustainability, scalability, equity, and ethics[2] are essential to consider as part of the prioritization and implementation of the proposed interventions, based on the specific context of a country. Non-economic considerations that may affect the feasibility of certain interventions in some settings have been included as a separate column in the Table.

Table. The 2022 updates to Appendix 3 of the global NCD action plan 2013–2030

	Menu of policy options[a]	Critical non-economic considerations[b]
OBJECTIVE 3		
TOBACCO USE		
Overarching/enabling actions	*For the Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC)*: • Strengthen the effective implementation of the WHO FCTC and its guidelines for implementation, as well as the Protocol to Eliminate Illicit Trade in Tobacco Products, if applicable • Establish and operationalize national coordinating mechanisms for the implementation of the WHO FCTC as part of a national tobacco control strategy with specific mandates, responsibilities and resources *For the Member States that are not Parties to the WHO FCTC*: • Consider implementing the measures set out in the WHO FCTC and its guidelines for implementation, as well as the Protocol to Eliminate Illicit Trade in Tobacco Products, if applicable, as the foundational instruments in global tobacco control	

[1] Available at https://www.who.int/tools/onehealth (accessed 18 December 2022).

[2] WHO. Principles of health benefit packages. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240020689, accessed 2 December 2022).

	Menu of policy options[a]	Critical non-economic considerations[b]
WHO-CHOICE analysis available[c]	• **Increase excise taxes and prices on tobacco products**	
	• **Implement large graphic health warnings on all tobacco packages, accompanied by plain/standardized packaging**	• Requires capacity for implementing and enforcing regulations and legislation
	• **Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship**	
	• **Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport**	
	• **Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke, and encourage behavioural change**	
	• **Provision of cost-covered effective population-wide support (including brief advice, national toll-free quit line services and mCessation) for tobacco cessation to all tobacco users**	• Requires trained providers in sufficient numbers and an effective health system
	• Provision of cost-covered effective pharmacological interventions to all tobacco users who want to quit, through the use of nicotine replacement therapy, bupropion and varenicline.	
WHO-CHOICE analysis not available	• Establish a tracking and tracing system to support the elimination of illicit trade in tobacco products that is in line with Article 8 of the Protocol to Eliminate Illicit Trade in Tobacco Products	
	• Ban cross-border tobacco advertising, promotion and sponsorship, including those through modern means of communication	
HARMFUL USE OF ALCOHOL		
Overarching/enabling actions	• Implement applicable recommendations in WHO's Global strategy to reduce harmful use of alcohol through multisectoral actions in the recommended target areas	
	• Implement WHO's global action plan on alcohol 2022–2030 to support and complement policy measures and interventions implemented at the national level in accordance with 10 areas recommended in the global strategy to reduce harmful use of alcohol	
	• Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol	
	• Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems	
WHO-CHOICE analysis available[c]	• **Increase excise taxes on alcoholic beverages**	• Levying taxes should be combined with other price measures, such as bans on discounts or promotions
	• **Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)**	• Requires capacity and infrastructure for implementing and enforcing regulations and legislation
	• **Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)**	
	• Enact and enforce drink-driving laws and blood alcohol concentration limits through sobriety checkpoints	
	• Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use	• Requires trained providers at all levels of health care

Menu of policy options[a]		Critical non-economic considerations[b]
WHO-CHOICE analysis not available	• Carry out regular reviews of prices in relation to level of inflation and income • Establish minimum prices for alcohol where applicable • Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets • Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people • Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services • Provide consumers with information, including labels and health warnings, about contents of alcoholic beverages and the harms associated with alcohol consumption	
UNHEALTHY DIET		
Overarching/enabling actions	• Implement WHO's Global Strategy on Diet, Physical Activity and Health, the Global strategy for infant and young child feeding jointly developed by WHO and UNICEF and WHO's Comprehensive implementation plan on maternal, infant and young child nutrition • Develop and implement national nutrient-and food-based dietary guidelines, as well as nutrient profile models for different applications as appropriate	
WHO-CHOICE analysis available[c]	• **Reformulation policies for healthier food and beverage products (for example, elimination of *trans*-fatty acids and/or reduction of saturated fats, free sugars and/or sodium)** • **Front-of-pack labelling as part of comprehensive nutrition labelling policies for facilitating consumers' understanding and choice of food for healthy diets** • **Public food procurement and service policies for healthy diets (for example, to reduce the intake of free sugars, sodium and unhealthy fats, and to increase the consumption of legumes, wholegrains, fruits and vegetables)** • **Behavioural change communication and mass media campaigns for healthy diets (for example, to reduce the intake of energy, free sugars, sodium, and unhealthy fats, and to increase the consumption of legumes, wholegrains, fruits and vegetables)** • **Policies to protect children from the harmful impact of food marketing on diet** • **Protection, promotion and support of optimal breastfeeding practices** • Taxation on sugar-sweetened beverages as part of fiscal policies for healthy diets	• Requires multisectoral actions with relevant ministries and support by civil society • Regulatory capacity along with multisectoral action is needed
WHO-CHOICE analysis not available	• Subsidies on healthy foods and beverages (for example, fruits and vegetables) as part of comprehensive fiscal policies for healthy diets • Menu labelling in food service for healthy diets (for example, to reduce the intake of energy, free sugars, sodium and/or unhealthy fats) • Limiting portion and package size for healthy diets (for example, to reduce the intake of energy, free sugars, sodium and/or unhealthy fats) • Nutrition education and counselling for healthy diets in different settings (for example, in preschools, schools, workplaces and hospitals)	

Menu of policy options[a]		Critical non-economic considerations[b]
PHYSICAL INACTIVITY		
Overarching/enabling actions	• WHO's global action plan on physical activity 2018–2030: more active people for a healthier world • ACTIVE: a technical package for increasing physical activity • WHO guidelines on physical activity and sedentary behaviour • Leadership and whole of government commitment to address physical inactivity using a life course approach • Strong advocacy to increase awareness and knowledge on the cross-cutting benefits of increasing physical activity, operational research and knowledge translation and improved monitoring and surveillance systems	
WHO-CHOICE analysis available[c]	• **Implement sustained, population-wide communication campaigns about best practices to promote physical activity, with links to community-based programmes and environmental improvements to enable and support behavioural change** • Provide physical activity assessment, counselling and behavioural change support as part of routine primary health care services through the use of a brief intervention	• Requires multisectoral actions with relevant ministries and support by civil society • Requires capacity, and staff with sufficient training in primary care
WHO-CHOICE analysis not available	• Implement urban and transport planning and urban design, at all levels of government, to provide compact neighbourhoods providing mixed-land use and connected networks for walking and cycling and equitable access to safe, quality, public open spaces that enable and promote physical activity and active mobility • Implement whole-of-school programmes that include quality physical education, and adequate facilities, equipment and programmes supporting active travel to and/or from school and support physical activity for all children of all abilities during and after school • Improve walking and cycling infrastructure ensuring universal and equitable access to enable and promote safe walking, cycling, other forms of micromobility (for example, wheelchairs, scooters and skates) by people of all ages and abilities • Implement multicomponent programmes for workplace physical activity • Provide and promote physical activity through provision of community-based (grassroots) sport and recreation programmes and conduct free mass participation events to encourage engagement by people of all ages and abilities	

	Menu of policy options[a]	Critical non-economic considerations[b]
OBJECTIVE 4		
Overarching/enabling actions	• 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 the health workforce and strengthen the capacity of the health system particularly at primary care level to address the prevention and control of noncommunicable diseases • Improve the availability of the 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 to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred health care and universal health coverage • Develop and implement a palliative care policy, including access to opioid analgesics for pain relief, together with training for health workers • Expand the use of digital technologies to increase health service access and efficacy for prevention of noncommunicable diseases, and to reduce the costs in health care delivery	
CARDIOVASCULAR DISEASE		
WHO-CHOICE analysis available[c]	• **Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin**	
	• Pharmacological treatment of hypertension in adults using any of the following: thiazide and thiazide-like agents; angiotensin-converting-enzyme inhibitors/angiotensin-receptor blocker; calcium channel blockers	• Feasible to implement in all settings and aligned to the latest WHO guidelines (2021) • Simple protocols can be followed by non-physician workers depending on the country context
	• Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level	
	• Drug therapy (treatment with an antihypertensive agent and a statin) to control cardiovascular disease risk using a total risk approach and counselling to individuals who have had a heart attack or stroke and to persons with a high risk (≥20%) of a fatal and non-fatal cardiovascular event in the next 10 years using WHO's updated cardiovascular disease risk charts	• Feasibility and practicality of implementation needs to be assessed and determined. Interventions on the control of blood pressure and glucose for people with diabetes are not included here but under the diabetes interventions.
	• Drug therapy (treatment with an antihypertensive agent) to control cardiovascular disease risk using a total risk approach and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥10%) of a fatal and non-fatal cardiovascular event in the next 10 years using WHO's updated cardiovascular disease risk charts	• Feasibility and practicality of implementation needs to be assessed and determined. Glucose control not included in this intervention, but in the diabetes intervention "Control of blood pressure in people with diabetes".
	• Treatment of new cases of acute myocardial infarction with acetylsalicylic acid, initially treated in a hospital setting with follow up carried out through primary health care facilities at a 95% coverage rate	• For the treatment of acute myocardial infarction, the selection of the treatment option depends on the health systems' capacity.

	Menu of policy options[a]	Critical non-economic considerations[b]
	• Treatment of new cases of acute myocardial infarction with acetylsalicylic acid and thrombolysis, with patients initially treated in a hospital setting with follow-up carried out through primary health care facilities at a 95% coverage rate • Treatment of new cases of acute myocardial infarction with acetylsalicylic acid, thrombolysis and clopidogrel, with patients initially treated in a hospital setting with follow-up carried out through primary health care facilities at a 95% coverage rate	
	• Treatment of acute ischaemic stroke with intravenous thrombolytic therapy	• Feasibility and practicality of implementation needs to be assessed and determined according to the health systems' capacity.
	• Low-dose acetylsalicylic acid within 24 to 48 hours for secondary prevention of ischaemic stroke	
	• Treatment of acute ischaemic stroke with mechanical thrombectomy within an experienced facility	• Feasibility and practicality of implementation needs to be assessed and determined according to the health systems' capacity; requires a surgical facility with appropriately trained workforce
	• Treatment of new cases of acute myocardial infarction with primary percutaneous coronary interventions, acetylsalicylic acid and clopidogrel, with patients initially treated in a hospital setting with follow up carried out through primary health care facilities at a 95% coverage rate	• For the treatment of acute myocardial infarction, the selection of the treatment option depends on the health systems' capacity
	• Comprehensive* care of acute stroke patients in stroke units *Comprehensive care includes strategies such as staffing by a specialist stroke multidisciplinary team, access to equipment for monitoring, and rehabilitation.	• Early multidisciplinary approach to be determined and depending on the country context. The composition of the rehabilitation workforce as an integral part of the multidisciplinary team depends on the health systems' capacity.
WHO-CHOICE analysis not available	• Treatment of congestive cardiac failure with angiotensin-converting-enzyme inhibitor, beta-blocker and diuretic • Cardiac rehabilitation after myocardial infarction • Anticoagulation for medium- and high-risk nonvalvular atrial fibrillation and for mitral stenosis with atrial fibrillation • Treatment of hypertension using single pill combination anti-hypertensive agents • Secondary prevention of coronary heart disease with a statin, angiotensin-converting-enzyme inhibitor, beta-blocker and acetylsalicylic acid (low dose) • Seasonal influenza vaccination for people with cardiovascular diseases • COVID-19 vaccination for people with cardiovascular diseases	
DIABETES		
WHO-CHOICE analysis available[c]	• Screening of people with diabetes for proteinuria and treatment with angiotensin-converting-enzyme inhibitor for the prevention and delay of renal disease • Control of blood pressure in people with diabetes • Use of statins in people with diabetes >40 years old • Foot care to prevent amputation in people with diabetes (including educational programmes, access to appropriate footwear and multidisciplinary clinics)	
	• Diabetic retinopathy screening for all diabetes patients and laser photocoagulation for prevention of blindness	• Requires health staff capacity for retinal assessment and photocoagulation
	• Glycaemic control for people with diabetes, along with standard home monitoring of glucose concentrations for people treated with insulin to reduce diabetes complications	

Menu of policy options[a]		Critical non-economic considerations[b]
WHO-CHOICE analysis not available	• Seasonal influenza vaccination for people with diabetes • COVID-19 vaccination for people with diabetes	
CHRONIC RESPIRATORY DISEASE		
WHO-CHOICE analysis available[c]	• **Acute treatment of exacerbations of asthma with inhaled bronchodilators and oral steroids** • **Acute treatment of exacerbations of chronic obstructive pulmonary disease with inhaled bronchodilators and oral steroids** • **Long-term management of chronic obstructive pulmonary disease with inhaled bronchodilator** • Long-term management of asthma with inhaled bronchodilator and low-dose beclometasone	• Requires trained providers at all levels of healthcare
WHO-CHOICE analysis not available	• Seasonal influenza vaccination for people with chronic respiratory disease • Access to improved stoves and cleaner fuels to reduce indoor air pollution • Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica and asbestos • COVID-19 vaccination for people with chronic respiratory diseases	
CANCER		
WHO-CHOICE analysis available[c]	• **Vaccination against human papillomavirus (1–2 doses) of 9–14-year-old girls** • **Cervical cancer: human papillomavirus DNA screening, starting at the age of 30 years with regular screening every 5–10 years (using a screen-and-treat approach or screen, triage and treat approach)** • **Cervical cancer: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment** • **Breast cancer: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment** • **Colorectal cancer: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment** • **Prevention of liver cancer through hepatitis B immunization[1]** • **Childhood cancer: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment, focusing on six index cancers of WHO's Global initiative for childhood cancer** • **Early detection and comprehensive treatment of cancer for those living with HIV** • Breast cancer: screening with mammography (once every two years for women aged 50–69 years) linked with timely diagnostic work-up and comprehensive breast cancer treatment in settings where a mammographic screening programme is recommended	• Requires systems for organized, population-based screening

[1] Cost effectiveness in prevention of liver cancer is optimal in countries with high hepatitis B prevalence and especially with vaccination in early childhood and at birth, taking into account the feasibility and cost of vaccination.

	Menu of policy options[a]	Critical non-economic considerations[b]
	• Oral cancer: early detection programme of oral cancer, including, as appropriate, targeted screening programme for high-risk groups in selected settings, according to disease burden and health system capacities linked with comprehensive cancer management	• Requires systems for organized, population-based screening
	• Prostate cancer: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment	
	• Colorectal cancer screening: population-based programmes, by means including stool-based tests, as appropriate, at age >50 years, linked with timely treatment in settings where a screening programme is recommended	• Requires systems for organized, population-based screening
	• Head and neck cancers including oral cancers: early diagnosis programmes linked with timely diagnostic work-up and comprehensive cancer treatment	
	• Basic palliative care for cancer: home-based and hospital care with multidisciplinary teams and access to opiates and essential supportive medicines	• Requires access to controlled medicines for pain relief
WHO-CHOICE analysis not available	• Influenza vaccination for patients with cancer	
	• COVID-19 vaccination for patients with cancer	

[a] Interventions in **bold** font are those with an average cost-effectiveness ratio of ≤Int$ 100 per healthy life year gained in low- and lower-middle-income countries.

[b] Cost-effectiveness alone does not imply the feasibility of an intervention in all settings. This column highlights some of the critical non-economic aspects that should be taken into account when considering the suitability of interventions for specific contexts.

[c] https://www.who.int/teams/health-systems-governance-and-financing/economic-analysis/health-technology-assessment-and-benefit-package-design/generalized-cost-effectiveness-analysis (accessed 19 December 2022).

= = =