**World Health Organization**

# Report of the Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases

1.     The Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, met from 5 to 7 November 2012 in Geneva and was chaired by Dr Bjørn-Inge Larsen (Norway). The session was attended by representatives of 119 Member States, one regional economic integration organization, one intergovernmental organization and 17 nongovernmental organizations.

2.     The revised WHO discussion paper (version dated 25 July 2012) on a comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases,[1] as well as a report summarizing the results of the discussions in each of the regional committees,[2] were considered by Member States.

3.     The attached global monitoring framework, including indicators (Annex 1) and a set of voluntary global targets for the prevention and control of noncommunicable diseases (Annex 2), were agreed by consensus. Monitoring of indicators should be done by key dimensions of equity including gender, age, and socioeconomic status, and key social determinants such as income level, education and relevant country-specific stratifiers, as appropriate.

4.     The formal meeting requests the Director-General to submit this report and attached global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly for its consideration and adoption.

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[1] Document A/NCD/INF./1.
[2] Document A/NCD/INF./2.

5.     The global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases will be integrated into work under way to develop a draft WHO global action plan for the prevention and control of noncommunicable diseases covering the period 2013–2020 for submission to the Sixty-sixth World Health Assembly, through the Executive Board.

6.     The formal meeting strongly recommends that the Executive Board consider this report and its attachments, with a view to adopting the framework and the set of voluntary global targets, and to recommending their adoption to the World Health Assembly without re-opening discussion on them.

ANNEX 1

## COMPREHENSIVE GLOBAL MONITORING FRAMEWORK FOR NONCOMMUNICABLE DISEASES, INCLUDING A SET OF INDICATORS

1.      Table 1 presents a set of 25 indicators. The indicators, covering the three components of the global monitoring framework, are listed under each component.

**Table 1. Indicators to monitor trends and assess progress made in the implementation of strategies and plans on noncommunicable diseases**

| **Mortality and morbidity** |
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| • Unconditional **probability of dying** between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases. <br><br> • **Cancer incidence**, by type of cancer, per 100 000 population. |
| **Risk factors** |
| *Behavioural risk factors:* <br><br> • Harmful use of **alcohol**:[1] Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context. <br><br> • Harmful use of **alcohol**: Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context. <br><br> • Harmful use of **alcohol**: Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context. <br><br> • Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of **fruit and vegetables** per day. <br><br> • Prevalence of insufficiently **physically active** adolescents (defined as less than 60 minutes of moderate to vigorous intensity activity daily). <br><br> • Age-standardized prevalence of insufficiently **physically active** persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent). <br><br> • Age-standardized mean population intake of **salt (sodium chloride)** per day in grams in persons aged 18+ years. <br><br> • Age-standardized mean proportion of total energy intake from **saturated fatty acids** in persons aged 18+ years.[2] <br><br> • Prevalence of current **tobacco** use among adolescents. <br><br> • Age-standardized prevalence of current **tobacco** use among persons aged 18+ years. |

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[1] Countries will select indicator(s) of harmful use of alcohol, as appropriate to national context and in line with WHO's global strategy to reduce the harmful use of alcohol, which may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality among others.

[2] Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations.

*Biological risk factors:*

- Age-standardized prevalence of raised **blood glucose/**diabetes among persons aged 18+ years (defined as fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose).

- Age-standardized prevalence of raised **blood pressure** among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg); and mean systolic blood pressure.

- Prevalence of **overweight and obesity** in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex).

- Age-standardized prevalence of **overweight and obesity** in persons aged 18+ years (defined as body mass index ≥25 kg/m² for overweight and body mass index ≥30 kg/m² for obesity).

- Age-standardized prevalence of raised **total cholesterol** among persons aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dl); and mean total cholesterol.

**National systems response**

- Proportion of women between the ages of 30–49 screened for **cervical cancer** at least once, or more often, and for lower or higher age groups according to national programmes or policies.

- Proportion of eligible persons (defined as aged 40 years and over with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease) receiving **drug therapy and counselling** (including glycaemic control) to prevent heart attacks and strokes.

- Availability and affordability of quality, safe and efficacious **essential** noncommunicable disease **medicines, including generics, and basic technologies** in both public and private facilities.

- Vaccination coverage against **hepatitis B** virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants.

- Availability, as appropriate, if cost-effective and affordable, of **vaccines against human papillomavirus**, according to national programmes and policies.

- Policies to reduce the impact on children of **marketing of foods and non-alcoholic beverages** high in saturated fats, *trans*-fatty acids, free sugars, or salt.

- Access to **palliative care** assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.

- Adoption of national policies that limit **saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils** in the food supply, as appropriate, within the national context and national programmes.

2.    The comprehensive global monitoring framework, including the set of 25 indicators, will provide internationally comparable assessments of the status of noncommunicable disease trends over time, and help to benchmark the situation in individual countries against others in the same region, or in the same development category.

3.    In addition to the indicators outlined in this global monitoring framework, countries and regions may include other indicators to monitor progress of national and regional strategies for the prevention and control of noncommunicable diseases, taking into account country- and region-specific situations.

ANNEX 2

## VOLUNTARY GLOBAL TARGETS FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

Table 2 provides nine voluntary global targets for consideration by Member States. Achievement of these targets by 2025 would represent major progress in the prevention and control of noncommunicable diseases.

**Table 2. A set of voluntary global targets for the prevention and control of noncommunicable diseases**

| Mortality and morbidity | Indicator |
|---|---|
| **Premature mortality from noncommunicable disease** | |
| Target: A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases. | • Unconditional probability of dying between ages 30 and 70 from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases. |
| **Risk factors** | **Indicators** |
| *Behavioural risk factors:* | |
| **Harmful use of alcohol[1]** | |
| Target: At least a 10 % relative reduction in the harmful use of alcohol,[2] as appropriate, within the national context. | • Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context.<br>• Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context.<br>• Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context. |
| **Physical inactivity** | |
| Target: A 10% relative reduction in prevalence of insufficient physical activity. | • Prevalence of insufficiently physically active adolescents defined as less than 60 minutes of moderate to vigorous intensity activity daily.<br>• Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent). |
| **Salt/sodium intake** | |
| Target: A 30% relative reduction in mean population intake of salt/sodium intake.[3] | Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years. |

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[1] Countries will select indicator(s) of harmful use as appropriate to national context and in line with WHO's global strategy to reduce the harmful use of alcohol and that may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality among others.

[2] In WHO's global strategy to reduce the harmful use of alcohol the concept of the harmful use of alcohol encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

[3] WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per day.

| Tobacco use | |
| --- | --- |
| Target: A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years. | • Prevalence of current tobacco use among adolescents. <br><br> • Age-standardized prevalence of current tobacco use among persons aged 18+ years. |
| *Biological risk factors:* | |
| **Raised blood pressure** | |
| Target: A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances. | Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure $\geq$140 mmHg and/or diastolic blood pressure $\geq$90 mmHg). |
| **Diabetes and obesity[1]** | |
| Target: Halt the rise in diabetes and obesity. | • Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose value $\geq$7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose. <br><br> • Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex and obese – two standard deviations body mass index for age and sex). <br><br> • Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index $\geq$25 kg/m² for overweight and body mass index $\geq$30 kg/m² for obesity). |
| **National systems response** | **Indicator** |
| **Drug therapy to prevent heart attacks and strokes** | |
| Target: At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes. | Proportion of eligible persons (defined as aged 40 years and over with a 10-year cardiovascular risk $\geq$30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes. |
| **Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases** | |
| Target: An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities. | Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities. |

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[1] Countries will select indicator(s) appropriate to national context.