

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

Report by the Director-General

1. The report is submitted in response to decision WHA72(11) (2019), in which the Health Assembly requests the Director-General “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.” Table 1 sets out the corresponding elements of this report.

Table 1. Mandates from paragraph 3(e) in decision WHA72(11) for progress reports in this document.

Progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health, including the following topics and the mandating resolution or decision:	Location in this document
<ul style="list-style-type: none"> • resolution WHA53.17 (2000) on prevention and control of noncommunicable diseases • resolution WHA66.10 (2013) on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases • decision WHA72(11) on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases 	Paragraphs 2 to 43
<ul style="list-style-type: none"> • resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach 	Annex 1
<ul style="list-style-type: none"> • resolution WHA57.17 (2004) on the global strategy on diet, physical activity and health • resolution WHA71.6 (2018) on WHO’s global action plan on physical activity 2018–2030 	Annex 2
<ul style="list-style-type: none"> • resolution WHA65.6 (2012) on comprehensive implementation plan on maternal, infant and young child nutrition 	Annex 3

Progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health, including the following topics and the mandating resolution or decision:	Location in this document
<ul style="list-style-type: none"> • resolution WHA68.19 (2015) on outcome of the Second International Conference on Nutrition • decision WHA70(19) (2017) on report of the Commission on Ending Childhood Obesity: implementation plan • resolution WHA71.9 (2018) on infant and young child feeding 	
<ul style="list-style-type: none"> • resolution WHA68.8 (2015) on health and environment: addressing the impact of air pollution and decision WHA69(11) (2016) on the related road map 	Annex 4

2. In addition, in decision WHA72(11) (2019) the Health Assembly requests the Director-General to submit information about the following requested actions to the Seventy-fourth World Health Assembly, through the Executive Board. See Table 2.

Table 2. Further actions requested of the Director-General in decision WHA72(11) (2019)

Relevant paragraph	Action	Location in this document
3(a)	to propose updates to the appendices of WHO's comprehensive mental health action plan 2013–2030	Annex 5 Appendix 1 Appendix 2
3(f)	to provide further concrete guidance to Member States in order to strengthen health literacy through education programmes and population-wide targeted and mass- and social-media campaigns to reduce the impact of all risk factors and determinants of noncommunicable diseases	Annex 6
3(g)	to present, based on a review of international experiences, an analysis of successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address the social, economic and environmental determinants of such diseases	Annex 7
3(h)	to collect and share best practices for the prevention of overweight and obesity, and in particular to analyse how food procurement in schools and other relevant institutions can be made supportive of healthy diets and lifestyles in order to address the epidemic of childhood overweight and obesity and reduce malnutrition in all its forms	Annex 8
1 and paragraph 40 of United Nations General Assembly resolution 73/2 (2018)	to provide support for implementation of the following action: strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure to treat people living with noncommunicable diseases and prevent and control their risk factors in humanitarian emergencies	Annex 9

Relevant paragraph	Action	Location in this document
United Nations Economic and Social Council resolution 2014/10	to inform the World Health Assembly on a regular basis about progress made by the United Nations Inter-Agency Task Force for the Prevention and Control of Non-communicable Diseases in the implementation of the WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030.	Annex 10

3. Table 3 lists two other mandated evaluations, which are discussed briefly below (see paragraphs 45–47) and will be published separately.

Table 3. Two further mandated evaluations, with source of mandate and document number

Resolution WHA66.10 (2013)	Mid-point evaluation of the WHO's global action plan for the prevention and control of noncommunicable diseases	Document EB148/7 Add.1
Document A67/14 Add.1, Appendix 1, paragraph 19	Final evaluation of the Global coordination mechanism on the prevention and control of noncommunicable disease	Document EB148/7 Add.2

THE BURDEN OF NONCOMMUNICABLE DISEASES (NCDs): WHERE WE STAND TODAY¹

4. WHO's World health statistics 2020 reveal that, compared with the advances against communicable diseases, progress in preventing and controlling premature death from NCDs has been inadequate.

5. An estimated 41 million people worldwide died of NCDs in 2016, equivalent to 71% of all deaths. Four NCDs caused most of those deaths: cardiovascular diseases (17.9 million), cancer (9.0 million), chronic respiratory diseases (3.8 million), and diabetes (1.6 million).

6. An estimated 15 million people worldwide died of NCDs between the ages of 30 and 70 years, defined as premature death. The probability (risk) of premature death from any one of the four main NCDs decreased by 18% globally between 2000 and 2016. The most rapid decline was seen for chronic respiratory diseases (40% lower), followed by cardiovascular diseases and cancer (both 19% lower). Diabetes, however, showed a 5% increase in premature mortality during the same period.

7. Despite the rapid progress made between 2000 and 2010 in reducing the risk of premature death from any one of the four main NCDs, the momentum of change has dwindled during 2010–2016, with annual reductions in premature mortality rates slowing for the main NCDs. In high-income countries, even though the premature mortality rate due to diabetes decreased from 2000 to 2010, it increased in 2010–2016. In low- and middle-income countries, the premature mortality rate due to diabetes increased across both periods.

¹ WHO. World health statistics 2020: monitoring health for the SDGs. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332070>).

8. The rising mortality rates from diabetes are associated with – among other factors – the increasing prevalence of obesity. Since 2000, the prevalence of obesity among adults (18 years and older) globally has increased 1.5 times and the prevalence in children (5–18 years) more than doubled (from 2.9% to 6.8%) in 2016.

9. In 2016, the prevalence of physical inactivity for adults aged 18 years or more was 27.5%. Levels of inactivity are twice as high in high-income countries as in low-income countries, and insufficient activity increased by 5% in high-income countries between 2001 and 2016.

10. Global prevalence of hypertension decreased by 11% from 2000 to 2015. The prevalence of hypertension was highest in low-income countries (28.4%) and lowest in high-income countries (17.7%) in 2015.

11. Tobacco use has decreased steadily globally. A little under one quarter (23.6%) of adults (15 years and older) globally used tobacco in some form in 2018, down from one third (33.3%) in 2000. The total number of adult tobacco users remains very high, however: about 1.3 billion in 2018.

12. The burden of mental health conditions remains high. According to the latest global burden of disease estimates (for 2017), mental, neurological and substance use disorders make up 11.1% of disability-adjusted life years lost worldwide and 26.7% of years lived with disability (compared to 10.2% and 26.8% respectively in 2012), and an estimated 971 million people have a mental disorder (compared to 916 million people in 2012). Almost 800 000 people die by suicide each year; it is the second leading cause of death in 15–29-year-olds.

13. Worldwide, alcohol consumption, measured in litres of pure alcohol per person of 15 years or older, has been relatively stable since 2010 and was estimated at 6.2 litres in 2018. However, trends observed and projections made before the pandemic of coronavirus disease (COVID-19) forecast an increase in global alcohol consumption per capita by 2025. The impact of the COVID-19 pandemic on the levels of alcohol consumption worldwide and predicted trends still needs to be assessed.

14. In 2016, nine out of 10 people breathed air that did not meet the WHO air quality guidelines and more than half the world's population was exposed to air pollution levels at least 2.5 times above the safety standard set by WHO. Although the proportion of the global population with access to clean cooking fuels and technologies has increased steadily since 2000 and reached 63% in 2018, the actual number of people without clean cooking has remained relatively constant over the past three decades.

PROGRESS TOWARDS TARGET 3.4 OF SUSTAINABLE DEVELOPMENT GOAL AND RELATED TARGETS: WHERE WE STAND TODAY

15. Target 3.4 of Sustainable Development Goal 3 is to reduce premature mortality from NCDs by a third by 2030 relative to 2015 levels, and to promote mental health and well-being. Only 17 countries are on track to meet that target for women and 15 for men.¹ There is some reduction in the global

¹ NCD Countdown 2030 Collaborators. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. *The Lancet*, 2020; 396(10255):918-934 ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31761-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31761-X/fulltext), accessed 29 October 2020).

age-standardized suicide rate¹ (8% reduction from 2010 to 2016)² but the indicator (3.4.2) shows that the suicide rate is still far from achieving the target.

16. Target 3.8 is to achieve universal health coverage. All income categories of countries have demonstrated almost no progress since 2000 in expanding the “universal health coverage service capacity and access coverage” for the prevention, screening, early diagnosis and appropriate treatment of NCDs.³ In particular, between 2010 and 2019, many countries showed lagging performance on effective coverage indicators for NCDs compared with those for communicable diseases and maternal and child health, suggesting that many health systems are not keeping pace with the rising NCD burden. There is a growing awareness that global ambitions to accelerate progress towards universal health coverage are increasingly unlikely to be realized without concerted action on NCDs.⁴

17. Overweight among children has shown a concerning upward trend. Worldwide, an estimated 5.6% – or 38.3 million children under five years of age – were overweight in 2019, compared with about 30.3 million in 2000.

18. Target 3.5 is to strengthen the prevention and treatment of substance abuse, including the harmful use of alcohol, which is a risk factor for NCDs and other health conditions. Since 2010 little progress has been made in reducing the harmful use of alcohol, and development and implementation of effective alcohol control measures have been uneven between countries and WHO regions.

19. Target 3.a is to strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, where progress is measured by the age-standardized prevalence of current tobacco use among persons aged 15 years and older. WHO estimates that the prevalence of current tobacco use among persons aged 15 years and older has declined globally since 2015, from 24.9% in 2015 to 23.6% in 2018.⁵ However, the implementation progress has been uneven for different articles of the Convention. Only 32 Member States are currently on track to achieve WHO’s voluntary target of a relative reduction in tobacco use prevalence of 30% between 2010 and 2025.

20. Over the past decade, the number of countries monitoring and reporting on air quality (indicator 11.6.2 on annual mean levels of fine particulate matter) has improved. Globally, the population exposed

¹ WHO. Mental health atlas 2017. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/272735>).

² WHO (https://www.who.int/gho/publications/world_health_statistics/2020/EN_WHS_2020_Main.pdf?ua=1, accessed 29 October 2020).

³ WHO. Primary health care on the road to Universal Health Coverage: 2019 Monitoring report. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1, accessed 29 October 2020).

⁴ GBD 2019 Universal Health Coverage Collaborators. Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, 2020; 396(10258):1250-1284 ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30750-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30750-9/fulltext), accessed 29 October 2020).

⁵ WHO. The Global Health Observatory. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/age-standardized-prevalence-of-current-tobacco-smoking-among-persons-aged-15-years-and-older>, accessed 7 December 2020).

to PM_{2.5} levels above the current WHO air quality guidelines (annual average of 10 µg/m³) has fallen by 4%, from 94% in 2010 to 90% in 2016.¹

21. In 2018, 63% (range 56–68%) of the global population had access to clean cooking fuels and technologies, leaving the global population without such access at 2.8 billion people,² a figure unchanged for around two decades now (indicator 7.1.2 on proportion of population with primary reliance on clean fuels and technology). Without prompt action, universal access will fall short of the relevant Goals by almost 30%.

22. In a growing recognition of air pollution as a public health threat, countries are scaling up commitments to implement air quality policies and to align climate and air quality. At the 2019 Climate Action Summit, 50 countries with in total more than one billion people committed themselves to reach WHO air quality guideline values and align climate and air quality policies by 2030.

23. For the poorest one billion people of the world, NCDs account for more than a third of their burden of disease. That includes almost 800 000 deaths annually among those aged younger than 40 years, more than HIV, tuberculosis and maternal deaths combined.

THE COVID-19 PANDEMIC: A DEADLY INTERPLAY WITH THE NCD EPIDEMIC

24. In May 2020, WHO conducted a rapid assessment survey of the impact of the COVID-19 pandemic on NCD resources and services,³ to which 163 Member States (84%) responded. In 122 countries, governments are collecting or collating data on comorbidities between persons infected with SARS-CoV-2 and persons living with NCDs. The Secretariat is analysing the data in order to derive global estimates on these comorbidities. Initial results seem to indicate that persons living with hypertension and/or diabetes appear to be two-to-four times more vulnerable to becoming severely ill with or die from the virus. People living with obesity or using tobacco may be suffering from undiagnosed or untreated hypertension or diabetes, which may be one of the reasons for a differential social impact of COVID-19 within countries.

25. More than 80 countries reported complete or partial disruptions to management services for people with hypertension or diabetes and diabetic complications. Countries most commonly reported that they used triaging in response to the disruptions to NCD-related services; telemedicine was also very widely used. However, the disruption of health services is particularly problematic for those living with NCDs who need regular care.

26. Several examples from countries show how the disruption of NCD services has directly affected people. Screening, case identification and referral systems for cancer have all been affected by the COVID-19 pandemic, resulting in a substantial decrease in cancer diagnoses. The fact that fewer patients with acute coronary syndrome are admitted to hospital often means increases in out-of-hospital deaths and long-term complications of myocardial infarction. The Secretariat is conducting a modelling

¹ Shaddick G, Thomas ML, Mudu P, Ruggeri G, Gumy S. Half the world's population are exposed to increasing air pollution. *npj Climate and Atmospheric Science* 2020; 3:23 (<https://doi.org/10.1038/s41612-020-0124-2>, accessed 7 December 2020).

² United Nations, Department of Economic and Social Affairs, Statistics Division. Ensure access to affordable, reliable, sustainable and modern energy for all (<https://unstats.un.org/sdgs/report/2020/goal-07/>, accessed 7 December 2020).

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://apps.who.int/iris/handle/10665/334136>).

exercise to forecast the long-term upsurge in premature deaths from NCDs resulting from the disruption of health services.

27. WHO's interim operational guidance on maintaining health services in the COVID-19 context includes considerations for NCDs, mental health and nutrition.¹ The joint policy brief on responding to NCDs during and beyond the COVID-19 pandemic provides examples of NCD-specific actions that could be considered in the development of national COVID-19 response and recovery plans.²

28. In September 2020, the United Nations General Assembly in its resolution 74/306 on a comprehensive and coordinated response to the COVID-19 pandemic called upon Member States "to further strengthen efforts to address non-communicable diseases as part of universal health coverage, recognizing that people living with non-communicable diseases are at a higher risk of developing severe COVID-19 symptoms and are among the most impacted by the pandemic".³

THE COVID-19 PANDEMIC: RESPONDING TO THE MENTAL HEALTH, NEUROLOGICAL AND SUBSTANCE USE CONSEQUENCES

29. The COVID-19 pandemic is profoundly affecting mental health and well-being. Mental and neurological manifestations, such as depression, anxiety and delirium/encephalopathy, are reported in COVID-19 patients. Many people with pre-existing mental, neurological and substance use disorders are facing exacerbation of symptoms due to stressors, while the limited available services are disrupted. Some people cope with stressors in harmful ways such as turning to alcohol, drugs or risky patterns of potentially addictive behaviours, including video gaming and gambling. Adversity is a potent risk factor for mental and behavioural disorders, such as depression and alcohol use disorders.

30. The Secretariat has assessed the impact of COVID-19 on services for mental, neurological and substance use disorders through a rapid survey between June and August 2020.⁴ Out of 130 countries, 121 (93%) countries reported disruptions in one or more of their services for these disorders and 116 (89%) reported that mental health and psychosocial support was part of their national COVID-19 response plans. Countries are responding to the disruptions through teletherapy interventions (70%), crisis hotlines (68%) and training for health-care providers (60%). The General Assembly resolution 74/306 encouraged Member States "to address mental health in their response to and recovery from the pandemic by ensuring widespread availability of emergency mental health and psychosocial support".

31. The Secretariat is coordinating different pillars of its COVID-19 response to integrate mental health and psychosocial support into the COVID-19 response effort.⁵ WHO co-chairs the Inter-Agency

¹ WHO. Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance, 1 June 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332240>).

² WHO, United Nations Development Programme. Responding to non-communicable diseases during and beyond the COVID-19 pandemic. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/334145>).

³ United Nations General Assembly, resolution 74/306 (2020), Comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic: operative paragraph 9.

⁴ WHO. The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/335838>).

⁵ Tedros AG. Addressing mental health needs: an integral part of COVID-19 response. *World Psychiatry* 2020; 19(2):129-130 (<https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20768>, accessed 30 October 2020).

Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings. A wide range of resources, available in numerous languages and formats, has been developed by WHO and its partners.¹ WHO established the Global Forum on Neurology and COVID-19 in order to exchange knowledge and enhance clinical practices.

BUILDING BACK BETTER

32. Over the past 20 years, NCDs have changed the world. They have become the leading cause of death in most countries, resulting in 200 million premature deaths among people aged between 30 and 70 years, most living in low- and middle-income countries. During the next 10 years, another 150 million people will die from NCDs between the ages of 30 and 70 years. Most deaths can be avoided or delayed.

33. In adopting resolution WHA53.17 in 2000, the Health Assembly recognized for the first time that the long-term needs of people living with NCDs are rarely dealt with. Accordingly, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2011 included a commitment from governments to explore the provision of adequate resources through, inter alia, domestic and bilateral channels. In 2016, NCDs represented 27% of domestic public spending and 9% of external funds for health across a dataset including 16 low-income countries and 24 middle-income countries.² Today, NCDs remain the largest, most internationally-underfunded public health issue globally, where most lives could be saved or improved.

34. Bilateral donors have not shown increased appetite for funding activities specifically earmarked as addressing NCDs to establish even the minimal critical capacity, mechanisms and mandates needed in low- and middle-income countries to pursue change. In the absence of such funding, groups with economic, market and commercial interests stepped up their efforts to lobby against implementation of interventions by WHO, discrediting WHO's scientific knowledge, available evidence and reviews of international experience, and bringing legal challenges against countries to oppose progress.³

35. The response to the COVID-19 pandemic must address precisely these failures that are being exposed and exploited by the pandemic. Investment in the prevention and control of NCDs as part of COVID-19 recovery is attractive, as cost-effective, high-impact interventions already exist but are not sufficiently implemented and scaled up in low- and middle-income countries. Tackling NCDs in general must be an integral part of the immediate response to COVID-19 and of the recovery at global, regional and national levels, as well as part of the strategies to build back better.

36. Pathway analyses show that every country still has options today for achieving target 3.4 of Sustainable Development Goal 3. No country could achieve the target by addressing only prevention or only counselling, screening, early diagnosis and appropriate treatment of NCDs.

¹ WHO. Mental health & COVID-19 (<https://www.who.int/teams/mental-health-and-substance-use/covid-19>, accessed 30 October 2020).

² WHO. Public spending on health: a closer look at global trends. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/276728>), p. 29.

³ Seventy-first World Health Assembly. Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018: report by the Director-General. Geneva: World Health Organization; 2018. Document A71/14, Table 5, row (v) (<https://apps.who.int/iris/handle/10665/276368>).

37. The final report of WHO's Independent High-level Commission on Non-communicable Diseases¹ recommended a specific set of the most effective and feasible interventions that should be considered as a priority to accelerate progress towards target 3.4, reducing premature mortality from NCDs by one third (Table 4).

Table 4. Interventions against specific risk factors and diseases

	Risk factor or disease²	Interventions
1	Tobacco use	<ul style="list-style-type: none"> • WHO mPOWER policy package³
2	Excess sodium consumption	<ul style="list-style-type: none"> • WHO SHAKE technical package
3	Cervical, liver, colon and other cancers	<ul style="list-style-type: none"> • Hepatitis B and human papillomavirus vaccination • Detection, screening and treatment of cervical and preventable or treatable cancers
4	Hypertension	<ul style="list-style-type: none"> • WHO HEARTS technical package for cardiovascular disease
5	Household air pollution	<ul style="list-style-type: none"> • World Bank: Household Energy for Cooking: Project Design Principles • WHO Guidelines for indoor air quality: household fuel consumption
6	Consumption of industrially-produced trans-fatty acids	<ul style="list-style-type: none"> • WHO REPLACE action package • WHO protocol for measuring trans-fatty acids in foods
7	Harmful use of alcohol	<ul style="list-style-type: none"> • Taxation; limitation of places and hours of sale; restrictions on marketing, promotion, and sponsorships

38. The report of the WHO/The Lancet's NCD Countdown 2030 in 2020 showed that essential components of any strategy to achieve target 3.4 of Goal 3 must include control of tobacco use and of the harmful use of alcohol, detection and treatment of hypertension and diabetes, primary and secondary prevention of cardiovascular diseases in high-risk individuals through multidrug treatment, and bronchodilators and low-dose inhaled corticosteroids for asthma and selected patients with chronic obstructive pulmonary disease.⁴

39. Progress in noncommunicable diseases towards relevant targets needs a major boost. The Secretariat is scaling up its programme on NCDs. The immediate aim is to catalyse tangible progress towards target 3.4 within the next three years, especially through new and bold innovative solutions that have a multiplier effect across the Sustainable Development Goals.

¹ WHO. WHO Independent high-level commission on noncommunicable diseases: final report: it's time to walk the talk. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/330023>).

² Physical inactivity is not included, owing to lack of adequate data.

³ Derived from key demand reduction measures in the WHO Framework Convention on Tobacco Control, thus supporting the achievement of SDG target 3.a.

⁴ NCD Countdown 2030 collaborators. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. *The Lancet*, 2020; 396(10255):918-934 (<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931761-X>, accessed 7 December 2020).

40. A major contribution to attaining target 3.4 will come from WHO's new initiative to eliminate cervical cancer in the next 100 years and reaching the 90-70-90 triple-intervention target by 2030:

- 90% of girls fully vaccinated against human papillomavirus by the age of 15 years;
- 70% of women screened using a high-performance test by the age of 35 years and again by the age of 45 years;
- 90% of women identified with cervical disease receive treatment (90% of women with pre-cancer treated and 90% of women with invasive cancer managed).

41. The Secretariat will develop similar strategic cross-cutting initiatives for diabetes, childhood cancer and breast cancer.

42. The current capacities for NCD surveillance remain inadequate in many countries and urgently require strengthening. Currently, many countries have few usable mortality data and weak information on risk factor exposure and morbidity. Data on NCDs are often not well integrated into national health information systems. Improving country-level surveillance and monitoring remains a top priority in the fight against NCDs. The Secretariat will continue to support the scaling up of national efforts to strengthen NCD surveillance and data systems, and expand the provision of strategic information for policy-making, service provision and accountability.

43. Other organizations in the United Nations system are also committed to aligning their relevant activities with the comprehensive United Nations response to COVID-19, for example through: (i) raising national awareness on the return on investment in NCD prevention and treatment so as to secure domestic budgetary allocations and international finance; (ii) supporting countries in including NCDs into their socioeconomic plans for the COVID-19 response; and (iii) participating in the WHO Working Group on COVID-19 and NCDs. The United Nations Inter-Agency Task Force on the Prevention and Control of NCDs and the Global Action Plan for Healthy Lives and Well-being for All continue to provide important platforms for many United Nations organizations to work through.

PREPARATORY PROCESS LEADING TO THE FOURTH HIGH-LEVEL MEETING OF THE UNITED NATIONS GENERAL ASSEMBLY ON THE PREVENTION AND CONTROL OF NCDs IN 2025

44. Table 5 sets out the process and scheduled meetings in preparation for the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. Outcomes will serve as an input into the process.

Table 5. Meetings planned to prepare for the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

2021
<ul style="list-style-type: none"> • Second WHO global dialogue on financing national NCD responses • Ninth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control • Second Session of the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products
2022

<ul style="list-style-type: none"> • Third WHO global meeting of national NCD Programme Directors and Managers
2023
<ul style="list-style-type: none"> • First WHO global ministerial conference for Small Island Development States on the prevention and control of NCDs • Tenth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control • Third Session of the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products
2024
<ul style="list-style-type: none"> • Third WHO global ministerial conference on the prevention and control of NCDs
2025
<ul style="list-style-type: none"> • United Nations dialogue with civil society and the private sector • Fourth high-level meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

EVALUATIONS

45. In accordance with paragraph 60 of the Global action plan for the prevention and control of noncommunicable diseases 2013–2020, in 2019 the Secretariat convened a representative group of stakeholders, including Member States and international partners, to conduct a mid-point evaluation of implementation of the global action plan. Its purpose was to assess progress towards the six objectives of the global action plan and identify the lessons learned throughout its implementation by Member States, by international partners and by the three levels of the Organization. The evaluation aimed to document successes and identify challenges and gaps in the implementation of the global action plan since 2013; to make strategic recommendations for improving implementation up until 2030; and to provide inputs into WHO's next global status report on noncommunicable diseases and other relevant reports. The Secretariat's Evaluation Office will submit an executive summary of the mid-point evaluation to the Seventy-fourth World Health Assembly, through the Executive Board (see document EB148/7 Add.1).

46. As specified in the terms of reference for the Global coordination mechanism on the prevention and control of noncommunicable diseases,¹ a final evaluation of the mechanism took place in 2020 in order to assess its effectiveness, its added value and its continued relevance to the achievement of the 2025 voluntary global targets, including its possible extension. The Evaluation Office will submit an executive summary of the final evaluation to the Seventy-fourth World Health Assembly, through the Executive Board (see document EB148/7 Add.2).

47. In line with the terms of reference of the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs, the evaluation of its contribution to the implementation of WHO's Global Action plan was described in the mid-point evaluation of that plan.

¹ Document A67/14 Add.1, Appendix 1.

ACTION BY THE EXECUTIVE BOARD

48. The Board is invited:

- to note the report and its annexes;
- to provide guidance on the continued relevance of WHO's Global action plan for the prevention and control of noncommunicable diseases and on any corrective measures which may be taken where actions have not been effective, and to reorient parts of the plan, as appropriate, in response to the 2030 Agenda on Sustainable Development and/or the United Nations Comprehensive Response to COVID-19, as appropriate;
- to provide guidance on the continued relevance of WHO's Global coordination mechanism for the prevention and control of noncommunicable diseases and the possible extension of its lifespan, taking into account the evaluation mentioned in paragraph 46, and decision WHA72(11) (2019), which extended the lifespan of WHO's Global action plan for the prevention and control of non-communicable diseases 2013–2020 to 2030.

49. The Board is further invited to consider the following draft decision:

The Executive Board, having considered the report of the Director-General on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,¹ decided to recommend to the Seventy-fourth World Health Assembly the adoption of the following decision:

The Seventy-fourth World Health Assembly, having considered the report of the Director-General, decided to adopt the proposed updates to the appendices of WHO's comprehensive mental health action plan 2013–2030 (contained in document EB148/7, Annex 5, appendices 1 and 2).

¹ Document EB148/7.

ANNEX 1

CANCER PREVENTION AND CONTROL IN THE CONTEXT OF AN INTEGRATED APPROACH

1. In 2017, the Seventieth World Health Assembly adopted resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach and requested the Director-General: to develop, before the end of 2019, the first periodic public health- and policy-oriented world report on cancer; to prepare a comprehensive technical report on pricing approaches and their impact on the availability and affordability of cancer medicines; to develop tool kits to establish and implement comprehensive cancer prevention and control programmes; to strengthen the capacity of the Secretariat both to support the implementation of cost-effective interventions and country-adapted models of care and to work with international partners; and to provide technical assistance, including support for the establishment of centres of excellence. This annex describes progress made in implementing the resolution.

2. The Secretariat has undertaken the following activities.

3. **WHO report on cancer.**¹ The report and accompanying cancer country profiles² were launched on World Cancer Day (4 February 2020), in coordination with the launch by the International Agency for Research on Cancer of its World Cancer Report on cancer research for cancer prevention. The content of both documents was harmonized.

4. The WHO report included an investment case for cancer, in line with the mandate from resolution WHA70.12, that demonstrated every US\$ 1 invested in cancer control yields a full social return based on both direct productivity and societal gains of US\$ 9.50. By investing US\$ 2.70 per person in low-income countries, US\$ 3.95 per person in lower-middle-income countries and US\$ 8.15 per person in upper-middle-income countries, an additional 7.3 million lives could be saved by 2030.

5. **Technical report on cancer medicine pricing approaches.** The requested comprehensive technical report on pricing of cancer medicines and its impacts was submitted to and noted by the Executive Board at its 144th session.³ In 2020 WHO updated the WHO guideline on country pharmaceutical pricing policies to support national policy development and implementation.⁴

6. **Toolkit for cancer prevention and control.** Among its multiple toolkits to support Member States with cancer policy formulation and guidance, WHO, working with the International Agency for

¹ WHO. WHO report on cancer: setting priorities, investing wisely and providing care for all. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/330745>).

² WHO cancer country profiles. Geneva: World Health Organization; 2020 (<https://www.who.int/cancer/country-profiles/en/>, accessed 30 October 2020).

³ Technical report: pricing of cancer medicines and its impacts: a comprehensive technical report for the World Health Assembly Resolution WHA70.12 (2017): operative paragraph 2.9 on pricing approaches and their impacts on availability and affordability of medicines for the prevention and treatment of cancer. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/277190>) and document EB144/2019/REC/2, summary records of the tenth meeting.

⁴ WHO. WHO guideline on country pharmaceutical pricing policies, 2nd ed. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/335692>).

Research on Cancer, has developed one that is linked to the OneHealth tool.¹ It allows for stepwise and resource-stratified scale-up in cancer prevention and control for adult and childhood cancers. It provides evidence on the most cost-effective interventions for all age groups and has been used to support five Member States in implementing cancer interventions.

7. WHO, working with the International Atomic Energy Agency, issues guidance, providing a framework for Member States to establish comprehensive cancer centres.

8. **Technical support to countries.** The Secretariat has provided broad technical support to Member States in the development and formulation of comprehensive programmes and policies on cancer prevention and control.

9. WHO collaborated with the International Atomic Energy Agency to support countries in enabling radiotherapy procurement by prioritizing radiotherapy technology aligned with health system capacity. Technical specifications for radiotherapy were jointly developed as part of inter-agency guidance on technical specifications for radiotherapy equipment in cancer treatment.

10. WHO has also worked with the International Atomic Energy Agency to increase coordination and support provided to Member States participating in an “imPACT review”. The imPACT methodology has been revised to improve the service and to provide more effective and coordinated support to Member States, including broad partner collaboration.

11. **Elimination of cervical cancer.** In resolution WHA73.2 (2020), the Seventy-third World Health Assembly adopted the global strategy to accelerate the elimination of cervical cancer as a public health problem. The global strategy outlines the 90-70-90 targets to be reached by 2030, on the basis of human papillomavirus vaccination, screening, and treatment of pre-invasive and invasive cancers, including palliative care. For the third target of the global strategy (the appropriate management of 90% of women identified with invasive cervical cancer), the Secretariat is preparing a framework for strengthening and scaling-up services for the management of invasive cervical cancer.

12. **WHO global initiative for childhood cancer.** In September 2018, this global initiative was launched. It aims to double the probabilities of survival from childhood cancer, which would save one million more lives by 2030, by improving access to and quality of services including treatment and palliative care. A technical package, *CureAll*, will be launched in 2021. Support to Member States has started in 12 countries.²

13. **Collaboration with stakeholders.** The Secretariat has strengthened engagement with broad multisectoral stakeholders within and beyond existing WHO initiatives. This has included enhanced coordination between the International Agency on Cancer Research and WHO at the management and working levels, as reflected in the development of standard operating procedures and routine communication on IARC Handbooks of Cancer Prevention.³

¹ OneHealth Tool. Geneva: World Health Organization; 2020 (<https://www.who.int/choice/onehealthtool/en/>, accessed 30 October 2020).

² Ghana, Mali, Morocco, Myanmar, Pakistan, Peru, Philippines, Senegal, Timor-Leste, Ukraine, Uzbekistan and Zambia.

³ Coordination and Communication Mechanisms between IARC and WHO – at management and working levels. Governing Council, Sixtieth Session (document GC/60/13). Lyon: International Agency for Research on Cancer; 2018 (https://governance.iarc.fr/GC/GC60/En/Docs/GC60_13_CoordinationWHO.pdf, accessed 30 October 2020).

14. The Secretariat has strengthened capacity, as requested, by increasing the number of staff working on cancer prevention and control, with more than 20 new staff positions and consultancy posts, equally distributed among all levels of the Organization. The result has been increased intensity and frequency of support to Member States.

15. The Secretariat will continue to support Member States in their efforts to prevent, identify and address cancer prevention and control through integrating cancer care within noncommunicable diseases policies and programmes and broader work to strengthen national health systems as part of universal health coverage.

ANNEX 2

GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH AND GLOBAL ACTION PLAN ON PHYSICAL ACTIVITY 2018–2030

1. This annex sets out the progress made in implementing resolutions WHA57.17 (2004) on global strategy on diet, physical activity and health and WHA71.6 (2018) on global action plan on physical activity 2018–2030.

GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH: PROGRESS TO DATE

2. To support Member States in implementing the set of recommendations on physical activity, the Secretariat produced a series of supporting global technical resources. In addition, regional technical tools and resources supported policy action across key settings and populations.

3. In 2010, WHO launched the first global recommendations on physical activity for health¹ outlining the substantial range of health benefits of regular physical activity for different age groups. These guidelines affirmed the substantial health benefits of regular physical activity for healthy growth and development, prevention of leading noncommunicable diseases and injuries, and improvement of mental health and well-being.

4. In 2013, the Health Assembly agreed the first global target to reduce physical inactivity by 10% by 2025 as part of the set of nine voluntary targets to reduce noncommunicable disease by 2025.² The global action plan for the prevention and control of noncommunicable diseases 2013–2020 had identified public awareness campaigns as a cost-effective intervention (“best buy”), and in 2017 an updated set of best buys identified an extended set of effective interventions³ to increase population levels of physical activity across the life course.

5. In all regions, technical support and multi-country training were developed and capacity-building workshops conducted, resulting in an increasing number of countries developing national policies or plans and surveillance. In addition, countries across all regions commenced, or updated, their surveillance of physical activity in adults and, to a lesser extent, adolescents.

6. Although in all WHO regional offices limited human and financial capacity dedicated to physical activity constrained the pace and scale of technical assistance to countries, the Regional Office for

¹ WHO. Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (<https://apps.who.int/iris/handle/10665/44399>).

² Resolution WHA66.10 (2013).

³ WHO. Tackling NCDs: “best buys” and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/259232>).

Europe developed a regional strategy on physical activity for the period 2016–2025¹ and the Regional Office for the Eastern Mediterranean issued a regional call for action.²

7. In 2016, the Commission on Ending Childhood Obesity reaffirmed the importance of addressing physical inactivity in children, especially young children.³ Its subsequent implementation plan⁴ called for countries to prioritize and strengthen the promotion of physical activity to children through schools and child care, to parents and families, and through supportive urban design and transport systems.

8. Throughout the period 2004–2016, the global strategy contributed to increased recognition globally of the importance of regular physical activity. Overall, however, the impact on the development and implementation of national policy and approaches was slow and uneven, and mostly limited to high-income countries. Rising concerns about the lack of progress in reducing levels of physical inactivity and the apparent widening of disparities prompted the request for a global action plan on physical activity, drawing on the latest scientific evidence on effective approaches and aligned with the goals of the 2030 Agenda for Sustainable Development.

GLOBAL ACTION PLAN ON PHYSICAL ACTIVITY 2018–2030: PROGRESS TO DATE

9. In resolution WHA71.6 (2018), the Seventy-first World Health Assembly endorsed the global action plan on physical activity 2018–2030, which provided an updated set of 20 evidence-based policy recommendations for accelerating progress towards the interim 2025 target, namely a 10% improvement in physical activity.

10. The Health Assembly requested five specific actions: (1) implementation of the actions for the Secretariat in the global action plan, including providing necessary support to Member States for implementation of the plan, in collaboration with other relevant partners; (2) finalization of a monitoring and evaluation framework on the implementation of the global action plan; (3) production of a global status report on physical activity, building on the latest evidence including that on sedentary behaviours; (4) updating the global recommendations on physical activity for health 2010; and (5) reporting on progress made in implementing the global action plan to the Health Assembly in 2021, 2026 and 2030. The following paragraphs respond to that request and outline key priorities for the remainder of the biennium 2020–2021 and challenges and opportunities for promoting physical activity.

¹ WHO Regional Office for Europe. Physical activity strategy for the WHO European Region 2016–2025. World Health Organization. Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/329407>).

² WHO Regional Office for the Eastern Mediterranean. Promoting physical activity in the Eastern Mediterranean Region through a life-course approach. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2014 (<https://apps.who.int/iris/handle/10665/116901>).

³ See decision WHA69(12) (2016).

⁴ Welcomed by the Health Assembly in decision WHA70(19) (2017). Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/275415>).

Responding to requests from Member States to support national efforts for implementing the recommendations of the global action plan

11. In 2018, WHO launched ACTIVE: a technical package on effective interventions to promote physical activity.¹ It provides guidance for Member States on how to plan, start and scale up the implementation of the policy recommendations across the four strategic areas of the global action plan, including strengthening governance and national policy frameworks and multisectoral collaboration.

12. Technical support on how to reduce disparities in physical activity between subpopulations will be described in modules on promoting physical activity to older adults, people living with disabilities or chronic disease, and strengthening community sport-health initiatives and partnerships.

13. At the regional level, tools and resources to support Member States' actions on physical activity and for sharing regional best practices have also been developed in priority areas including: communication campaigns, health-promoting schools, counselling in primary health care, workplaces, healthy ageing, and healthy cities.

14. Training courses have been held to strengthen skills and knowledge on physical activity within context of health promotion and/or NCD prevention programmes at the global, regional and national levels. Often these have been conducted in collaboration with WHO collaborating centres and supported by stakeholders; during 2018–2019 more than 100 countries have participated.

15. New global comparative analyses of levels and trends in physical activity estimated that in 2016 one quarter of adults and three quarters of adolescents did not meet global recommendations, with negligible improvements since 2001.² Furthermore, gender disparities between men and women, and boys and girls, appeared to be widening.

Updating the global recommendations on physical activity for health 2010

16. In 2019–2020, the Secretariat completed the requested updating of the global recommendations from 2010. The work was supported by a 27-member Guideline Development Group and included a web-based public consultation.

17. WHO's new guidelines on physical activity and sedentary behaviour³ have been finalized for children and adolescents (aged 5–17 years), adults (18–64 years), older adults (65 years and above) and include, for the first time, specific recommendations on physical activity in subpopulations such as pregnant women and those living with chronic conditions or disability. The guidelines are thus aligned with the goals of the global action plan. The global launch took place on 25 November 2020.⁴

¹ WHO. ACTIVE: a technical package for increasing physical activity. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/275415>).

² WHO. The Global Health Observatory: noncommunicable diseases: risk factors (https://www.who.int/gho/ncd/risk_factors/physical_activity/en/, accessed 2 November 2020).

³ WHO. WHO guidelines on physical activity and sedentary behaviour. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/336656>).

⁴ WHO. Every move counts towards better health – says WHO (<https://www.who.int/news/item/25-11-2020-every-move-counts-towards-better-health-says-who>, accessed 7 December 2020).

18. To support preparation and accelerate country adoption of the new global guidelines, virtual workshops were held in each of WHO's six regions (June–July 2020), bringing together more than 67 Member States responsible for national guideline development across multiple ministries. The workshops and piloting of the adoption framework will support Member States to develop or update their national physical activity guidelines.

Developing a global monitoring and evaluation framework to track progress on implementation of a global action plan

19. In developing a monitoring and evaluation framework the Secretariat has included identification, where possible, of existing indicators and data sources suitable for tracking progress on implementation of the 20 policy recommendations (see paragraph 9 of this annex). Consultation with Member States and relevant stakeholders began with an expert meeting in November 2018 and continues, for instance with organizations in the United Nations development system, particularly United Nations Development Programme, United Nations Educational, Scientific and Cultural Organization and United Nations Human Settlements Programme (UN-Habitat), to ensure alignment with other relevant monitoring frameworks and Sustainable Development Goals.

20. The framework, comprising a set of process, outcome and impact indicators, is scheduled for publication as a technical report on the WHO website by the end of 2020.

Global status report on physical activity

21. Preparation of the requested first global status report on physical activity began in parallel with work on the monitoring and evaluation framework. During 2019–2020 relevant data, including those from WHO's global survey in 2019 of national capacity for NCD prevention and control¹ and WHO's road safety survey 2018,² were analysed.

22. Workplans for 2020, including proposed global and regional consultations, collection and launch (scheduled for December 2020) of country best practice case studies, have been heavily disrupted by COVID-19. Consequently, the publication of this report has been postponed to 2021 to allow for full engagement of all relevant stakeholders.

23. The emerging findings reaffirm that progress on physical activity remains modest and uneven in reach and scale between and within regions. Further, the rate of country implementation suggests that continuing a “business as usual” approach is unlikely to achieve the global target of a 15% reduction in the global prevalence of physical inactivity by 2030. Impediments to implementing recommended, cost-effective actions at national and subnational levels must be identified and mitigated in order to accelerate global progress and impact.

Major obstacles to increasing physical activity

24. Impediments identified across all regions include: (1) a lack of prioritization of policy on physical activity within and beyond the health sector; (2) lack of human and financial resources within the

¹ WHO. Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2019 global survey. Geneva: World Health Organization 2020 (<https://apps.who.int/iris/handle/10665/331452>).

² WHO. Global status report on road safety 2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/276462>).

Secretariat and countries to develop, disseminate and implement policy actions on physical activity; (3) weak capacity to integrate approaches across multiple sectors and implement whole-of-system approaches; and (4) insufficient capacity to engage and sustain civil society, research communities and other key partners at national and subnational levels, particularly between health and relevant authorities for sport, transport, urban planning, design and environment.

Accelerating increases in physical activity

25. In most Member States multiple opportunities exist to strengthen and accelerate actions aimed at retaining or increasing physical activity, particularly through walking and cycling, with the achievement of multiple other policy priorities. Areas of strong policy alignment include: healthy ageing; road safety; climate change mitigation; air quality; environmental sustainability; liveable cities and communities; and reduction of inequalities.

26. To support the scaling up of country efforts, WHO has strengthened partnership with stakeholders, including the sport and technology sectors, and established dialogues with the relevant private sector operators¹ to engage and align their efforts towards achieving common goals of the global action plan.

27. Progress in implementation of the global action plan can also be accelerated by increased investment in the promotion of physical activity to youth and adolescents; expansion of workforce capacity and skills in the promotion of physical activity; strengthening national multisectoral coordination; investment in research and knowledge transfer, particularly in low- and middle-income countries; and removing social, environmental and economic barriers to participation.

Impact of COVID-19 on physical activity and responses

28. COVID-19 has had an unprecedented impact on how, where and for how long people can be physically active. Ensuring that the importance and protective benefits of physical activity on mental and physical health are recognized in countries' responses to COVID-19 is vital, as is securing the inclusion of policies that embed equitable opportunities for physical activity in strategies to "build back better".

¹ WHO. Engagement with the private sector for SDG target 3.4 on NCDs and mental health (<https://www.who.int/ncds/governance/private-sector/en/>, accessed 9 November 2020).

ANNEX 3

ENDING ALL FORMS OF MALNUTRITION

1. Sustainable Development Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture) has set the ambitious targets to eliminate all forms of malnutrition by the year 2030. The Health Assembly has been concerned about nutrition since its early years. In the past two decades it has dealt with unhealthy diets through the global strategy on diet, physical activity and health, endorsed in 2004 (resolution WHA57.17); all forms of malnutrition through the comprehensive implementation plan on maternal, infant and young child nutrition, endorsed in 2012 (resolution WHA65.6 and later resolution WHA71.9 (2018) on infant and young child feeding); and the implementation plan of the Commission on Ending Childhood Obesity, welcomed in 2017 (decision WHA70(19)). The Health Assembly also endorsed the Rome Declaration, the outcome of the Second International Conference on Nutrition in 2014 (resolution WHA68.19 (2015)), and progress on its implementation has subsequently been reported biennially, together with the progress on the United Nations Decade of Action on Nutrition, 2016–2025.
2. This annex provides an overview of the progress in the global nutrition situation and the policy response and reports more specifically on the outcomes of the Second International Conference on Nutrition. Progress in implementing resolutions WHA65.6 (2012) and WHA71.9 (2018) and decision WHA70.19 (2017) are reported in greater detail in the biennial reports delivered in even years.

PROGRESS IN ACHIEVING GLOBAL TARGETS ON DIET AND NUTRITION

3. The concept of “all forms of malnutrition” is reflected in the global nutrition targets established by the Health Assembly in 2012 (resolution WHA65.6),¹ which cover child wasting, stunting and overweight; anaemia in women of reproductive age; low birth weight; and exclusive breastfeeding. The first four targets are included in the formal monitoring system for the Sustainable Development Goals. In addition, in 2013 the Health Assembly endorsed the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and adopted its nine voluntary global targets for 2025 in resolution WHA66.10 (2013), including the targets of halting the rise in diabetes and obesity and reducing the intake of salt/sodium.
4. The prevalence of adult obesity continues to rise in all WHO regions, from 11.8% in 2012 to 13.1% in 2016, so that the global target to halt the rise in obesity by 2025 is unlikely to be achieved. Excessive salt consumption is still responsible for an estimated three million deaths from heart disease, stroke and related causes.
5. In addition, in 2019, before the COVID-19 pandemic, almost 690 million people (8.9% of the global population) were undernourished and two billion people (25.9% of the global population) experienced hunger or did not have regular access to nutritious and sufficient food.

¹ Document WHA65/2012/REC/1, Annex 2 (Comprehensive implementation plan on maternal, infant and young child nutrition) (https://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf).

6. Unhealthy diets account for an additional 11 million deaths. Sub-optimal diets are now responsible for 20% of premature (disease-mediated) mortality worldwide, as well as for 20% of all disability-adjusted life years lost to ill-health.

PROGRESS IN THE IMPLEMENTATION OF FOOD AND NUTRITION POLICIES

7. WHO's Global database on the Implementation of Nutrition Action¹ contains information on national policies and strategies with nutrition goals, strategies or indicators in 194 Member States, of which 180 have comprehensive or topic-specific nutrition policies (on, for example, healthy diet, anaemia and breastfeeding). A third Global Nutrition Policy Review is in process.

8. **National strategies that include specific goals, objectives, and actions to promote healthy diets.** Most countries have adopted the global nutrition targets for 2025, covering for example stunting (117 Member States), anaemia in women (104), low birth weight (119), child overweight (137), exclusive breastfeeding (130) and wasting (111). The vast majority (186 Member States) include actions to promote healthy diets in their national policies and strategies, aiming to reduce consumption of fats (100 Member States), salt/sodium (142) or sugars (86). Population information policies through counselling or media campaigns are more common (181 Member States) than those that seek to change the food environment through nutrition labelling, marketing restrictions, fiscal policies or reformulation (156).

9. **Labelling and health claim.** Nutrition labelling was the intervention that saw the largest increase between WHO's first and second global nutrition policy reviews in 2009–2010 and 2016–2017, respectively. National nutrition-labelling legislation defines the details on the information that should be available to consumers on pre-packaged food, including list of ingredients, nutrient declaration and the health or nutrient claims producers make on labels. As reported to the second review, 73 countries provided detailed information on their implementation of nutrient declaration and 69 countries on their regulation of nutrition and health claims.

10. **Promotion of food products consistent with a healthy diet.** Reformulation of food and beverage products is being implemented to reduce the content of saturated fatty acids, trans-fatty acids, sugars and salt/sodium. The recent WHO report on global trans-fatty acid elimination 2020² found that 58 countries so far have introduced laws to eliminate trans-fatty acids from the food supply; if successful, elimination will protect 3.2 billion people from those harmful substances by the end of 2021.

11. **Fiscal policies.** Currently 73 Member States impose taxes on sugar-sweetened beverages, although the definitions, type and level of tax and range of products covered vary greatly. Twenty-nine Member States identify subsidies on healthy foods and beverages (for instance, fruits and vegetables) as suitable approaches to support healthy diets in their national strategies.

¹ WHO. Global database on the Implementation of Nutrition Action (GINA) (<https://extranet.who.int/nutrition/gina/en>).

² WHO. News release: more than 3 billion people protected from harmful trans fat in their food. Geneva: World Health Organization; 2020 (<https://www.who.int/news/item/09-09-2020-more-than-3-billion-people-protected-from-harmful-trans-fat-in-their-food>, accessed 7 December 2020).

12. **Food programmes.** Among the respondents to the Global Nutrition Policy Review 2016–2017,¹ 85 countries reported food distribution programmes as part of their social safety nets employed to address underlying causes of malnutrition, typically either emergency food aid programmes or special foods for infants and young children (or both).

13. **School policies and programmes.** The Global Nutrition Policy Review 2016–2017 recommended the strengthening of school health and nutrition programmes to ensure nutrition-friendly schools where policies, curriculum, environments and services are designed to promote healthy diets and support good nutrition. Most countries (89% of 160) reported having school health and nutrition programmes, but individual components of school programmes had largely deteriorated since the first Global Nutrition Policy Review in 2009–2010.

14. **Health and other services.** Among respondents to the Global Nutrition Policy Review 2016–2017, 153 countries reported employing nutrition professionals (that is, trained nutritionists or dietitians). However, the density was low (particularly in the African Region) – six countries had no nutrition professionals, and the global median among 126 countries providing details was only 2.3 trained nutrition professionals per 100 000 population. Pre-service and in-service training of health professionals in maternal, infant and young child nutrition was reported to be offered in 140 countries, although the number of hours in the pre-service curriculum dedicated to this topic was generally less than the number of hours dedicated to this subject area in WHO’s breastfeeding training course curricula.

SECOND INTERNATIONAL CONFERENCE ON NUTRITION AND THE UNITED NATIONS DECADE OF ACTION ON NUTRITION

15. Following up on the outcomes of the Second International Conference on Nutrition, governments, organizations in the United Nations system, civil society and the private sector have been active in improving awareness and stimulating action to respond to a new nutritional reality characterized by all forms of malnutrition. A second report of the United Nations Secretary-General on the implementation of the United Nations Decade of Action on Nutrition was published on 13 April 2020.²

Mid-term review

16. In keeping with the United Nations Economic and Social Council’s resolution E/RES/1989/84 on international decades, commitments made in the Rome Declaration on Nutrition should be reviewed at mid-term and at the end of the Decade of Action on Nutrition, in an open and participatory process.

17. The mid-term review foresight paper³ summarizes the progress in the six action areas of the Decade:

- (a) **Sustainable, resilient food systems for healthy diets.** In growing numbers, high-level reports and resolutions have underlined the crucial role of sustainable, resilient food systems for

¹ WHO. Global Nutrition Policy Review 2016–2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Geneva: World Health Organization, 2018 (<https://apps.who.int/iris/handle/10665/275990>).

² UN General Assembly. Implementation of the United Nations Decade of Action on Nutrition (2016–2025). New York: United Nations; 2020 (<https://undocs.org/en/A/74/794>).

³ United Nations Decade of Action on Nutrition (2016–2025). Mid-term review foresight paper (https://www.who.int/docs/default-source/nutritionlibrary/departmental-news/mid-term-review---un-decade-of-action-on-nutrition/nutrition-decade-mtr-foresight-paper-en.pdf?sfvrsn=c3c14085_8, accessed 7 December 2020).

healthy diets and improved nutrition. Numerous alliances have been established to bring together different actors, beyond the traditional nutrition actors, for sustainable food systems. Recognition of agroecology and biodiversity, increased consideration of sustainability issues in national food-based dietary guidelines, growing implementation of measures to reduce food loss and waste, and action to enhance resilience of the food supply in crisis-prone areas have been noticed. Measures to reduce or eliminate industrially-produced trans-fatty acids have been accelerated, and voluntary or mandatory reformulation of processed food products has been carried out to reduce their salt/sodium content.

(b) **Aligned health systems providing universal coverage of essential nutrition actions.** A clear understanding of the effective interventions to be delivered by health systems has emerged during the first half of the Decade, but there has been significant under-investment in both ensuring adequate coverage of high-impact nutrition interventions and improving their quality. To accelerate progress on wasting in children under five years of age, a United Nations global action plan on child wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals¹ was published on 9 March 2020. This plan will enable organizations of the United Nations development system to develop a more targeted road map for action in 2021. Strong health systems are needed to deliver nutrition actions, and the increasing political momentum for achieving universal health coverage presents new opportunities for expanding coverage and for mainstreaming WHO's essential nutrition actions² through the life-course.

(c) **Social protection and nutrition education.** The contributions of social protection to food security and nutrition will depend on its integration at policy level. To ensure that social protection policies holistically combat all forms of malnutrition, a nutrition-sensitive approach needs to be applied in their design and implementation. Policy measures for improving food access, social protection and food assistance are prevalent in some WHO regions, while in other WHO regions this continues to be an area of under-investment. Nutrition education is widely implemented in schools, but policies to ensure that education is supported by healthy school environments are lacking and implementation of school health and nutrition programmes has deteriorated in recent years. Although most countries train health workers on nutrition, the level of training is often inadequate and, more generally, nutrition action continues to be hampered by a lack of trained nutrition professionals. The potential of multi-component school-based programmes to educate about food and nutrition has been increasingly recognized as an important programmatic area for sustainable development.

(d) **Trade and investment for improved nutrition.** Trade can be a key element in enhancing food security and nutrition, but there has been increasing recognition of the need for coherence between trade policy and nutrition action and the importance of governance and cross-sectoral cooperation. A finance gap persists, despite the need for responsible and sustainable investments in agriculture and food systems. Certain global value chains and agri-food industries currently produce environmentally unsustainable food products which commonly are rich in unhealthy fats, sugars and/or salt/sodium. Increased globalization of the food supply means populations are more

¹ WHO. Global action plan on child wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/m/item/global-action-plan-on-child-wasting-a-framework-for-action>, accessed 7 December 2020).

² WHO. Essential nutrition actions: mainstreaming nutrition through the life-course. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/326261>).

exposed to different food hazards. Rather than driving healthy diets, trade and investment policies are exacerbating malnutrition in all its forms. Increased foreign direct investment, for example, has been linked to higher consumption of sugar-sweetened beverages. Prioritizing health over short-term economic gain has been shown to lead to greater economic gains in the long term.

(e) **Safe and supportive environments for nutrition at all ages.** Creation of healthy food environments – encompassing availability, affordability, promotion and quality of food supporting healthy diets – has become a central consideration in nutrition policy-making. There is increasing momentum for the creation of healthy urban environments, with food environments an important element. Policies to create healthy food environments in schools, to protect and support breastfeeding or to fortify staple foods with micronutrients are widespread, although their implementation is often inadequate. Implementation of fiscal policies to promote healthy diets (particularly taxes on sugar-sweetened beverages) has accelerated over the first half of the Decade. There remains much scope to scale up and improve regulation of the marketing of foods and non-alcoholic beverages to children, strengthen the focus on adolescent nutrition and effectively integrate nutrition and water, sanitation and hygiene programmes.

(f) **Strengthened governance and accountability for nutrition.** Generating commitments and new financing for nutrition has progressed significantly. Despite considerable advances, however, the inadequate and highly variable progress towards the global nutrition and diet-related NCD targets reflects insufficient action to strengthen nutrition governance, policy and accountability systems. It also points to a persistent gap in global nutrition financing and the implementation of policy, legislative and regulatory measures, including fiscal measures as appropriate, aimed at ending all forms of malnutrition. Donor funding for nutrition increased during the first half of the Decade, but it is estimated that an additional US\$ 7 billion is needed to achieve the global nutrition targets. Improved global data now identify those regions and countries that are progressing or falling behind, but weak or non-existent nutrition information systems and insufficient data – particularly on nutritional status in specific groups and over a long enough period to track trends – remain a substantial challenge.

Contributions by different actors

18. **Member States.** Action by Member States is described above (paragraphs 7–17). No additional formal commitments have been made to the Decade besides those already published.

19. The Decade encourages United Nations Member States to strengthen collaboration on nutrition action by establishing action networks, which are informal coalitions of countries, with global or regional scope, aimed at accelerating and aligning efforts around specific topics linked to the Decade's Work Programme. Led and coordinated by one or more countries, the action networks allow countries to exchange knowledge and good practices, successes and challenges, and provide mutual support to accelerate progress with the objective of improving food systems, diets and nutrition for all through policies and legislation.¹ To date, the following global action networks have been convened under the Decade:

(a) Global Action Network on Sustainable Food from the Oceans and Inland Waters for Food Security and Nutrition – lead country: Norway.

¹ United Nations Decade of Action on Nutrition 2016-2025. Action networks. New York: United Nations (www.un.org/nutrition/action-networks, accessed 2 November 2020).

- (b) Global Action Network on Nutrition Labelling – lead countries: Australia, Chile and France.
- (c) Global Action Network on Traditional, Healthy and Sustainable Diets – lead country: Italy.
20. In October 2019, Germany announced plans to form a world coalition on healthy school meals. Brazil and Sri Lanka are jointly developing a work programme.
21. Additionally, several regional networks have been convened for the Americas and the Pacific, namely:
- (a) Regional Action Network on Strategies for Reducing Salt Consumption for the Prevention and Control of Cardiovascular Disease in the Americas – lead countries: Brazil, Colombia and Costa Rica.
- (b) Regional Action Network on Food Guidelines for the Region of the Americas – lead countries: Brazil and Uruguay.
- (c) Regional Action Network for the Americas on Food and Nutrition Security Governance – lead country: Brazil.
- (d) Regional Action Network for the Americas on Public Purchasing of Family-produced Food – lead country: Brazil.
- (e) Regional Action Network for the Americas on Sustainable School Feeding – lead country: Brazil.
- (f) Regional Action Network for the Americas on Healthy Food Environments – lead country: Chile.
- (g) Regional Action Network for Ending Childhood Obesity in the Pacific – lead country: Fiji
22. In order to support the implementation of the Decade, the Food and Agriculture Organization and WHO published in 2018 a guide¹ for countries to translate the policies and actions recommended in the Framework for Action of the Second International Conference on Nutrition into country-specific commitments and a policy brief² on driving commitment for nutrition within the Decade.
23. **Organizations in the United Nations system** have contributed to the Decade in accordance with their respective mandates. The **Food and Agriculture Organization** focuses on the role of agriculture

¹ FAO, WHO. Strengthening nutrition action: a resource guide for countries based on the policy recommendations of the Second International Conference on Nutrition (ICN2). Rome and Geneva: Food and Agriculture Organization of the United Nations and World Health Organization; 2018 (www.fao.org/3/ca1505en/CA1505EN.pdf, accessed 3 November 2020).

² WHO, FAO. Driving commitment for nutrition within the UN Decade of Action on Nutrition: policy brief. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/WHO-NMH-NHD-17.11>, 12 January 2021).

and food systems in reducing malnutrition. Its strategy and vision for its work in nutrition¹ were informed by the main challenges in nutrition and the Organization's comparative strengths.

24. **WHO** published various normative products to support countries in the implementation of the commitments made at the Second International Conference on Nutrition, including essential nutrition actions, assessing and managing children at primary health care facilities to prevent overweight and obesity, fortification of rice with vitamins and minerals,² effective actions for improving adolescent nutrition,³ and implementation guidance for the revised baby-friendly hospital initiative.⁴

25. The **International Atomic Energy Agency** has focused on strengthening collective actions across organizations, countries and communities to accelerate work on tackling the double burden of malnutrition, in particular in assessing the impact of programmes and initiatives targeting that double burden. Furthermore, attention needs to be paid to the role of stable isotope techniques in understanding biological pathways.

26. The **International Fund for Agricultural Development** issued in 2019 its nutrition action plan 2019–2025,⁵ with the overall objective to accelerate mainstreaming of nutrition in its investments and to realize its commitment to increasing the target of mainstreaming nutrition into 50% of projects in their design stage and improve the nutrition of 12 million people by 2021.

27. The vision of **UNICEF's** strategic plan for 2018–2021⁶ is to consolidate and expand the programmatic gains of addressing child malnutrition in all its forms around the world, in order to meet by 2021 three annual targets of reaching at least: (i) 250 million children under five years of age with services to prevent stunting and other forms of malnutrition; (ii) 100 million adolescents with services to prevent anaemia and other forms of malnutrition; and (iii) 6 million children with services to treat severe wasting and other forms of acute malnutrition in development and humanitarian contexts.

28. The **World Food Programme** continued delivering optimal nutrition programming on treatment and prevention as an emergency response, while integrating nutrition-sensitive approaches across the humanitarian-development nexus.

29. The **United Nations Standing Committee on Nutrition** continued working towards maximizing coherence of United Nations policies and accountability, with advocacy for nutrition, building bridges,

¹ FAO. Strategy and vision for FAO's work in nutrition. Rome: Food and Agriculture Organization of the United Nations; 2014 (<http://www.fao.org/3/a-i4185e.pdf>).

² WHO. Guideline: fortification of rice with vitamins and minerals as a public health strategy. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/272535>).

³ WHO. Guideline: implementing effective actions for improving adolescent nutrition. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/260297>).

⁴ WHO, UNICEF. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised baby-friendly hospital initiative. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/272943>).

⁵ IFAD. Mainstreaming nutrition in IFAD: Nutrition action plan 2019-2025. Rome: International Fund for Agricultural Development; 2019 (www.ifad.org/en/document-detail/asset/41237860, accessed 3 November 2020).

⁶ UNICEF strategic plan, 2018-2021 (<https://www.unicef.org/reports/unicef-strategic-plan-20182021>, 12 January 2021).

exploring new and emerging nutrition-related issues in collaboration with its members and through various knowledge products.

30. The **United Nations Inter-Agency Task Force on Non-communicable Diseases**, through its thematic working group on nutrition convened by the Standing Committee on Nutrition, continued to work on all forms of malnutrition.

31. The 2019 report of the **Special Rapporteur on the Right to Food** to the General Assembly focused on the Sustainable Development Goals¹ through a human rights-based approach to nutrition policies, emphasizing in particular the inequitable distribution of food and productive resources as a significant barrier to the realization of the right to food and nutrition.

Non-State actors

32. **Global initiatives.** The Tokyo Nutrition for Growth Summit, postponed to December 2021,² will provide an opportunity for taking stock and making new financial and policy commitments at the mid-term of the Decade. It will bring together countries, donors and partners to present clear commitments and demonstrate progress towards the targets endorsed by the Health Assembly and those of the Sustainable Development Goals. It aims to obtain commitments in five priority areas: (1) health: making nutrition integral to universal health coverage for sustainable development; (2) food: building food systems that promote healthy diets and nutrition, ensure livelihoods of producers and are climate-smart; (3) resilience: tackling malnutrition effectively in fragile and conflict-affected contexts; (4) promoting data-driven accountability; and (5) securing new investment and driving innovation in nutrition financing. In 2019, WHO led the development of the universal health coverage component of the Nutrition for Growth's commitment framework and published the Nutrition in UHC policy brief.³

33. In 2021, United Nations will convene a Food Systems Summit as part of the Decade of Action. The Summit will cover five action tracks: (1) ensuring access to safe and nutritious food for all (enabling all people to be nourished and healthy, progressive realization of the right to food); (2) shifting to sustainable consumption patterns (promoting and creating demand for healthy and sustainable diets, reducing waste); (3) boosting nature-positive production at sufficient scale (acting on climate change, reducing emissions and increasing carbon capture, regenerating and protecting critical ecosystems and reducing food loss and energy usage, without undermining health or nutritious diets); (4) advancing equitable livelihoods and value distribution (raising incomes, distributing risk, expanding inclusion, promote full and productive employment and decent work for all); and (5) building resilience to vulnerabilities, shocks and stress (ensuring the continued functionality of healthy and sustainable food systems). WHO has been asked to be the anchor United Nations body for track (2).

¹ UN Special Rapporteur on the right to food. Report on Sustainable development Goal 2 and the right to food. Geneva: Office of the High Commissioner on Human Right; 2019 (<https://www.ohchr.org/EN/Issues/Food/Pages/SDG2.aspx>, accessed 7 December 2020).

² Tokyo Nutrition for Growth Summit 2021 (<https://nutritionforgrowth.org/events/>, accessed 7 December 2020).

³ WHO. Nutrition in universal health coverage. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329493>).

ANNEX 4

**HEALTH AND THE ENVIRONMENT:
ADDRESSING THE HEALTH IMPACT OF AIR POLLUTION**

1. This annex summarizes progress in the implementation of resolution WHA68.8 (2015) on addressing the health impact of air pollution and the related road map for an enhanced global response to the adverse health effects.¹ (For further information see the progress report submitted to the Seventy-third World Health Assembly.)²
2. Work has substantially advanced the development of knowledge products and tools to measure the health effects and health-care cost of air pollution. These include the means to assess health impact and health economic and sector-specific tools, at both national and subnational levels. The update of the WHO air quality guidelines is at an advanced stage.
3. WHO has reported and will continue to report regularly on three air pollution-related Sustainable Development Goal indicators: 3.9.1 (mortality rate attributed to household and ambient air pollution), 7.1.2 (proportion of population with primary reliance on clean fuels and technology) and 11.6.2 (annual mean levels of fine particulate matter (for example, PM_{2.5} and PM₁₀) in cities (population weighted)). To further support countries in monitoring these indicators, the Secretariat has developed more robust statistical methods and enhanced survey tools to better assess the health impacts of ambient air pollution and household energy use.
4. WHO's databases on ambient air pollution and household energy have been updated regularly and expanded to include more locations, pollutants and sources of exposure.
5. Advances have been made to raise the priority accorded to air pollution on regional agendas through the development of regional plans of action and the creation of country air pollution and health profiles in selected Member States at their request.
6. WHO, in collaboration with other organizations in the United Nations development system, has developed the global BreatheLife Network to raise awareness about the scale and importance of air pollution as a health risk and to share solutions and mobilize action. Since its launch in October 2016, 76 city, regional or country governments level have officially joined the BreatheLife Network; global awareness was raised in 2018 through WHO's First Global Conference on Air Pollution and Health. With growing recognition of air pollution as a public health threat, countries are scaling up commitments to implement air quality policies and to align climate and air quality. In 2018, at the first WHO international conference on air pollution and health, 26 countries, 12 cities, 11 organizations of the United Nations development system, 39 nongovernmental organizations and the European Union committed themselves to a range of interventions to address air pollution. At the United Nations Climate

¹ Welcomed by the Health Assembly in decision WHA69(11) (2016) (https://apps.who.int/gb/ebwha/pdf_files/WHA69-REC1/A69_2016_REC1-en.pdf#page=27, accessed 5 November 2020).

² WHO. Progress reports. Seventy-third World Health Assembly, document A73/32, section I. Geneva: World Health Organization; 2020 (https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_32-en.pdf, accessed 5 November 2020).

Action Summit in 2019, 50 countries with more than one billion people committed themselves to reaching WHO air quality guideline values and aligning climate and air quality policies by 2030.

7. WHO, with other organizations of the United Nations development system, launched the Health and Energy Platform for Action¹ at a side-event at the Seventy-second World Health Assembly in 2019. The Platform aims to strengthen the political and technical cooperation between the health and energy sectors at global, regional and country levels to accelerate the transition to clean energy, with an initial focus on clean cooking and electrification of health care facilities.

8. One highly significant achievement is the recognition of air pollution as a fifth major risk factor for NCDs at the third High-level Meeting of the General Assembly on prevention and control of non-communicable diseases in 2018 and the inclusion of air pollution into multisectoral regional and national NCD action plans. In this context the Secretariat has advanced its work on developing policy options on ambient and household air pollution that will contribute to the achievement of the objectives and voluntary global targets of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. The first phase of this work consists in compiling a compendium of WHO's and other United Nations' guidance on health and environment, including air pollution. Subsequent in-depth analyses of the effectiveness of existing interventions will draw on the compendium and other existing WHO guidelines and recommendations.

9. Over the past years, WHO has been developing and enhancing a set of analytical tools to build the evidence of the health and economic effects of air pollution, for instance the AirQ+ software tool and sector-specific tools such as the health and economic assessment tool for walking and cycling. The Secretariat has undertaken rapid situational assessments and stakeholder mappings for the Clean Household Energy Solutions Toolkit in countries where reliance on the use of biomass for cooking purposes is heavy. It is currently developing training materials for health-care professionals, aimed at strengthening capacity to understand the risks of air pollution to health and to communicate them to patients and communities.

10. The Secretariat has been working continuously to provide direct country support, with targeted technical training workshops intended to enhance institutional capacities to address air pollution and health. In addition, WHO has undertaken several joint missions with other United Nations bodies in order to plan and enhance country support.

¹ WHO, UNDP. Accelerating SGD 7 achievement: Action brief 2 – Global energy and health platform of action. New York: United Nations, Department of Economic and Social Affairs, Division for Sustainable Development Goals; 2019 (https://sustainabledevelopment.un.org/content/documents/24066ab2_cover.pdf, accessed 8 December 2020).

ANNEX 5

**UPDATES TO THE APPENDICES OF WHO'S COMPREHENSIVE
MENTAL HEALTH ACTION PLAN 2013–2030**

1. In response to paragraph 3(a) of decision WHA72(11) (2019), in which the Health Assembly requests the Director-General, *inter alia*, to propose updates to the appendices of WHO's comprehensive mental health action plan, in consultation with Member States and taking into account the view of other stakeholders, the Secretariat has taken the following steps to update Appendix 1 (Indicators for measuring progress towards defined targets) and Appendix 2 (Options for the implementation of the comprehensive mental health action plan 2013–2020) of that action plan:

- **March 2020.** A virtual consultation with Member States was organized by the regional offices for Africa, the Americas, South-East Asia, Europe and the Eastern Mediterranean in order to seek views on the “zero draft” of updated Appendix 1 and the pre-existing (2013) version of Appendix 2. Additionally, Member States of the Western Pacific Region were consulted by email to seek views on the “zero draft” of updated Appendix 1. A web-based consultation for Member States, organizations in the United Nations system and non-State actors on the “zero draft” of updated Appendix 1 and the pre-existing (2013) version of Appendix 2 was conducted
- **July 2020.** Virtual consultations were organized by the Regional Office for the Western Pacific to seek the views of the Region's Member States on the pre-existing (2013) version of Appendix 2.
- **August–September 2020.** A virtual consultation with Member States was organized by the regional offices for Africa, the Americas, South-East Asia, Europe and the Eastern Mediterranean to seek views on the “zero draft” of updated Appendix 2. That text was also the subject of a web-based consultation for Member States, organizations in the United Nations system and non-State actors.

2. The resulting updated Appendix 1 (see below) includes the updated indicators and targets to monitor the comprehensive mental health action plan up to 2030.

3. The resulting updated Appendix 2 (see below) has been modified through strengthened text on suicide prevention, workplace mental health, universal health coverage, mental health of children, mental health across the life course, multisectoral work, human rights, and involvement of people with lived experience of mental health conditions.

Appendix 1

**PROPOSED UPDATED APPENDIX 1 OF THE COMPREHENSIVE MENTAL
HEALTH ACTION PLAN 2013–2030: INDICATORS FOR MEASURING
PROGRESS TOWARDS DEFINED TARGETS**

1. The updated indicators for assessing progress towards meeting the global targets of Comprehensive mental health action plan 2013–2030 represent a subset of the information and the reporting needs that Member States require to be able to monitor adequately their mental health policies and programmes. Given that targets are voluntary and global, each Member State is not necessarily expected to achieve all the specific targets but can contribute to a varying extent towards reaching them jointly.
2. The global targets established for each objective provide the basis for measurable collective action and progress by Member States towards global goals and should not negate the setting of more ambitious national targets, particularly for those countries that have already reached global ones.
3. As indicated under Objective 4 of the plan, the Secretariat will continue providing guidance, training and technical assistance to Member States, upon request, on the development of national information systems for capturing data on indicators of mental health system inputs, activities and outcomes. The aim is to keep building on existing information systems rather than creating new or parallel systems.

Objective 1: To strengthen effective leadership and governance for mental health

Global target 1.1: 80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments, by 2030.
Indicator 1.1: Existence of a national policy or plan for mental health that is being implemented and in line with international human rights instruments.
Means of verification: Physically available policy or plan; confirmation that it accords with international and regional human rights standards; and assessment of implementation status.
Comments, assumptions and/or rationale: For countries with a federated system, the indicator will refer to policies or plans of most states or provinces within the country. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans. Human rights standards include provisions for (i) transition to mental health services based in the community; (ii) respect of human rights; (iii) comprehensive support and services; (iv) promotion of a recovery approach; and (v) participation in decision making processes. Implementation status includes (i) estimation and allocation of human resources; (ii) estimation and allocation of financial resources; (iii) monitoring and evaluation of specified indicators or targets.

Global target 1.2: 80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments, by 2030.
Indicator 1.2: Existence of a national law covering mental health that is being implemented and in line with international and regional human rights instruments.
Means of verification: Physically available law, confirmation that it accords with international and regional human rights standards, and assessment of implementation status.
Comments, assumptions and/or rationale: For countries with a federated system, the indicator will refer to the laws of most states/provinces within the country. Laws for mental health may be stand-alone or integrated into other general health or disability laws. Human rights standards include provisions for (i) transition to mental health services based in the community; (ii) promotion to exercise legal capacity; (iii) prevention of coercive practices; (iv) procedures to file appeals and complaints; (v) regular inspections of mental health services. Implementation status refers to (i) existence of a dedicated authority or independent body to assess compliance with human rights standards; (ii) regular inspection of mental health services by the dedicated authority or body; and (iii) systematic response to complaints and reporting of its findings.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

Global target 2.1: Service coverage for mental health conditions will have increased at least by half, by 2030.
Indicator 2.1.1: Proportion of persons with psychosis who are using services over the past 12 months [%].
Means of verification: Numerator: number of people with psychosis in receipt of services, derived from routine information systems or a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. Denominator: total number of people with psychosis in the sample population, derived from national surveys or, if unavailable, based on subregional prevalence estimates.
Indicator 2.1.2: Proportion of people with depression who are using services over the past 12 months [%].
Means of verification: Numerator: number of people with depression in receipt of services, derived from household surveys or epidemiological studies or routine information systems, or a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. Denominator: Total number of people with depression in the sample population, derived from national surveys or, if unavailable, based on subregional prevalence estimates.
Comments, assumptions and/or rationale: Estimates of service coverage are needed for all mental disorders, but are restricted here to psychosis and depression as tracer indicators for severe and common mental disorders respectively to limit measurement effort. Health facilities range from primary care centres to general and specialized hospitals; they may offer social care and support as well as psychosocial and/or pharmacological treatment on an outpatient or inpatient basis. To limit measurement effort, and where needed, countries may restrict the survey to hospital-based and overnight facilities only (with some loss of accuracy due to omission of primary care and other service providers).

Global target 2.2: 80% of countries will have doubled number of community-based mental health facilities, by 2030.
Indicator 2.2: Number of community-based mental health facilities.
Means of verification: Availability and number of community-based facilities that manage mental health conditions and related clinical and social problems.
Comments, assumptions and/or rationale: In the context of improving access to care and service quality, development of comprehensive community-based mental health and social care services is recommended. Community-based services can be outpatient or inpatient services as well as home help and support services.

Global target 2.3: 80% of countries will have integrated mental health into primary health care, by 2030.
Indicator 2.3: Existence of a system in place for integration of mental health into primary health care.
Means of verification: Description from countries using the following criteria: guidelines for integration of mental health into primary health care available and adopted; pharmacological and psychosocial interventions provided at primary health care level; and training and supervision for non-specialized health workers at primary care level.
Comments, assumptions and/or rationale: Integration of mental health into primary health care is essential to ensure universal health coverage. A range of mental health services including promotive, preventive, treatment and care services can be provided when integrated into primary health care.

Objective 3: To implement strategies for promotion and prevention in mental health

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes, by 2030.
Indicator 3.1: Functioning programmes of multisectoral mental health promotion and prevention in existence.
Means of verification: Inventory or project-by-project description of currently implemented programmes.
Comments, assumptions and/or rationale: Programmes may – and preferably should – cover both universal, population-level promotion or prevention strategies or locally-identified vulnerable groups. Examples include programmes on: suicide prevention; mental health awareness/anti-stigmatization; mental health promotion at the workplace; school-based mental health; and maternal mental health prevention and promotion. Criteria to identify functioning include dedicated financial and human resources, defined plan of implementation, and documented evidence of progress and/or impact.

Global target 3.2: The rate of suicide will be reduced by one-third, by 2030.
Indicator 3.2: Suicide mortality rate (per 100 000 population).
Means of verification: Routine annual registration of deaths due to suicide.
Comments, assumptions and/or rationale: Effective action towards this target requires joint action from multiple sectors outside health/mental health sector. Obtaining accurate surveillance data is difficult and, because of more accurate reporting of suicides, population ageing and other possible factors, total recorded suicides may not decrease in some countries; however, the rate of suicide (as opposed to total suicides) best reflects improved prevention efforts. The target (and indicator) is aligned with those for Sustainable Development Goal 3 (target 3.4 and indicator 3.4.2).

Global target 3.3: 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters, by 2030.
Indicator 3.3: Existence of a system in place for mental health and psychosocial preparedness for emergencies/disasters.
Means of verification: Description from countries for a system in place for mental health and psychosocial preparedness using the following criteria: defined plan of implementation, dedicated financial and human resources, and documented evidence of progress and/or impact.
Comments, assumptions and/or rationale: Planning for disaster and/or emergency response is a priority as expressed in the Sendai Framework for Disaster Risk Reduction (2015–2030) and in the Inter-agency Standing Committee Guidelines for Mental Health and Psychosocial Support in Emergency Settings.

Objective 4: To strengthen information systems, evidence and research for mental health

Global target 4.1: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems, by 2030.
Indicator 4.1: Core set of identified and agreed mental health indicators routinely collected and reported every two years.
Means of verification: Reporting and submission of measurements against the core mental health indicator sent to WHO every two years.
Comments, assumptions and/or rationale: Core mental health indicators include those relating to specified targets of this action plan, together with other essential indicators of health and social system actions (for example, training and human resource levels, and service availability and utilization). The data need to be disaggregated by sex and age groups. Where needed, surveys can also be used to complement data from routine information systems. Data will be collected, analysed and reported by WHO as part of its Mental Health Atlas.

Global target 4.2: The output of global research on mental health doubles, by 2030.
Indicator 4.2: Number of published articles on mental health research (defined as research articles published in the databases).
Means of verification: Literature searches centrally-conducted every two years, stratified by country of origin, topics and types of research, using bibliometric data sourced for the most recent calendar year.
Comments, assumptions and/or rationale: The indicator measures the output of mental health research as defined by national published research studies. The annual published research output in peer-reviewed and indexed journals is a proxy for the amount (and quality) of mental health research being conducted in a country. It indirectly assesses a country's commitment to mental health research, which will ultimately have an impact on outcomes for people with mental health conditions.

Appendix 2

**PROPOSED UPDATED APPENDIX 2 OF THE COMPREHENSIVE MENTAL
HEALTH ACTION PLAN 2013-2030**

**Options for the implementation of the comprehensive mental health
action plan 2013-2020**

Objective 1: To strengthen effective leadership and governance for mental health	
Actions	Options for implementation
<p>Policy and law: Develop, strengthen, keep up-to-date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.</p>	<ul style="list-style-type: none"> • Develop and implement a comprehensive mental health policy and plan that complies with international human rights instruments, includes allocated human and financial resources and undergoes regular monitoring against indicators or targets for implementation. • Decriminalize suicide, suicide attempts and other acts of self-harm. • Set up a functional mental health unit or coordination mechanism(s) in the health ministry, with an allocated budget and responsibility for strategic planning, coordination, needs assessment, interministerial and multisectoral collaboration and service evaluation for mental health across the life-course. • Ensure coordination of mental health and social care activities at all relevant subnational levels (for example, district, municipality and community levels). • Sensitize policy-makers to mental health and human rights issues through the preparation of policy briefs and scientific publications and the provision of leadership courses and other learning and knowledge exchange opportunities in mental health. • Undertake capacity-building among stakeholders including policy-makers regarding strategies to promote respect for people's will and preference in mental health and related services. • Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into all sectoral policies, laws and strategies (for example, health, social affairs, education, justice and labour/employment) including emergency preparedness and response, poverty reduction and development. • Improve accountability by setting up mechanisms, using independent bodies, to monitor, prevent and respond to torture or cruel, inhuman and degrading treatment and other forms of ill-treatment and abuse; collect data on restraint and seclusion and involuntary treatments; and involve appropriate stakeholder groups in these mechanisms, for example, lawyers and people with mental disorders and psychosocial disabilities, in a manner consistent with international human rights instruments. • Amend or repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities.

	<ul style="list-style-type: none"> • Monitor and evaluate the implementation of policies and legislation to ensure compliance with international human rights conventions including the Convention on the Rights of Persons with Disabilities and the Convention on the Right of the Child, as appropriate, and feed this information into the reporting mechanism of these conventions. • Establish supported decision-making mechanisms; help people to develop advance plans that state their will and preference should they experience a crisis in the future; and ensure that people have all the supports they require in order to make a decision, including access to trusted persons and advocates and provision of valid information about all matters relevant to their decision.
<p>Resource planning: Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.</p>	<ul style="list-style-type: none"> • Include mental health services, such as psychosocial and psychological interventions and basic medicines for mental disorders, in universal health coverage and financial protection schemes and offer financial protection for socioeconomically disadvantaged groups. • Use – and if indicated, collect – data on epidemiology and resource needs in order to inform the development and implementation of mental health plans, budgets and programmes. • Set up mechanisms for tracking expenditures for different types of mental health services in health and other relevant sectors such as education, employment, criminal justice and social services. • Identify available funds at the planning stage for specific community-based, culturally-appropriate, cost-effective activities so that implementation can be assured. • Join with other stakeholders to effectively advocate increased resource allocation for mental health including through investment cases for mental health.
<p>Stakeholder collaboration: Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.</p>	<ul style="list-style-type: none"> • Convene, engage with, and solicit consensus from all relevant sectors and stakeholders when planning, developing and implementing policies, laws and services relating to health, including sharing knowledge about effective mechanisms to improve coordinated policy and care across formal and informal sectors. • Build local capacity and raise awareness among relevant stakeholder groups about mental health, law and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.
<p>Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations: Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.</p>	<ul style="list-style-type: none"> • Provide logistic, technical and financial support to build the capacity of people with mental disorders and psychosocial disabilities and their organizations, including youth and carers, in understanding and advocating the realization of human rights conventions, policy, law and services, based on their needs and preferences. • Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities and establish formal mechanisms to ensure their full and effective participation in the development and implementation of mental health policies, laws and services as well as their monitoring and evaluation. • Involve people with mental disorders and psychosocial disabilities in the assessment and monitoring of all public and private mental health services including psychiatric hospitals and social care homes. • Include people with mental disorders and psychosocial disabilities and their organizations in capacity-building of stakeholders, including policy-makers and health workers delivering mental health care.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	
Actions	Options for implementation
<p>Service reorganization and expanded coverage: Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped-care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.</p>	<ul style="list-style-type: none"> • Develop a phased and budgeted plan for scaling down and closing long-stay psychiatric institutions and replacing them with support for discharged residents to live in the community. • Work towards a gradual shift of financial resources and staff towards community-based care, closing long-stay institutions once there are adequate community alternatives. • Accompany the process of scaling down long-stay psychiatric institutions with (a) human rights protection and improvements in quality of life in institutions and (b) ensuring continuity of care and welfare provision for discharged long-stay residents (for example, livelihoods and housing support, including places in small group homes). • Provide outpatient mental health services and an inpatient mental health unit in general hospitals. • Build up interdisciplinary community-based mental health services for people across the life course, through for instance outreach services, home care and support, primary health care, emergency care, community-based rehabilitation and supported housing. • Integrate mental health and social care into disease-specific programmes and services, such as those for HIV/AIDS, tuberculosis, noncommunicable diseases and neglected tropical diseases, and into population-specific programmes and services, such as maternal, sexual and reproductive health, child and adolescent health, gender-based violence and family health and well-being programmes and services. • Engage service users and family members and/or carers with practical experience as peer support workers. • Support the establishment and implementation of community mental health services run by nongovernmental organizations, faith-based organizations and other community groups, including self-help and family support groups, which protect, respect and promote human rights and are subject to monitoring by government agencies. • Consider the use of evidence-based innovative approaches to provide psychological support at scale (for example, guided self-help, digital self-help, collaborative and stepped-care approaches). • Develop and implement tools or strategies for self-help and care for persons with mental disorders, including strengthening the use of electronic and mobile technologies, potentially as part of a stepped-care system. • Develop capacity, policies and operational procedures for remote delivery of services (for example, telehealth) and use digital health solutions to support practitioners in providing care where feasible. • Provide in-home and other community-support services for carers of children and of adults with psychosocial disabilities including carer skills training and other multidisciplinary services (for example, physical and occupational therapy, nutritional support, housing, education support, and early childhood development).

<p>Integrated and responsive care: Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing and education) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.</p>	<ul style="list-style-type: none"> • Encourage health workers to initiate and support recovery plans and link people with services and resources based on their needs and preferences including education, work, health care, and livelihood opportunities. • Develop the planning and delivery of services jointly with people with mental health conditions and psychosocial disabilities. • Implement guidelines for the management of physical health in persons with severe mental health conditions. • Advocate with other sectors (for example, livelihoods support, housing, education, vocational training, employment, social welfare and legal support) the inclusion and support of people with mental disorders and psychosocial disabilities in their services and programmes. • Cultivate recovery-oriented and culturally-appropriate care and support through awareness-building opportunities and training for health and social service providers. • Provide information to people with mental disorders, their families and carers on causes and potential impacts of disorders, treatment and recovery options, as well as on healthy lifestyle behaviours in order to improve overall health and well-being. • Foster the empowerment and involvement of persons with mental disorders, their families and caregivers in mental health care. • Procure and ensure the availability of basic medicines for mental disorders included in the WHO Model List of Essential Medicines at all health system levels, ensure their rational use, and enable non-specialist health workers with adequate training to prescribe such medicines. • Build competencies of health professionals to provide accurate information about a range of feasible evidence-based psychosocial and pharmacological interventions and to discuss benefits and risks, including possible side and withdrawal effects of interventions. • Address the mental well-being of children and carers when a family member with severe illnesses (including those with mental disorders) presents for treatment at health services. • Provide services and programmes to children and adults who have experienced adverse life events, including ongoing domestic violence, civil unrest, conflict or disaster, that meet people's mental health needs, promote recovery and resilience, and prevent further distress for those who seek support. • Implement interventions to manage family crises and provide care and support to families and carers in primary care and other service levels. • Provide early interventions for children and adolescents with mental health conditions through family-centred and child and adolescent-responsive health care, at primary health care, school and community levels. • Implement the use of WHO QualityRights standards to assess and improve quality and human rights conditions in inpatient and outpatient mental health and social care facilities including policies and procedures to stop the use of coercive practices in services.
<p>Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters): Work with national emergency committees to include mental health and psychosocial</p>	<ul style="list-style-type: none"> • Work across sectors with national and subnational actors on integrating mental health and psychosocial support in all national and local emergency preparedness and response policies, plans, procedures and actions as outlined in the Sphere Handbook's minimum standards and the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

<p>support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.</p>	<ul style="list-style-type: none"> • Prepare for emergencies by training health and community workers in basic psychosocial support, such as psychological first aid. • During emergencies, ensure coordination with partners across health, protection, nutrition and education sectors on the application of the Sphere Handbook’s relevant minimum standards and the Inter-Agency Standing Committee guidelines mentioned above. • Include mental health and psychosocial support as an integral, cross-cutting component in public health emergency responses (for example, to COVID-19 and Ebola virus disease) as part of a range of pillars or domains, such as case management, risk communication and community engagement, continuation of services, response coordination, and operations (for instance, staff support). • Use emergencies as an opportunity to build or rebuild sustainable community-based mental health and social care systems, and to demonstrate the feasibility and effectiveness of community models of care that address the long-term increase in mental disorders in emergency-affected populations.
<p>Resource planning: Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders as well as to refer people, as appropriate, to other levels of care.</p>	<ul style="list-style-type: none"> • Develop and implement a strategy for building and retaining human resource capacity to deliver mental health and social care services across the life course in health, social and educational settings, such as primary health care, general hospitals and schools. • Support pre-service and in-service training of health workers in WHO’s Mental Health Gap Action Programme’s intervention guide for the identification and management of mental, neurological and substance use disorders in non-specialized settings, evidence-based psychological interventions and associated training and supervision materials for prioritized expanded care.¹ • Ensure that health and social care workers have access to a cadre of supervisors with experience in evidence-based interventions who can provide continued mentoring and support. • Collaborate with universities, colleges, other relevant educational entities and professional associations to define and incorporate a mental health component in undergraduate and postgraduate curricula, to offer continued education and knowledge exchange on mental health and to ensure accreditation and oversight of mental health professionals. • Ensure an enabling service context for training health, education and social care workers that focuses on the ongoing development, monitoring and evaluation of competencies and that includes clear task definitions, referral structures, supervision and mentoring. • Improve the capacity of health, education and social care workers in all areas of their work (for example, covering clinical, human rights and public health domains), including eLearning methods where appropriate. • Ensure inclusion of human rights and person-centred recovery-oriented approaches in the curricula of undergraduate and graduate courses, continuing professional development opportunities and professional accreditation mechanisms, and offer internships and learning placements in services that promote such approaches.

¹ See document EB146/7 (2019), Annex 1: Menu of policy options cost-effective interventions to promote mental health and well-being (https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_7-en.pdf).

	<ul style="list-style-type: none"> • Establish or strengthen supervised clinical training for prospective mental health professionals, including psychologists, social workers, psychiatric nurses and psychiatrists. • Improve working conditions, financial remuneration and career progression opportunities for mental health professionals and others, including lay workers, in order to attract and retain the mental health workforce. • Collaborate with educational institutions and places of employment to improve recruitment and retention of persons from various backgrounds (including persons with lived experience of mental health conditions and psychosocial disabilities) to amplify their voices and diversify the mental health workforce and leadership.
<p>Address disparities: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.</p>	<ul style="list-style-type: none"> • Identify and assess the mental health needs and determinants of different sociodemographic groups in the community and also of vulnerable people who may not be using services (such as people living with homelessness, children, older people, persons in the criminal justice system, persons in detention, internally displaced persons, asylum seekers, refugees, migrants, minority ethnic groups, persons who identify as LGBTIQ+, indigenous populations, people with physical and intellectual disabilities, and people affected by emergency situations) and address the barriers that they face in accessing treatment, care and support. • Develop a proactive strategy for targeting these people and groups and provide services that meet their needs. • Build competencies of health and social care workers to better understand the needs of vulnerable people and the social determinants of mental health, including poverty, inequality, discrimination and violence, and to respond adequately to these factors when providing care and support.

Objective 3: To implement strategies for promotion and prevention in mental health	
Actions	Options for implementation
<p>Mental health promotion and prevention: Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for promoting mental health and preventing mental disorders and for reducing stigmatization, discrimination and human rights violations, and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.</p>	<ul style="list-style-type: none"> • Develop and implement national, multisectoral mental health promotion and prevention programmes. • Increase public knowledge and understanding about mental health, how to stop discrimination and how to access services, through media awareness campaigns and initiatives that involve persons with lived experience of mental disorders and psychosocial disabilities. • Include mental health care and support as part of home- and health facility-based antenatal and postnatal care for new parents and/or carers including skills training for carers. • Provide early childhood programmes that address the cognitive, sensory-motor and psychosocial development of children as well as promote healthy child–caregiver relationships. • Reduce the harmful use of alcohol by implementation of measures included in WHO’s global strategy to reduce the harmful use of alcohol. • Introduce brief interventions for hazardous and harmful substance use. • Implement programmes to prevent and address domestic violence, including attention to violence related to alcohol use.

	<ul style="list-style-type: none"> • Protect children and adults from abuse by introducing or strengthening community protection networks and systems. • Address the needs of children with parents with chronic mental disorders within promotion and prevention programmes. • Develop universal and indicated (targeted) school-based promotion and prevention, including for instance socioemotional life and skills programmes; programmes to counter bullying and violence; programmes to counter stigmatization and discrimination of persons with mental disorders and psychosocial disabilities; raising awareness of the benefits of a healthy lifestyle and the risks of substance use; and early detection and intervention for children and adolescents with emotional or behavioural problems (including disordered eating) or neurodevelopmental disorders. • Address discrimination in educational institutions and the workplace and promote full access to educational opportunities, work participation and return-to-work programmes for people with mental disorders and psychosocial disabilities. • Promote safe, supportive and decent working conditions for all (including informal workers), with attention to organizational improvements in the workplace; implement evidence-based programmes to promote mental well-being and prevent mental health conditions, including training managers in order to benefit employees' mental well-being; introduce interventions for stress management and workplace well-being programmes; and address stigmatization and discrimination. • Enhance self-help groups, social support, community networks and community participation opportunities for people with mental disorders and psychosocial disabilities and other vulnerable people, using digital interventions where possible. • Encourage the use of evidence-based traditional and cultural practices for promotion and prevention in mental health (such as yoga and meditation). • Enhance the use of social media in promotion and prevention strategies. • Implement preventive and control strategies for neglected tropical diseases (for instance, taeniasis and cysticercosis) in order to prevent neurological and associated mental health consequences. • Develop policies and measures to be implemented by relevant ministries (for example, finance, labour and social welfare) for the protection of vulnerable populations during financial and economic crises.
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<p>Suicide prevention: Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.</p>	<ul style="list-style-type: none"> • Develop, keep up-to-date, implement and evaluate national suicide prevention strategies that guide governments and stakeholders to implement effective preventive interventions, raise public awareness, increase help-seeking and reduce stigmatization of suicidal thoughts and behaviours. • Increase public, political and media awareness of the magnitude of the problem and the availability of evidence-based effective suicide-prevention strategies. • Ban highly hazardous pesticides and restrict access to other means of self-harm and suicide (for instance, high places, medicines and firearms). • Promote responsible media reporting in relation to cases of suicide by training media professionals and others producing content for screen or stage on how to cover suicide. • Implement universal and indicated school-based socioemotional learning programmes and other interventions to support adolescents in their problem-solving and coping skills. • Promote workplace, school-based and other community-based initiatives for suicide prevention that are tailored to groups at risk including adolescents and older persons. • Improve responses in the health system and other sectors to self-harm and suicide, including training of staff (for example, non-specialized health workers, social workers, teachers, police, persons working in the criminal justice system, firefighters, other first responders and faith leaders) in the assessment, management and follow-up of self-harm and suicide. • Engage communities in suicide prevention and optimize psychosocial support from available community resources for both those who self-harmed or who attempted suicide and families of people who died by suicide. • Develop community-level strategies for suicide prevention including access to formal and informal services, volunteer social support groups and other culturally-appropriate programmes. • Ensure financing of suicide prevention by allocating adequate resources. • Ensure all relevant groups at risk of suicide, including indigenous people, are involved in developing suicide-prevention strategies. • Conduct a situation analysis (for instance, rates of suicide and self-harm, specific populations at risk, common methods of suicide, existing suicide prevention activities and gaps) to inform the planning of suicide prevention activities.
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Objective 4: To strengthen information systems, evidence and research for mental health	
Actions	Options for implementation
<p>Information systems: Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and prevention strategies and to feed into the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).</p>	<ul style="list-style-type: none"> • Establish a surveillance system for monitoring mental health and self-harm and/or suicide and suicide attempts, ensuring that records are disaggregated by facility, gender, age, disability, method and other relevant variables. • Embed mental health and self-harm and/or suicide information needs and indicators, including risk factors and disabilities, within national population-based surveys and health information systems. • Collect detailed data from secondary and tertiary services in addition to routine data collected through the national health information system. • Include mental health indicators within information systems of other sectors. • Analyse and publish data collected on the availability, financing and evaluation of mental health and social care services and programmes to improve services and population-based interventions.
<p>Evidence and research: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.</p>	<ul style="list-style-type: none"> • Develop and promote a prioritized and funded national research agenda in the area of mental health, based on consultation with all stakeholders. • Improve research capacity to assess needs and to evaluate the effectiveness, implementation and scale up of services and programmes, including human rights and recovery-oriented approaches. • Enable strengthened cooperation between universities, institutes, and health and social services and other relevant settings (such as educational) in the field of mental health research. • Conduct research, in different cultural contexts, on local understandings and expressions of mental distress, practices that are harmful (for instance, human rights violations and discrimination) or protective (for instance, social supports and traditional customs) and ways of help-seeking (for instance, traditional healers), as well as the efficacy, acceptability and feasibility of interventions for treatment and recovery, prevention and promotion. • Develop methods for characterizing mental health disparities that occur among diverse subpopulations in countries, including factors such as race and/or ethnicity, sex, socioeconomic status and geography (urban versus rural), and evaluate interventions that are responsive to the needs of specific groups and address social determinants. • Strengthen collaboration between national, subnational and international research centres for mutual interdisciplinary exchange of research and resources between countries. • Promote high ethical standards in mental health research, ensuring that: research is conducted only with the free and informed consent of the person concerned; researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting people to participate in the research; research is not undertaken if it is potentially harmful or dangerous; all research is approved by an independent ethics committee functioning according to national and international norms and standards; and research is carried out with meaningful involvement of local collaborators and stakeholders in the design, implementation and dissemination of research findings.

	<ul style="list-style-type: none">• Ensure that people with mental health conditions and psychosocial disabilities and their organizations contribute to mental health research, for instance through setting the research agenda, advising on the research methods and design, and in informing about their lived experience.• Ensure the translation of results from research to practice and the transfer of knowledge from academic to service settings by training stakeholders, including policy-makers and mental health professionals, in critical appraisal of evidence and providing open access to unbiased and easy-to-understand information.
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ANNEX 6

CONCRETE GUIDANCE TO STRENGTHEN HEALTH LITERACY

1. This annex describes progress in providing Member States with concrete guidance to strengthen health literacy through education programmes and population-wide targeted and mass- and social-media campaigns to reduce the impact of all risk factors and determinants of noncommunicable diseases.

Context

2. In 2014, at the second High-level Meeting of the General Assembly on Non-communicable Diseases, ministers and representatives of States and Governments committed themselves to “continue to develop, strengthen and implement appropriate multisectoral public policies and action plans to promote health education and health literacy, with a particular focus on populations with low health awareness and/or literacy.”¹

3. The Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development, adopted at the 9th Global Conference on Health Promotion, held in China from 21 to 24 November 2016,² highlighted health literacy as one of the main pillars of health promotion for achieving the 2030 Agenda for Sustainable Development.

4. At the third High-level Meeting of the General Assembly on Non-communicable Diseases in 2018, Heads of State and Government committed themselves to “empower the individual to make informed choices by providing an enabling environment, strengthening health literacy through education, and implementing population-wide and targeted mass and social media campaigns that educate the public about NCD risk factors.”³

5. These commitments remain largely unmet.

6. During the current COVID-19 pandemic, health literacy has been shown to be one of the key drivers of a successful response, as people’s knowledge and abilities to obtain, understand, judge and take decisions based on evidenced-based information are essential.

Providing Member States with concrete guidance to strengthen health literacy approaches for the prevention and control of NCDs and mental health conditions

7. The Director-General convened a working group on health education and health literacy for NCDs⁴ of global experts nominated by Member States from 2017 to 2019 and supported by WHO’s Global coordination mechanism for the prevention and control of noncommunicable diseases to recommend ways and means of encouraging Member States and non-State actors to promote health education and health literacy for the prevention and control of NCDs. The group focused in particular

¹ In accordance with paragraph 30(a)(iii) of United Nations General Assembly resolution 68/300.

² In accordance with preambular paragraph 6 of resolution WHA71.2.

³ In accordance with paragraph 334 of United Nations General Assembly resolution 73/2.

⁴ WHO. The WHO GCM/NCD Working Group on health education and health literacy for NCDs (Working Group 3.3, 2016–2017) (<https://www.who.int/global-coordination-mechanism/working-groups/working-group-3-3/en/>, accessed 7 December 2020).

on populations with low health awareness and/or literacy and took into account WHO's best buys and other recommended interventions for the prevention and control of NCDs.

8. The final report from the working group has been designated a WHO Global Public Health Good for the period 2020–2021 and is being finalized. Its guidance will support the implementation of practical health literacy approaches to accelerate the prevention and control of NCDs at national level, including use of an implementation toolkit. The draft final report will be presented for broad consultation, including Member States, all three levels of WHO, and selected and relevant external stakeholders, during the first quarter of 2021, before its recommendations are piloted across WHO regions.

9. Under the auspices of the WHO Working Group on health education and health literacy, the Secretariat, developed ways to support the implementation of national health literacy demonstration projects across WHO's regions.

10. The Secretariat created a community of practice whose members met to build expertise and resources to improve health literacy approaches for the prevention and control of NCDs and mental health conditions.

11. The WHO European Action Network on Health Literacy for Prevention and Control of Noncommunicable Diseases¹ was launched in 2019 to support Member States in the European Region to attain target 3.4 of Sustainable Development Goal 3 (by 2030 reduce by one third pre-mature mortality from noncommunicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being) through interventions based on health literacy.

12. In 2019 the Regional Committee of Europe at its sixty-ninth session, in resolution EUR/RC69/R9 "Towards the implementation of health literacy initiatives through the life course", took note of the WHO European road map for implementation of health literacy initiatives through the life course and urged Member States to strengthen implementation of health literacy initiatives in various areas of action, environments and settings, including by using innovations.

Providing Member States with concrete guidance to strengthen health literacy through education programmes and population-wide targeted and mass- and social-media campaigns to reduce the impact of all risk factors and determinants of NCDs

13. Recommendation 2 of the final report of the WHO Independent High-level Commission on Noncommunicable Diseases² requests the Secretariat to "support countries in their national efforts to empower individuals to make healthy choices and make the healthiest choice the easiest choice, including through the creation of enabling environments and the promotion of health literacy".

¹ Drapkina O, de Graca Freitas M, Mikkelsen B, Breda J, Salakhov E, Lopatina M, Silva da Costa A, Koylyu A, Williams J, Wickramasinghe K, Telo de Arriaga M. The WHO European Action Network on Health Literacy for Prevention and Control of Noncommunicable Diseases. *Public Health Panorama* 2019; 5(2–3):123–129 (<https://apps.who.int/iris/handle/10665/327056>, accessed 12 January 2021).

² WHO. It's time to walk the talk: WHO Independent High-level Commission on Noncommunicable Diseases – summary. Geneva: World Health Organization; 2019 (<https://www.who.int/ncds/governance/high-level-commission/en/>, accessed 12 January 2021).

14. The Secretariat is developing a toolkit for behavioural change communication campaigns on NCD risk factors and mental health conditions, targeted at children and adolescents. This toolkit will build on the WHO Strategic Communications Framework¹ and will prioritize a catalogue of communications knowledge, skills, contextual best practices, innovative approaches and resources for effective communication to particular target audiences and the use of emerging technologies in communicating messages about NCD risk factors and the promotion of healthy behaviours.
15. In 2020, WHO published a handbook on life skills education about prevention of noncommunicable diseases.² Its purpose is to support schools in implementing interventions aimed at reducing the main modifiable risk behaviours for noncommunicable diseases.
16. The Secretariat will update this annex in its report to the Seventy-fourth World Health Assembly in May 2021.

¹ WHO. WHO Strategic Communications Framework. Geneva: World Health Organization; 2020 (<https://www.who.int/mediacentre/framework-at-a-glance-slides.pdf>, accessed 7 December 2020).

² WHO. Life skills education school handbook: prevention of noncommunicable diseases: introduction. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/331948>).

ANNEX 7

ANALYSIS OF SUCCESSFUL APPROACHES TO MULTISECTORAL ACTION FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

1. This annex describes the process that the Secretariat will follow to analyse, on the basis of a review of international experiences, successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address their social, economic and environmental determinants.
2. WHO's 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases included an action for the Secretariat to “conduct a review of international experience in the prevention and control of noncommunicable diseases, including community-based programmes, and identify and disseminate lessons learned”. Owing to lack of resources, this first global stocktaking report on multisectoral action for NCDs was not prepared at the time. Taking into account this gap, decision WHA72(11) (2019) reiterated this request to the Director-General: to submit “in the consolidated report to the Seventy-fourth World Health Assembly in 2021, based on a review of international experiences, an analysis of successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address the social, economic and environmental determinants of such diseases”.
3. The Secretariat will take the following actions:
 - In 2022, it will launch a publicly-accessible NCD multisectoral action repository to serve as a tool for governments to:
 - draw attention to national or local multisectoral projects in support of target 3.4 of Sustainable Development Goal 3 (by 2030 reduce by one third pre-mature mortality from NCDs through prevention and treatment, and promote mental health and well-being) at the global level;
 - submit descriptions of national projects serving as best practices for others, and update on a continuous basis;
 - extend networks by contacting directly project owners in other countries.
 - In 2022, it plans to launch the first stocktaking report on multisectoral action for NCDs with the aim of updating governments and partners on multisectoral activities undertaken to accelerate progress towards target 3.4. The report will be updated annually, building on calls for new entries into the database.
 - In 2023, the Secretariat will submit an analysis of successful approaches to the Executive Board at its 150th session.

ANNEX 8

ANALYSIS OF HOW FOOD PROCUREMENT IN SCHOOLS AND OTHER RELEVANT INSTITUTIONS CAN BE MADE SUPPORTIVE OF HEALTHY DIETS

1. This annex reports the progress on the implementation of decision WHA72(11) (2019) that requested the Director-General “to collect and share best practices for the prevention of overweight and obesity, and in particular to analyse how food procurement in schools and other relevant institutions can be made supportive of healthy diets and lifestyles in order to address the epidemic of childhood overweight and obesity and reduce malnutrition in all its forms”.

Context

2. Every day, foods, beverages, meals and snacks are served and sold in public institutions. In addition, many governments also purchase foods for government-funded programmes, such as school meal programmes and social protection programmes. Collectively, these public settings and programmes have a large population reach, including vulnerable groups such as children and older people.

3. Governments worldwide therefore have a unique opportunity – as well as responsibility – to lead by example through the implementation of healthy public food procurement policies that ensure that the food served or sold in public settings or purchased (or subsidized) by government contributes to promoting healthy diets and preventing all forms of malnutrition, including obesity and diet-related NCDs. In addition to these public health benefits, healthy public food-procurement policies can have economic benefits, improve productivity and educational attainment, help to increase the availability of healthy, affordable foods and may also contribute to boosting local agriculture.

School food policies

4. In the Global Nutrition Policy Review 2016–2017, most countries (89% of 160) reported having school health and nutrition programmes, but schools remain an underused delivery platform for promoting good nutrition and healthy diets, especially as they can address issues related to both undernutrition and overweight and obesity.

5. The Secretariat has analysed measures applied to foods and beverages served or sold in and around schools, drawing on 128 documents from 83 Member States included in WHO’s Global database on the implementation of nutrition action.¹ About half (42 Member States) had legislative measures (such as laws, decrees and ordinances) published in official gazettes, often including an enforcement mechanism. These were issued as stand-alone school food and nutrition legislation or incorporated into broader school-related laws (on, for instance, feeding programmes, health or hygiene) or into other legislative measures (for example, marketing restrictions, public catering laws, public health codes, and child health and nutrition laws). Another 10 countries had compulsory standards for foods and beverages in schools, while 25 countries had government-issued guides for school foods and beverages that were typically promoted through ministry websites or reports. Nine countries had stated the requirements for school food and beverages in national school nutrition policies. Among the 77 countries with legislation,

¹ This includes 8 countries in the African Region, 17 in the Region of the Americas, 4 in the South-East Asia Region, 37 in the European Region, 6 in the Eastern Mediterranean Region, and 11 in the Western Pacific Region.

standards or guides on school foods and beverages, 73 countries covered foods and beverages offered during school lunches and often also other meals or snacks provided. Furthermore, 52 countries had measures that covered foods and beverages sold at school, in cafeterias, food stores, snack bars or vending machines. Less frequently, measures covered foods and beverages available at school activities or events (10 countries) or extended to sales around schools (for example, in radius of 200 meters around the school premises – three countries). Several countries (22) extended the measures to foods and beverages marketed in schools, including sponsorships. Only three countries extended the measures to foods brought from home.

6. The measures typically involved food-based criteria that promoted healthier foods and beverages (74 countries) especially fruits and vegetables (69 countries), water for drinking (57 countries) and whole-grain varieties of cereals and cereal products (43 countries). For proteins, the measures recommended leaner cuts of meat, fish or eggs (38 countries) or the use of pulses and legumes (43 countries), often as replacement of animal-sourced products on a number of days of the week. The measures often recommended the use of unsaturated oils for cooking (26 countries). Fewer measures promoted fortified foods, including iodized salt (12 countries) or fortified staple foods (six countries).

7. Most countries also listed foods and beverages that were prohibited, to be avoided or to be limited in schools (67 countries). This most commonly applied to various kinds of confectionary, savoury snacks, cakes and pastries (49 countries), fried foods (36 countries) and salt and condiments with a high sodium content (35 countries). For beverages, 48 countries prohibited or limited carbonated and non-carbonated soft drinks, and 26 countries prohibited energy and sport drinks. Specific prohibitions or limitations were less common for other sugar-sweetened beverages, such as juice drinks (22 countries), sweetened flavoured milks (19 countries), beverages prepared from liquid and powder concentrates (16 countries) or 100% fruit or vegetable juices (12 countries). In fact, many countries promoted juices (both diluted and 100%) to be served or sold in schools.

8. In 46 countries the measures included nutrient-based criteria for foods and beverages offered in schools, based on total fat (36 countries), sugars (34 countries), salt/sodium (33 countries), energy (28 countries), saturated fatty acids (23 countries) or trans-fatty acids (18 countries). Many countries provided indications on the portions to be served in school, and 28 countries used this policy measure as a way to limit items that do not form part of healthy diets.

Action Framework for Developing and Implementing Public Food Procurement Policies for a Healthy Diet¹

9. To support Member States in implementing a healthy public food procurement policy, the Secretariat has collected several country examples and developed an action framework for developing and implementing public food procurement policies for a healthy diet. The action framework was peer-reviewed by experts, policy-makers and practitioners from Member States from all WHO regions and contains various country case studies and best practices.²

10. The framework illustrates key steps to take in developing or revising a healthy public food-procurement policy, and ways to prepare an implementation plan and to monitor and enforce the policy. It proposes how to conduct a landscape analysis and engage with a lead government authority to review existing policies in consultation with stakeholders. A step-wise approach is also suggested. Nutrient or food-based criteria, as well as other criteria such as portion size, will have to complement such policies, and food safety considerations will have to be included. The framework contains the links to the specific case studies and available tools.

¹ WHO. Action Framework for Developing and Implementing Public Food Procurement Policies for a Healthy Diet. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240018341>, accessed 12 January 2021).

² Settings and facilities considered are: day-care centres or child-care facilities, schools, after-school/summer programmes, post-secondary institutions, universities, hospitals, long-term and residential aged care facilities, government workplaces, farmers' markets, public parks, community centres, sport and recreation facilities, railway stations, public bus stands, airports, military bases, prisons and juvenile detention facilities, cafeterias/cafes, canteens, restaurants, snack shops, food kiosks, tuck shops, and vending machines. The analysis also considered school meal programmes, social services, social support programmes, homeless shelters, food pantries, supplemental feeding programmes, sport events held in public settings, government-sponsored meetings and conferences.

ANNEX 9

GUIDANCE ON HOW TO STRENGTHEN THE DESIGN AND IMPLEMENTATION OF POLICIES, INCLUDING FOR RESILIENT HEALTH SYSTEMS AND HEALTH SERVICES AND INFRASTRUCTURE TO TREAT PEOPLE LIVING WITH NONCOMMUNICABLE DISEASES AND PREVENT AND CONTROL THEIR RISK FACTORS IN HUMANITARIAN EMERGENCIES

1. This annex describes the process that the Secretariat is following to draw up guidance to Member States, in response to paragraph 40 of the Political Declaration of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,¹ on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure to treat people living with NCDs and to prevent and control their risk factors in humanitarian emergencies.
2. It also provides an update on the Secretariat's work in response to paragraphs 31, 46 and 48 of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030² to ensure continuity of essential NCD services, including availability of life-saving technologies and essential medicines, in humanitarian emergencies.

Context

3. The number of people currently affected by humanitarian emergencies worldwide is unprecedented. The United Nations Office for the Coordination of Humanitarian Affairs estimated that 168 million people would need humanitarian aid and protection in 2020.³ The ongoing COVID-19 pandemic is aggravating this situation, placing an additional burden on already fragile health systems and disrupting essential health services around the world.
4. NCDs such as cancer, cardiovascular disease, chronic respiratory disease and diabetes are the leading causes of death and disability worldwide, disproportionately affecting low- and middle-income countries, which are especially vulnerable to the effects of conflict, epidemics, natural disasters, and forced displacement. In 2017, NCDs accounted for between 24% and 68% of mortality in the top five source countries for refugees.
5. Interruption of care, sudden shifts in priorities of the health care system, the inability of health facilities to function safely and provide quality care for all patients, changes in diet and physical activity habits, increase in stress levels, decrease in medication adherence and precipitation of an acute

¹ United Nations General Assembly. Political Declaration of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Resolution A/RES/73/2 (<https://digitallibrary.un.org/record/1648984>, accessed 4 November 2020), paragraph 40.

² Resolution WHA66.10 (2013), Annex.

³ OCHA. Global humanitarian overview 2020. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2019 (<https://www.unocha.org/global-humanitarian-overview-2020>, accessed 4 November 2020).

exacerbation in a chronic condition – all result in excess morbidity and mortality related to NCDs during emergencies and disasters.¹

6. The health component of humanitarian responses to emergencies has traditionally focused on communicable diseases and injury management, with NCDs being poorly addressed. Capacity and resources for NCD service provision are often already inadequate in low- and lower middle-income settings. A humanitarian emergency makes this more evident, causing NCD-related premature mortality, morbidity and economic difficulty on top of the damage caused by other aspects of the emergency.

7. The COVID-19 pandemic has brought a new level of urgency to the need for improving NCD management as part of emergency preparedness and response. NCDs and their risk factors increase both susceptibility to infection and the likelihood of severe outcomes from COVID-19. At the same time, NCD services have been severely disrupted,² leaving many people with NCDs without the health services and medicines they need.

Ensuring continuity of NCD services in humanitarian emergencies: work to date

8. Some progress has been made in raising awareness and producing guidance to support Member States and humanitarian agencies in ensuring continuity of NCD care in emergencies:

- **NCDs in emergencies:** a WHO/UNHCR policy brief³ describes global minimum standards and priority actions for NCD care in preparation for, response to and recovery from humanitarian emergencies.
- **Integration of NCD care in emergency response and preparedness:** a technical guidance document from the Regional Office for South-East Asia⁴ outlines relevant priority actions to integrate NCD interventions into national health emergency preparedness and responses.
- **Prevention and control of noncommunicable diseases in refugees and migrants:** technical guidance from the Regional Office for Europe⁵ outlines key priority areas for interventions within refugee and migrant groups.
- In June 2015 an **informal working group on NCDs in humanitarian settings** was set up as an informal platform to share lessons learned and to harmonize and draft technical guidance for

¹ WHO Regional Office for South-East Asia. Integration of NCD care in emergency response and preparedness. Manila: World Health Organization Regional Office for South-East Asia; 2018 (<https://apps.who.int/iris/bitstream/handle/10665/272964/9789290226352-eng.pdf?sequence=1&isAllowed=y>).

² 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://apps.who.int/iris/handle/10665/334136>).

³ WHO. Noncommunicable diseases in emergencies. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/204627>).

⁴ WHO Regional Office for South-East Asia. Integration of NCD care in emergency response and preparedness. Manila: World Health Organization Regional Office for South-East Asia; 2018 (<https://apps.who.int/iris/handle/10665/272964>).

⁵ WHO Regional Office for Europe. Prevention and control of noncommunicable diseases in refugees and migrants: Technical guidance. Copenhagen: World Health Organization Regional Office for Europe; 2019 (<https://apps.who.int/iris/handle/10665/311461>).

dealing with NCDs in humanitarian settings. It is chaired by the United Nations High Commissioner for Refugees and WHO participates.

- WHO's **operational guidance for maintaining essential health services in the COVID-19 context**¹ provides an entry point for prioritizing essential NCD services in emergencies. The Secretariat is adapting guidance for the humanitarian context the Global Health Cluster COVID-19 Task Team.

9. The Inter-Agency Emergency Health Kit² has been revised to include essential NCD medicines. The Regional Office for the Eastern Mediterranean developed an additional NCD kit³ to provide essential medicines and medical devices for the management of most common NCDs encountered at primary health care level. Since 2017, the kit has been used in, Afghanistan, Bangladesh, Central African Republic, Democratic Republic of the Congo, Ethiopia, Iraq, Libya, Syrian Arab Republic and Yemen, and is pre-positioned in the occupied Palestinian territory, including east Jerusalem and the WHO Operations Supply and Logistics Hub in Dubai.

10. NCDs remain a neglected aspect of humanitarian responses, however, with significant gaps in technical and operational guidance, lack of capacity and resources in the Secretariat at headquarters and in regions and countries, and insufficient integration of NCDs into emergency preparedness and response plans, humanitarian data collection systems, and dashboards.

Process to develop guidance to Member States on ensuring continuity of essential NCD services in humanitarian emergencies

11. In order to support Member States in their commitment to strengthen policies to treat people living with NCDs and prevent and control their risk factors in humanitarian emergencies, the Secretariat is undertaking work in the following areas:

- **governance:** to establish an integrated approach to addressing NCDs in humanitarian emergencies across the Organization, including the Global Health Cluster.
- **normative work:** to comprehensively map existing policies, guidelines and tools to address NCDs in humanitarian settings in order to fill gaps in guidance for governments and humanitarian agencies.
- **technical assistance:** to propose ways to improve support to countries across preparedness, response and recovery, leveraging crises as an entry-point to build health systems back better through development of sustainable NCD services.
- **research:** to continue existing work with academic partners to shape the research agenda so as to inform policies to strengthen emergency preparedness and responses.

¹ WHO. Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance, 1 June 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332240>).

² WHO. The interagency health kit 2017: medicines and medical devices for 10 000 people for approximately three months. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/279428>).

³ Slamam S, Lee J, Aragno M, Laroche S, Hogerzeil H. The development of the noncommunicable diseases emergency health kit. *Eastern Mediterranean Health Journal* (special issue on scaling up health workforce in the Eastern Mediterranean Region), 2018; 24(1):92-98 (<https://doi.org/10.26719/2018.24.1.92>, accessed 7 December 2020).

- **financing:** to advocate with donors the prioritization of building bridges with a view to prioritizing NCDs in humanitarian emergencies across the health, development and peace-building sectors.

12. The Secretariat will update this annex in its report to the Seventy-fourth World Health Assembly in May 2021.

ANNEX 10

UPDATE ON THE WORK OF THE UNITED NATIONS INTER-AGENCY TASK FORCE ON THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

1. This annex provides an update on the work of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases in the implementation of WHO's global action plan for the prevention and control of non-communicable diseases 2013–2020, the Political Declaration on the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (General Assembly resolution 73/2 (2018)), Health Assembly decision WHA72(11) (2019) on follow up to that political declaration, and resolution E/RES/2019/9 of the United Nations Economic and Social Council on the Task Force.¹
2. The Task Force ensures coordinated action across the United Nations system to support Member States achieve the Sustainable Development Goals related to NCDs. It delivers high-quality technical support to advance multisectoral action in countries. Over the past year, three members of the Task Force – the United Nations High Commissioner for Refugees, International Labour Organization and Organisation for Economic Co-operation and Development - have published briefs on NCDs; altogether now 12 members have published briefs under the Task Force.²
3. The report of the Director-General on the Task Force, submitted to the Economic and Social Council in March 2020,³ described progress and achievements over the past year in line with the Task Force's strategic priorities,⁴ including joint programming missions, joint programmes and initiatives, the Global Action Plan for Healthy Lives and Well-being for All⁵ and progress on establishing a United Nations NCD and mental health multi-partner trust fund to support countries in scaling up action on NCDs and mental health. The report also highlighted the linkages between NCDs and COVID-19.
4. The Economic and Social Council, in resolution 2020/22 on the work of the Task Force,⁶ called upon the members of the Task Force to continue to work together to identify additional technical

¹ United Nations Economic and Social Council. United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases: draft resolution. Document E/2019/L.16 (<https://undocs.org/E/2019/L.16>).

² WHO. United Nations agency briefs: responding to the challenge of NCDs. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/327396/WHO-UNIATF-19.98-eng.pdf?ua=1>).

³ United Nations Economic and Social Council. United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases. New York: United Nations; 2020, document E/2020/51 (<https://undocs.org/en/E/2020/51>).

⁴ WHO. United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases. 2019–2021 strategy. Geneva: World Health Organization; 2019 (<https://www.who.int/groups/un-inter-agency-task-force-on-ncds>, accessed 12 January 2021).

⁵ WHO. About the Global Action Plan for Healthy Lives and Well-being for All. Geneva: World Health Organization (<https://www.who.int/initiatives/sdg3-global-action-plan/about>, accessed 7 December 2020).

⁶ United Nations Economic and Social Council. Resolution E/RES/2020/22: United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases (<https://digitallibrary.un.org/record/3874500?ln=en>).

resources to enhance their support to Member States in line with the Task Force strategy for 2019–2021, paying particular attention to the needs of Member States during their COVID-19 response and recovery.

5. In September 2020, the publication of WHO, United Nations Development Programme and the Task Force on responding to NCDs during and beyond the COVID-19 pandemic, to which more than 30 Task Force members contributed, was launched.¹ It builds on WHO's operational guidance on how to maintain essential health services for NCDs and mental health during the pandemic. It is aimed at governments, policy-makers, organizations in the United Nations system and development partners and explains why strong action on NCDs must be an integral part of the COVID-19 response and recovery.

6. The Economic and Social Council's resolution E/RES/2019/9 on the work of the Task Force in 2019 encouraged the mobilization of resources through innovative funding mechanisms, including a dedicated multi-partner trust fund. As a result, the Task Force Secretariat has drafted terms of reference with the United Nations Multi-Partner Trust Fund Office as the administrative agent. In the first instance, the trust fund will support low- and middle-income countries accessing catalytic resources to tackle NCDs, as part of their national COVID-19 response and recovery plans.

7. In February 2020, the Task Force and WHO's Global Tuberculosis Programme undertook a joint mission to Nigeria with 15 agencies and bilateral development partners.

8. Members of the Task Force continue to deliver joint programmes to support countries in advancing action on NCDs. One example is the WHO/United Nations Development Programme joint project to catalyse multisectoral action on NCDs, which to date has worked with Member States to deliver 26 cases for investment in NCD prevention and control and mental health. The investment cases provide countries with evidence and arguments to strengthen legislative, fiscal and regulatory measures at the country level.

9. An example of a new programme established in reaction to the COVID-19 pandemic is the Access Initiative for Quitting Tobacco² which works with governments, the United Nations and the private sector to accelerate tobacco cessation in low- and middle-income countries.

10. Task Force members are committed to align their NCD and mental health activities with the United Nations' comprehensive response to COVID-19, for example through: (i) raising national awareness on return on investment in NCD prevention and treatment to secure domestic budgetary allocations and financing for development discussions; (ii) by helping countries to include NCDs into their socioeconomic response plans; and (iii) participating in the WHO Working Group on COVID-19 and NCDs. WHO's global action plan for healthy lives and well-being continues to provide an important platform for many members of the Task Force to work through.

¹ WHO/UNDP. Responding to non-communicable diseases during and beyond the COVID-19 pandemic. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/334145>).

² WHO. WHO and partners to help more than 1 billion people quit tobacco to reduce risk of COVID-19 (<https://www.who.int/news-room/detail/09-07-2020-who-and-partners-to-help-more-than-1-billion-people-quit-tobacco-to-reduce-risk-of-covid-19>, accessed 5 November 2020).

11. A “Friends of the Task Force” event was held in the margins of the United Nations General Assembly on 24 September 2020 that allowed Member States and development partners to provide updates on their work on NCDs and mental health and for the Task Force to provide an update on its activities. WHO’s Director-General announced the winners of the 2020 Task Force award.¹

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¹ WHO. UNIATF Awards 2020 (<https://www.who.int/news-room/detail/25-09-2020-uniatf-awards-2020>, accessed 5 November 2020).