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

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

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

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

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

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

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

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[2] A/NCD/INF./2

ANNEX 1

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

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

Table 1: A set of 25 indicators to monitor trends and to assess progress made in the implementation of strategies and plans on noncommunicable diseases

Mortality and morbidity:

Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.

Cancer incidence, by type of cancer per 100 000 population.

Risk factors (FOOTNOTE: The secretariat has received a proposal from a Member State to order the risk factors with behavioural to be followed by biological risk factors):

Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.

Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years (FOOTNOTE: Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations)

Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day.

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

Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO Growth Reference, overweight-one standard deviation BMI for age and sex and obese-two standard deviations BMI for age and sex).

Age-standardized prevalence of insufficiently active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent).

Prevalence of insufficiently active adolescents defined as less than 60 minutes of moderate to vigorous intensity activity daily.

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

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

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

Harmful use of alcohol: (FOOTNOTE Countries will select indicator(s) of harmful use as appropriate to national context and in line with the WHO Global Strategy to Reduce the Harmful Use of Alcohol and that may include heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality among others)

- Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol as appropriate, within the national context.
- Age-standardized prevalence of heavy episodic drinking among adolescents and adults as appropriate, within the national context.
- Alcohol-related morbidity and mortality among adolescents and adults as appropriate, within the national context

Tobacco use:

- Age-standardized prevalence of current tobacco use among persons aged 18+ years
- Prevalence of current tobacco use among adolescents

National system response:

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

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

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

Availability, as appropriate, if cost-effective and affordable, of HPV vaccines, according to national programmes and policies

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

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

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

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

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

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

ANNEX 2

VOLUNTARY GLOBAL TARGETS FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

Table 2 provides 9 voluntary global targets for consideration by Member States. Achievement of these targets by 2025 would represent major progress in the prevention and control of noncommunicable diseases.

Table 2: A set of 9 voluntary global targets for the prevention and control of noncommunicable diseases

Mortality and morbidity	**Indicators**
Premature mortality from NCDs	
25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	Unconditional probability of dying between ages 30–70 from, cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
Risk factors (FOOTNOTE: The secretariat has received a proposal from a Member State to order the risk factors with behavioural risk factors to be followed by biological risk factors)	**Indicators**
Harmful use of alcohol (ADD FOOTNOTE A)	
At least 10 per cent relative reduction in the harmful use of alcohol, as appropriate, within the national context (ADD FOOTNOTE B: i.e. full definition of harmful use of alcohol taken from the Global Strategy)	• Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol as appropriate, within the national context. • Age-standardized prevalence of heavy episodic drinking among adolescents and adults as appropriate, within the national context. • Alcohol-related morbidity and mortality among adolescents and adults as appropriate, within the national context [FOOTNOTE A: Countries will select indicator(s) of harmful use as appropriate to national context and in line with the WHO Global Strategy to Reduce the Harmful Use of Alcohol and that may include heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality among others]
Physical inactivity	
10% relative reduction in prevalence of insufficient physical activity	• Age-standardized prevalence of insufficiently active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent). • Prevalence of insufficiently active adolescents defined as less than 60 minutes of moderate to vigorous intensity activity daily
Raised blood glucose/diabetes (FOOTNOTE) and obesity	

Halt the rise in diabetes and obesity	• Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose • Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index greater than 25 kg/m² for overweight or 30 kg/m² for obesity). • Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO Growth Reference, overweight-one standard deviation BMI for age and sex and obese-two standard deviations BMI for age and sex). FOOTNOTE: Countries will select indicator(s) appropriate to national context
Raised blood pressure	
25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) and mean systolic blood pressure.
Salt/sodium intake	
30% relative reduction in mean population intake of salt/sodium intake (footnote: WHO recommendation is less than 5 grams of salt or 2 grams of sodium per person per day)	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.
Tobacco Use	
30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	• Age-standardized prevalence of current tobacco use among persons aged 18+ years • Prevalence of current tobacco use among adolescents
National systems response	**Indicators**
Drug therapy to prevent heart attacks and strokes	
At least 50% of eligible people receive drug therapy and counselling (including glycemic control) to prevent heart attacks and strokes	Proportion of eligible persons (defined as aged 40 years and over with a 10-year cardiovascular risk greater than or equal to 30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycemic control) to prevent heart attacks and strokes.
Essential NCD medicines and basic technologies to treat major NCDs	
80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities	Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities.

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