The NCD Alliance

Putting non-communicable diseases on the global agenda

Submission to WHO Consultation on a Comprehensive Global Monitoring Framework, Indicators and Targets for the Prevention and Control of NCDs, October 2012

The NCD Alliance welcomes the opportunity to contribute to this World Health Organization consultation on a global monitoring framework, indicators and targets for non-communicable diseases (NCDs).

At the UN High-Level Meeting on the Prevention and Control of NCDs last year, Member States emphasised the importance of surveillance and monitoring of progress on NCDs and mandated WHO to develop a ***"comprehensive global monitoring framework****, including a* ***set of indicators*** *... to monitor trends and assess progress on NCDs"* and a *"****set of voluntary global targets***" by the end of 2012.

Over the past year, the consultative process has highlighted that **all stakeholders are in consensus of the importance of a robust global monitoring framework (GMF)** for the global NCD response. It will ensure that results and resources are identified, recognised, reviewed and reported in order to accelerate global progress on NCDs.

It will be the first time all UN Member States adopt a global set of NCD targets, signalling a new era of accountability for NCDs. The GMF will encourage governments to honour their commitments, improve data collection and surveillance on NCDs, and demonstrate how actions and investments translate into **tangible results and better long-term outcomes for people with NCDs.**

Significant progress has already been made in scoping the GMF, including the landmark decision at the World Health Assembly (WHA 65 (8)) to **adopt the global target of a 25% reduction in premature NCD mortality by 2025.** All 193 UN Member States have committed to this **bold and ambitious vision** of millions fewer people suffering avoidable illness, disability and death from these diseases.

Now, Member States need to agree a **comprehensive set of targets and indicators that will drive progress towards the "25 by 25" goal**. As WHO Director General Margaret Chan previously stated, "**what gets measured, gets done."**

In summary, **the NCD Alliance has five key recommendations:**

1. **Establish and resource a robust global monitoring framework**
2. **Adopt a comprehensive set of bold targets to drive progress towards "25 by 25"**
3. **Strike a balance between targets on prevention, treatment and care**
4. **Agree a rigorous reporting system, including national reporting every two years to WHA and UNGA**
5. **Support the application of global targets to regional and national levels**

In addition, the NCD Alliance recommends **the GMF consultation be viewed in relation to other current global consultations.** These consultations – to define global NCD targets, arrangements for global multisectoral NCD partnerships, and the next Global NCD Action Plan (GAP) 2013-2020 – should be seen as the **building blocks of a comprehensive Global NCD Framework.** But only by overtly making the connections and explicitly integrating one to the other will the international community achieve a coherent Framework to drive and monitor a coordinated response for NCDs

The NCD Alliance was founded by:

International Diabetes Federation

International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

UICC
global cancer control

WORLD HEART FEDERATION®

Specifically, the NCD Alliance identifies the following synergies and areas for integration:

- **The priorities** in the GAP 2013-2020, the GMF, and the evolving global partnership arrangements for NCDs are **consistent and reflect the commitments in the UN Political Declaration on NCDs;**
- Elements of the **GMF are incorporated into the GAP 2013-2020** to monitor progress, with "25 by 25" NCD mortality as the overarching goal of the Plan;
- The global partnership arrangements for NCDs includes a multisectoral **global coordinating mechanism** to mobilise resources and partners and drive progress on the objectives of the GAP 2013-2020*;*
- Elements of the GAP 2013-2020 and targets within the GMF are **integrated into the Post-2015 Development Framework.**

The NCD Alliance's Five Key Recommendations on the GMF, targets and indicators on NCDs:

1. Establish and resource a robust global monitoring framework

- The UN Political Declaration on NCDs calls upon WHO to develop a comprehensive GMF with the purpose of monitoring trends and assessing progress in NCDs. In order to serve this purpose, the GMF must be broad, and include the **three cyclical elements of accountability: monitoring results and resources; reviewing and reporting on progress; and action.**
- The principles that underlie the GMF must be **equity, national ownership, transparency and integration.** Due to the inequalities in the distribution of the global NCD epidemic and the major risk factors, indicators need to cover key equity dimensions including gender, age, and socio-economic status.
- The GMF should draw upon the **experience and lessons learnt of existing accountability mechanisms in other global health and development priorities,** particularly the Global AIDS Response Reporting, the Millennium Development Goals (MDGs) reporting mechanism, the Commission on Information and Accountability for Women's and Children's Health, and the Conference of the Parties to the Framework Convention on Tobacco Control (FCTC COP).
- The Political Declaration clearly recognises the leading role of WHO in the development of the GMF. But due to the multisectoral nature of NCDs, the **implementation of the GMF should be supported by an interagency group and advised by an independent technical advisory group**, modelled on the Independent Expert Review Group (IERG) for the Commission on Information and Accountability for Women's and Children's Health.
- **The GMF must be central to the next GAP 2013-2020, related to the evolving global partnership arrangements for NCDs, and integrated into the post-2015 global development framework.**
- **A critical element of accountability that is neglected in the GMF is the tracking and reporting of resources for NCDs**. Tracking resources is important for transparency, credibility, and being able to link funds to results, outcomes and impact. Currently both the level of global expenditure on NCDs, particularly through Official Development Assistance (ODA), and the means by which global resource flows on NCDs are reported and monitored (e.g. by WHO and OECD) is wholly inadequate. The GMF must therefore **aim to improve tracking of global NCD resources**, with the **long-term goal of securing sustainable financing for NCDs.**

2. Adopt a comprehensive set of bold targets to drive progress towards "25 by 25"

- The NCD Alliance welcomes the **adoption of the global target to reduce premature NCD mortality by 25% by 2025**. All 193 UN Member States have now committed to a vision of millions fewer people suffering avoidable illness, disability and death from these diseases. This vision of "25 by 25" needs to be framed, not as one of a number of targets but rather, as **the overarching goal within the GMF**.

- Member States now need to **agree a comprehensive and bold set of targets and indicators to drive progress towards this "25 by 25" goal**. Decision WHA 65 (8) outlines ten potential targets with varying levels of support. Due to the complexity of this epidemic – spanning four major diseases, four common risk factors, and a web of underlying social determinants – **the NCD Alliance strongly recommends the adoption of these ten targets, with some revisions (see Annexes 1 and 2).**
- ***Ten targets is not too many*** **for what is one of the most complex public health issues the world has ever had to deal with.** Governments are currently being monitored on 10 targets for the global AIDS response. Member States need to signal their leadership and commitment to NCDs by adopting a comparable number for NCDs.
- In its 3rd Discussion Paper, WHO proposes that **interim targets for 2015 and 2020** will be set once the 2025 global targets are agreed.**The NCD Alliance fully supports this** as it will be important for countries to check they are on track to achieve the longer-term 2025 goals.
- In addition to this set of ten global NCD targets**, the GMF should incorporate other NCD-related targets that have already been adopted by Member States**. These include the UN Political Declaration on NCDs target to **develop or strengthen national NCD plans and policies by 2013**. In relation to this target, WHO needs to clearly define the criteria for what constitutes a national NCD plan, including taking into account whether the plan is operational and adequately resourced.

3. Strike a balance between targets on prevention, treatment and care

- In decision WHA 65 (8), Member States re-stated their commitment to a **set of targets that cover outcomes, exposure to risk factors and health system responses**. Both implementation of the UN Political Declaration on NCDs and achievement of the "25 by 25" goal **require a balance of prevention and disease management targets,** including early diagnosis, treatment and care.
- The NCD Alliance specifically requests Member States to **support targets on *all four major risk factors, including the harmful use of alcohol*.** The set of targets will not be credible or comprehensive without all four risk factors, and will not reflect the WHO official definition of NCDs. Member States expressed strong support for reaching consensus on targets relating to the four main NCD risk factors in decision WHA 65 (8).
- The NCD Alliance commends the ambition of other prevention targets, including the target to "halt the rise in obesity prevalence". This target is a major political statement and could have great impact in catalysing political leadership on an issue that is of significant concern to the general population in most countries.
- The NCD Alliance specifically **requests Member States to *support the health systems response targets on drug therapy and on the availability of essential NCD medicines/technologies*** (80% availability already agreed as a target in the WHO Medium-Term Strategy to 2013). The international community is still falling short on providing treatment and care to millions of people with NCDs. If Member States are serious about achieving the "25 by 25" goal, targets to drive progress on the **availability of effective medicines and technologies to diagnose, treat and monitor NCDs are critical**.

4. Adopt a rigorous reporting system, including national reporting every two years to WHA and UNGA

- The frequency of reporting by countries to the GMF is important. Drawing from the lessons of the HIV/AIDS global reporting system, the NCD Alliance **recommends national governments report on progress every two years.** This can be done and will elevate NCDs to the appropriate level of priority on national and global agendas. This will be in line with the reporting requirements of the FCTC and the GMF should explicitly recognise the FCTC COP as the global forum for tobacco control monitoring and accountability. To minimise the reporting burden and facilitate the reporting process, the role of WHO in providing operational guidelines and technical advice will be critical.

- As WHO Discussion Paper 2 states, due to the multisectoral nature of NCD prevention and control, **global and national progress should be reviewed and discussed at both the World Health Assembly *and* the UN General Assembly.**
- Both follow-up steps mandated in the UN Political Declaration - the UN Secretary General's Progress Report on the UN Political Declaration due in 2013 and the comprehensive review and assessment in 2014 – should be **leveraged to take stock on the GMF**.
- Similar to the HIV/AIDS review process, **the NCD Alliance strongly recommends that the comprehensive review and assessment in 2014 take the format of a High-Level Meeting of the General Assembly** and that it receives the first biennial progress report on the GMF and targets.

5. Support the application of global targets to regional and national levels

- In parallel to the development of the GMF, the UN Political Declaration on NCDs commits UN Member States to "*consider the development of national targets and indicators based on national situations".* **National targets are essential for the NCD response**, as it is countries themselves that are the foundations of accountability.
- **The set of global NCD targets and indicators should provide a template and guidance for countries to develop their own national targets.** National targets need to be consistent with the global targets, but be **adapted to specific national contexts including relative burden and etiology of NCDs**. Adaptations should be based on criteria similar to those used by WHO for the global targets – measurability, achievability, and feasibility.
- **Regional targets on NCDs will also be important in ensuring harmonisation and coordination within regions.** A good example of regional NCD targets can be seen in the recently adopted PAHO Regional NCD Strategy, which includes a comprehensive set of regional targets and indicators.
- There is a **clear leadership role for WHO in providing guidance to governments and strengthening capacity in countries** to facilitate the translation of global NCD targets and indicators to the national level. This was explicitly referenced in the UN Political Declaration on NCDs and WHO Discussion Paper 2.
- The more successful global monitoring efforts have been accompanied by **investments in country-level surveillance and institutional capacity strengthening**, including developing the health workforce. As mandated in the UN Political Declaration, international collaboration is required to strengthen country-level NCD surveillance and monitoring, including the development of population-based registries and the integration of NCD surveillance into national health information systems.
- **Civil society has a key role in the accountability process**, particularly at the national level. National monitoring and reporting requires the **active engagement of governments with communities and civil society, including NGOs, academics and people with NCDs**. Drawing from the HIV/AIDS response, the establishment of **national NCD commissions** could facilitate this.

Annexes

- **Annex 1: NCD Alliance proposed set of global NCD targets and indicators**

  The NCD Alliance's proposed set of global NCD targets and indicators for adoption by Member States, based upon the WHO Discussion Papers.

- **Annex 2: NCD Alliance detailed comments on the WHO proposed global NCD targets and indicators**

  The NCD Alliance's detailed comments and recommendations on the WHO proposed set of global NCD targets and indicators.

Annex 1: NCD Alliance Proposed Set of Global NCD Targets and Indicators

Targets		Indicators
GOAL	**Premature mortality from NCDs** *25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease*	*Unconditional probability of death 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
1	**Tobacco smoking** *30% relative reduction in prevalence of current tobacco smoking*	*Age-standardized prevalence of current tobacco smoking among persons aged 15+ years*
		Average price of 100 cigarettes, expressed as a percentage of GDP per capita.
2	**Dietary salt intake** *30% relative reduction in mean adult (aged 18+) population intake of salt, with aim of achieving recommended level of less than 5 grams per day*	*Age-standardized mean population intake of salt (sodium chloride) per day in grams in adults aged 18+ years*
3	**Raised blood pressure** *25% relative reduction in prevalence of raised blood pressure*	*Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as mean systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*
4	**Physical inactivity** *10% relative reduction in prevalence of insufficient physical activity in adults aged 18+ years*	*Age-standardized prevalence of insufficiently active adults aged 18+ years (defined as less than 150 minutes of moderate intensity activity per week, or equivalent)*
5	**Alcohol** *10% relative reduction in overall alcohol consumption (including hazardous and harmful drinking)*	*Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol*
		Recommend an additional indicator is developed to monitor children/youth exposure to marketing of alcohol.
6	**Obesity** *Halt the rise in obesity prevalence.*	*Age-standardized prevalence of obesity (defined as BMI equal or greater than 30 kg/m2) in adults aged 18+ years.*
	Refer to existing target No increase in childhood overweight by 2025 for infants and young children under the age of 5 (WHA65[6])	*Age-standardized prevalence of overweight in adults aged 18+ years and adolescents (defined as body mass index equal or greater than 25 kg/m² for adults and according to the WHO Growth Reference for adolescents)*
		Recommend an additional indicator is developed to capture obesity and overweight in school-aged children aged 5-18, using WHO Growth Reference Standards
		Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day
		National policies that virtually eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and replace with polyunsaturated fatty acids (PUFA)
		Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, added sugars, or salt.
		Recommend two additional indicators are developed to capture data on energy density: *Age-standardised mean population intake of added sugar per day as a percentage of total energy.* *Age-standardised mean population intake of total fats per day as a percentage of total energy.*

7	**Fat intake** *15% relative reduction in mean proportion of total energy intake from saturated fatty acids (SFA), with aim of achieving recommended level of less than 10% of total energy intake*	*Age-standardized mean proportion of total energy intake from saturated fatty acids (SFA) in adults aged 18+ years.*
		Age-standardized mean proportion of total energy intake from polyunsaturated fatty acids in adults aged 18+ years.
8	**Raised cholesterol** *20% relative reduction in prevalence of raised total cholesterol*	*Age-standardized prevalence of raised total cholesterol among adults aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dl)*
9	**Drug therapy to prevent heart attacks and stroke** *50% of eligible people receive drug therapy and to prevent heart attacks and strokes, and counselling*	*Drug therapy to prevent heart attacks and strokes (includes glycemic control), and counselling for people aged 40 years and over with a 10 year cardiovascular risk≥30 per cent (includes those with existing cardiovascular disease).*
		Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as mean fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)
10	**Availability of essential NCD medicines and technologies to treat major NCDs** *80% availability of essential medicines and technologies required to treat major NCDs in both public and private facilities.*	*Availability of essential medicines and technologies required to treat major NCDs in public and private sector facilities, including primary care facilities.*
		Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.
Additional indicators		
		Recommend more detail is provided: *Vaccination against infectious cancers: Human Papillomavirus (HPV) and Hepatitis B virus (HBV)*
		Prevalence of women between ages 30-49 screened for cervical cancer at least once
		Additional indicator recommended to monitor commitment made in para 43k of Political Declaration to "Promote increased access to cost-effective cancer screening programmes, as determined by national situations": *% districts with breast cancer screening services for women aged 40-64*

Annex 2: NCD Alliance Detailed Comments on the WHO Proposed Global NCD Targets and Indicators

WHO proposed target		WHO proposed indicators	NCD Alliance comments and recommendations
GOAL	**Premature mortality from NCDs** *25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease*	*Unconditional probability of death between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.*	**Recommend describing this adopted target as the 'goal' of the Global Monitoring Framework (GMF).**
			This proposed indicator relates to the combined mortality risk of the four major NCDs and so progress across all four will be critical to achieve this target.
		Cancer incidence, by type of cancer per 100,000 population	**Recommend edit (in bold) to indicator** to align with globally accepted practice: *Cancer incidence, by type of cancer per 100,000 population **and stage (as appropriate)**"*
1	**Tobacco smoking** *30% relative reduction in prevalence of current tobacco smoking*	*Age-standardized prevalence of current tobacco smoking among persons aged 15+ years*	**Recommend additional indicator**on affordability of tobacco, sourcing data on price through country reports on FCTC implementation (or national CPI): *Average price of 100 cigarettes, expressed as a percentage of GDP per capita*. **Rationale:** In order to see whether a country is making progress (or moving backward) on tobacco taxation, it is important to measure changes in affordability. To compare countries with vastly different levels of income, prices need to be compared to income levels; GDP per capita is the most easily available measure. Most countries collect tobacco price information as part of routine data-gathering for Consumer Price Index. In the minority of countries where cigarettes are not the dominant product, some alternative approach might be required. **The GMF should explicitly recognize the role of the FCTC Conference of the Parties** as the primary global forum for discussions on tobacco control implementation and accountability. **Targets to reduce oral tobacco use** should be developed by WHO for adaptation and adoption at national levels, as appropriate.
2	**Dietary salt intake** *30% relative reduction in mean adult (aged 18+) population intake of salt, with aim of achieving recommended level of less than 5 grams per day*	*Age-standardized mean population intake of salt (sodium chloride) per day in grams in adults aged 18+ years*	**Recommend support as is.**
3	**Raised blood pressure** *25% relative reduction in prevalence of raised blood pressure*	*Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*	**Recommend edit (in bold) to indicator:** *Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as **mean** systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*

4	**Physical inactivity** *10% relative reduction in prevalence of insufficient physical activity in adults aged 18+ years*	*Age-standardized prevalence of insufficiently active adults aged 18+ years (defined as less than 150 minutes of moderate intensity activity per week, or equivalent)*	**Recommend support as is.**
5	**Alcohol** *10% relative reduction in overall alcohol consumption (including hazardous and harmful drinking)*	*Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol*	**Recommend an additional indicator**be developed to monitor children/youth exposure to marketing of alcohol.
6	**Obesity** *Halt the rise in obesity prevalence.*	*Age-standardized prevalence of obesity (defined as BMI equal or greater than 30 kg/m2) in adults aged 18+ years.*	**Recommendthe recently adopted global target for "no increase in childhood overweight by 2025 for infants and young children under the age of 5 (WHA65[6])"** is integrated into this GMF, along with an indicator to capture obesity and overweight in school-aged children aged 5-18, using WHO Growth Reference Standards. **Rationale:** Overweight and obese children face many of the same health conditions as adults, and can be particularly sensitive to the effects on their self-esteem and peer-group relationships. Moreover, the most significant outcome of childhood obesity is the likelihood that these children will progress to being obese adults and suffer chronic diseases at a much younger age. There is also evidence that a target on childhood obesity is achievable, given recent data suggested that obesity prevalence is stabilising among certain age groups in some countries.
		Age-standardized prevalence of overweight in adults aged 18+ years and adolescents (defined as body mass index equal or greater than 25 kg/m² for adults and according to the WHO Growth Reference for adolescents)	
		Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day	**Recommend support as is.**
		National policies that virtually eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and replace with polyunsaturated fatty acids (PUFA)	**Recommend support as is.**
		Policies to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt	**Recommend edits (in bold) to indicator:** *Policies to reduce the impact on children of marketing of foods **and non-alcoholic beverages** high in saturated fats, trans-fatty acids, ~~free~~ **added** sugars, or salt.*

			Recommend two additional indicators to capture data on energy density: *Age-standardised mean population intake of added sugar per day as a percentage of total energy.* *Age-standardised mean population intake of total fats per day as a percentage of total energy.* **Rationale:** Low energy-dense diets are associated with a lower risk of overweight and obesity. Currently there are no indicators (or targets) to capture data on energy density. Thesetwo additional indicatorswill ensure this GMF is in line with recommendations from the joint WHO/FAO consultation on diet, nutrition and the prevention of chronic diseases. Food Balance Sheets (or 'disappearance sheets') from the FAO have previously been used by WHO to provide a picture of energy intake, sugar and/or total fat intake. Using such an approach would limit the reporting burden on Member States.
7	**Fat intake** *15% relative reduction in mean proportion of total energy intake from saturated fatty acids (SFA), with aim of achieving recommended level of less than 10% of total energy intake*	*Age-standardized mean proportion of total energy intake from saturated fatty acids (SFA) in adults aged 18+ years.*	**Recommend support as is.**
		Age-standardized mean proportion of total energy intake frompolyunsaturated fatty acids in adults aged 18+ years.	**Recommend support as is.**
8	**Raised cholesterol** *20% relative reduction in prevalence of raised total cholesterol*	*Age-standardized prevalence of raised total cholesterol among adults aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dl)*	**Recommend support as is.**
9	**Drug therapy to prevent heart attacks and stroke** *50% of eligible people receive drug therapy and to prevent heart attacks and strokes, and counselling*	*Drug therapy to prevent heart attacks and strokes (includes glycemic control), and counselling for people aged 40 years and over with a 10 year cardiovascular risk≥30 per cent (includes those with existing cardiovascular disease).*	**Recommend support as is.**
		Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)	**Recommend edit (in bold) to indicator:** *Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as **mean** fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)*

10	**Availability of genericessential NCD medicines and basic technologies to treat major NCDs** *80% availability of basic technologies and generic essential medicines required to treat major NCDs in both public and private facilities*	*Availability of basic technologies and generic essential medicines required to treat major NCDs in public and private sector facilities, including primary care facilities.* *The minimum list would include: Medicines - at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant. Technologies - at least a blood pressure measurement device, a weighing scale, blood sugar and blood cholesterol measurement devices with strips and urine strips for albumin assay.*	**Recommend edits (in bold) to both target and indicator:** Availability of ~~**generic**~~essential NCD medicines and ~~**basic**~~ technologies to treat major NCDs**.** **We also recommend <u>deleting</u> the minimum list.** **Rationale:** The focus should be on the availability of essential, affordable and quality-assured medicines and technologies, whether or not they are generic or basic. We recommendalignment with the well-established and comprehensive WHO Model Essential Medicines Lists (EML and EMLc) which are selected against globally agreed criteria, updated every two years and adopted at national level. Definition of a baseline for future monitoring and/or a sub-set of the essential medicines and technologies will require further consultation to ensure a balance across the four major NCDs, as well as reflecting the WHO criteria for selection of indicators.
		Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.	**Recommend support as is.**
Additional indicators		**WHO proposed indicators**	**NCD Alliance comments and recommendations**
		Vaccination against infectious cancers: Human Papillomavirus (HPV) and Hepatitis B virus (HBV)	**Recommend support but this indicator requires more detail.** Suggestions include: delivery of Hepatitis B vaccine within 24 hours of birth; prevalence of HBsAg carriers in children aged ≤ 1 year; number of girls aged 15 in target population who have received three doses of the HPV vaccine / Total number of 15 year old girls in target population x 100
		Prevalence of women between ages 30-49 screened for cervical cancer at least once	**Recommend support as is.**
			Recommend an additional indicator to monitor commitment made in para 43k of Political Declaration to "Promote increased access to cost-effective cancer screening programmes, as determined by national situations": *% districts with breast cancer screening services for women aged 40-64*