UN resolution on the prevention and control of non-communicable
diseases: An opportunity for global action

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In May 2010, the United Nations (UN) General Assembly unanimously adopted a resolution on non-communicable diseases (NCDs) that called for high-level meetings to address the global burden of NCDs. This paper highlights the growing global burden of NCDs (cardiovascular diseases, cancer, chronic obstructive pulmonary diseases and diabetes), provides a brief historical background on the adoption of the UN NCDs resolution and argues that the resolution provides a remarkable new opportunity for improved international collaboration to address NCDs. Additionally, the paper argues that while the existing World Health Organisation programme on NCDs be continued and expanded, the UN can provide the expanded political leadership that is necessary for multi-sectoral collaboration and can serve as a respected forum for dealing with the issue across numerous key UN agencies.

Keywords: non-communicable diseases (NCDs); United Nations (UN) resolution; global health; tobacco control; burden of disease

Introduction

In May 2010, the UN General Assembly unanimously adopted a resolution on prevention and control of non-communicable diseases (NCDs) (UN General Assembly 2010) calling for:

(1) A high-level NCDs meeting of the General Assembly in September 2011; discussion of NCDs at a high-level plenary meeting during the General Assembly’s review of the Millennium Development Goals (MDGs) in September 2010.

(2) A Secretary-General’s report on the global status of NCDs in preparation for the September 2011 meeting.

The resolution marks a critical moment in addressing NCDs at the global level that began nearly 20 years ago with the Global Burden of Disease Project (GBDP) (Alleyne \textit{et al.} 2010, Fuster and Kelly 2010, Narayan \textit{et al.} 2010, Piot 2010). First
commissioned in 1991 by the World Bank, the GBDP provided the first standardised, data-driven evidence of the impact of NCDs not only in high-income countries but also in low- and middle-income countries (LMIC). Since then, updates and refinements in the GBDP have made even clearer the toll of NCDs in high-, middle- and low-income countries. Approximately 60% of the world’s mortality, or 35 million deaths in 2005, resulted from NCDs (cardiovascular diseases, cancer, chronic obstructive pulmonary diseases and diabetes), and 80% of these occurred in developing countries (WHO 2005). While the proximate causes of this disease burden are individual lifestyle behaviours mediated by societal and environmental factors, the globalisation of alcohol, food processing and tobacco marketing – as well as industrialisation and urbanisation – have contributed to the increase of NCDs worldwide, demanding improved global collective action in response.

The growing challenge of NCDs has been overshadowed by traditional issues in international health, including unfinished agendas in infectious disease and maternal and child health. The MDGs were lauded for identifying goals to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases. Yet, there is no mention of NCDs, which are affected by poverty and may, in turn, exacerbate poverty due to the high costs of treating established NCDs (Alleyne et al. 2010, Fuster and Kelly 2010, Narayan et al. 2010). NCDs are therefore a major development issue for the twenty-first century. However, unlike infectious diseases that are spread by bacteria, virus and pathogens, NCDs are mostly related to human commerce, information asymmetry regarding health risks and preventable behavioural risks. NCDs must be addressed not only through individual lifestyle changes (tobacco use cessation, limiting alcohol use, healthy diet and physical activity), but also through public policy interventions to modify societal and environmental factors that affect the context within which individuals make behavioural choices. These include interventions such as requiring food companies to eliminate trans-fats, improving community access to healthy foods, restricting marketing of unhealthy foods and tobacco, and transformation of health systems to assure application of clinical prevention approaches. Additionally, because of the globalisation of alcohol, food and tobacco industries worldwide, there is a need for global collaboration among stakeholders, including states, governmental and non-governmental organisations and the private sector, on prevention of NCDs as a global public good.

The absence of an NCD-related goal in the MDGs and the overall lack of attention to NCDs within the dominant health and development framework have led to an independent stream of work in NCDs apart from the broader development agenda. At the World Health Organisation (WHO), this began in 2000 with the Global Strategy for the Prevention and Control of Non-communicable Diseases (World Health Assembly 2000) followed by the Global Strategy on Infant and Young Child Feeding in 2003 (WHO 2003a), the Framework Convention on Tobacco Control (FCTC) in 2003 (WHO 2003b), the Global Strategy on Diet, Physical Activity and Health in 2004 (WHO 2004) and the Global Alliance against Chronic Respiratory Diseases (GARD) (Bousquet et al. 2007). The culmination of work in these areas was the 2008 Action Plan on the Global Strategy for the Prevention of Chronic Disease (APGSPCD) (WHO 2008), which also involves other governmental and non-governmental institutions. These efforts, spanning almost 20 years, have resulted in very limited, if any, policy change at the country level. This may be
principally due to the complexity and cross-cutting nature of NCDs, but may also be a result of inadequate political leadership at the global level.

In May 2009, the UN Economic and Social Council (ECOSOC) Western Asia Ministerial Meeting on NCDs resulted in a statement for the need of a UN General Assembly Special Session on NCDs in developing countries. An ECOSOC meeting in July 2009 called for the implementation of the APGSPCD. At the UN General Assembly meeting in September 2009, Trinidad and Tobago called for a high-level meeting on NCDs, subsequently introducing a May 2010 draft resolution to the UN General Assembly, which was unanimously supported by Member States. With this political commitment, NGOs such as the Non-communicable Disease Alliance and the Framework Convention Alliance (Mamudu and Glantz 2009) were empowered to make further policy recommendations such as those found in the 2009–2013 WHO Action Plan on NCDs. These include developing regulatory measures on the use of salt, fat and sugar in processed food, eliminating subsidies for harmful crops and strengthening health systems to make available and accessible treatment for NCDs (Fuster and Kelly 2010, Narayan et al. 2010, Piot 2010). At the same time, it is important to sustain governmental and non-governmental interest in NCDs and to create a venue for global deliberations on NCDs that could encourage national actions as well.

An opportunity for action

WHO’s NCD efforts over the last two decades have been encouraged and supported by governmental and non-governmental organisations. Limited in scope, the number of stakeholders involved, funding, or a combination of these factors, none of the organisations outside the UN system have the political authority to drive the global response on NCDs. This authority and the necessary technical leadership and credibility of all UN agencies may be mobilised through the NCDs resolution. It has become abundantly clear, as outlined in the 1986 Ottawa Charter for Health Promotion, that policy approaches through prevention, especially in tobacco use and obesity, are the most efficient and cost-effective ways of dealing with NCDs (Fuster and Kelly 2010). These approaches must also be complemented with the transformation of health-care systems to better address secondary and tertiary approaches to NCD prevention (Novotny 2008). The approach to global NCDs by the UN should address the following issues:

Visibility of NCDs

NCDs are a low global health priority despite their economic and human burden on countries. The prioritisation of NCDs for institutional UN support can raise its visibility as a critical health and development challenge.

Leadership

Global initiatives on NCDs are fragmented. Although the WHO has provided technical leadership on NCDs, it lacks the political authority and governance to motivate concerted action by the wide range of global stakeholders. These efforts need to be complemented by the international political support that can only be
obtained through the UN overall. UN leadership can better fill the current void of political commitment, creating a more encompassing environment for governmental and stakeholder action on NCDs and elevating the issue on the domestic policy agendas of Member States. Thus, while the current NCD work of WHO should be continued, expanded and endorsed during the 2011 UN Summit, additional strength should be added to NCD strategies through broader UN action.

**Coordination and collaboration**
The UN could help to coordinate global activities on NCDs and foster collaboration among the numerous stakeholders, including governments, Bretton Woods institutions, private foundations and donors, NGOs, civil society, corporate actors and academia.

**Priority setting**
The expertise and convening power of UN agencies could promote a well-defined set of priorities for global action on NCDs based on the APGSPCD (WHO 2008).

**Mobilise resources**
Expertise in UN agencies and resources made available through collaboration with other entities can expand financial and human resources necessary for NCDs prevention and control. Globally, the total development assistance for health for developing countries between 2001 and 2008 was US$22 billion, of which only 3% (US$503 million) was spent on NCDs (Nugent and Feigl 2010). Moreover, the governance of multinational organisations such as the WHO and UN is inhibited by budgetary limitations such as the requirement for zero-nominal growth of the regular budget under the US Helms Biden Legislation (The 106th US Congress 1999). These data suggest that both national and global health expenditures on NCDs are very little compared to the scale of the disease burden. Given the current budgetary restrictions of the UN specialised agencies, one possible solution is that donors for extra-budgetary priorities should specifically earmark funding for NCDs for the UN operating budget.

**Multi-sectoral collaboration**
The NCDs issue has become globalised beyond the capacity of any single country or organisation. The UN Ad Hoc Interagency Task Force on Tobacco Control, chaired by WHO and comprising 22 Agencies of the UN system, as well as the World Bank and the World Trade Organisation, provides a model for a UN system-wide multi-sectoral collaboration on NCDs. A similar effort to coordinate activities across the UN to reduce the burden of obesity and overweight would include the World Food Program, UN Food and Agricultural Organisation, UN Children’s Fund, UN Conference on Trade and Development and UN Development Program.

While the private sector role in addressing NCDs is absolutely critical, partners must be selected cautiously. Industries such as the tobacco industry should continue to be screened out of any involvement in UN work, and alliances with alcohol,
beverage and pharmaceutical companies should be approached with caution, avoiding any suggestion of policy influence not based on evidence and ethical standards. Similarly, NGOs and civil society must ensure that the interests and perceived needs of communities affected by NCDs be met. In this respect, government–private sector collaborations such as Global Alliance for Vaccines and Immunisation, Global Alliance for Improved Nutrition and International AIDS Vaccination Initiative provide additional models for global multi-sectoral collaboration on NCDs. Multi-sectoral collaboration should take into consideration private sector initiatives such as the Global Alliance on Chronic Diseases, formed in June 2009 to mobilise resources for NCD research in developing countries. In addition, the Oxford Health Alliance, a private–public partnership established in 2003 and involving leading academics, NGOs, activists, corporate and industry executives, patients’ rights advocates and health professionals, addresses tobacco use, physical activity and poor diet as the three major risk factors for NCDs.

**Transparency and accountability**

Large foundations and donors drive efforts on global health issues, and these are coming under scrutiny for lack of transparency in their grant-making decisions (Sridhar and Batniji 2008). As such, governmental and non-governmental decisions and actions on NCDs should be public and accessible to all stakeholders. Multi-level negotiations and public–private sector agreements on NCDs should be conducted in the public domain. Information on NCD-related activities from the decision-making process to monitoring of policies and programmes and reporting of research results should be available and accessible to the public, through electronic media or upon request of stakeholders. In the financing system in particular, there should be transparency on the source of funding, how funds are allocated and what the measurable results for the expenditures were. By conducting NCD-related transactions in the public domain, individuals, governments and governmental and non-governmental organisations could be more accountable to the multinational governance structure represented by the UN. Through transparency and accountability, progress or lack of progress in the global efforts to combat NCDs can be documented.

**Research**

Over the past several decades, accumulated data have shown how NCDs have been increasing and more globalised. The existing data, however, do not paint a complete picture of NCDs in developing countries. Country- and region-specific studies that cover the broad research spectrum of basic science to advocacy and policy are needed. Governmental and non-governmental efforts, including those by the Global Alliance for Chronic Diseases (Daar *et al.* 2009) and the National Heart, Lung and Blood Institute (Fuster and Kelly 2010), facilitate NCD research and garner global support for multinational collaboration. It is important to re-calibrate the resource base for implementation research to identify best practices in both developed countries and LMIC.
Nationalisation

The gap between multinational recommendations and national policies should be closed. Broad-based resolutions and declarations should stimulate specific national obligations that set the floor for policy actions and standards for which states could be held accountable. The ‘soft law’ of international agreements only irregularly stimulates national actions; ‘hard law’ such as the FCTC might become more important governance structures to assure committed national action on a broad range of NCDs. To this end, research on the implementation of the FCTC at regional and national levels is needed.

The UN is uniquely positioned to assume a strong political leadership role to complement WHO’s technical lead in the fight against NCDs. The high-level meeting on NCDs to take place in September 2011 holds promise as a turning point for truly coordinated global efforts on NCDs. Since the early 1990s, besides the FCTC, efforts towards collective action in NCDs have merely resulted in declarations such as those on cardiovascular diseases (Victoria in 1992 and 2000; Catalonia in 1995 and 1997; Singapore in 1998; Osaka in 2001; and Milan in 2004) or resolutions such as 2007 UN resolution on diabetes with no concrete obligation on countries to develop policies and programmes for NCDs or allocate (earmark) resources for it. The upcoming UN summit on NCDs presents an opportunity that cannot be wasted on rhetoric or political infighting; the burden of NCDs requires immediate action.

References


