Measuring progress on NCDs: one goal and five targets

Heads of states and governments made commitments to the prevention and control of non-communicable diseases (NCDs) in the Political Declaration from the UN High-level Meeting on NCDs in September, 2011.[1] A key commitment in the Political Declaration calls upon WHO to develop a comprehensive global monitoring framework to assess progress in the implementation of national strategies and plans for the four main NCDs: cardiovascular diseases (CVD), diabetes, cancer, and chronic respiratory diseases.

Central to the monitoring framework is the selection of goals and targets for NCDs. WHO member states have agreed on an NCD target of a 25% reduction by 2025 in the probability of dying from the four main NCDs for people aged 30–70 years.[2] We refer to this target as the overarching NCD goal ("25 by 25"). The latest WHO proposals include ten targets to reach this goal.[3] Although these targets address important areas of NCD prevention, the choice and hierarchy of the ten targets is based on their level of support by member states. There is strong support from member states for targets on raised blood pressure, tobacco smoking, salt intake, and physical inactivity. Targets deemed as "requiring further development" relate to obesity, fat intake, alcohol consumption, raised total cholesterol, the availability of essential generic NCD medicines and basic technologies to treat major NCDs, and drug therapy to prevent heart attacks and strokes.[3] Member states will discuss these proposed targets at a consultation in November, 2012, and the monitoring framework will be finalised at the World Health Assembly in May, 2013.

In our view, the key criteria for choosing any target should be that it has a strong scientific basis, is sensitive to change, and that achieving it will have a major impact on the global NCD mortality goal. Other criteria include empirical evidence that the target is achievable with cost-effective interventions that are feasible for scaling up, and that baseline data and robust methods for assessing progress are available.[4] Unlike WHO, we propose that implementation of interventions should initially be limited to only a small number of priority targets to ensure that existing resources are used most efficiently, with additional targets added as country experience and success builds. In proposing targets, we underline technical considerations over political consensus. Further, to promote equity, the targets must be reported in relation to measures of socioeconomic status, for example, education, and gender.

Based on earlier work undertaken with WHO,[5] we propose five priority targets to meet the NCD mortality goal by 2025, with 2010 as the baseline (figure). The priority targets include two of the main risk factors for NCDs—tobacco use and salt reduction (as the key dietary target)—and one treatment target. Physical inactivity and alcohol reduction have been included because they are the other two main risk factors for NCDs highlighted in the Political Declaration.[1]

Tobacco control is the key NCD target and is relevant for the prevention of a wide range of NCDs. The current global prevalence of tobacco smoking is about 23%, with major variations by country and gender.[6] We propose a 40% relative reduction in prevalence of tobacco use, including smokeless tobacco, by 2025; this target would achieve a global adult smoking prevalence of about 14%. The required rate of change has already been reached in several countries, including middle-income countries such as Uruguay.[7] Achievement of this target requires accelerated implementation of all elements of the WHO Framework Convention on Tobacco Control. Some countries have committed to being tobacco free by 2025.[8] An even longer-term global goal is for a tobacco free world by 2040, with a prevalence of adult tobacco use of less than 5%.[4]

The key dietary target is a reduction in population levels of salt consumption to reduce population blood

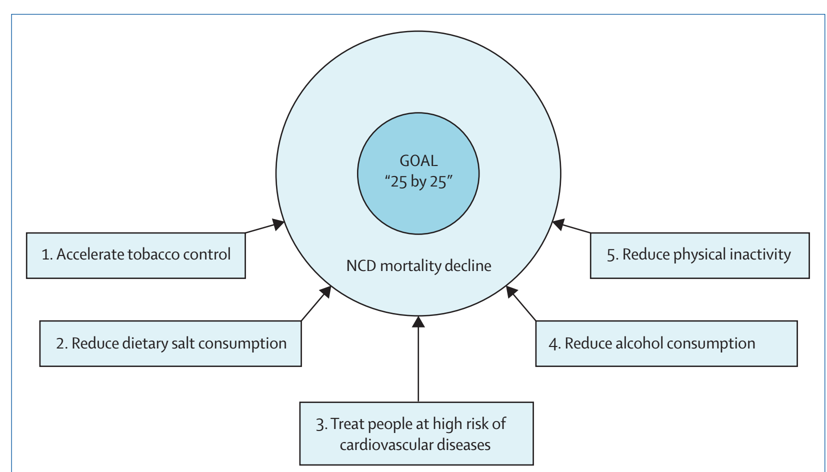

Figure: **Overarching NCD goal and five targets for 2025**

pressure. The target for 2025 is to achieve the WHO target of 5 g of salt intake per adult per day;[9] the current global daily salt intake is about 9–12 g of salt per adult.[10] There has been progress on population-wide reductions in salt consumption in countries such as the UK;[11] Brazil, Chile, Argentina, and South Africa are implementing ambitious programmes that engage with industry.

The key treatment target is to increase coverage of multidrug therapy, preferably fixed dose combination therapy, to at least 50% for people older than 50 years whose risk of a heart attack or stroke in the next 10 years is 30% or more, or for anyone who has already had a heart attack or stroke. The two populations for this treatment target—high-risk individuals with and without a history of CVD—present different challenges that could be addressed sequentially. Initially, it will be easier to focus on people with a history of CVD since many of them will have been identified in primary care settings; in low-income and middle-income countries, most of these people are not receiving any treatment.[12] Community health workers can identify people at high risk of a CVD event through opportunistic screening and use of risk charts in primary care settings. The treatment target is also an indicator for the provision of essential medicines for NCDs. It requires reorienting health systems away from expensive treatments delivered by secondary and tertiary facilities. Progress on a risk-based approach to the management of established CVD is being made in a few countries.[13]

On the basis of earlier estimates for 23 low-income and middle-income countries with a high burden of NCDs, the "25 by 25" NCD goal is achievable if the two population-wide targets on tobacco control and dietary salt reduction and the treatment target are widely adopted.[14,15]

The alcohol target is for a 10% relative reduction in per capita adult alcohol consumption by 2025; this could be achieved by affordable and cost-effective interventions, especially measures to make alcohol more expensive and less available.[16] Reductions in alcohol consumption have been achieved in several high-income and middle-income countries but harmful drinking remains a particular challenge in Russia and other countries of the former Union of Soviet Socialist Republics.[17]

The target on physical inactivity is for a 10% relative reduction in adult inactivity levels by 2025. This target provides an entry point for the health sector to engage with other sectors, for example, transport, energy, and urban planning; some programmes have been effective in low-income and middle-income countries.[18]

Once good progress has been made on the priority areas, countries may wish to consider other targets, such as childhood obesity and reduction in intake of trans and saturated fats. The World Health Assembly has adopted a global target for no increase in overweight among children younger than 5 years by 2025. Childhood obesity provides an important connection with the life course approach to NCD prevention, as well as with health agendas on reproductive, maternal, and child health. Many obesity prevention programmes are underway, especially in schools, but the need for evidence of long-term benefit remains and these programmes will have virtually no effect on the 2025 mortality goal.

For dietary components other than salt reduction, the best empirical evidence on consumption of fats is to restrict the use of trans fats, either through voluntary agreement with industry or outright bans.[19] There is also evidence from low-income and middle-income countries on the feasibility of reducing saturated fat consumption through policies that promote consumption of polyunsaturated fats, as in Poland and Mauritius.

Despite it being strongly supported by countries, we urge replacing the proposed WHO target on blood pressure, which is based on a cutoff point for hypertension, with one that is based on mean population blood pressure. A reduction in mean blood pressure through salt reduction and other population-based strategies, where feasible, is the best way to reduce the proportion of people with hypertension and the overall CVD burden associated with raised blood pressure. Unless achieved through a shift in the population distribution, a blood pressure target based on an arbitrary cutoff point runs the risk of mass treatment, since up to one in three adults in many countries could be considered as hypertensive. Such a strategy is not only costly but is also inadequate because half of all disease caused by high blood pressure occurs in people without hypertension.[20] Similar reasoning applies to blood cholesterol lowering based on an arbitrary cutoff point.

Achieving the priority targets for NCDs will require strong and sustained government commitment

and leadership in the context of multisectoral action supported by translational research. Many of the actions to achieve the targets will require "whole of government" and "whole of society" approaches. Achieving the proposed population-wide targets will benefit people of all ages and will contribute to improving mental health outcomes and other NCDs, such as asthma and oral health.

Serious challenges face countries and WHO as they move towards the global "25 by 25" NCD goal. Unfortunately, there is weak national NCD capacity and WHO has limited capacity and ability to respond to requests from countries for assistance. Budgetary allocations for NCDs by countries and within WHO are not commensurate with the scale of the problem, and resources to support low-income and middle-income countries through bilateral and multilateral channels are inadequate. The priority targets for NCDs need to be integrated into national health planning processes, and surveillance requires integration into national health information systems. Finally, a greater focus on integrated chronic care within primary health care is needed in all countries to meet the long-term requirements of NCDs. WHO, as the lead agency for NCDs, has the additional task of coordinating the actions of all UN agencies.

These challenges mean that countries should be wary of including too many targets on NCDs. Measuring progress on NCDs will, of course, require holding governments, international agencies, and donors accountable for all the commitments in the Political Declaration. If our proposed targets are widely adopted and the associated interventions implemented, progress in NCD prevention and management will meet the expectations raised by the UN High-level Meeting on NCDs.

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