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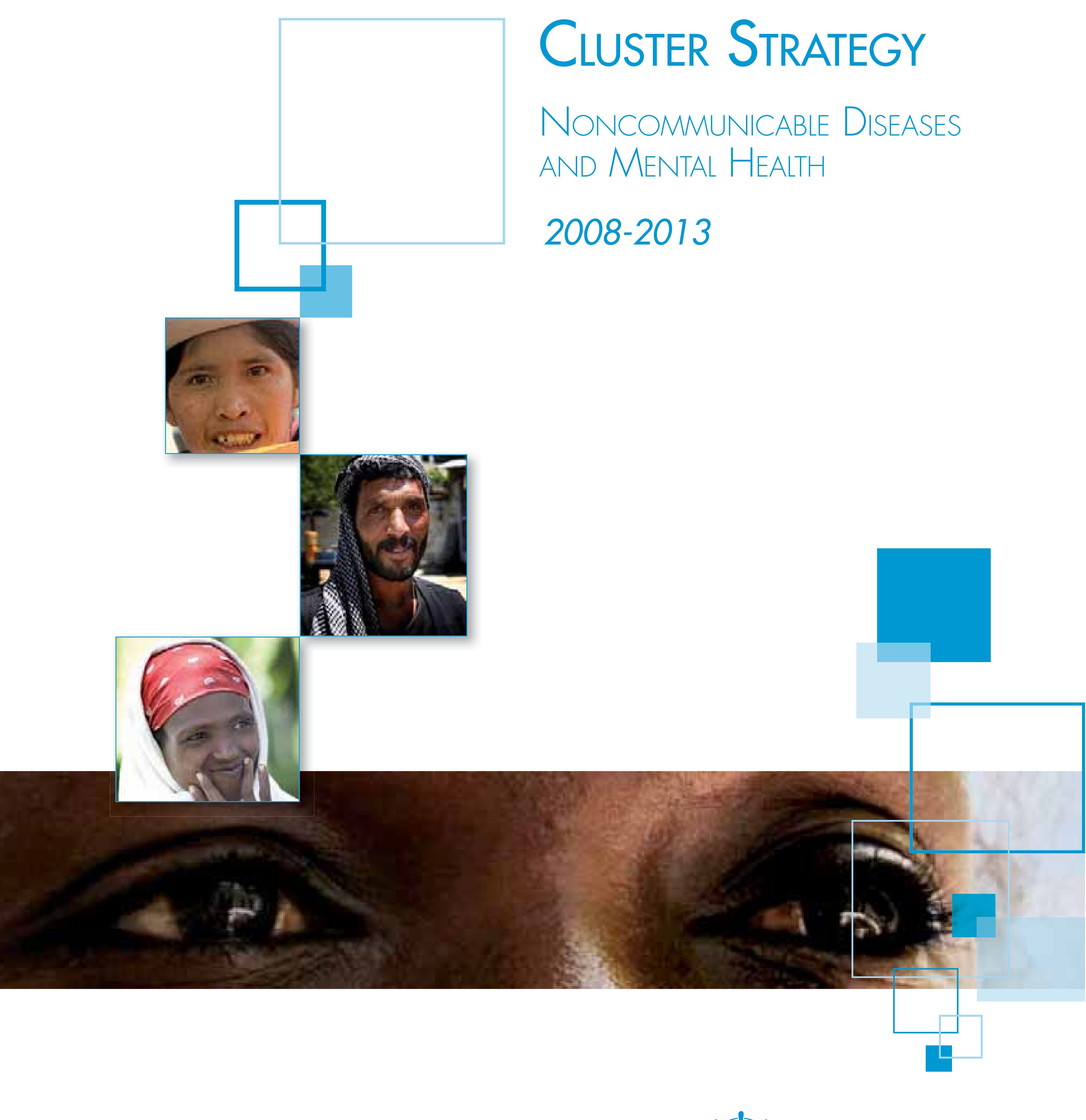
Cluster Strategy

Noncommunicable Diseases and Mental Health

2008-2013



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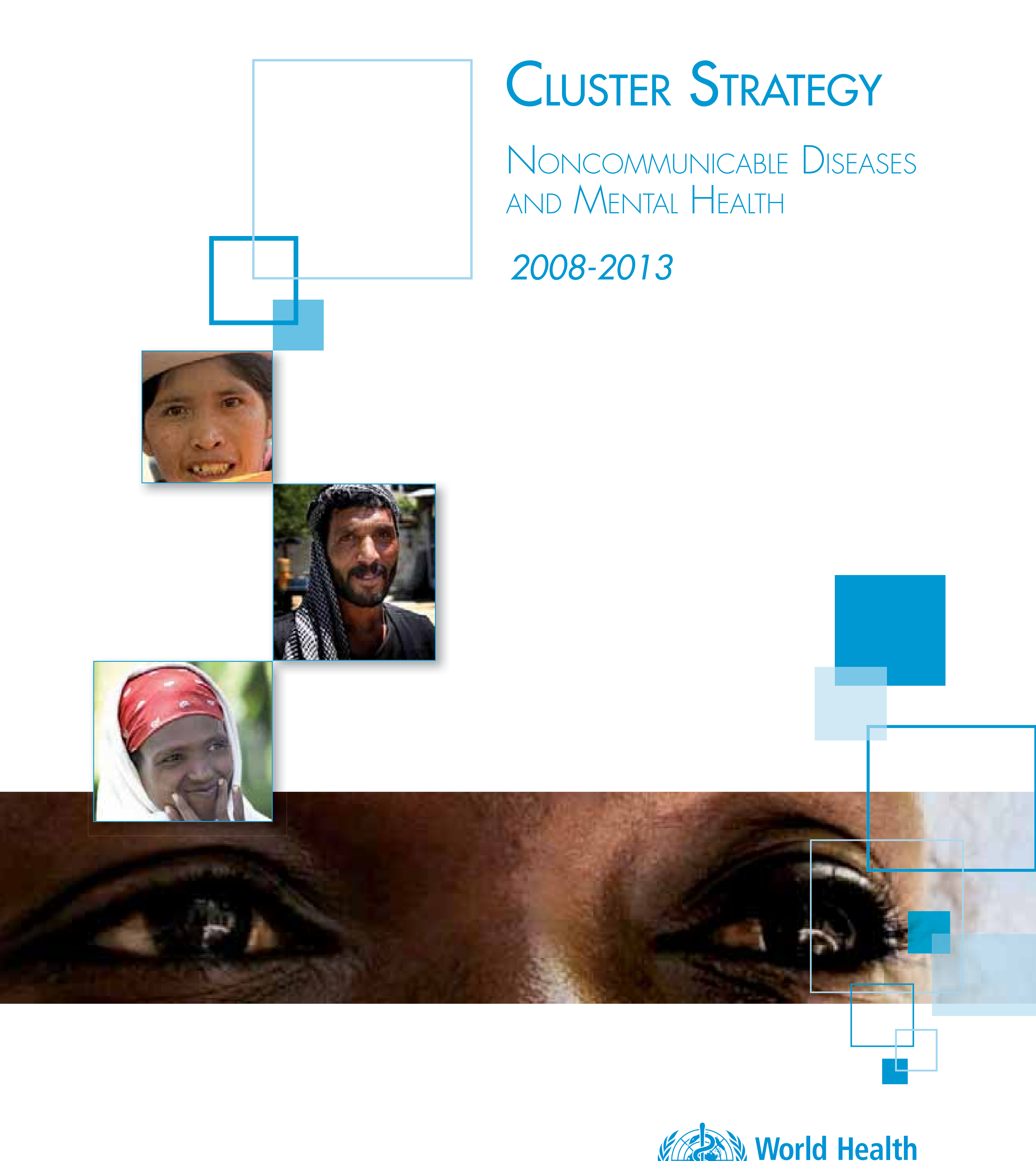

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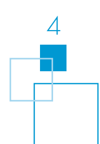
Cluster Strategy

Noncommunicable Diseases and Mental Health 2008-2013



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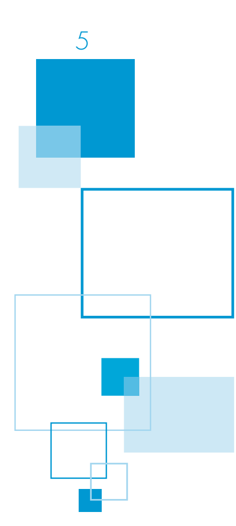

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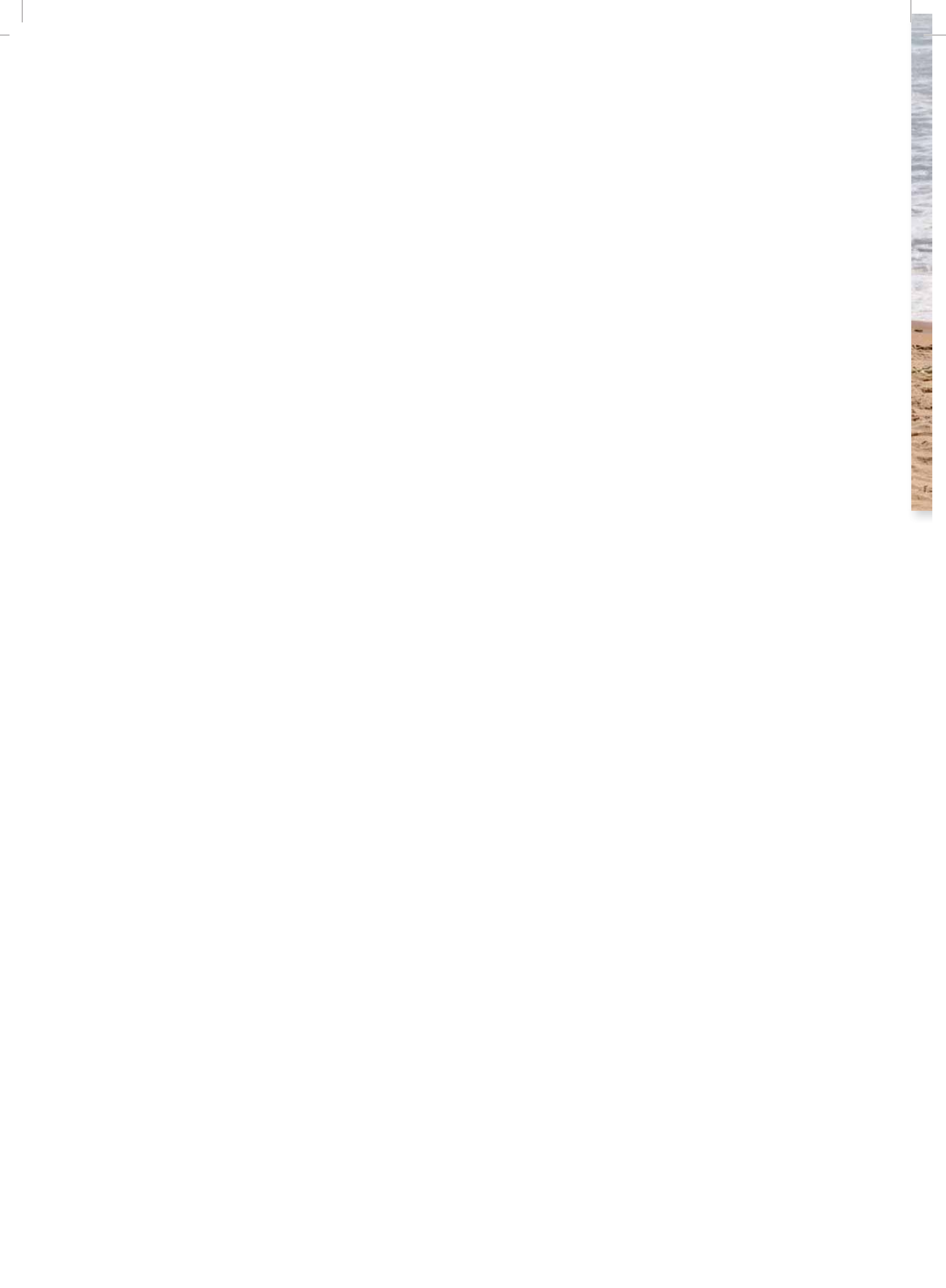


Foreword

In 2004, five of the top ten leading causes of death were related to noncommunicable diseases, nutritional deficiencies, mental disorders, violence and injuries. This is predicted to rise to eight of ten by 2030. Unless effective and coordinated global action is taken the increasing burden of noncommunicable conditions (NCCs) and malnutrition is set to derail international efforts in health and poverty reduction in low- and middle-income countries. The World Bank estimates an annual 1-5% reduction in GDP due to the impact of NCCs.

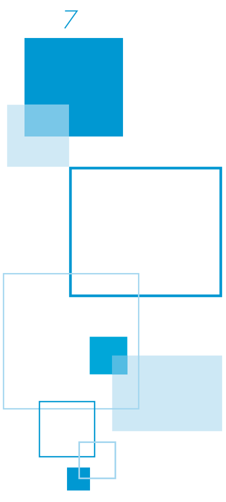
Socio-economic development is slowed as people die or are incapacitated, often during their most productive years. For the individuals affected and their families, the costs of NCCs and malnutrition create a poverty trap because of a loss of household income and out-of-pocket expenditure on health care in the presence of health systems that are ineffective in addressing the needs of people affected by these conditions.

However, affordable solutions exist today to prevent millions of premature deaths each year in developing countries, mainly through policy change, effective surveillance and monitoring, initiatives to reduce common risk factors, and the strengthening of health systems. A stronger commitment to tackle NCCs and malnutrition and forge new partnerships are critical to making progress.

This Cluster Strategy reviews the strategic directions adopted by the Noncommunicable Diseases and Mental Health (NMH) Cluster to address the NCC and malnutrition challenges and provides an outline of the expected outcomes for the Cluster during the period 2008-2013. It also presents NMH priorities in a user-friendly way to help international partners to determine investment priorities in WHO.

It is hoped that the Cluster Strategy will reinvigorate dialogue with partners on priorities for joint work in a global commitment to scaling up proven interventions for tackling NCCs and malnutrition.

Dr Ala Alwan
Assistant Director-General



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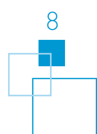
Noncommunicable Diseases and Mental Health 2008-2013



1. Magnitude and determinants

Purpose of the Strategy

The Strategy reflects the response of the Cluster to the enormous challenges in the global health agenda and the increasing demands to support countries in addressing noncommunicable diseases and conditions. It was developed through a process of consultation within the Cluster and with other Clusters and Regional Offices, guided by WHO's Medium-term Strategic Plan 2008-2013 and the relevant World Health Assembly resolutions and documents. A draft version was discussed with the Director-General and Assistant Directors-General (ADsG) during an ADsG's Retreat. A final version was approved by the Director-General on 2 September 2008. It was further updated in November 2009 to include developments and responses to resolutions adopted and decisions made by the Governing Bodies.

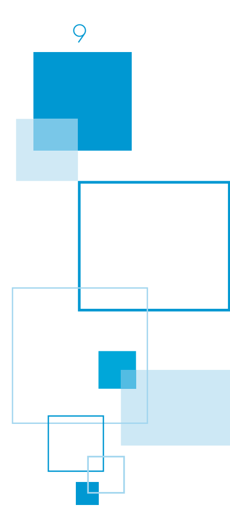
The leading causes of death and disease burden

The rapid rise of noncommunicable diseases (NCDs), mental disorders, injuries and violence represents one of the major health challenges to global development in the 21st century. These conditions are collectively responsible for almost 70% of all deaths[1]. NCDs alone caused an estimated 35 million deaths in 2004 (almost 60% of all deaths globally) and mortality is projected to increase by 17% over the next 10 years[2]. In 23 selected low- and middle-income countries which represent 80% of chronic disease mortality, NCDs were responsible for 50% of the disease burden in 2005[3]. Worldwide, deaths attributed to 8 out of the top 10 leading risk factor causes of death were related to NCDs, nutritional deficiencies, mental disorders, violence and injuries in 2004, including 7 out of the 10 leading risk factors in low-income countries. While 5 out of 10 leading causes of death were related to NCDs, nutritional deficiencies, mental disorders, violence and injuries in 2004, 8 out of the 10 leading causes of death will be linked to these conditions[4] by 2030.

Ten percent of the global population lives with a disability, representing about 600 million people[5]; ageing, chronic diseases, injuries, communicable diseases and improvements in medical care which prolong life, are among the causes of the continued increase in this number. Mental and substance use disorders are major causes of disability. In 2002, they accounted for 13% of the global burden of disease and this figure is rising[6]. By 2030, it is projected that depression alone is likely to be the second highest cause of disease burden – second only to HIV/AIDS[7]. In high-income countries, depression will become the single highest contributor to the overall disease burden[8].

The rapidly increasing burden is predominantly affecting low- and middle-income countries

80% of total deaths due to NCDs and 90% of all injury and violence related deaths occur in low- and middle-income countries. WHO estimates up to 8 million people die prematurely from NCDs in developing countries under the age of 60, or 14 million under the age of 70. If no action is taken the highest increase in deaths from NCDs over the next 10 years will occur in Africa (24%), followed by the Eastern Mediterranean Region (23%)[9]. The highest number of deaths in 2015 from NCDs are forecasted to occur in the Western Pacific (11,415,701 deaths) and South-East Asia (9,474,567 deaths)[10]. The rich-poor gradient *within* countries is also significant for NCDs: in the world's two poorest quintiles, NCDs accounted in 2005 for one-third of the disease burden[11] and the mortality rate is twice as high for the two poorest quintiles than for the richest[12]. The



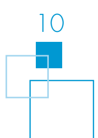
highest increase in deaths from injuries and violence (19%) is forecast to occur in the world's 43 poorest countries, predominantly due to the increasing number of deaths from road traffic crashes[13].

80% of people living with disabilities and serious mental disorders live in low- and middle-income countries where the majority are inadequately supported. Severely injured people are twice as likely to die in a low- or middle-income country than in the industrialized world[14]. It is estimated that up to 80% of persons with epilepsy, 75% with alcohol use disorders, 50% with depression and 30% with psychoses do not receive any treatment in low- and middle-income countries[15].

The nutrition-related MDGs and the double burden of malnutrition

Overall, the proportion of children under five years old suffering from undernutrition (according to WHO Child Growth Standards) declined from 27% in 1990 to 20% in 2005. However, progress has been uneven and an estimated 112 million children are underweight. There is a growing international awareness that several MDGs will not be reached in developing countries unless undernutrition is more effectively tackled. It is estimated that maternal and child undernutrition is the underlying cause of 3.5 million deaths annually and 35% of the total disease burden in children under 5 years of age. It is the direct cause of 11% of the total global disease burden, measuring deaths, disability and other disease outcomes. Stunting, or failure to thrive, affects 178 million or 32% of the world's children under 5 years of age, mainly in Sub-Saharan Africa and South-East Asia and among low-income groups throughout the world[16]. Furthermore, intrauterine growth retardation affects 24% or approximately 30 million newborn babies per year, profoundly influencing survival and physical and mental capacity in childhood. Deficiencies of vitamin A, zinc, iodine and iron are responsible for a considerable disease burden[17].

At the same time, overweight and obesity are increasing rapidly among young children and adolescents in developed and developing countries alike. Today, 20 million children under 5 years of age are estimated to be overweight[18]. Evidence suggests that maternal undernutrition and low birth weight predispose to adulthood obesity and chronic diseases.



Risk factors and determinants

Four of the most prominent NCDs – cardiovascular disease, cancer, chronic respiratory disease and diabetes – share preventable risk factors related to lifestyles. These factors are tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.

Tobacco kills up to half the people who use it. More than 1 billion people worldwide currently smoke tobacco and tobacco use currently kills more than 5 million people worldwide each year. Tobacco is a risk factor for 6 of the 8 leading causes of death[19].

Inappropriate diet and physical inactivity, both separately and in concert, contribute to the rise in obesity prevalence. Around 40% of people, worldwide, are not participating in sufficient physical activity to benefit their health. The resultant death toll in 2002 is estimated at 1.9 million. In 2000, at least 2.6 million people died of causes attributable to obesity[20].

Harmful use of alcohol is ranked as the third leading risk factor cause of disability-adjusted life years (DALYs) worldwide and is estimated to cause about 2.3 million premature deaths worldwide and is responsible for more than 4% of the global burden of disease[21].

Other modifiable risk factors representing important contributions to the burden include infections leading to cancer, excessive speeding, not wearing seat belts or helmets (road safety), substance abuse, gender and income inequalities (violence) and easy access to pesticides (suicide).

In 2002, it was estimated that chronic hepatitis B infection was killing 340,000 people per year from liver cancer and cirrhosis. A quarter of a million women were dying annually from cervical cancer. Vaccines now exist to prevent most of these deaths. Occupational carcinogens were estimated to kill at least 152,000 people per year. Indoor and outdoor air pollution was estimated to lead to 71,000 cancer deaths annually[22].

Visual loss is ranked as the second leading cause of years lived with disability. In 2007, 314 million people were visually impaired. The vast majority of visual impairment can be avoided through cost-effective interventions[23]. Globally, about 85% of all visual impairment and 75% of blindness could be prevented or cured. Hearing loss is the fourth leading cause of years lived with disability; in 2005, 278 million people worldwide lived with moderate to profound hearing loss in both ears[24]. At least half of all hearing impairment is preventable.

Serious implications on socio-economic development

These health problems have serious implications for macroeconomic development and may also derail other international efforts at poverty reduction. If left unaddressed, an estimated US$84 billion of economic production will be lost from heart disease, stroke, and diabetes alone in 23 low- and middle-income countries – these countries account for 80% of mortality from noncommunicable diseases in developing countries[25]. Among low- and middle-income countries, total diabetes-related costs have been estimated at between 2 and 4% of GDP income in some countries. GDP lost to malnutrition in low- and middle-income countries has been estimated to run as high as 2 to 3%[26]. The yearly cost of road traffic crashes to developing countries exceeds US$500 billion, twice the amount those countries receive yearly in official development assistance[27]. The global cost of the harmful use of alcohol in 2002 has been estimated to be between US$ 210 - 665 billion[28].

The economic burden attributable to these health problems can also be approached in terms of household impact. In the poorest households in some developing countries, 5-15% of total disposable income can be

spent on tobacco, and 15-25% of household income for treatment of diabetes[29]. Many people living with disabilities are trapped in a life of poverty because of the barriers disabled people face to taking part in education, employment and social activities.

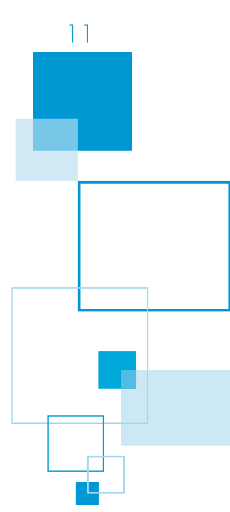
2. Response to the global challenge

Much of the NCDs, nutritional deficiencies, mental health and substance abuse disorders, disabilities, and violence and injuries can be prevented or treated by low-cost, high-impact, and evidence-based interventions. Investing in such interventions, particularly those related to primary prevention, provide the highest return in health and economic terms.

The importance to global health of addressing these health problems has been receiving increasing recognition and attention. The United Nations General Assembly, the World Health Assembly, and the WHO Regional Committees have adopted resolutions and calls for action, highlighting the need to raise awareness and institute effective prevention and control measures. While more calls for action are needed, there is also an urgent need for greater support and collaboration with public and private partners to avoid duplication and fragmentation. The strategy of the NMH Cluster is primarily guided by these resolutions and the lessons learned over the past decade to help improve the ability of partners to work more effectively together. Annex 1 contains a list of key resolutions.

3. The six-point agenda

All six areas for results included in the Director-General's agenda are relevant to the work of the Cluster. Of particular importance to the NMH Cluster are those included in the following table:



Six-Point Agenda	NMH priorities
Health and development	- Advocating for greater recognition of the bi-directional links between poverty and those conditions of concern to NMH, and addressing these links to accelerating progress to the MDGs. - Strengthening intersectoral work to address health risks and socio-economic determinants.
Health and security	- Addressing the consequences of rapid urbanization on the conditions of concern to NMH. - Addressing mental health and psychosocial needs, malnutrition and chronic diseases during crises and in recovery states. - Providing assistance to countries in strengthening trauma care and mass casualty management systems.
Health systems	- Strengthening health systems to bridge the prevention and treatment gaps, including scarcity of trained human resources and affordable health technologies and essential medicines, particularly in primary health care. - Integrating management of chronic noncommunicable diseases, nutrition and mental health services, injury and disability prevention, and rehabilitation into primary health care. - Developing synergies with other chronic conditions like AIDS and TB, which have similar health system needs.
Information, knowledge	- Improving national capacities to collect, analyse, and monitor data on the magnitude, risk factors and determinants of NCDs. - Working with the Information, Evidence and Research Cluster to strengthen global monitoring of NMH conditions and determinants. - Devising guidelines on evidence-based interventions for health promotion, risk reduction and control of these conditions.
Partnerships	- Promoting partnerships for the prevention and control of noncommunicable diseases, nutritional deficiencies, mental and substance use disorders, violence and injuries, and disabilities.
Performance	- Monitoring NCDs, nutritional deficiencies, mental and substance abuse disorders, violence and injuries, and disabilities, and their determinants and evaluating progress at the national, regional and global levels.

4. Mission of the NMH cluster

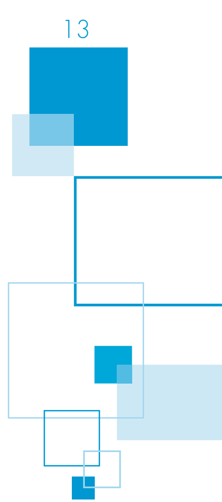
The mission of the Cluster is to provide the leadership and the evidence base for international action on surveillance, prevention and control of noncommunicable diseases, mental and substance abuse disorders, malnutrition, violence and injuries, and disabilities.

Working jointly with Regional and Country Offices, the NMH Cluster will support Member States in promoting health and in preventing premature death and disability from these conditions by addressing their key risk factors and determinants and improving health care and rehabilitation services.

5. Lessons learned from international experience and WHO's work in countries

Much is known about the prevention and control of NCDs, mental and substance abuse disorders, malnutrition, violence and injuries. Countries can reverse the advance of these health problems if appropriate action is taken. The NMH strategy is guided by the lessons learned from existing knowledge and experience, some of which are summarized below:

- Restricting strategies to reducing exposure to established risk factors is insufficient. A comprehensive prevention strategy must also include prevention of the emergence of risk factors in the first place and address their social determinants.
- In any population, most people have a moderate level of risk factors, and a minority has a high level. Those at moderate risk contribute more to the burden of disease than those at high risk. Consequently, strategies need to combine an approach to reduce risk factor levels in the whole population, while simultaneously targeting high-risk individuals.
- In order to achieve substantial reductions in morbidity and disease outcomes, delivery of interventions should be of appropriate scale, coverage and intensity and sustained over extended periods of time.
- Success of interventions requires community participation, supportive policy decisions, intersectoral action, legislation and collaboration with NGOs and the private sector.
- Joint work with non-health sectors is essential. Decisions made outside the health sector have a major influence on risk factors and determinants. More health gains are achieved by influencing policies in other domains than by changes in health policy alone.
- The long-term needs of people with NCDs and disabilities are rarely met successfully by the present organizational and financial arrangements of health care. Priority should be given to integrating basic prevention and control measures into primary health care and re-orienting health systems for more effective care for chronic conditions.
- For mental and substance use disorders, human rights considerations are important. Basic rights of people with these disorders are often violated and protection of these is an important need.
- Several MDGs will not be achieved in many countries unless undernutrition is addressed more effectively[30]. There is a need to adjust WHO priorities in nutrition to address gaps and to respond to emerging developments like the food crisis, impact of climate change, as well as population and economic trends.



- Although not included in the MDGs, noncommunicable conditions (NCCs), such as noncommunicable diseases, mental health disorders and road traffic injuries, impose a heavy burden on socio-economic development and are closely associated with poverty. The Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, 2002)[31] includes a call to action to "Develop or strengthen … programmes to address noncommunicable diseases and conditions, such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases, injuries, violence and mental health disorders and associated risk factors, including alcohol, tobacco, unhealthy diets and lack of physical activity." An ECOSOC resolution on tobacco control[32] recognizes the link between tobacco use and poverty. Bilateral policies for development assistance have started to recognize that low- and middle-income countries increasingly face a problem with NCCs[33]. The world's largest private foundations have started to call on governments in low- and middle-income countries to implement interventions to reduce tobacco use and save lives[34]. Hence, international public health advocacy in this area must be driven by one key idea: NCCs are closely linked to socio-economic development. These conditions are closely related to poverty and contribute to poverty: they should, therefore, no longer be excluded from global discussions on development. If the high mortality and heavy burden of disease experienced by low- and middle-income countries are to be tackled comprehensively, global development initiatives must take into account the prevention and control of NCCs.

6. Strategic directions

The strategic directions of the Cluster are based on the mandates given by resolutions of the United Nations General Assembly, the governing bodies of WHO, the general directions and priorities of the Medium-term Strategic Plan for 2008-2013, and the lessons learned from international experience and WHO's work in countries. The Cluster will strategically focus on five broad interrelated areas:

- *Advocacy:* Targeting stakeholders with the best available evidence for prevention and treatment to provide authoritative impetus to plan and

implement national responses. Advocacy tools will include data and trends on mortality, disease burden, economic impact estimates and cost-effectiveness, as well as the World Reports on NCDs, mental health and substance abuse, tobacco control, road safety, child injury prevention and disabilities.

- *Normative work:* Providing norms and standards, including definition of key indicators of diseases and conditions and their determinants, classifications of major conditions, diagnostic criteria and evidence-based prevention and management guidelines.
- *Technical support:* Supporting implementation of programmes at national level, jointly with Regional and Country Offices, by providing technical support to countries in assessing the current situation, defining appropriate policies, building national capacity and monitoring progress.
- *Strategic support for research and development:* Promoting the development of an agenda for research on conditions of NMH concern, with emphasis on priorities for prevention and control, including analytical, operational and behavioural aspects.
- *Global partnerships:* Taking the lead in strengthening international partnerships for surveillance, prevention, health promotion and management. Networking of national and regional programmes will be encouraged in order to disseminate information, exchange experiences and support national initiatives.

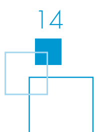
7. SPECIFIC TECHNICAL/DEPARTMENTAL STRATEGIES

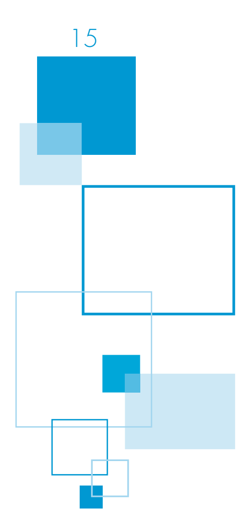
The departments of the NMH Cluster and the WHO Kobe Centre share important challenges and have inter-related agendas and cross-cutting themes, requiring close coordination and joint work. They are guided by the same principles of work. However, each has specific mandates, priorities and expected outcomes.

A common theme that runs not only across the work of the NMH Cluster but also across all other technical clusters at WHO, is health promotion, a comprehensive approach that is founded in the tradition of Alma Ata. It focuses on the enhancement of protective factors for health through empowerment of communities to control the determinants of their own health. A series of global commitments to health promotion, starting with the Ottawa Charter in 1986 and culminating in the 2005 Bangkok Charter on Health Promotion in a Globalized World and the 2009 Nairobi Call to Action have been the defining points to integrate health promotion and actions into the work of WHO. The responsibility for implementing health promotion actions into the work of WHO lies with WHO staff at all levels, while the process is catalysed by the Health Promotion Unit.

7.1. Noncommunicable Diseases

The broad strategic directions and lines of action are primarily based on the Global Strategy for the Prevention and Control of Noncommunicable Diseases (WHA53.17) and the corresponding Action Plan to implement the Global Strategy (A61/18, WHA61.14).





Objectives

The Global NCD Strategy has three main objectives:

- *Surveillance:* To map the emerging epidemics of NCDs and their major risk factors and to analyze the social, economic, behavioural and political determinants with particular reference to poor and disadvantaged populations;
- *Disease prevention and health promotion:* To reduce the level of exposure of individuals and populations to the common risk factors for NCDs, namely tobacco consumption, unhealthy diet, physical inactivity, harmful use of alcohol, and their determinants;
- *Management:* To strengthen health care for people with NCDs by developing norms and guidelines for cost-effective interventions, with priority given to cardiovascular diseases, cancer, diabetes and chronic respiratory diseases.

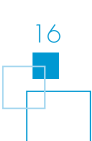
Priorities (2008-2013)

To translate the Global NCD Strategy into concrete action for implementation, a Global NCD Action Plan has been developed, which was discussed with and endorsed by Member States. The priorities are covered in the following six main components of the Global Strategy Action Plan:

- Placing NCDs higher on the global and national development agendas and integrating their prevention and control into policies across the whole of government.
- Establishing and strengthening national policies and plans for the prevention and control of NCDs and supporting the re-orientation of health systems towards more effective health care for chronic conditions.
- Strengthening interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity, harmful use of alcohol.
- Promoting research for the prevention and control of noncommunicable diseases.
- Promoting partnerships for the prevention and control of noncommunicable diseases.
- Monitoring noncommunicable diseases and their determinants and evaluating progress at the national, regional and global levels.

Cluster Strategy

Noncommunicable Diseases and Mental Health 2008-2013

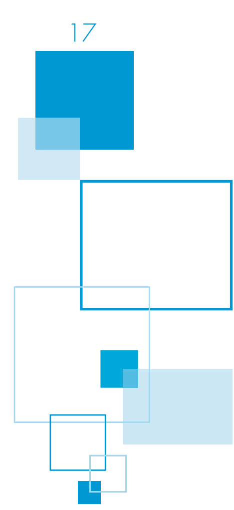


Expected Outcomes at two years (*) and six years

- Updated assessment of the public health burden imposed by NCDs and its impact on socio-economic development. *
- Assessment of national capacity for the prevention and control of NCDs and evaluation of approaches to fill existing gaps in capacity (Second Global Survey). *
- A publication on the connections between the findings of the Commission on Social Determinants of Health and NCD prevention and control, and the evidence base for integrating NCD prevention into the global and national development agenda. *
- Review of international experience in the prevention and control of NCDs including community-based programmes and their impact on risk factor levels and on morbidity and mortality associated with NCDs in different populations.
- Case studies of different organizational patterns of health care institutions in improving the management of chronic conditions, with special focus on primary health care.
- Models for integrating the management of common conditions into primary health care.
- Updated diagnostic criteria and classification of hypertension, diabetes and other forms of glucose intolerance (including definition of metabolic syndrome).
- Training Seminars on the epidemiology and public health aspects of the major NCDs (in collaboration with the Regional Offices). *
- Recommendations on marketing of food and non-alcoholic beverages for children. *
- Guidelines to enhance access to essential medicines and affordable medical technology for common NCDs.
- Development of a prioritized research agenda for NCDs in line with WHO's global research strategy.
- An information system, as part of the Global Health Observatory, to collect, analyze and disseminate data on trends in respect of mortality, disease burden, risk factors, policies, plans and programmes.
- Strengthened international partnerships for NCD prevention and control through the establishment of a new Global Noncommunicable Diseases Network (NCDnet) involving Member States, UN agencies, International Finance Institutions, research agencies, philanthropy, collaborating centres, NGOs and the private sector.
- International partners, Member States and the WHO Secretariat work collaboratively through NCDnet in supporting the implementation of the NCD Action Plan by improving collective advocacy, defining innovative resourcing mechanisms and catalyzing country-level partnerships.

Expected outcomes (Health Promotion)

- An Organization-wide package of comprehensive evidence-based approaches to health promotion to guide countries. *
- Global Conference on Health Promotion 'Health & Development: Closing the Implementation Gap' (Nairobi, 25-30 October 2009). *
- Country-based projects that implement and evaluate elements of the health promotion framework.



Expected outcomes (Preventable Blindness and Visual Impairment)

- Concerted and coordinated advocacy strengthened to increase Member States' political, financial and technical commitment to eliminate avoidable blindness and visual impairment.
- Increase number of national policies, plans and programmes developed and strengthened for eye health and prevention of blindness and visual impairment.*
- Priority research identified and promoted for the prevention of blindness and visual impairment.
- Coordination improved between partnerships and stakeholders at national and international levels for the prevention of blindness and visual impairment.
- Progress monitored in elimination of avoidable blindness and national, regional and global levels.

7.2. Tobacco Control

The WHO Framework Convention on Tobacco Control (WHO FCTC)[35] is one of the most widely supported treaties in the history of the United Nations, which offers the principles and context for policy development, planning of interventions and mobilization of political and financial resources for tobacco control.

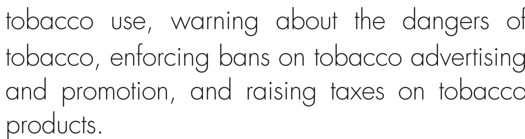
The MPOWER measures to reduce global tobacco use requires that proven tobacco policies and interventions for demand reduction be implemented.

Objectives

- To place tobacco control higher in public policy agendas.
- To develop global policy recommendations for the most cost-effective tobacco control interventions.
- To increase country capacity to implement effective tobacco control measures including monitoring tobacco use, protecting people from tobacco smoke, offering help to quit

CLUSTER STRATEGY

NONCOMMUNICABLE DISEASES AND MENTAL HEALTH 2008-2013



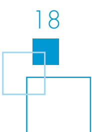
tobacco use, warning about the dangers of tobacco, enforcing bans on tobacco advertising and promotion, and raising taxes on tobacco products.

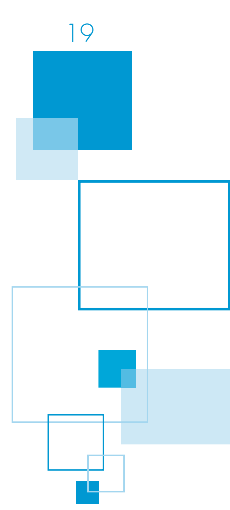
Priorities 2008-2013

- Supporting health system development by building the capacity of decision makers and partners in technical and policy relevant issues at the regional and country level.
- Addressing economic policy issues with evidence-based knowledge and information, and filling knowledge gaps by strengthening policy relevant research.
- Strengthening partnerships with strategic international organizations, decision makers and civil society at the country and global level.
- Providing technical support and relevant documents on tobacco control legislation and enforcement to all Member States in a timely manner.
- Scaling up capacity for implementation of tobacco control interventions and the WHO FCTC, in close coordination with Regional Offices and the FCTC Secretariat.
- Strengthening surveillance monitoring and evaluation systems.
- Communication and advocacy activities at country level, including support to communication campaigns.

Expected Outcomes at two years (*) and six years

- Strong participation in the World Conference on Tobacco or Health. *
- An economic and tax data base as well as regional and country-specific economics of tobacco control portfolios for dissemination. *
- Updated recommendations on tobacco cessation policies, tax and pricing policies.*
- Capacity assessment in two priority countries. *
- Target setting to assess global and regional progress in tobacco control. *
- Population based surveillance (implementation of global adult survey in 15 high-burden countries and the second global report on tobacco control). *
- A global partnership for economics of tobacco control. *
- Technical support to the Parties in the implementation of WHO FCTC. *
- Country-based advocacy and communications tools and campaigns.
- A methodology for capacity assessment for tobacco control implementation.
- A global consortium for tobacco dependence, management and treatment.
- Country based tax and economic documents in 15 high-burden countries to address Ministry of Finance and Tax and Customs concerns surrounding higher taxes and tax administration.
- Tobacco control knowledge hub in Africa to strengthen capacity to implement tobacco control policies.
- An aligned work plan in conjunction with the Convention Secretariat aiming to reflect the key areas to which WHO can contribute to the work plan of the Conference of Parties (COP), to the WHO FCTC and the activities of Convention Secretariat (CSF).





7.3. Nutrition

Eight of the 20 most important determinants of the total burden of disease are diet and nutrition factors. Undernutrition is still estimated to cause 30% of the deaths of children under 5. Maternal and child undernutrition account for 11% of the global burden of disease. WHO commits to address the whole spectrum of nutrition problems throughout the life-course towards attaining the Millennium Development Goals (MDGs) and other nutrition-related international commitments, including the prevention the diet-related chronic diseases, through building and implementing a science-based, comprehensive and integrated policy and programmes at global, regional and country levels.

Objectives

- To update the scientific basis of the relationship between nutrition and health.
- To review the evidence base of nutrition interventions targeting different stages of the life course.
- To assist Member States with the development and operationalization of integrated food and nutrition policies based on evidence.
- To monitor and assess nutritional trends through nutrition surveillance systems and databases.
- To support countries in building their capacity for identifying problems and defining best policy and programme options, implementing the required nutrition interventions, monitoring progress and assessing impact.
- To advocate for nutrition within global and regional strategies and initiatives.

Priorities (2008-2013)

- Undertaking situation and response analyses at national levels to promote accelerated action in nutrition in order to strengthen the contribution to MDGs 1, 4 and 5.
- Assisting Member States in the revision of their food and nutrition policies and action plans and in the implementation at scale of key nutrition actions.

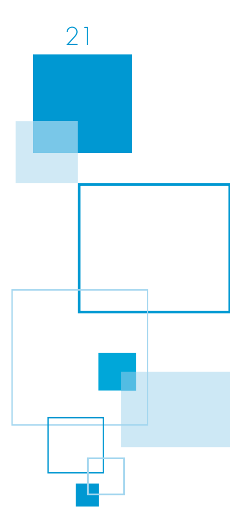
- Advocating for nutrition in the context of global initiatives.
- Strengthening technical collaborations and partnerships between agencies active in nutrition, food safety and food security.
- Scaling up integrated nutrition surveillance.
- Updating the scientific basis of the relationship between nutrition and health.
- Scaling up efforts in infant and young child feeding practices through implementation of the Global Strategy for Infant and Young Child Feeding[36], including children living in difficult circumstances.
- Scaling up the management of undernutrition through strengthening capacity of health care providers in hospitals and communities.
- Scaling up obesity prevention through strengthened monitoring and surveillance.
- Strengthening nutritional support as part of the care and prevention of TB and HIV/AIDS.

Expected Outcomes at two years (*) and six years

- Global review of the implementation of food and nutrition policies.
- Revised package of essential policies and programmes to address food security and nutrition.
- Library of evidence and a database of good practices in the area of public health nutrition interventions throughout the life course. *
- Updated recommendations on carbohydrates and fat in human nutrition.
- Methodological guidelines on the development of nutrient profiles of food .*
- Recommendations for management of moderate malnutrition and severe acute malnutrition. *
- Strengthened implementation of the Global Strategy on Infant and Young Child Feeding - adoption, implementation and monitoring of the strategy in 95 countries. *
- Expanded adoption of the WHO Child Growth Standards - adoption and growth velocity standards for children defined in 80 countries. *
- Definition of overweight and obesity in school-age children (including new criteria for waist-hip measurements). *
- Nutrition integrated within HIV/AIDS action plans including monitoring and evaluation in 35 countries.*
- Food and nutrition integrated into the care of TB patients.
- Updated guidelines on control of micronutrient deficiencies and food fortification for vulnerable groups.*
- Revision of technical guidelines on nutrition surveillance.*
- Update of global databases covering the key indicators of nutritional status (child, adolescent and adult anthropometry; vitamins and minerals; infant and young child feeding; food and nutrition policy) and integration into the Global Health Observatory. *

7.4. Mental Health and Substance Abuse

Mental, neurological and substance use disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. Effective and affordable interventions for prevention and treatment are available and could be applied on a large scale through primary



care. At present, the capacity of Member States in addressing the gap between the needs and the response is extremely weak.

Objectives

- To enhance the priority given to the mental, neurological and substance use area within the health and overall development agenda.
- To provide a reliable information base on magnitude, burden, risk factors, available resources and service systems for the mental, neurological and substance abuse area.
- To provide up-to-date technical guidance on policy, legislation and services for prevention and management of mental, neurological and substance use disorders (including in emergency settings).
- To support Member States' capacity in scaling up mental health services.

Priorities (2008-2013)

- Launching and implementing the Mental Health Gap Action Programme in priority low- and middle-income countries.
- Developing and strengthening assessment and evaluation systems.
- Implementing suicide prevention strategies in Member States with high suicide rates.
- Supporting training of health care personnel in Africa in identifying and managing depression among women in perinatal period.
- Supporting Regional and Country Offices in reducing the treatment gap for epilepsy in selected countries.
- Developing and implementing, in collaboration with Member States, the Global Strategy to reduce harmful use of alcohol.
- Supporting initiatives to monitor alcohol marketing in Africa.
- Promoting community mental health care for severe mental disorders.
- Promoting mechanisms for decreasing human rights violations against persons with mental disorders.
- Integrating mental health into primary health care.

Cluster Strategy

Noncommunicable Diseases and Mental Health
2008-2013

Expected Outcomes at two years (*) and six years

- A package of essential health care for mental, neurological and substance use disorders, based on the Mental Health Global Action Programme (mhGAP)[37]. *
- Implementation of mhGAP in at least 6 countries (1 from each WHO region).*
- Comprehensive assessment of mental health systems in 60 low- and middle-income countries. *
- Technical assistance provided to develop community based projects to decrease pesticide-related suicides in 4 countries. *
- Training package for PHC providers on the identification and management of depression during the perinatal period. *
- Final draft of the Global Strategy to reduce the harmful use of alcohol[38] to be submitted to the Sixty-third World Health Assembly, through the Executive Board. *
- Monitoring instrument for assessing human rights conditions in mental health facilities. *
- Implementation of mhGAP in 24 countries.
- Global Strategy to reduce the harmful use of alcohol implemented in 30 countries.
- Monitoring human rights conditions in mental health facilities in 15 countries.

7.5. Violence and Injury Prevention and Disability

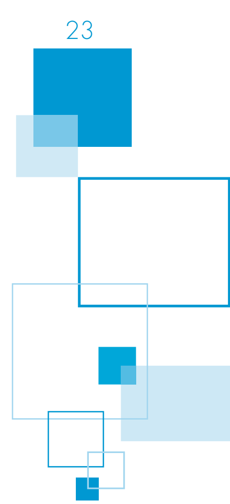
There are as many deaths from injuries and violence as there are from HIV, malaria and TB combined. Recognition of injuries, violence and disability as health and development and human rights issues, has increased in recent years. Several World Health Assembly and United Nations General Assembly resolutions have been adopted recently on these topics, and more countries than ever are working to implement them. However, considerably more action is needed.

Objectives

- To strengthen international and national commitment to address violence, injuries and disabilities.
- To place violence and injury prevention and responses to disability higher on the public policy agendas.
- To strengthen appropriate responses at national and local levels.
- To develop capacity to respond to injuries, violence and disability.

Priorities (2008-2013)

- Publishing World Reports and technical guidance tools based on the best scientific evidence;
- Monitoring progress on the implementation of existing World Reports and technical guidance tools.
- Developing and implementing an advocacy and communications strategy.
- Supporting the development and evaluation of national or local responses in view of identifying successful interventions.
- Including violence and injury prevention and responses to disability in select international agendas.



Expected Outcomes at two years (*) and six years

- World Reports on Child Injury Prevention, and on Disability and Rehabilitation. *
- Road Safety Status Reports. *
- Guidelines, best practice and other normative documents on wheelchairs, community-based rehabilitation, seatbelt programmes, quality of trauma care, and burns prevention. *
- Multi-country programmes on road safety, child maltreatment prevention, trauma care and rehabilitation.
- Web-based training programme on injuries and violence prevention. *
- Multi-sectoral partnerships on road safety (UN Road Safety Collaboration), violence prevention (Violence Prevention Alliance) and strategic product specific alliances.

7.6. Urbanization and Health

As an integral part of the WHO Secretariat, the Kobe Centre conducts research into the health consequences of social, economic, environmental and technological change and its implications for health policies.

Objectives

- To develop strategies and focused areas of research: building an evidence-base, developing public health methodologies for health equity assessment and response, exploring new areas for research for policy generation;
- To advocate for adoption and implementation of healthy urbanization policies and programmes: (a) raising the priority accorded to urbanization and health in development work at global and national levels through the planned World Health Day 2010 on 'Urbanization and Health' (in collaboration with UNHABITAT); and (b) advocating a global platform for action on health in urban settings through the Global Forum on Urbanization and Health in 2010 (Kobe, Japan; tentative dates 15-17 November 2010);
- To respond to local needs: identifying local best practices for global application, enhancing collaborative research and disseminating information in local communities.

Noncommunicable Diseases and Mental Health 2008-2013

Priorities (2008-2013)

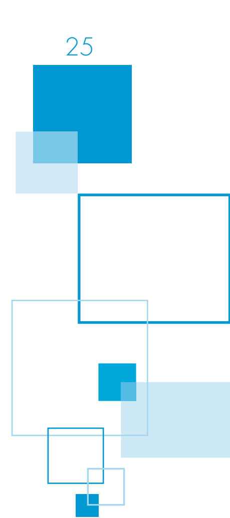
- Promoting partnerships for healthy urbanization through (1) World Health Day 2010 on Urbanization and Health; (2) The WHO/ UNHABITAT Report on Urbanization and Health; and (3) Global Forum on Urbanization and Health and other fora.
- Developing evidence and engaging support for placing "urbanization and health" higher on the global, regional, national and local development and governance agenda.
- Increasing evidence, new knowledge and publication on promoting health and improving health equity in urban settings.
- Increasing number of cities that have adopted and implemented healthy urbanization programmes aimed at reducing health inequities.
- Testing of health equity tools such as the Urban Health Equity Assessment and Response Tool (Urban HEART)[39], emphasizing both assessment of and response to health inequities.
- Increasing awareness, research and technical support in deriving and delineating evidence for decision-making on the link between health and the social, political, economic and physical environments.

Expected Outcomes at two years (*) and six years

- Urban HEART finalized and validated and core indicators for urban health equity identified. *
- A review of international experience in intersectoral/multisectoral work for health; and guidelines for development of intersectoral interventions on NCDs in urban settings. *
- Guidelines for development of interventions on smoke-free cities. *
- A technical report on linkages between climate change and NCDs.
- Urban HEART scaled up and implemented in at least 52 cities.
- Expansion of the evidence base on the linkages among climate change and health and emergency preparedness and emerging health issues at the city level.
- A global report on reducing health inequities in urban settings.
- A global forum on healthy urbanization to invoke action from countries to reduce health inequities in urban settings.
- A declaration of action on healthy urbanization agreed by and initially implemented in 52 cities.

8. Basic principles and NMH's way of working

Giving priority to public health advocacy: The aim is to raise the priority accorded to NCDs, mental health, substance abuse, nutrition, and violence and injury prevention in development work at global and national levels and to integrate prevention and control initiatives into policies across all government departments. Instruments such as the MDGs, Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, 2002), ECOSOC Ministerial Declarations, as well as bilateral policies for development assistance and calls of private foundations on governments to address noncommunicable conditions in low- and middle-income countries provide opportunities for synergy, as do strategies for poverty alleviation and mechanisms that harmonize and manage development aid for results.



Placing special emphasis on addressing the burden in low- and middle- income countries: Assistance will particularly focus on tracking of regional and national trends, developing integrated approaches to prevention and management, and on integrating basic standards of health care into primary health care.

Adopting mechanisms of outcome-oriented approaches: Achieving expected results and precise accountability for delivery of strategic products are essential for strengthening WHO's credibility and meeting expectations as well as gaining the trust of partners and donors.

Working as one WHO: The Cluster will work jointly with Regional and Country Offices to develop and implement one-WHO strategies and, whenever possible, one-WHO work plans. Joint planning and close collaboration with the International Agency for Research on Cancer (IARC) will be crucial. Beyond its role with Member States, the NMH Cluster has a role in supporting the work of the WHO Secretariat to fulfill its mandate within the common global results-based management framework. Key areas of collaboration are listed in Annex 2. The Cluster will also strengthen joint work within the Organization on cross-cutting themes.

Ensuring that scientific evidence plays a central role. Strategies and interventions adopted by the NMH Cluster should be based on evidence and best practice.

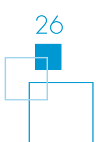
Assigning a more effective role to collaborating centres and other institutions. Meeting the ambitious plans of the Cluster will require very close collaboration of joint work with collaborating centres, other public health institutions, centres of excellence, and professional associations in relation with WHO.

9. Monitoring and evaluation

Target setting: To provide a solid base for country commitments to improve health outcomes, NMH will convene groups of technical experts to advise and offer technical support in the development of a new target setting approach through a modelling process, using the best available evidence on prevalence and trends of main NCD risk factors and impact of cost-effective interventions. Targets will be agreed with Member States through regional and country consultations. Target setting following this methodology has already been applied in WHO by other Clusters with successful results.

MTSP: One of the challenges of the NMH Cluster is to migrate from a process-oriented to an outcome-based evaluation and monitoring approach. Evaluation and monitoring will therefore be essential components of all initiatives, and will be considered in early phases of project design and implementation.

Monitoring and Evaluation of the NCD Action Plan: Target setting and outcome based evaluation methodologies will be applied in the development of the NCD Global Status Reports, and the NCDnet monitoring and evaluation reports. Key outcomes from both the Global Status Report and the NCDnet evaluation will be synthesized for ease of communication and use into the NCD Action Plan dashboard.



10. Working with international partners

International partners increasingly share WHO's interest in addressing NMH issues. However, there is a growing number of global partners with whom the NMH Cluster needs to strike productive working relationships to raise the priority accorded to noncommunicable diseases, nutritional deficiencies, mental and substance abuse disorders, violence, injuries and disabilities in development work at global and national levels. While various partnership approaches have been applied over many years, currently conscious efforts are being made to identify partnership best practices and to share lessons learned across the Cluster. The latest Executive Board guidance on partnerships and collaborative arrangements is being applied.

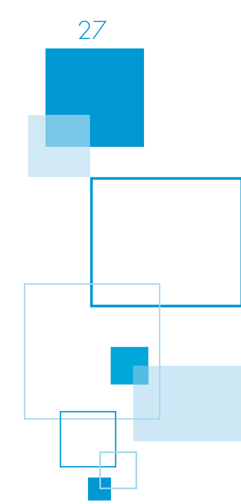
Based on the above analysis of partnership best practices, as well as current WHO guidance, the new Global Noncommunicable Disease network (NCDnet) has been launched. NCDnet is a voluntary collaborative arrangement managed by WHO with the aim of facilitating a political, social and public health movement to help implement the NCD Action Plan with a particular focus on low- and middle-income countries.

11. Resource mobilization

Strengthen strategic engagement with potential donors: Offical Development Assistance (ODA) for health is increasing and the range of international partners is growing dramatically. To capture this momentum, NMH will strengthen strategic engagements with:

- 23 OECD/DAC donors and the European Commission to advocate raising the priority accorded to NMH conditions in their respective bilateral and multilateral development assistance frameworks;
- emerging donors who are considering to establish ODA-funded programmes;
- strategic philanthropic foundations with an emerging interest in issues related to NMH (including the Bill & Melinda Gates Foundation in the area of tobacco control, as well as undernutrition; Bloomberg Philanthropies in the area of tobacco, as well as road safety);

Explore the possibilities of establishing innovative funding mechanisms: NMH will consider possibilities of working with other partners to explore innovative funding mechanisms (e.g. multi-donor trust funds, rapid financing facilities, global facilities, earmarking tobacco taxes, etc).



12. Communications

Rally stakeholders and people to NMH causes: To ensure NMH's visibility among critical sources of support (e.g. WHO Member States, government public health and development officials, donors, NCC advocates, parliamentarians, other international organizations and the private sector), NMH will strengthen its external communications strategy across WHO's most important external communications vehicles by:

- Strengthening professional relationships with journalists, responding to their queries with improved speed on NMH priorities;
- Promoting training of journalists on NMH priorities, as part of journalist training programmes in the UN system and the international journalism community;
- Strengthening NMH's presence on the Internet, and increasing user traffic to NMH web sites.

Communicate new information, global agendas and calls to action to stakeholders: NMH will use a planned series of activities to reach specific audiences and build momentum for longer term results by:

- Launching and disseminating World Reports, guidance, recommendations and other publications to showcase NMH's best available science;
- Strengthening the content and presentation of the e-NMH Newsletter containing updates on activities and new developments;
- Working on issues of communications and advocacy together with international partners, including international NGOs;
- Addressing high-level, strategic events and resultant press conferences.

ANNEX 1

KEY GOVERNING BODIES RESOLUTIONS AND REPORTS

The strategy of the NMH Cluster is primarily based on the key resolutions of the Governing Bodies and the strategies, treaties, and global reports endorsed. These include:

To address noncommunicable diseases and their risk factors:

- WHO Global Strategy on the Prevention and Control of Noncommunicable Diseases (WHA53.17, 2000)
- WHO Framework Convention on Tobacco Control (WHA56.1, 2003)
- WHO Global Strategy on Diet, Physical Activity and Health (WHA57.17, 2004)
- ECOSOC Resolution on Development and Tobacco (E/2004/55, 2004)
- WHO Global Report on Chronic Disease (2005)
- Decisions of the Conference of the Parties to the WHO Framework Convention on Tobacco Control from its first and second sessions (FCTC/COP1(1-18) , 2006 and FCTC/COP2(1-16), 2007)
- UN General Assembly Resolution on Diabetes (A/RES/61/225, 2007)
- First WHO Report on the Global Tobacco Epidemic (2008)
- Prevention and Control of Noncommunicable Diseases: Implementation of the Global Strategy (A/61.8 and WHA61.14, 2008)
- Doha Declaration on NCDs and Injuries adopted at the ECOSOC Regional Ministerial Meeting on NCDs and Injuries (Doha, May 2009)
- ECOSOC Ministerial Declaration (2009)
- Second Global Report on the Global Tobacco Epidemic (2009)
- First WHO Report on the NCD Epidemic (2010)

To address nutritional deficiencies:

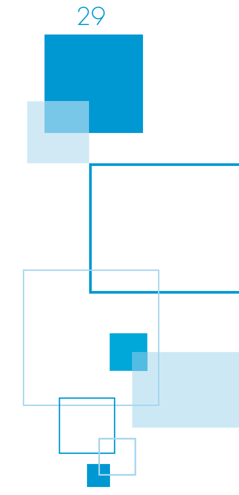
- WHO Global Strategy for Infant and Young Child Feeding (2002)
- Infant and Young Child Nutrition (WHA59.21, 2006)
- Nutrition and HIV/AIDS (WHA59.11, 2006)
- WHO Child Growth Standards (2006)
- Sustaining the Elimination of Iodine Deficiency Disorders (WHA60.21, 2007)
- Infant and Young Child Nutrition (WHA61.20, 2008)

To address mental, neurological and substance abuse disorders:

- The World Health Report 2001 - Mental Health: New Understanding, New Hope
- WHO Global Action Programme for Mental Health (2002)
- Neurological Disorders: Public Health Challenges (2006)
- WHO global strategies to reduce the harmful use of alcohol (A/61.13 and WHA61.4, 2008)
- WHO Mental Health Gap Action Programme 2008-2013 (2008)

To address violence, injuries and disability:

- World Report on Violence and Health (endorsed by WHA 56.24, 2003)
- World Report on Road Safety and Health (endorsed by WHA57.10, 2004)
- Disability, Including Prevention, Management and Rehabilitation (WHA58.23, 2005)
- Health Systems: Emergency-care systems (WHA60.22, 2007)
- World Report on Child Injury Prevention (2008)
- UN General Assembly Resolution on Improving Global Road Safety (A/RES/62/244, 2008)
- World Report on Disabilities and Rehabilitation (2010)



To address mainstream health promotion in the work of WHO:

- Ottawa Charter on Health Promotion (1986)
- WHA Resolution on Health Promotion (WHA51.12, 1998)
- WHA resolution on Health Promotion and Healthy Lifestyles (WHA57.16, 2004)
- Bangkok Charter on Health Promotion in a Globalized World (2005)
- WHA Resolution on Health Promotion in Globalized World (WHA60.24, 2007)
- The Nairobi Call to Action adopted by the participants of the 7th Global Conference on Health Promotion: "Promoting health and development: closing the implementation gap" (Nairobi, 26-30 October 2009)

To address eye and hearing health:

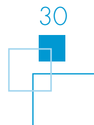
- Action Plan for the Prevention of Avoidable Blindness and Visual Impairment (A62/7)
- WHA Resolution on Prevention of Avoidable Blindness and Visual Impairment (WHA59.25)
- WHA Resolution on Elimination of Avoidable Blindness (WHA56.26)
- WHA Resolution on Global Elimination of Blinding Trachoma (WHA 51.11)
- WHA Resolution on Prevention of Hearing Impairment (WHA 48.9)

Annex 2

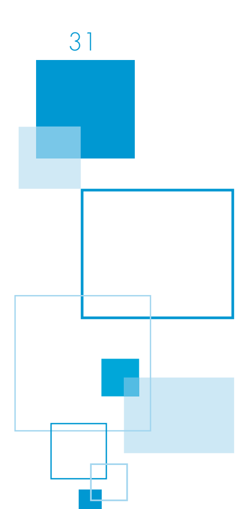
WORKING WITH OTHER CLUSTERS

As part of the strategic directions, the NMH Cluster has a role in coordinating and working jointly with other Clusters in areas of common concern and interest. Areas of collaboration include:

WHO Secretariat	Main objectives of collaboration
- Health Security and Environment	- Provide food-related scientific advice.
- HIV/AIDS, TB, Malaria and Neglected Tropical Diseases	- Pursue policies and practices that promote the integration of nutrition into a comprehensive response to HIV/AIDS. - Learn from successful experiences in strengthening health care for NCCs and in scaling-up national responses. - Exchange knowledge on the links between harmful use of alcohol and communicable diseases and drug use. - Promote the Basic Principles and Psychosocial Support of Drug Dependent People Living with HIV/AIDS[40].
- Health Systems and Services	- Reorient and strengthen health systems to ensure that provision of health care for NCCs is dealt with in the context of overall health system strengthening. - Improve the availability and affordability of medicines to control NCDs and mental health disorders. - Develop a package of essential NCC and mental health services for primary health care.
- Information, Evidence and Research	- Monitor NMH conditions and evaluate progress at the national, regional and global levels. - Revision of diagnosis and classification systems, including ICD-10. - Build and disseminate information about the evidence base and surveillance data in order to inform policy makers on the links between NCCs an socio-economic development.



WHO Secretariat	Main objectives of collaboration
- Information, Evidence and Research	- Draw up a document pointing out the connections between the findings of the Commission on Social Determinants of Health and the prevention and control of NCDs, and take forward the work on social determinants of health as it relates to NCDs. - Develop a research agenda for NCCs in line with WHO's global research strategy.
- Family and Community Health	- Mainstream nutrition into the Global Campaign for the Health MDGs 4, 5 and 6. - Strengthen the response to childhood injuries and violence.
- Health Action in Crises	- Nutrition and international food price crisis. - Enhance the management of major NCDs in emergency and humanitarian settings. - Enhance the humanitarian response to emergencies in the nutrition sector. - Improve mental health and psychosocial care during crises and emergencies. - Improve mass casualty management and response to injuries in emergencies. - Improve response to emergencies for the disabled.
- Partnerships and UN Reform	- Improve the effectiveness of existing partnerships and collaborative arrangements through consultation with PUN. - Involve PUN in the design of all new partnerships and collaborative arrangements including the new Global Noncommunicable Diseases Network, as well as the Global Tobacco Cessation Consortium



Annex 3

RELEVANT WORLD HEALTH STATISTICS

Table 1: Leading causes of death, 2004 and 2030 compared *(World Health Statistics 2008, WHO)*

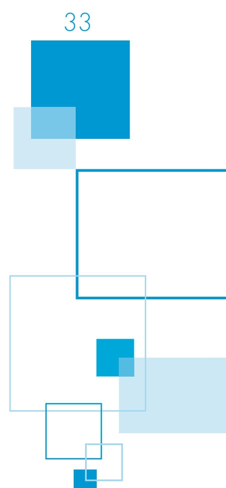
2004 Disease or injury	Deaths (%)	Rank	Rank	Deaths (%)	2030 Disease or injury
Ischaemic heart disease	12.2	1	1	14.2	Ischaemic heart disease
Cerebrovascular disease	9.7	2	2	12.1	Cerebrovascular disease
Lower respiratory infections	7.0	3	3	8.6	Chronic obstructive pulmonary disease
Chronic obstructive pulmonary disease	5.1	4	4	3.8	Lower respiratory infections
Diarrhoeal diseases	3.6	5	5	3.6	Road traffic accidents
HIV/AIDS	3.5	6	6	3.4	Trachea, bronchus, lung cancers
Tuberculosis	2.5	7	7	3.3	Diabetes mellitus
Trachea, bronchus, lung cancers	2.3	8	8	2.1	Hypertensive heart disease
Road traffic accidents	2.2	9	9	1.9	Stomach cancer
Prematurity and low birth weight	2.0	10	10	1.8	HIV/AIDS
Neonatal infections and other*	1.9	11	11	1.6	Nephritis and nephrosis
Diabetes mellitus	1.9	12	12	1.5	Self-inflicted injuries
Malaria	1.7	13	13	1.4	Liver cancer
Hypertensive heart disease	1.7	14	14	1.4	Colon and rectum cancers
Birth asphyxia and birth trauma	1.5	15	15	1.3	Oesophagus cancer
Self-inflicted injuries	1.4	16	16	1.2	Violence
Stomach cancer	1.4	17	17	1.2	Alzheimer and other dementias
Cirrhosis of the liver	1.3	18	18	1.2	Cirrhosis of the liver
Nephritis and nephrosis	1.3	19	19	1.1	Breast cancer
Colon and rectum cancers	1.1	20	20	1.0	Tuberculosis
Violence	1.0	22	21	1.0	Neonatal infections and other*
Breast cancer	0.9	23	22	0.9	Prematurity and low birth weight
Oesophagus cancer	0.9	24	23	0.9	Diarrhoeal diseases
Alzheimer and other dementias	0.8	25	29	0.7	Birth asphyxia and birth trauma
			41	0.4	Malaria

Table 2: Attributable mortality by risk factor (% of total deaths) *(WHO World Health Risks, 2009)*

	Risk factor	Deaths (millions)	Percentage of total		Risk factor	Deaths (millions)	Percentage of total
	World				***Low-income countries***[a]		
1	High blood pressure	7.5	12.8	1	Childhood underweight	2.0	7.8
2	Tobacco use	5.1	8.7	2	High blood pressure	2.0	7.5
3	High blood glucose	3.4	5.8	3	Unsafe sex	1.7	6.6
4	Physical inactivity	3.2	5.5	4	Unsafe water, sanitation, hygiene	1.6	6.1
5	Overweight and obesity	2.8	4.8	5	High blood glucose	1.3	4.9
6	High cholesterol	2.6	4.5	6	Indoor smoke from solid fuels	1.3	4.8
7	Unsafe sex	2.4	4.0	7	Tobacco use	1.0	3.9
8	Alcohol use	2.3	3.8	8	Physical inactivity	1.0	3.8
9	Childhood underweight	2.2	3.8	9	Suboptimal breastfeeding	1.0	3.7
10	Indoor smoke from solid fuels	2.0	3.3	10	High cholesterol	0.9	3.4
	Middle-income countries[a]				***High-income countries***[a]		
1	High blood pressure	4.2	17.2	1	Tobacco use	1.5	17.9
2	Tobacco use	2.6	10.8	2	High blood pressure	1.4	16.8
3	Overweight and obesity	1.6	6.7	3	Overweight and obesity	0.7	8.4
4	Physical inactivity	1.6	6.6	4	Physical inactivity	0.6	7.7
5	Alcohol use	1.6	6.4	5	High blood glucose	0.6	7.0
6	High blood glucose	1.5	6.3	6	High cholesterol	0.5	5.8
7	High cholesterol	1.3	5.2	7	Low fruit and vegetable intake	0.2	2.5
8	Low fruit and vegetable intake	0.9	3.9	8	Urban outdoor air pollution	0.2	2.5
9	Indoor smoke from solid fuels	0.7	2.8	9	Alcohol use	0.1	1.6
10	Urban outdoor air pollution	0.7	2.8	10	Occupational risks	0.1	1.1

Table 3: Attributable DALYs by risk factor (% of total DALYs) *(WHO World Health Risks, 2009)*

	Risk factor	DALYs (millions)	Percentage of total		Risk factor	DALYs (millions)	Percentage of total
	World				***Low-income countries***[a]		
1	Childhood underweight	91	5.9	1	Childhood underweight	82	9.9
2	Unsafe sex	70	4.6	2	Unsafe water, sanitation, hygiene	53	6.3
3	Alcohol use	69	4.5	3	Unsafe sex	52	6.2
4	Unsafe water, sanitation, hygiene	64	4.2	4	Suboptimal breastfeeding	34	4.1
5	High blood pressure	57	3.7	5	Indoor smoke from solid fuels	33	4.0
6	Tobacco use	57	3.7	6	Vitamin A deficiency	20	2.4
7	Suboptimal breastfeeding	44	2.9	7	High blood pressure	18	2.2
8	High blood glucose	41	2.7	8	Alcohol use	18	2.1
9	Indoor smoke from solid fuels	41	2.7	9	High blood glucose	16	1.9
10	Overweight and obesity	36	2.3	10	Zinc deficiency	14	1.7
	Middle-income countries[a]				***High-income countries***[a]		
1	Alcohol use	44	7.6	1	Tobacco use	13	10.7
2	High blood pressure	31	5.4	2	Alcohol use	8	6.7
3	Tobacco use	31	5.4	3	Overweight and obesity	8	6.5
4	Overweight and obesity	21	3.6	4	High blood pressure	7	6.1
5	High blood glucose	20	3.4	5	High blood glucose	6	4.9
6	Unsafe sex	17	3.0	6	Physical inactivity	5	4.1
7	Physical inactivity	16	2.7	7	High cholesterol	4	3.4
8	High cholesterol	14	2.5	8	Illicit drugs	3	2.1
9	Occupational risks	14	2.3	9	Occupational risks	2	1.5
10	Unsafe water, sanitation, hygiene	11	2.0	10	Low fruit and vegetable intake	2	1.3



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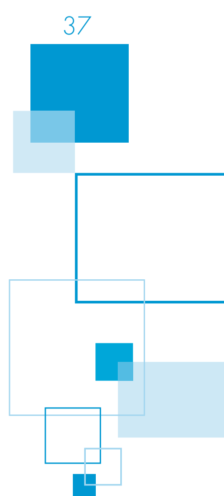

endorsed on 18 May 2002 by the Fifty-fifth World Health Assembly and on 16 September 2002 by the UNICEF Executive Board (http://www.who.int/nutrition/topics/global_strategy/en/index.html, accessed 21 August 2008)

37. The Mental Health Gap Action Programme (mhGAP) is WHO's action plan to scale up services for mental, neurological and substance use disorders for low- and middle-income countries. The essence of mhGAP is building partnerships for collective action and to reinforce the commitment of governments, international organizations and other stakeholders (http://www.who.int/mental_health/mhGAP/en/index.html, accessed on 21 August 2008)

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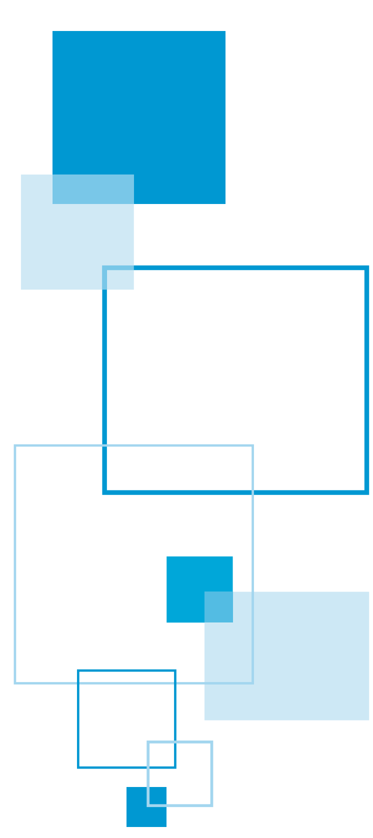

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