

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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Center for Strategic and International Studies
1800 K Street, NW, Washington, DC 20006
Tel: (202) 887-0200
Fax: (202) 775-3199
Web: www.csis.org



GETTING THE POLITICS RIGHT FOR THE SEPTEMBER 2011 UN HIGH-LEVEL MEETING ON NONCOMMUNICABLE DISEASES

Devi Sridhar, J. Stephen Morrison, and Peter Piot¹

Seize the Moment

The UN General Assembly's decision to convene a "high-level meeting on the prevention and control of noncommunicable diseases (NCDs) worldwide" in September 2011 creates a major, timely opportunity to elevate chronic diseases onto the global stage. Just as the 2001 UN General Assembly Special Session on HIV/AIDS was a pivotal moment in the global response to AIDS, there is hope that the September session on NCDs can become a historic rallying point.

But we need to be realistic. Time to prepare adequately is short. NCDs do not enjoy many of the advantages that helped propel AIDS to become a global priority. High-level leadership is thus far missing, and the odds are long that the September meeting will have a transformative impact. Important gains are indeed possible in September but only with disciplined pragmatism and urgent, focused action taken to seize the moment.

There are four key propositions that if acted upon in a timely way could help raise the prospects of success for this high-level session.

First, there is the urgent need to focus advocacy efforts on four disease areas—cancer, cardiovascular disease, chronic respiratory disease, and diabetes. At the same time, attention needs to be concentrated on common risk factors for the four diseases—tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, environmental carcinogens, and indoor and outdoor pollution. Global tobacco control can and should be a lead engine.

¹ Devi Sridhar is research fellow in politics at All Souls College and director of the Global Health Governance Project, Oxford. J. Stephen Morrison is senior vice president and director of the Global Health Policy Center at CSIS. Peter Piot is director of the London School of Hygiene and Tropical Medicine. The authors wish to thank Suzanne Brundage, program manager at the CSIS Global Health Policy Center, who was integral to conceptualizing and moving this project from start to finish. We also thank the 109 respondents to the online survey on noncommunicable diseases and are grateful for the generous time given by Sir George Alleyne, Trevor Gunn, Prabhat Jha, Bridget Kelly, Sunny Kishore, Rachel Nugent, Greg Paton, Ngaire Woods, and Derek Yach.

Second, there is an urgent need to improve the packaging and delivery of key data to reach a nontechnical audience.

Third, there is the need for tough-minded realism and quick action to generate far more robust political leadership. It is critical both to take account of the special challenges facing the NCD sector and leverage strategically the special political assets that are at hand: notably the UN secretary general, the WHO director general, and the NCD Alliance.

Fourth, there is the need for clear, feasible, and measurable goals that governments and their citizens can work toward achieving in the coming years.

This report draws on several sources: an online qualitative survey, released to the public as well as to invited select experts, which resulted in 109 detailed responses; nine expert interviews with key leaders in global health; and recent reports on noncommunicable diseases by the Institute of Medicine, *The Lancet*, the World Health Organization (WHO), and the Center for Global Development. The responses to the survey are available upon request, and we have drawn on these data to identify areas of agreement and challenges ahead.

Proposition 1: There is an urgent need to focus advocacy efforts. Real progress can be made by: (i) restricting the definition of NCDs to the morbidity and mortality caused by the four major health conditions—cancer, cardiovascular disease, chronic respiratory disease and diabetes; (ii) targeting their common risk factors—tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, environmental carcinogens, and indoor and outdoor pollution; and (iii) addressing access to treatment.

What is a noncommunicable disease? Although this question might seem straightforward and technical, it in fact attracts divergent responses. Inherently, the numerous definitions create confusion and a major communications and branding dilemma. At times, it appears the only shared ground across definitions is agreement that a noncommunicable disease encompasses conditions that are not infectious. That does not get us very far and is terrible branding—anything that begins with “non” may be considered a “non-issue” or a “non-starter.” It is critical to move beyond indicating what noncommunicable diseases *are not* to defining what they in fact *are*.

Recent major reports on NCDs draw on diverse definitions. The Institute of Medicine report limits its focus to cardiovascular diseases encompassing cardiac disease, vascular diseases of the brain and kidney, and peripheral vascular disease as well as the modifiable risk factors—e.g., tobacco use, unhealthy dietary changes, reduced physical activity, increasing blood lipids, and hypertension. *The Lancet* focuses on the four priority NCDs, which are cancer, cardiovascular disease, chronic respiratory disease, and diabetes, and their four common risk factors—tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol. The Center for Global Development and World Bank draw on the WHO definition, which classifies disease burden into three categories—communicable, maternal, perinatal, and nutritional conditions; chronic noncommunicable diseases; and injuries. The second category encompasses conditions ranging from cancer and diabetes to mental illness, blindness, deafness, and genetic diseases. (See table 1).

Table 1. WHO Type II Disease Categories

| Category | Global Burden of Disease (GBD) Cause Name |
|-----------------------------------|--|
| Neoplasms | Mouth and oropharynx cancer |
| | Esophageal cancer |
| | Stomach cancer |
| | Trachea, bronchus, and lung cancer |
| | All other cancers |
| Diabetes mellitus | |
| Endocrine disorders | |
| Neuropsychiatric disorders | |
| Sense organ diseases | |
| Cardiovascular diseases | Rheumatic heart disease |
| | Hypertensive heart disease |
| | Ischemic heart disease |
| | Cerebrovascular (CV) disease |
| | Other CV disease |
| Respiratory diseases | Chronic obstructive pulmonary disease |
| | Other respiratory diseases |
| Digestive causes | |
| Genitourinary diseases | |
| Skin diseases | |
| Musculoskeletal diseases | |
| Congenital anomalies | |
| Oral conditions | |

Source: Center for Global Development, "Where Have All the Donors Gone? Scarce Donor Funding for Non-Communicable Diseases," Working Paper 228, <http://www.cgdev.org/content/publications/detail/1424546>.

Other analyses focus on chronic diseases of lifestyle, defined as “a group of diseases that share similar risk factors as a result of exposure, over many decades, to unhealthy diets, smoking, lack of regular exercise, and possibly stress. The major risk factors are high blood pressure, tobacco addiction, high blood cholesterol, diabetes, and obesity. These result in various long-term disease

processes, culminating in high mortality rates attributable to strokes, heart attacks, tobacco- and nutrition-induced cancers, chronic bronchitis, emphysema renal failure, and related conditions.”

If the September session is to be meaningful and focused, quick action is needed to overcome confusion over what constitutes NCDs. Boundaries must be set.

In our view, there is a strong case for focusing on the big four health conditions as laid out in *The Lancet* series. These four are at the base of the epidemiological and demographic shift that has occurred in low- and middle-income countries where NCDs are rising swiftly. They account for the lion’s share of NCD burden in these countries and present and future projected growth of burden. They share common risk factors and common approaches to prevention, management, and care.

A related factor is the creation in May 2010 of the NCD Alliance comprising the International Diabetes Federation, the Union for International Cancer Control, the International Union against Tuberculosis and Lung Disease, and the World Heart Federation. Supported by a \$1 million grant from Medtronic, the alliance now provides a single organizational body dedicated to advocating for these four NCDs.

Critics of this limited definition argue that mental health and road traffic and other unintentional injuries contribute significantly to the global burden of disease, remain isolated from the larger NCD agenda, and do not receive adequate high-level attention. These are all valid, compelling concerns, and the NCD high-level meeting should acknowledge them and include a forceful call for future action that could elevate attention, better inform opinion, and set robust targets. Mental health, in particular, merits a separate session focusing on its unique determinants and challenges.

However, the UN High-Level Meeting on NCDs, if it is to be productive, needs to pick its focus carefully—the four disease areas outlined above and their shared risk factors—and maintain a disciplined, strategic agenda. This needs to include a sharp focus on treatment—e.g., exploring the most cost-effective means to ensure treatment of the most common NCDs, availability of medications on the essential drug lists, and training of skilled health personnel. If the meeting widens to include mental health and injuries, among possibly other subjects, it could spread attention across too many topics and potentially defeat the purpose of the gathering: to focus world attention on the central drivers of NCDs and lay out a course of future action that is intelligible and feasible.

Proposition 2: Urgent action is needed to create quality, concise data tools that can effectively tell the NCD narrative. A critical step is identifying and funding an institution (or institutions) to spread understanding among policymakers, traditional and new social media, and an interested public.

Powerful data can be a strategic driver of action. There is currently a disconnect between NCD experts, who are familiar with the strong evidence base that proves the rising significance of NCDs, and the nonexperts—political leaders, policymakers, media, and interested publics who are often only dimly aware of this reality. Partly as result of this gap, certain myths about NCDs

persist—that they pose no global urgency; that they are of marginal significance in low- and middle-income countries, with little connection to poverty alleviation and development; and that they are largely a matter of individual choice versus a public health challenge. The growing contribution of NCDs to the looming insolvency of health care systems is also minimally understood: it should be highlighted and quantified.

While ample data is available, it often is not in an accessible or powerful format. The World Health Organization is best placed to assume this role but has mainly produced technical reports. In lieu of WHO, it is our view that a group of donors should identify and fund a group or groups to generate downloadable, concise, and clear policy briefs, power points, and graphs. Special attention should be paid to reaching a young audience through new social media. Successful models of innovative data packages include UNAIDS’s work on AIDS and work by the Kaiser Family Foundation on U.S. development assistance for health.

Special attention needs to be paid to surveillance (incidence, prevalence, mortality, and morbidity), present and future trend lines, and associated risk factors; economic impacts (the burden on individuals, households, health systems, and economic growth); cost effectiveness of key interventions, including “best buys” in prevention and treatment; the component elements of effective national plans and their projected costs; and future research priorities.

Proposition 3: Quick action is required to elevate and strengthen the leadership that will be essential to preparing and delivering a successful September 2011 meeting. This requires a realistic assessment of the special constraints that are at play, along with a focus on leveraging existing assets, most notably the UN secretary general, the director general of WHO, and the recently formed NCD Alliance. A new prominent lead personality—an interim NCD czar, operating under a UN flag, and overtly empowered to lead—would be invaluable.

Overly optimistic, misleading comparisons are often made between the 2001 UNGASS on HIV/AIDS and the upcoming NCD meeting. The reality is that the NCD meeting occurs under far less propitious circumstances, which need to be fully taken into account in devising a leadership strategy.

Several special factors contributed to the success of the HIV/AIDS Summit in 2001. Most of these factors are not in play with respect to NCDs.

- *Epidemiology and tools:* HIV/AIDS is a single infectious disease that by the late 1990s had come to be seen as approachable through a few interventions. This built pressure on governments to act and increased consensus that reduced morbidity and mortality could be achieved in a measurable and short-time scale through improved access to antiretrovirals, along with expanded care and prevention services.
- *Ripeness:* At the start of the twenty-first century, the global response to HIV/AIDS already had a 15-year history from when the U.S. government gave \$2 million to WHO in 1986. This was followed in 1987 by a major Global AIDS Programme at the WHO and the launch of an entire UN body devoted to HIV/AIDS, the Joint UN Programme on HIV/AIDS (UNAIDS).

In December 2000, the World Bank launched the MAP Programme, which committed more resources to AIDS in Africa in 2001 than all previous years combined. Especially from 1996 onward, donors had shown slowly increasing financial and political commitment to HIV/AIDS. This commitment became coupled with a sense of moral urgency and a fear of contagion, the risk of an exponential rise in cases, and a mounting sense that HIV/AIDS constituted a new form of transnational security threat that could destabilize societies.

- *Leadership and a vocal, coherent social movement:* UNAIDS assumed leadership of the summit, including coordination of diverse stakeholders, such as a strong civil movement comprising persons living with HIV and seasoned advocates who could articulate the economic, security, and moral case for action on specific goals and apply pressure on individual states, the United Nations, the G-8, and other international groupings, and appeal to heads of state.
- *Strategy:* The AIDS community had specific “asks,” targets, and funding requests.

The situation facing NCDs is fundamentally different.

- *Multiple diseases and epidemiologies:* As discussed earlier, the term NCD encompasses a number of different health conditions that have diverse risk factors, treatment regimes, and populations affected. The evidence base for cost-effective care and agreement on a common set of priorities among so many different disease communities remains difficult. A risk in seeking consensus among too many diverse partners is that the message becomes the lowest common denominator. Perhaps most significantly, NCDs are not perceived as a strategic threat to societies and sovereign stability, and the costs and consequences of inaction or ineffective mobilization are far less visible or understood.
- *Ripeness in an age of austerity:* The United States and Western Europe are currently in the midst of an economic recession with governments slashing budgets and policymakers looking for ways to increase efficiency in the context of limited or shrinking funds. This is already apparent with respect to the replenishment of the Global Fund where commitments fell below even the most pessimistic expectations. NCDs advocates are aware that they cannot win the advocacy battle in a climate where even the Global Fund is struggling. This suggests that significant additional finance from high-income countries for NCDs is unlikely. In addition, there exists a push for increased financing to come from domestic sources and less reliance on donors. While the economic growth in Asia and Latin America create opportunities for new domestic funds, accessing these monies will require different political and mobilization strategies. Adding to this is fatigue among high-income donors, exacerbated by recent summits on global health such as for maternal and child health and road traffic injuries. The global response to NCDs is also quite recent among donor governments such as the United Kingdom and United States, which remain reluctant to prioritize these conditions within their development portfolios.

- *Unclear leadership, absence of a social movement:* Current preparatory efforts for the NCD meeting lack a focal point, organized social movement, and unified international leadership. As the two co-facilitators of the meeting, Jamaica and Luxembourg are playing a major role in the modality resolution and in setting the agenda. But they need to be supported by political champions among the UN member states, including a few permanent representatives in New York who are willing to dedicate a significant proportion of their time to the preparation of the session. The WHO has taken formal leadership of the meeting within the United Nations, but given its health focus there are fears that this could lead to a narrow approach limited to the health sector and with primarily ministers of health attending. At the country level, the CARICOM countries were the chief advocates for the push for a UN resolution and meeting. However, NCDs have failed to make the agenda of the G-20 and have not been prominent in discussions among IBSA (India-Brazil-South Africa club), the BRICs, or the G-8. The Obama administration has taken some steps to invest new resources in building research capacity in NCDs but has been reluctant to make NCDs a new focal priority in its Global Health Initiative. Private foundations such as the Bill & Melinda Gates Foundation, poverty and development groups such as Oxfam GB and Save the Children UK, and the private sector (pharmaceutical, food industry) have kept a distance. While the NCD Alliance is emerging as the main force of civil society engagement, in some cases national and international member societies are dominated by medical professionals and do not significantly involve people living with and affected by NCDs.
- *Strategy:* When the UN High-Level Meeting was announced in 2010, a coherent plan did not exist. In the past few months, the NCD Alliance has strived to devise objective targets. Yet there is still no consensus on financial, policy, and institutional asks, a reflection of the continued ambiguity over the scope of the meeting and what will be considered within the NCD umbrella. There is continued debate over the question of how big an emphasis to give to the role of improved health systems. It is generally agreed that a vertical approach, such as has been taken for certain infectious diseases, is not appropriate for addressing NCDs. However, it is often also not clear what is meant by health system and how to measure capacity. Moreover, much of the NCD agenda is prevention centered, and much of it is to be executed outside of formal health systems per se.
- *Next steps:* In this situation, a strategic focus on leveraging existing assets is essential to building robust leadership. The WHO director general and the UN secretary general are committed in principle, have a stake in a successful outcome in September, and are capable of much higher levels of engagement. They should seek under UN auspices the appointment of a prominent NCD czar charged with liaising with civil society and private sector, rallying high-level head-of-state participation, becoming an active envoy in capitals, clarifying the key asks, and ensuring technical accuracy. Another key asset is the NCD Alliance. It can and should be a vital partner with the UN leadership.
- *Don't forget business:* One of the major areas where progress can be made is in discussions between public and private stakeholders on how to move forward on NCD prevention.

Whereas the agenda must be driven by public health concerns and led by states and groups acting on behalf of citizens, the private sector, particularly the food and beverage industries, is extremely important to finding durable solutions. For that reason it is essential to include these industries in preparatory discussions; several key asks, including regulatory measures, will directly affect their markets. Here, the tobacco industry must be treated separately, given that there is no compromise possible over promoting a product that is implicated in over 8 million deaths per year. However, there is a clear incentive, and interest, for the food and beverage industries to have a seat at the table and work toward a shared framework with target goals around both new norms and regulation. While industry has so far aimed for corporate self-regulation, and several major global firms have begun reformulations to alter salt, sugar, and fat contents and achieve greater disclosure of contents on labels, more is needed. Clear guidelines need to be promoted and implemented by governments. This is not an easy ask given the strong lobbying pressures from these interests and the market stakes. Leadership, such as New York City mayor Michael Bloomberg's commitment to regulating the food and beverage industry, offers an important precedent on achieving progress.

The involvement of the private sector has largely been pursued outside of the UN system through the World Economic Forum and through an informal network among interested companies. The main challenge is to find an institutional platform that is trusted by all stakeholders. With the WHO taking the lead within the United Nations on organizing the September meeting, there is distrust on both sides as to whether a meaningful dialogue can take place. This is in contrast to UNAIDS, which was able to play an intermediary role through its established relationships with private-sector players. There is currently no intermediary actor that can play a similar convening role. An independent academic or think-tank entity could assume this function to facilitate preparatory discussions to reach a common framework pre-September.

Proposition 4: Clear, specific, and measurable goals should be put forward before the meeting, focused around awareness, national planning, disease prevention and treatment, innovative finance, regulation and cross-sectoral coordination. Overcoming barriers to implementation of the Framework Convention on Tobacco Control should play a central role in the discussions.

Clear, specific, and measurable goals are important to ensure progress on NCDs and as instruments of accountability. There are five areas that progress could be made in.

- *Recognition and awareness:* The first is recognition of the scale of morbidity and mortality caused by NCDs and the economic consequences for households, the health system, and overall economic development. Of particular importance is an estimate of the funding gap and the astronomical cost of inaction. During the meeting this would involve attendance by heads of state and major political leaders, and in the outcomes document, this could be manifest by the inclusion of a NCD measure in discussions on post-MDG indicators, an

endorsement of the WHO Plan on NCDs, and a costing study of the impact on economies of inaction.

- *National plans:* Governments could also commit to developing national NCD plans for example through convening a multisectoral national task force or commission to flesh out country-specific strategies and targets. The WHO could support countries in this process. These plans could be required by 2013, with updates on select targets by 2015 and continuous monitoring by the United Nations.
- *Financing:* There is general agreement that it is unlikely that new monies will be pledged at the meeting and that it could actually be detrimental to focus on raising a specific amount of funding given that it might distract governments from other key asks. Rather than pushing for a new type of institution such as a Global Fund for NCDs, three feasible asks are: first, discussion of joint financing mechanisms, such as public-private partnerships; second, commitment to investing in health system reforms to address relevant issues, such as supply of essential drugs and devices for NCDs, health worker retention, and provision of diabetes care through primary providers; third, investment made to add NCDs as a line item to health budgets to help monitor budgetary allocations.
- *Regulation:* Governments should agree on strengthening national regulation over key risk factors of NCDs including pushing for real change in the food industry. Preparatory work, including roundtable discussions with the food industry, is important to ensure success in this area. These include: (i) bans on trans fats; advertising, sponsorship, and promotion of confectionary and high salt and sugar processed foods, soft drinks, and alcohol to children and youth; and (ii) regulation of salt and sugar content of common foods and regulation of school nutrition environments including nutritional content of school meals and physical education programs.
- *Cross-sectoral coordination:* One of the major challenges for Ministries of Health is that key preventive activities lie outside their purview, thus pointing to the need for cross-sectoral coordination supported at the highest level. A first step could be a commitment to internal public policy audits of the impacts in various sectors, such as education, employment, transport, urban and rural development. Of specific relevance are the:
 - Ministry of Finance: To ensure sufficient funds are budgeted for health to build capacity overall;
 - Ministry of Agriculture: To work toward elimination of national and EU subsidies for harmful crops;
 - Ministry of Trade: To ensure access to essential medicines, implementation of the FCTC, and trade in harmful goods (including obesogenic foods) are acknowledged and prioritized in trade negotiations;

- Ministry of Urban Planning: To increase physical activity through improved opportunities for individuals to use public transport and improved safety of pedestrians and cyclists.

With the above five components, member states could develop a strong outcomes document with agreed set targets and reporting mechanisms to ensure accountability to commitments.

Tobacco in particular could lead discussions in each of these areas. Tobacco control has already made considerable policy gains. These include a Framework Convention on Tobacco Control (FCTC); commitments of over \$500 billion from Bloomberg Philanthropies and the Bill & Melinda Gates Foundation; MPOWER, a coherent public health strategy; and increasing attention to the role of tobacco in bilateral trade agreements, in taxation policy, and in agriculture.

A focus on tobacco control could be the “low-hanging fruit” given that 167 countries have already pledged to strategies to reduce tobacco consumption. Despite major gains, there is still much work required on curbing tobacco use. Having the UN secretary general make a strong declaration to support the FCTC in New York will add significant weight to previous commitments made in Geneva. While smoking is declining in most wealthy countries, it is increasing in many poor countries of the world, with profound consequences for the future of public health and development. As stock prices for tobacco rally—underscoring the confidence of the markets in tobacco—there need to be clear decisions made on overcoming barriers to implementation of the FCTC such as: investment treaties and associated pressures to open markets; agriculture and loss of employment; subsidies for harmful crops; difficulties in regulating the private sector; illicit trade in cigarettes and tobacco smuggling; and constraints to implementing tobacco taxation.

The Way Forward

In our view, with the right preparation, the High-Level Meeting could bring about a shift of world opinion, build consensus around core feasible goals in an intermediate and long-term time frame, and better integrate this area of steeply rising significance into broader global health approaches by member countries, donors, and international organizations. Upcoming meetings such as the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow in April 2011 provide key stepping stones to start addressing and resolving the four propositions outlined in this paper.

But time is short, and strategic thinking needs to be coupled with realism on what can be achieved. We now need to get the politics right for noncommunicable diseases.

List of Key Resources

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1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org