Zero draft – Political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being

World Heart Federation's comments

Preambular paragraphs

1. Paragraph 5: We recommend mentioning that low- and middle-income countries (LMICs) bear the greatest burden of NCDs and CVD, with 82% of premature NCD-related deaths occurring in LMICs.
2. We recommend including reference to air pollution, as major risk factors for cardiovascular disease (CVD), especially in the context of the WHO 5 x 5 framework.
3. We suggest including reference to climate change, given the vulnerability of people living with CVD to its effects.
4. Paragraph 7: We recommend mentioning social, commercial and economic determinants as critical drivers of poor cardiovascular health, beyond recognizing behavioural, environmental and metabolic risk factors as modifiable and preventable.
5. Paragraph 16: We recommend editing the reference to the private sector to: *private sector actors whose interests align with public health goals*, to avoid conflicts of interest and recognize that commercial determinants have a major impact on the CVD burden.
6. We recommend amending the target of 150 million more people on hypertension control by 2030 to 500 million more people on hypertension treatment, which would lead to 50% hypertension control. We believe the hypertension control target in the zero draft is too conservative and not ambitious enough, considering that hypertension is the leading risk factor for cardiovascular disease and bears an enormous burden on individuals, families and communities.
7. We recommend adding specific reference to the interconnectivity between obesity, cardiovascular, renal and metabolic diseases. We are concerned that obesity is marginalised in the draft text with absolutely no recognition of the interconnectivity between obesity, cardiovascular, renal and metabolic (CVRM) diseases, despite evidence of the complex, long-term and multi-morbid nature of the CVRM diseases.
8. We recommend referencing dyslipidemia, particularly elevated LDL-cholesterol, as a key risk factor for cardiovascular disease, recognizing its compounding effects with other NCD risk factors.

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9. We recommend greater attention to non-modifiable risk factors, including genetic conditions – such as familial hypercholesterolemia and elevated lipoprotein(a) – which contribute to early onset and progression of NCDs.

Create health-promoting environments through action across government

1. We recommend adding reference to increasing excise taxes to at least 50% of retail price for both alcohol and sugar-sweetened beverages. We welcome the specific target on increased excise taxes on tobacco, alcohol and sugar-sweetened beverages to levels recommended by the WHO by 2030 after paragraph 29. While we agree on the percentage of excise taxes on tobacco recommended by WHO, we believe that the ones on alcohol and SSBs need to be higher than 20% for SSBs and set at minimum 50% for alcohol.
2. Paragraph 27: We recommend revising the text to "*tobacco and recreational nicotine use*", as well as mentioning implementation of all WHO MPower measures.
3. Paragraph 27b: We recommend revising it to "*restrict and regulate newer tobacco and nicotine products, such as electronic nicotine delivery systems and electronic non-nicotine delivery systems*".
4. Paragraph 27f: We suggest adding "*ending subsidies and phasing out fossil fuels*".
5. Paragraph 27f: We suggest adding specific reference to the 2021 WHO Air Quality Guidelines and reference to recommended levels and interim targets for common air pollutants: PM, O_3, NO_2, and SO_2.The current text appears to be too general, with no specific reference to air quality targets.
6. Paragraph 28: We recommend adding reference to alcohol consumption.
7. We recommend adding commitment to adopting and implementing existing technical packages and action plans, such as the Acceleration Plan to Stop Obesity, the WHO Global Action Plan on Physical Activity 2018-2030, among others.

Strengthening primary healthcare

1. This section would benefit from stronger reference to expansion of Universal Health Coverage as a critical step to ensure a strong, comprehensive and well-funded primary healthcare system.
2. Paragraph 30: We recommend explicitly mentioning *cardiovascular disease* as a focus area alongside hypertension and diabetes. This reflects the need for integrated CVD management beyond risk factor control. In addition, we recommend explicitly referencing lipid disorders under sub-point (i) to ensure comprehensive coverage of key cardiovascular risk factors.

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3. Paragraph 30: We recommend adding reference to Resolution WHA 76.5 on Strengthening diagnostics capacity in and highlighting the need to:
    a. Establish national diagnostic strategies in support of NCDs
    b. Ensure the provision of diagnostics services for the prevention and early detection of NCDs
    c. Harmonize regulatory policies and adopt reliance for diagnostics
4. We recommend greater specificity in defining referral pathways and follow up, explicitly mentioning task-sharing models that support better follow up, adherence to treatment and retention.
5. Paragraph 30: We recommend adding specific reference to the need for technical and financial support to LMICs to strengthen their PHC and implement integrated CVD services.
6. Paragraph 31: We recommend:
    a. Adding reference to the HEARTS Technical Package, to reinforce evidence-based guidance.
    b. Include task-sharing approaches (e.g., allowing nurses and community health workers to manage hypertension) as a means to scale care in resource-limited settings.
    c. Including language on children and adolescents at risk of or affected by CVD.
    d. Including reference to primary care-based detection and management of heart failure, atrial fibrillation and rheumatic heart disease, particularly in LMICs.
    e. We recommend including early testing for and management of lipid disorders under point (iii) to reduce lifetime cardiovascular risk. In addition, we recommend revising the term statin-based therapies to lipid-lowering therapies under point (iii), to reflect the broader range of effective treatment options available.
7. Paragraph 37: We recommend adding reference to task sharing in paragraph 37 for CVD and hypertension management at PHC level.

Increase sustainable financing

1. Paragraph 41: we recommend adding reference to *private sector actors whose interests align with public health*. Language on "innovative financing mechanisms and partnerships with the private sector" is vague and may risk engagement with actors whose products undermine cardiovascular health (e.g., tobacco, alcohol, ultra-processed food industries).
2. Paragraph 42: We recommend adding a specific target for the percentage of public health budgets dedicated to CVD. At the moment, reference is only to mental health.

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3. Paragraph 45: we recommend highlighting the catastrophic costs of CVD, including heart attack, stroke and hypertension and encouraging countries to prioritize financial protection for high-burden NCDs within health benefits packages.

Strengthening governance

1. Paragraph 46: We recommend adding reference to national cardiovascular health plan. More than 70% of NCD deaths are due to CVD, yet national CVD plans are often missing or under-resourced.
2. Paragraph 46: We suggest adding reference to meaningful engagement of people living with NCDs.
3. Paragraph 48: We recommend adding reference to misinformation from commercial actors.

Strengthen data and surveillance to monitor progress and hold ourselves accountable

1. We recommend including population-based surveys, such as STEPS, disaggregated facility-based information systems and integration of key indicators such as blood pressure control and access to essential CVD medicines. Without tracking hypertension diagnosis, treatment, and control rates, or heart attack and stroke outcomes, health systems can't measure progress on CVD
2. We recommend alignment with the WHO NCD Global Monitoring Framework and ensure that countries report on hypertension control, CVD mortality and treatment coverage as part of SDG 3.4 reporting.

Follow up

Paragraph 57: We recommend including interim progress reports, before 2030.

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