Policy Document

Noncommunicable Diseases

BACKGROUND

The Australian Medical Students’ Association (AMSA) is the peak representative body of Australia’s medical students. AMSA believes that all communities have the right to the highest attainable level of health. Accordingly, AMSA advocates on issues that affect local, national and global health outcomes, including noncommunicable diseases (NCDs).

NCDs are a group of diseases that are characteristically chronic in duration, progressive, and are due to a combination of genetic, environmental and behavioural factors [1]. The World Health Organization (WHO) has identified four main NCDs: cardiovascular diseases (CVDs), cancers, chronic respiratory diseases and diabetes mellitus [1]. NCDs are the leading cause of global mortality, killing 40 million people each year (70% of global mortality) [1]. In Australia, NCDs contribute to 91% of total deaths [2]. Of the four main NCDs, CVD is the biggest killer globally and in Australia, causing 17.7 million deaths each year, followed by cancers which cause 8.8 million, respiratory diseases which are responsible for 3.9 million, and diabetes which kills 1.6 million people annually [2,3].

NCDs disproportionately affect low- and middle-income countries (LMICs), with three-quarters of NCD-related deaths occurring in LMICs. Forty-eight percent of these deaths occur before age of 70 [4]. In Australia, the prevalence of NCDs is higher in Indigenous Australians than non-Indigenous Australians [5], which contributes to the significant health inequity that exists between these two groups. For example, the mortality rate from diabetes in 2016 among Indigenous Australians is five times higher than that of non-Indigenous Australians [6]. An Indigenous child born in 2010-2012 is expected to live approximately ten years less than a non-Indigenous child born in the same year [7]. Socioeconomic status is also significantly related to NCD burden, with those with lower socioeconomic status being most affected [4]. Specifically, lower socioeconomic status has been associated with higher rates of hypertension, hypercholesterolaemia, excessive alcohol consumption, physical inactivity, stroke and obesity [8,9]. It is clear that those in lower socioeconomic groups and Indigenous Australians are disproportionately burdened by NCDs, and thus a particular targeted focus on these at risk groups is required to ensure that healthcare is equitably distributed for all Australians.

There are common modifiable risk factors that contribute to the development of the four main NCDs, making them important targets for both prevention and treatment-focused lifestyle interventions. These risk factors include tobacco use, alcohol consumption, poor quality diet and physical inactivity [10]. In addition, AMSA recognises poor mental health as having a significant bidirectional relationship with the other physical NCDs [11]. Given that these risk factors are largely modifiable, AMSA recognises the important role of preventative medicine in the field of NCDs, a principle which informs AMSA’s position on these issues.

Tobacco

The use of tobacco in Australia and worldwide remains a significant cause of morbidity and early mortality, with one in ten deaths attributed to tobacco use globally [12]. The 2013 WHO report on the Global Tobacco Epidemic [13], set a target to reduce global tobacco use by 30% by 2025, which is on track according to the 2017 report [14]. It is particularly noteworthy that smoking prevalence rates are declining in middle-income countries, which house the largest number of smokers, with overall rates down from 23.2% in 2007 to 20.8% in 2015 [14]. This can largely be attributed to strategies which control the usage of tobacco, such as comprehensive surveillance of tobacco use, promotion of smoke-free environments, availability of cessation programs, packaging regulations, mass media campaigns, advertising bans, and taxation on tobacco products [13]. Australia has been particularly proactive in both prevention and cessation of tobacco use, with interventions existing in the majority of these domains, as is outlined in the National Tobacco Strategy 2012-2018 [15]. Given that these
measures have been widely successful in preventing the initiation of smoking, the continuation of these campaigns and taxation measures, along with further expansion into mass media is logical [13,15].

The issues posed by tobacco use have been recently compounded by the increasing popularity of electronic cigarettes or ‘e-cigarettes’ within Australia [16]. Nicotine e-cigarettes are banned in Australia[16], and although the existing non-nicotine e-cigarettes are less harmful than conventional cigarettes, evidence on the short and long-term health implications of the active and passive usage remains inconclusive [17].

Additionally, no e-cigarette product is endorsed by the Therapeutic Goods Administration as an aid for smoking cessation, however e-cigarettes that do not contain nicotine can be sold in retail stores so long as no ‘therapeutic’ claims are made about their benefits[17,18]. There is no compelling evidence that e-cigarettes are effective aids for smoking cessation, and the evidence is currently inconclusive as to whether there is the potential for their use to normalise smoking behaviour [19-21]. This is a particular concern for adolescents and young adults, as e-cigarette companies use marketing strategies to target this younger age group in an attempt to capture an audience which otherwise has a low smoking prevalence [18,22]. In addition, tobacco companies have a vested commercial interest in continuing to promote smoking behaviour due to their dual ownership of major traditional and electronic cigarette brands, which may complicate the policy process [19].

Alcohol

Alcohol consumption, in particular chronic harmful alcohol consumption, contributes substantially to the burden of NCDs, contributing to 3.3 million deaths worldwide every year [23]. Australian guidelines recommend that adults drink no more than two standard drinks (2 x 10g of alcohol) on any day to reduce the risk of alcohol-related harm over a lifetime [24]. Despite this fact, harmful alcohol consumption continues to be a central component of social gatherings worldwide, including in Australia [25].

Marketing and advertising of alcohol in particular are known to increase immediate alcohol purchase and consumption in students over 18 [26,27]; and in addition, exposure to alcohol advertising during sporting events causes viewers’ attitudes to alcohol to become more positive [28]. Moves towards an industry-independent regulatory system have begun in Australia over the last 4 years through the Alcohol Advertising Review Board (AARB), with more consumer complaints and removed advertisements than previously [29,30]. Further, deliberate education associating excessive long-term alcohol consumption with harm can reduce consumption[31]. Refer to AMSA’s ‘Alcohol Misuse and Harms’ policy.

Prescription and Recreational Drugs

Prescription drug abuse is a rising problem in Australia [32], being one of the most frequent contributors to overdose deaths across many states in recent years [33]. Indeed, 4.8% of Australian adults in 2013 had used pharmaceutical drugs for non-medical purposes in the preceding 12 months, rising from 3.8% in 2004, according to the National Drug Strategy Household Survey [33]. The type of drugs abused can change over time, and primarily depends on two main factors: legislative action by governments such as schedule changes, and pharmaceutical company marketing of drug products. For instance, the Australia-wide rescheduling of alprazolam (Xanax) from a schedule 4 to schedule 8 drug in 2014 produced a 35% reduction in prescription dispensation in the first 12 months [33]. More importantly, monthly calls to the Poisons Information Centre involving alprazolam were halved in this 12 month period [34].

The usage of recreational drugs has also increased in Australia in recent years, particularly in those aged in their 40s and 50s [35]. Currently, the 4 most commonly used recreational drugs in Australia are cannabis, cocaine, ecstasy and amphetamines [35]. According to the Australian Institute of Health and Welfare, in 2016, 16% of Australians aged 14 or older had used an illicit drug in the last 12 months [35]. In 2016, the use of such drugs was highest among 20–29 year olds (28%), however the use of any illicit drug has increased most significantly among the 40-49 and 50-59 year old age groups (from 12% to 16% and 6.7% to 12% respectively) between 2001 and 2016 [36,37].

Frequent or regular use of some prescription and recreational drugs can result in drug addiction and abuse, which affects around 1 in 20 Australians, and has a range of
In the context of NCDs, it is well recognised that drug abuse is associated with mental illness, in some cases in a causative way, while at other times it can simply exacerbate pre-existing mental health conditions [39]. One serious mental health consequence of illicit drug abuse is increased suicide risk in youth, with heavy use of cannabis in particular, being associated with an increased risk of suicide in the younger age groups (14-15 year olds) [39]. Drugs also have systemic effects, and in the long term, their abuse can contribute to the development of NCDs such as cardiovascular disease [40].

Strategic principles for encouraging the safe use and curbing abuse of recreational drugs vary depending on the drug in question. Currently, state health departments fund drug services, which support prevention, harm minimisation and treatment approaches to drug abuse. They are available to those affected by both prescription and recreational drug dependencies [41]. Moreover, the National Drug Strategy identifies formal events and campaigns which educate about the use and abuse of prescription and recreational drugs as integral components of the demand reduction response to this issue [42].

Obesogenic Environments

Obesity is identified by the Australian Burden of Disease Study as a risk factor for 22 diseases including NCDs such as diabetes, several cancers, and CVDs [43]. Indeed, it was found to underlie 53% of the diabetes disease burden, and 7% of the total Australian health burden [43]. The obesogenicity of an environment refers to the impact that it has on promoting obesity development in the individuals and communities within it [44]. Two large components of obesogenicity include access to adequate nutrition, and the relationship between available infrastructure and physical activity. As such, knowledge of these environmental factors informs the response to obesity at the urban planning level [44].

Nutrition

A poor quality diet is one of the key modifiable risk factors for NCDs identified by the WHO [45]. The disease burden of poor nutrition is considerable, with it contributing to CVDs including coronary heart disease (CHD), type II diabetes, and such cancers as lung and bowel [46]. Indeed, poor quality diets also accounted for 18.8% of the global deaths in 2016 [47]. The Australian Dietary Guidelines developed by the National Health and Medical Research Council [48] characterise a nutritious diet as consisting of limited consumption of saturated fat, added sugars, salt, and alcohol, and also identifies trans-fatty acids as to be avoided. It also comprises daily consumption of vegetables; fruits; grains; lean meats, poultry, fish, eggs, nuts, seeds and legumes; and dairy products. Despite this, non-nutritious diets remain an issue for the Australian population with, for example, over half exceeding the WHO recommendation regarding sugar-derived energy intake [49]. As such, efforts to promote adoption of the above dietary habits are key to the prevention of NCDs.

One such measure is the introduction of a Sugar-Sweetened Beverage (SSB) Tax, as suggested by the WHO [50], given that SSBs lack nutritional value and contribute to weight gain [51], metabolic syndrome and type II diabetes [52]. SSB taxes may reduce the incidence of obesity [53], with evidence of reduced SSB purchases following implementation in Mexico [54], and Australian modelling suggesting subsequent reductions in health-related expenditure [55]. In addition, SSB tax revenue may be earmarked to subsidise fresh fruit and vegetables to reduce the impact on low-income communities. Such subsidies have been effective in increasing fruit and vegetable consumption in low-income groups [56]. Refer to AMSA’s ‘Food and Nutrition’ policy for further detail.

Additionally, there is evidence of the significant influence of junk food advertising, namely via television and the internet, which targets children [57,58]. Indeed, industry self-regulatory mechanisms have been ineffective in reducing the extent of such advertising on Australian television for example [59]. Thus prohibition of advertising such food products to children may be of population health benefit, with regulatory interventions being particularly effective [60], and such measures reducing fast food consumption in Quebec [61], and potentially reducing the prevalence of obesity according to US-based modelling [62]. Also, there have been efforts to extend the above principles regarding diet and nutrition promotion to healthcare settings, for example regarding the sale of SSBs via vending machines in hospitals, clinics and other health service locations. Indeed, an intervention to implement nutrition guidelines for vending machines at New Zealand hospitals proved effective in, for example, reducing the saturated fat and total sugar content of products by 41% and 30% respectively [63]. In the Australian context, NSW Health have developed the Healthy Food and Drink in NSW Health Facilities for...
Staff and Visitors Framework, with 95% of SSBs removed from sale in the Murrumbidgee Local Health District in 2016/17 [64].

With regard to sodium intake, the chronic disease consequences of excessive intake include hypertension, each year responsible for 9.4 million deaths globally [65], stroke, and CVD [66]. As such, the adoption of the WHO-developed SHAKE policy initiative [65] to reduce individual salt intake in Australia to within safe limits, would aid in addressing the NCD burden [67]. This initiative includes industry food content reformulation, improvement of front-of-packet nutrition labelling systems, and educational health-awareness programs. In addition, saturated and trans fatty acid consumption increases the risk of a range of NCDs including CHD and type II diabetes [68]. Thus, the above SHAKE measures may also be extended to saturated and trans fatty acids. Furthermore, the Health Star Rating system, currently under review [69], is of limited efficacy in influencing consumer decision making according to product nutritional value [70] and thus may be strengthened by the addition of the above. Refer to AMSA’s ‘Food and Nutrition’ policy for further detail.

In light of higher obesity rates, and greater prevalence of diet-related NCDs including CVD, and type II diabetes within Australia’s Indigenous population [71], the above measures are particularly significant. In particular, government-owned Outback Stores administers 36 community food stores across the Northern Territory, Western Australia, and South Australia for Indigenous communities in remote areas [72]. Health strategies implemented for these stores, which include reducing the sale of highly sugared products by 2020, identified in the 2018 Closing the Gap Report have resulted in reduced sugar consumption, and significant provision of fresh fruit and vegetables [72].

Physical activity

Physical inactivity is defined as ‘failing to meet the guidelines for recommended physical activity set by WHO which are ‘150 to 300 minutes of moderate intensity physical activity or 75 to 150 minutes of vigorous intensity physical activity (or an equivalent combination) each week’ [73]. Importantly, physical inactivity has been identified as the fourth leading risk factor for mortality globally, causing approximately 3.2 million deaths worldwide [74], and 60% of Australian adults are physically inactive [74]. The impact of NCDs associated with physical inactivity on the Australian economy per year can be quantified as $13.8 billion AUD [75].

Interventions for increasing physical activity have included mandatory sport classes in schools, incentivising participating in social sports or joining a gym, and strategies to increase active transport [75]. Amongst these, active transport, such as walking, cycling and taking public transport [76], has been shown to increase physical activity in a way that is more cost-effective than structured exercise programs[77]. Australian active transport initiatives include the ‘Live Lighter’ campaign, which was run in 2012 in Western Australia and involved a mass media campaign demonstrating simple changes to increase physical activity and adopt a healthy diet [78]. The campaign messages reached the target audience (overweight adults were more likely to intend to exercise), however it was concluded that significant long-term success in increasing active transport requires larger infrastructural changes [78,79]. For example, in the Netherlands, 16% of the total road network is dedicated to cycle paths, which increases active transport, with 55% of women and 41% of men participating in more than the minimum recommended levels of physical activity [80]. This suggests that urban planning, and infrastructure which encourage active transport and physical activity, are essential tools in addressing the obesogenic environment and its impacts.

Mental Health and Social Isolation

Mental illness is an important NCD that has to date not been considered with the four major NCDs identified above. This is in spite of mental illness being the leading contributor to the non-fatal disease burden in Australia [46]. There is a complex and bidirectional interplay between mental health and the physical NCDs, and thus it is important to prevent and address both [11]. For example, individuals with depression are predisposed to myocardial infarction, which reciprocally increases the likelihood of depression[44]. In addition, mental health disorders share common risk factors with the 4 main NCDs, such as physical inactivity and the harmful use of alcohol [45]. Like the physical NCDs, mental illness disproportionately affects disadvantaged and stigmatised groups [8]. Furthermore, the stigma associated with mental illness can act as a barrier to accessing treatment for these [81]. This, compounded with other barriers related to mental illness, can reduce healthcare engagement for treatment of NCDs, and so affected individuals may experience a greater disease burden [82].
Finally, social isolation is an important risk factor for mental and physical NCDs that is currently gaining momentum in research and literature [83]. A 2015 meta analysis associated social isolation with an average 29% increased mortality, placing it on par with established physical predictors of mortality [84]. Social relationships are thought to influence health through their provision of tangible resources to buffer stress, their association with shared healthy behaviours, and their link to self-esteem and a sense of meaning [85]. Improving a community’s connectedness is therefore an important means of tackling NCDs, as individuals with stronger social relationships in one study had a 50% increased likelihood of survival compared to those living alone [85].

POSITION STATEMENT

AMSA believes that:

1. NCDs pose a significant health threat globally and include mental ill health, which has particular relevance to the medical students who AMSA represents.
2. NCDs are not uniformly distributed among the Australian population, with higher representation among lower socioeconomic groups and Indigenous Australians.
3. Australia requires a comprehensive plan to address the increase in incidence of NCDs and associated risk factors, acknowledging that equitable access to primary, secondary and tertiary prevention and treatment is essential.
4. There is a need for a substantially greater focus on evidence-based preventative health care within Australia, at the individual, community and wider systems levels (e.g. addressing the issue of an obesogenic environment).

Policy recommendations

AMSA calls upon:

1. The Federal and State Governments to:
   a. Implement a comprehensive, evidence-based, long-term strategy to address NCDs in Australia.
      i. Address the social determinants of NCDs to ensure health equity within this strategy.
      ii. Recognise that NCDs are not uniformly distributed among the Australian population, with higher representation among lower socioeconomic groups and Indigenous Australians. Health policy efforts and resourcing should be culturally-appropriate and aim to reduce this inequity.
      iii. Recognise that this requires an approach that considers commercial, healthcare-related and public interests.
      iv. Ensure that medical research regarding the prevention and equitable treatment of NCDs is made a funding priority, and includes research participants from a representative proportion of the population with respect to sex, ethnicity, age and other NCD risk factors.
      v. Recognise and frame mental health illness as both a NCD and a risk factor for development of other NCDs.
   b. With respect to tobacco control:
      i. Legislate and enforce smoke-free zones for all hospitals, schools and government agencies.
      ii. Ensure that smoke-free zones are available in all public areas, for example, public parks.
      iii. Continue to enforce packaging regulations and taxation for tobacco products.
      iv. Fund tobacco addiction programmes and public awareness campaigns to increase knowledge of these.
      v. Divest, and cease to accept political donations from the tobacco industry.
      vi. Continue to fund research investigating the potential health consequences of long term electronic cigarette use.
vii. Consider the validity of measures to restrict e-cigarette use, including electronic cigarettes in laws that regulate smoke-free zones and consider legislating to restrict the advertising and promotion of electronic cigarettes, consistent with current tobacco advertising prohibitions.

c. With respect to alcohol-related harms:
   i. Legislate against marketing of alcohol products that are targeted at young adults.
   ii. Legislate against marketing of alcohol at sporting events.
   iii. Enforce the FSANZ Code regarding the display of alcohol content on all alcohol packaging.
   iv. Enforce responsible service of alcohol at all licensed venues.
   v. Continue to use public awareness campaigns to increase societal knowledge of safe drinking behaviours and the risks of long-term alcohol abuse.

d. With respect to prescription and recreational drugs
   i. Consider legislative changes to the scheduling of prescription drugs which are identified as posing a significant community abuse risk.
   ii. Implement and support public awareness campaigns to address the growing issue of inappropriate usage of prescription drugs and its associated harms.
   iii. Continue to fund treatment programs which help individuals control or cut down on their use of recreational drugs.
   iv. Continue to support public awareness campaigns which address the issue of recreational drug use incidence amongst the age groups most affected.

e. With respect to obesogenic environments:
   i. Implement guidelines for the sale of food and drink in health care centres, including hospitals, nationwide, such as an institution-appropriate adaptation of the Healthy Food and Drink in NSW Health Facilities for Staff and Visitors Framework.
   ii. Implement a tax on Sugar-Sweetened Beverages (SSBs), with a commitment to regular reviews to assess effectiveness and potential negative impacts.
   iii. Consider earmarking revenue from an SSB tax to subsidise the provision of fresh fruit and vegetables.
   iv. Legislate against the targeted advertising of energy-dense, nutrient-poor food and beverages to children.
   v. Adopt the WHO SHAKE policy recommendations with regard to salt intake.
   vi. Extend, and make mandatory, the SHAKE recommendations for front-of-pack labelling to added sugars, saturated and trans fatty acids.
   vii. Commit to the regular review and refinement of the Health Star Rating system following its current review period.
   viii. Continue to support programs which provide equitable food access to communities in rural and remote areas, including Indigenous communities.
   ix. Promote active transport through public health education and awareness campaigns.
   x. Invest more heavily in infrastructure to increase access for commuters to safe walking paths and cycleways, as well as public transport.
   xi. Ensure that urban planning prioritises access to and promotion of physical activity (e.g. adequate green open spaces).

f. With respect to mental health:
   i. Continue to implement national strategies and legislation which addresses stigmatisation, discrimination and human rights violation in society.
   ii. Promote, support and fund multifaceted, community-based interventions that provide opportunity to foster meaningful relationships and involve a broad range of people (e.g. ParkRuns and Men’s Shed).

2. International Non-Government Organisations to:
   a. Critically assess the response of all governments to NCD prevention, publicise these assessments and make recommendation for future improvements.
b. Establish campaigns and programmes that address NCD prevention.
c. Facilitate multi-sectoral cooperation for global action against NCDs.

3. Medical students to:
   a. Advocate for NCD prevention and risk factor reduction in patients. This should be appropriate to the student’s capacity and under the supervision of a qualified health professional.
   b. Advocate for improved food environments for their fellow students by promoting the adoption of an institution-appropriate adaptation of the Healthy Food and Drink in NSW Health Facilities for Staff and Visitors Framework by their universities.
   c. Reduce barriers to treatment, including stigma associated with NCD risk factors, by ensuring their conduct is professional and non-judgemental.
   d. Promote mental health awareness amongst fellow students.
   e. Encourage and take on self-care strategies such as organising a personal GP.
   f. Engage in the promotion of healthy eating and exercise habits, avoidance of smoking and excessive consumption of alcohol and other drugs.

4. Health professionals and healthcare providers to:
   a. Adopt nutrition guidelines regarding the sale of food and drink, such as an implementing an institution-appropriate adaptation of the Healthy Food and Drink in NSW Health Facilities for Staff and Visitors Framework, in all health care centres.
   b. Reduce barriers to treatment, including stigma associated with NCD risk factors, by ensuring their conduct is professional and non-judgemental.
   c. Actively engage with evidence-based strategies to screen, treat and prevent NCDs in their patients such as diabetic health screens.
   d. Engage in the promotion of healthy eating and exercise habits, avoidance of smoking and excessive consumption of alcohol and other drugs.
   e. Incorporate measures of social well-being into preventative health screenings.
   f. Promote social connectedness as a preventative medical intervention for chronic diseases, through strategies such as engaging with ParkRun or Men’s Sheds.
   g. Recommend and build disease-specific support networks for patients with chronic diseases.
   h. Be aware of the risk of dependence and overdose with any drugs they prescribe, but particularly common/currently abused drugs of dependence.

5. Medical schools and societies, universities and educational institutions to:
   a. Incorporate increased preventative health care and the social determinants of health into the medical curriculum, including with regard to NCD risk factors.
   b. Provide an environment that fosters both physical and psychological welfare, for example, via the provision of counselling services, wellbeing and mindfulness programs, and GP location services.
   c. Subsidise student access to physical activity such as memberships for gyms and university sporting programs.
   d. Promote the importance of good quality nutrition and physical activity for general health and wellbeing.
   e. Ensure campuses adhere to smoke free regulations.
   f. Reduce the emphasis placed on alcohol use in university and college-related functions.
   g. Educate students on the increased risk of NCDs from long-term harmful alcohol consumption.

6. Private Sector Companies to:
   a. Ensure advertising adheres to government regulations and limit advertising of energy-dense foods to vulnerable demographics; in particular, cease the advertising of energy-dense food to children.
   b. Ensure food packaging adheres to the relevant government standards and ensure clear display of nutritional and caloric information on food and beverage packaging.
   c. Provide front-of-pack labelling of food and beverage item content in accordance with the SHAKE recommendations, with regard to salt, added sugars, sodium, saturated and trans fatty acids.
   d. Increase adoption of the Health Star Rating System on the front of all food and beverage product packaging.
e. Engage in food and beverage product content reformulation in accordance with government, NHMRC, or WHO standards with regard to added sugars, sodium, saturated and trans fatty acids.

f. Abide by the FSANZ Code regarding the displays of relevant health advice and messages on alcohol packaging and advertisements.

g. Ensure workplace design is conducive to primary prevention of NCDs, with the removal of SSBs and other easily accessible ‘occasional’ food, as a workplace-appropriate adaptation of the Healthy Food and Drink in NSW Health facilities for Staff and Visitors Framework.

h. Provide adequate facilities that enable active transport to and from workplaces, such as bike racks and showers.

i. Provide facilities for cooking and storage of pre-prepared lunches and meals.

j. Ensure workplaces adhere to smoke free regulations.

k. Reduce alcohol provision at workplace events.

REFERENCES


57. American Heart Foundation [Internet]. Dallas TX. USA: American Heart Foundation; 2018. Illegal Drugs and Heart Disease; 2017 May 17 [cited 2018 Mar 18]; [about 2 screens]. Available from: http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/Illegal-Drugs-and-Heart-Disease_UCM_428537_Article.jsp#Wq5TtahuZyw


83. The Conversation [Internet]. Saeri A, Sibley CG, Barlow FK, Strong S, Cruwys T. Are you part of a social group? Making sure you are will improve your health [Internet]; 2017 Sep 6 [cited 2018 February 4]. Available from https://theconversation.com/are-you-part-of-a-social-group-making-sure-you-are-will-improve-your-health-81996


POLICY DETAILS
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