

The NCD Challenge: Progress in responding to the global NCD challenge and the way forward

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Discussion Paper
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INTRODUCTION

In July, 2014, Member States of the United Nations General Assembly (UNGA) convened the second high-level meeting on noncommunicable diseases (NCDs). The objective was to take stock of the progress made in implementing the commitments set out in the Political Declaration of the first High-level Meeting on the Prevention and Control of NCDs, adopted by the General Assembly in resolution A/RES/66/2 of September 2011¹.

In July 2014, The UNGA met again to review progress since the first meeting in 2011. Despite many positive developments since 2011, Member States recognized that “progress in the prevention and control of NCDs was insufficient and highly uneven, due in part to their complexity and challenging nature, and that continued and increased efforts are essential for meeting the 2011 commitments”².

Many developing countries were still struggling to move from commitment to action and, in this regard, the UNGA reiterated the call upon Member States to scale up the development of national programmes and the implementation of the proven, cost-effective multisectoral interventions. Moving forward, Member States set a timeframe to implement a set of four specific commitments by 2015 and 2016 in the areas of governance, surveillance, reduction of risk factors, and health care and requested the Secretary General of the United Nations (UN) to report, towards the end of 2017, on the progress achieved in preparation for a comprehensive review, during a third high-level meeting of the UNGA in 2018.

It is now clear that the improvements in meeting both the 2011 and 2014 commitments are largely unmet and that there are major constraints that impede further progress.

This discussion paper attempts to review the progress in responding to the global NCD challenge, identify the barriers facing countries and other stakeholders and provide the background for an objective, transparent and focused discussion on solutions and way forward for accelerated action. The discussion paper starts with a brief historical analysis of global NCD initiatives over the past two decades, highlighting strategic directions set and commitments made, followed by brief analysis of the reasons for the limited progress in achieving these commitments and how to address them.

HISTORICAL BACKGROUND AND MILESTONES OF THE GLOBAL NCD INITIATIVE

The Global Strategy for the Prevention and Control of NCDs (World Health Assembly, May 2000)

When Dr Brundtland took office in 1998 as Director-General of WHO, a higher priority was given to the prevention and control of NCDs within WHO. Two major milestones followed: the development of a global strategy on NCDs which was endorsed by the World Health Assembly in May 2000³ and

¹ Resolution available at <http://www.who.int/ncds/governance/en/>

² <http://www.who.int/nmh/events/2014/a-res-68-300.pdf>

³ See document A53/14 available at http://apps.who.int/gb/archive/pdf_files/WHA53/ea14.pdf

the adoption of the Framework Convention for Tobacco Control (FCTC) by WHO Member States in 2003⁴.

The global strategy considered that the rapid rise of NCDs, which in 1998 was responsible for 60% of global deaths and 43% of the global burden of disease, represents one of the major challenges to global development in the 21st century. The strategy predicted that by the year 2020 these diseases were expected to account for 73% of deaths. Already in 2015, NCD deaths have risen to 70% of global mortality and there is evidence that the increasing trend is continuing in most regions. WHO estimates that about 43% of NCD deaths (almost 17 million or one third of all deaths) are deaths occurring prematurely before 70 years of age and that 15 million deaths occur between the ages of 30-70.

Global estimated deaths (2015)

	All deaths	NCD deaths	Percentage
Male	30.1 million	20.5 million	68%
Female	26.3 million	19.0 million	72%
Total both sexes	56.4 million	39.5 million	70%

Estimated premature deaths from NCDs (2015)

	< 60	< 70	30-70
Total both sexes	9.2 million	16.9 million	15.0 million
Compare to global NCD deaths	39.5 million	39.5 million	39.5 million
Percentage	23%	43%	38%

Table 1: Causes of premature deaths in 2015 (WHO Global Health Estimates)

The global strategy was based on extensive review of evidence and international experience conducted between 1998 and 2000. The strategic directions adopted were guided by the lessons learned from existing knowledge and experience. The strategy focused on the four most prominent NCDs which are currently responsible for more than 80% of all premature NCD deaths occurring between the ages of 30-69⁵. These are cardiovascular disease, cancer, chronic pulmonary disease and diabetes. They are caused by common preventable risk factors related to lifestyle. The key preventable risk factors are tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. Action to prevent the vast majority of premature deaths and disease burden should, therefore, focus on controlling the risk factors in an integrated manner and providing better health care for those with already established conditions.

The strategy has three components:

- a surveillance component to map NCDs and to track and analyze their behavioral risk factors as well as their social, economic and political determinants, with particular reference to poor and disadvantaged populations
- a prevention component to reduce the level of exposure to common risk factors and their determinants
- a health care component to strengthen the management of NCDs in national health systems by developing and implementing cost-effective and equitable interventions.

The 2000 global strategy emphasized the critical importance of other arms of the government. It stated that more health gains in terms of prevention are achieved by influencing public health policies in domains like trade, finance, agriculture, food, and urban development than by changing

⁴ Resolution WHA56.1 available at http://apps.who.int/gb/archive/pdf_files/WHA56/ea56r1.pdf

⁵ Paragraph 4 of document A70/27 available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_27-en.pdf

health policy alone. Tackling issues outside the health sector and placing prevention and health promotion high on the public agenda is regarded as a major strategic direction.

The FCTC is the first international treaty negotiated under WHO's umbrella and has become one of the most widely and rapidly ratified treaties in the history of the United Nations⁶.

Work on developing technical guidance on reduction of the key risk factors continued. In 2004, the Global Strategy on Diet, Physical Activity and Health (DPAS) was endorsed and in 2010, the World Health Assembly adopted the strategy on the harmful use of alcohol following extensive consultation with Member States and other stakeholders.

Other key risk factors

As mentioned above, the global strategy focused primarily on the four groups of NCDs responsible for the majority of NCD mortality and premature death and which share common risk factors, the same prevention approaches, and a common pathway for monitoring and assessing progress. However, there are additional risk factors that are also important in the causation of NCDs. One notable example is poor air quality. Air pollution, both indoor and outdoor, has emerged since the endorsement of the strategy in 2000 as a major public health problem and one of the key underlying cause for millions of deaths due to ischemic heart disease, chronic lung diseases, and cancers. Evidence and international experience clearly indicate that air pollution can be effectively reduced by instituting appropriate intersectoral interventions and that reducing particulate matter pollution will contribute to reduction of air pollution related deaths⁷. It is therefore critical for all countries to include proven measures to reduce air pollution in the list of core interventions to improve health and prevent NCDs.

The case of mental health disorders as high-burden noncommunicable conditions

Mental health disorders are other noncommunicable conditions that account for 13% of the global disease burden and like the other NCDs their socioeconomic consequences are equally large⁸. However, mental disorders comprise a broad range of problems with different health and social manifestations and require distinct approaches and somewhat different prevention and control strategies. Main examples include depression, psychotic disorders, intellectual disabilities including dementia, suicide, and substance abuse disorders. Many of these conditions can be successfully treated but because of the low priority given to these problems and the weak health and social systems in many countries, the majority of people with mental health disorders have no access to basic treatment and care.

The treatment gap and inappropriate systems of health and social care, particularly in LMICs, together with human rights violations, stigmatization, marginalization and the social isolation of people with mental health disorders represent the main challenges in tackling the mental health challenge. Although some strategic interventions, like those addressing alcohol use and risk factors of dementia as well as measures to strengthen health systems, are already addressed by the NCD strategy, many policy aspects for preventing, managing and monitoring mental disorders are unique and substantially different. As stated in the Mental Health Action Plan 2013/2020, response to the mental health gap requires special strategic directions to provide integrated and responsive mental health and social care services including in community based settings, specific interventions for mental health promotion, special approaches for measuring progress, and a different monitoring

⁶ Bulletin of the WHO 2010, 88:83/83

⁷ WHO Air quality guidelines available at <http://www.who.int/mediacentre/factsheets/fs313/en/>

⁸ http://www.who.int/mental_health/action_plan_2013/en/

framework. While the Action Plan provides a comprehensive menu of effective interventions based on evidence and best practice, there is a pressing need to establish another high-level global movement that adopts a more focused approach to raise the awareness and commitment and scale up national and global action. For this purpose, the comprehensive Action Plan needs to be translated into a practical framework of evidence-based policies and a set of high-impact interventions that can be feasibly implemented in LMICs⁹.

Global Strategy Action Plan 2008-2013

In 2007, the World Health Assembly requested the Director-General to translate the 2000 Global Strategy into concrete action¹⁰. Accordingly, an action plan was developed in collaboration with Member States with input provided by the 122nd session of the WHO Executive Board in January 2008 and informal consultations with WHO Member States and other stakeholders (January-March 2008). In May 2008, the World Health Assembly passed resolution WHA61.14¹¹ endorsing the Global Strategy Action Plan for the period 2008-2013. The Action Plan sets out six objectives, actions to be implemented over the six-year period, and performance indicators to guide work at national, regional and global levels.

The plan's objectives are:

- To raise the priority accorded to NCDs in development work at global and national levels, and to integrate NCD prevention and control into policies across all government departments
- To establish and strengthen national policies and plans for the prevention and control of NCDs
- To promote interventions to reduce the main shared modifiable risk factors: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol
- To promote research for the prevention and control of NCDs
- To promote partnerships for the prevention and control of NCDs
- To monitor NCDs and their determinants and evaluate progress at the national, regional and global levels.

In each of the three objectives, the plan had specific actions recommended to countries, WHO, and its international partners. Implementation of the plan's recommendations was effective in: raising the awareness and priority given to NCDs, moving the NCD agenda from the World Health Assembly to the United Nations General Assembly, developing guidance for countries in the areas of surveillance, prevention, and health care including the endorsement of a set of evidence-based, cost-effective interventions "best buys" and a global monitoring framework.

The first United Nations General Assembly High-level Meeting on NCDs

As an outcome of the work done in implementing the 2008-2013 Action plan, the UNGA held, in September 2011, the High-level Meeting on the prevention and control of NCDs. The meeting was a major breakthrough, attended by 34 Heads of State and Government, and was the second time the UNGA had met on a health issue. World leaders adopted a Political Declaration that outlined the actions to be taken to tackle NCDs at international and national levels¹².

The Heads of State and Government acknowledged that the global burden of NCDs constitutes one of the major challenges to socioeconomic development in the 21st century and threatens the achievement of internationally agreed development goals.

⁹ http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_18700.pdf?ua=1

¹⁰ Paragraph 2(1) of resolution WHA60.23 starting on page 87 of http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/WHASS1_WHA60REC1-en.pdf

¹¹ Available on page 17 of http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_REC1-en.pdf

¹² Resolution A/RES/66/2 available at <http://www.who.int/ncds/governance/en/>

The declaration considered that responding to the challenge is a whole of government and whole of society responsibility and adopted a comprehensive list of recommendations and measures that countries committed to take in order to respond to the global NCD challenge. The commitments covered four broad areas of action: governance, surveillance and monitoring, reduction of risk factors, and health care.

Global NCD Action Plan 2013-2020

To update the 2008-2013 Action Plan and to realize the commitments made in the 2011 UNGA Political Declaration on NCDs, the World Health Assembly adopted, in May 2013, the Global Action Plan 2013-2020 with nine voluntary targets and 25 indicators for achievement in 2025¹³. The new plan provided, in Appendix 3, a menu of recommended policy options and cost-effective interventions to contribute to the achievement of the voluntary targets. Countries were urged to develop their own national targets for 2025 based on the nine global targets, while taking into account their own circumstances and needs.

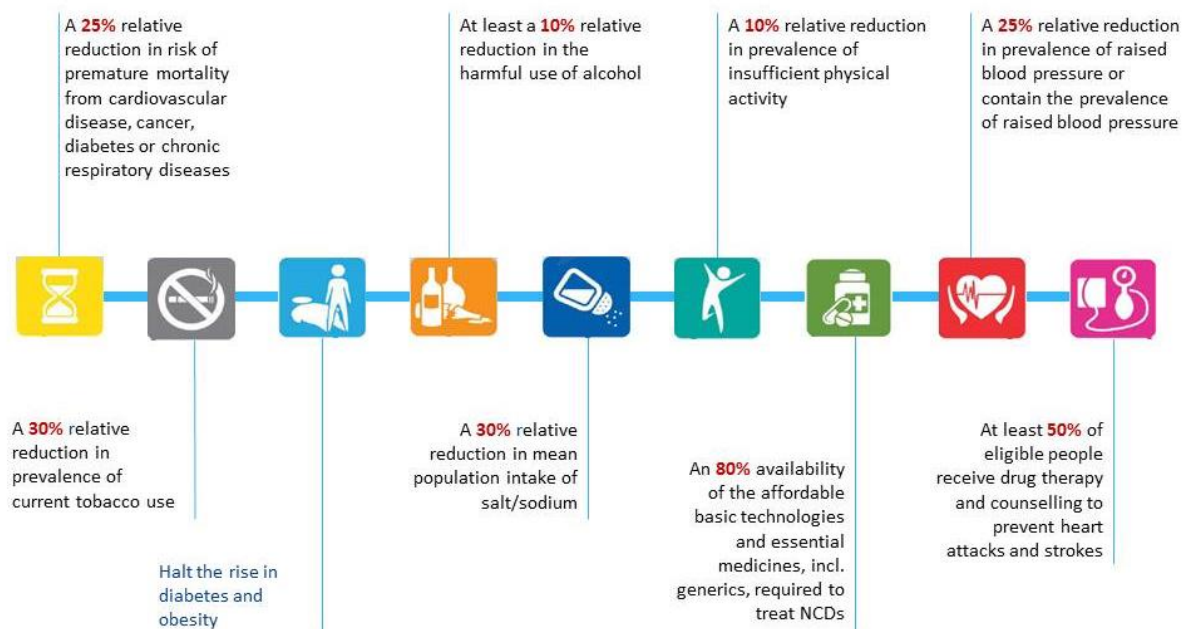


Figure 2: Nine voluntary global NCD targets to be attained by 2025¹⁴

The menu of policy options and interventions included in Appendix 3 of the Action Plan has been updated in 2017 to incorporate new evidence and lessons learned and the current list of policy options has increased from **62** to **86** and the set of the most cost-effective interventions – best buys – increased from **14** to **16**. Part of the expansion is due to the need to disaggregate some previous interventions (such as “reduce salt intake”) into more clearly defined and implementable actions¹⁵.

¹³ Available at <http://www.who.int/nmh/publications/ncd-action-plan/en/>

¹⁴ See Appendix 2 of A66/8 starting on page 7 of http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_8-en.pdf

¹⁵ The updated Appendix 3 endorsed by the World Health Assembly in May 2017 is available in Annex 1 of document A70/27 starting on page 8 of http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_27-en.pdf

The **16** most cost-effective “best buys” interventions are:

- Increase excise taxes and prices on tobacco products
- Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages
- Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship
- Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, public transport
- Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke
- Increase excise taxes on alcoholic beverages
- Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)
- Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)
- Reduce salt intake through reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals
- Reduce salt intake through the establishment of supportive environment in public institutions to enable lower sodium options to be provided
- Reduce salt intake through a behavior change communication and mass media campaigns
- Reduce salt intake through the implementation of a front-of-pack labeling
- Implement public awareness and motivational communications for physical activity, including mass media campaigns for physical activity behavioral change
- Drug therapy (including glycemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and non-fatal cardiovascular event in the next 10 year
- Vaccination against human papillomavirus (2 doses) of 9–13 year old girls
- Prevention of cervical cancer by screening women aged 30–49, either through: Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions, pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions, or human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions.

WHAT IS IMPEDING A MORE EFFECTIVE RESPONSE?

The commitments for Member States, WHO and international partners included in the 2011 political declaration, the 2014 UNGA outcome document and WHO Action Plan include a long list of actions, some of which are duplicated or subsequently modified. However, they can be easily summarized in a core list of commitments under the four areas of action: governance, surveillance, prevention and health care, including the “best buys” mentioned above.

The conclusion of Member States in 2014 on the slow progress in implementing these commitments is supported by the currently available reviews of the ten indicators that WHO will use for 2018 UNGA report¹⁶. Scaling up actions so that countries can make real investments in the most promising and proven interventions is a pressing priority for regaining the momentum.

But in order to scale up it will be essential to explore, in an objective and transparent way, the existing gaps and reasons behind the slow response. The following are areas of underlying constraints that impede recommended action and limit the translation of declared commitments into sustained investments.

¹⁶ <http://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1>

1. Political commitments among policy makers at the country level and other stakeholders

There is no doubt that great progress has been achieved in increasing global awareness on the magnitude of NCDs and the need to put in place policies to tackle the progressively increasing negative impact on health and overall development. Information from WHO indicates that NCDs are now a leading area of work considered a priority by countries in their collaborative programs with WHO¹⁷. However, experience over the past 5 years shows that, despite the increasing number of countries declaring commitment to tackle NCDs, commitments have not been translated into effective action in most countries.

At the country level: According to the WHO NCD Progress Monitor 2015, only two countries scored 14 out of a total of 18 fully achieved measures included in the indicators that have been adopted by WHO to measure progress by 2018. There are also some other countries that have made important strides but a significant number of countries show very poor achievement of these progress indicators, with 14 countries not achieving a single progress indicator and a further 20 countries only achieving one of the indicators¹⁸.

The results of the 2015 WHO global survey on assessment of national capacity for the prevention and control of NCDs and more recently the 2017 survey indicate that^{19 20}:

- Only 41% of countries had national multisectoral national strategies or plans covering the four groups of NCDs. All countries should have met this commitment by 2015.
- Only 34% of countries have operational multisectoral commissions.
- The number of countries initiating policies to reduce the impact of inappropriate marketing of foods and non-alcoholic beverages to countries, five years after the endorsement of the WHO recommendations by the World Health Assembly, remains disappointingly low: less than 10% in two regions and 30% in three other regions.
- The proportion of countries implementing policies on saturated fat and eliminating trans-fat was as low as 3% in one region to 9% in another. Almost similar low levels of implementation apply to the “best buy” on salt reduction.
- In the area of surveillance, less than one third of countries are conducting NCD risk factors surveys at regular intervals and within the last three years. Monitoring NCD mortality is equally challenging. According to the World Health Statistics Quarterly 2017, only around 28% of global deaths are reported by ICD code and even then many such deaths are assigned a garbage codes, leaving just 23% of deaths reported with precise and meaningful information on their cause. Assessing health system response to NCDs which is the third key component of NCD surveillance is equally problematic. There is yet no reliable information collected to specifically measure health system performance.

Although there are several important reasons for the slow progress in countries, some of which are mentioned below, commitment of policy makers at the highest level of government and in the health sector and engagement of several key non-health sectors are key determinants of the extent and quality of response to the national NCD challenge. It is important to build on the commitment made by all Member States at the UN General Assembly in 2011 and 2014, and more recently in 2015 by integrating NCD prevention and control into the SDGs, and take action, at the global and national levels to reinforce commitments and elevate the priority given to NCDs in sustainable development strategies and plans.

¹⁷ See figure 3 on page 5 of “WHO delivering for results” http://www.who.int/about/finances-accountability/budget/20170113_delivering-for-results_background-paper_draft.pdf

¹⁸ See <http://www.who.int/nmh/events/2015/technical-note-en.pdf?ua=1>

¹⁹ <http://apps.who.int/iris/bitstream/10665/246223/1/9789241565363-eng.pdf>

²⁰ http://apps.who.int/iris/bitstream/10665/184688/1/9789241509459_eng.pdf

WHO, other UN agencies, and the World Bank

As mentioned before, the development of the global strategy in 2000 and subsequent work including the translation of the strategy into global action plans and the 2011 UNGA high-level meeting were important developments that led to a positive shift in awareness and commitment to NCDs both in countries and at WHO and the UN.

The engagement of the UN agencies, starting with the discussion on NCDs at the Ministerial Segment of the Economic and Social Council in 1999, followed by the UNGA resolutions on NCDs in 2010, the two high-level meetings in 2011 and 2014, and more recently the inclusion of NCDs as a target in the SDGs were turning points moving the NCD agenda from being just a health topic to an important sustainable development issue. However, the priority given to NCDs in WHO's 12th General Program of Work has not been translated into effective actions to strengthen the leadership of the Organization in this area of work. In practical terms, there has been no increase in financial resources necessary to implement the ambitious action plans and to reinforce the technical workforce. The following biennial budgets of the NCD area of work is incommensurate with the huge NCD global burden and premature mortality.

WHO biennial budget for NCDs²¹:

- 2010-2011: \$ 160.9 million
- 2012-2013: \$ 135.0 million
- 2014-2015: \$ 192.1 million
- 2016-2017: \$ 198.3 million
- 2018-2019: \$ 179.0 million.

Taking the highest allocation in 2016-2017, less than 5% of the total WHO budget is allocated to cover WHO's work in supporting countries to prevent 70 % of all global deaths²².

The negative trend is continuing. In May 2017, the World Health Assembly approved WHO's Programme Budget for 2018-2019 which is even lower at \$179 million (i.e. 4.2% of the total WHO budget)²³. NCDs remain the most underfunded among all other WHO programs. The low funding situation is compounded by the fact that not all allocated funds will be mobilized and used. For example, funds available for NCDs work during the biennium 2016-2017 were only 55% of the allocated funding level at the end of 2016²⁴.

There are several reasons why NCDs receive low funding. First, the overall WHO funding for all programs does not match the mandate and functions of the Organization and it is fair to state that all priority WHO programs, including pandemic preparedness and response, are currently underfunded, taking into account their mandate and the extent and quality of the technical support they are expected to deliver. But since NCDs is responsible for the highest disease burden and mortality and are currently the most underfunded program area in WHO, it is important to explore why this is the case. If donor countries and funding agencies recognize NCDs as a major global challenge, as Member States consistently declare in World Health Assembly and General Assembly resolutions, they, together with the WHO Secretariat should reconsider the resources allocated to NCDs. WHO should also be committed to reinforcing its technical capacity. One of the factors that

²¹ This covers the budgets for WHO's programme area 2.1 (NCDs), and excludes mental health, drug abuse, road safety, violence and injuries, disability and rehabilitation, and undernutrition. See WHO's Programme Budgets available at <http://apps.who.int/gb/>

²² Taking into account WHO's Programme Budget 2016-2017, which includes US\$198 million for WHO's programme area 2.1 (NCDs) vs WHO's total programme budget of US\$4.4 billion represents 4.5% (see http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)

²³ Taking into account WHO's Programme Budget 2018-2019, which includes US\$179 million for WHO's programme area 2.1 (NCDs) vs WHO's total programme budget of US\$4.3 billion represents 4.2% (see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_7-en.pdf)

²⁴ See WHO Programme Budget Web Portal at <http://open.who.int/>

determines the effectiveness of resource mobilization efforts is the confidence of Member States and the donor community in the technical products the Organization delivers. This point has been repeatedly highlighted in governing bodies discussions on financing reform. The credibility of the Organization and the support it delivers will depend on how successful the Organization will be in strengthening its technical competence and the quality of response to country needs.

International development agencies: As will be seen below, the progress made in increasing development assistance for health (DAH) has not been very significant and the changes in policies of development agencies and donors towards prioritizing NCD support and funding are not seen as a significant shift.

Civil society and professional Organizations: Reversing the epidemic of NCDs is not only a responsibility of the government. It also requires engagement from civil society and the business sector. Civil society institutions are uniquely placed to mobilize political awareness and support for NCD prevention and control. They play a key role in advocating for NCDs to be a part of the global development agenda²⁵. Civil society institutions and nongovernmental organizations also contribute to capacity-building and they, in some cases, play a significant and important role in providing prevention and treatment services for cardiovascular disease, cancer, diabetes and respiratory diseases, often filling gaps between services provided by the private and government sectors.

An impressive global movement in support of the NCD cause, effectively led by the NCD Alliance²⁶, was established following the development and endorsement of the 2018-2013 action plan and it continues to play an important role and a strong platform for global advocacy and action in increasing awareness and commitment and in strengthening partnerships. However, the role of civil society in the NCD area is generally still weak at the country level in low- and middle-income countries despite some positive examples in selected countries.

Questions

- What approaches should be considered to reinforce commitments of policy makers and scale up action at country level?
- How can WHO, under the new leadership, increase its commitment to NCDs, strengthen technical leadership and increase budgetary resources?
- How can the key stakeholder including international NGOs reinforce efforts to create stronger civil society movements in support of NCD prevention in Member States?

2. Unmet needs and demands for technical assistance to be provided through domestic, bilateral and multilateral channels

Despite the clear vision and sound road map recommended by the Global strategy and plans and the 2001 UN Political Declaration on NCDs, the capacity and experience of countries to implement the recommended actions require considerable strengthening and demand substantial technical support.

Policy makers generally endorse the NCD road map set by WHO and the UNGA and recognize the need to take action but they require technical support on implementation. It is now clear from review of WHO collaborative programs in countries that NCDs is the leading area where technical

²⁵ First WHO Global Status Report 2010 (available at http://www.who.int/chp/ncd_global_status_report/en/)

²⁶ <https://ncdalliance.org/>

support is requested by national authorities²⁷. But experience clearly indicates that the technical assistance provided to national programs remains fragmented and grossly insufficient.

The gaps that require action by WHO and technical partners can be grouped in two key areas:

- 1) normative functions, with countries requesting robust technical and managerial guidance, based on evidence and international experience, on “how to” implement and evaluate recommended actions in the four areas of governance, surveillance, prevention and health care, and
- 2) field support to respond to the increasing country needs and demands for consultation and expert advice on the development and management of national programs and initiatives.

There are several important areas where gaps in technical guidance exist and should be covered. Examples include:

- Establishing NCD surveillance frameworks as part of the national health information systems, strengthening cause specific mortality reporting, and objective monitoring of health system response and performance
- Developing a practical framework for monitoring of progress
- Formulating managerial and technical guidelines to implement the prevention “best buys” based on evidence and best practice
- Refining and updating guidance on early detection and screening of common NCDs,
- Recommending innovative and affordable approaches to address major health system constraints that impede progress in LMICs, including access to essential medicines and technologies
- Collecting, analyzing and disseminating successful experiences and lessons learned in integrating the management, including screening and early detection, of common NCDs into primary health care
- Providing guidance on financing NCD programs in LMICs including innovative financing,
- Providing support to address inefficient analytical, legal and tax administration capacity to increase domestic taxes on health harming products,
- Counteracting industry interference that blocks the implementation of prevention measures.

Countries also require a higher level of technical support in planning, implementing and evaluating national NCD programs. Technical assistance currently provided by WHO and other agencies is patchy and grossly inadequate. There are very few technical staff with concrete knowledge and experience in country programs and who can provide effective advice. Efforts to develop networks of qualified external experts capable of providing authoritative advice have not achieved significant success. Assessment of national capacity in NCD prevention and control based on global surveys has been very useful but do not always generate sufficiently reliable and validated results. Number of sustainable training/capacity building programs offered at global or regional levels has also been limited.

Questions

- What are the priorities for strengthening technical assistance and building capacity in countries?
- What is the contribution of other agencies and professional organizations in filling the gap?

²⁷ See WHO delivering for results available at http://www.who.int/about/finances-accountability/budget/20170113_delivering-for-results_background-paper_draft.pdf

3. Weak health systems and inadequate national capacity in public health

Most low- and middle-income countries have serious gaps in their own health systems, affecting all the building blocks and impeding effective response to the NCD challenge. The nature and extent of the health system impediments range from country to country depending on existing capacity and resources but common to most low and lower middle income countries are the lack of adequate preparation and training of the health workforce, insufficient finance, lack of adequate and sustainable access to essential medicines and technologies, and inefficient information systems.

However, experience and lessons learned demonstrate that all countries, irrespective of income, can make a difference in addressing the health system gaps by committing to universal health coverage (UHC) and designing and implementing policies and areas of action for each gap. For example, there are effective national policies to address lack of access to essential medicines in the areas of drug selection, procurement, distribution, storage, generic substitutions, rational use, and surveillance that, if implemented, can result in considerable improvement, even in low income countries. Such policies and action areas were reviewed during the Ministerial meeting on NCDs organized before the UNGA high-level meeting, in Moscow in April 2011 but they now need to be updated based on a more extensive review of international experience.

Overall, countries will need to develop a vision and a road map for UHC focusing on expanding coverage, improving health financing performance, enhancing financial risk protection, and expanding coverage of essential health services. Support from WHO, World Bank, and other development partners will be critical and should include assisting countries in establishing a monitoring system to assess health system performance and equity in responding to the NCD challenge.

Questions

- What specific guidance is needed to address the health system weaknesses and provide practical strategies for improving performance in the areas of health care delivery, financing, health workforce, and essential technologies and medicines?

4. Lack of access to adequate financing for national NCD programmes and interventions

Low- and middle-income countries have the highest global NCD burden and although most recommended actions to address the burden are high-impact and cost-effective, there is still a mismatch between the cost of action including for essential health care and the financial resources available to the health sector, particularly in low- and lower middle-income countries. Lack of appropriate health care for the early detection and treatment of curable cancers, life-saving cardiovascular intervention, treatment of diabetes and chronic lung conditions is one of the most serious challenges that health systems in these countries face and often leads to catastrophic expenditures and poverty affecting all households. This also represents a major impediment in implementing the NCD road map in many countries and calls for realistic approaches to address the gap, through mobilization of domestic resources, combined, in some cases, with increased external funding.

Mobilizing domestic resources

Health systems are increasingly overwhelmed with the rapidly escalating magnitude of NCDs and their complications and the rising demands and expectation of people for better health care in the context of limited financial resources. In responding to this situation, the health sector will need to mobilize additional resources. Reprioritization of government budgets to meet the increasing demand is one potential source of increased funding which is also justified by the negative socioeconomic impact of NCDs on socioeconomic development and their inclusion in the SDGs agenda.

Other policy makers, particularly in Finance and Planning, must be fully engaged. In order to obtain their commitment it is crucial for the health sector to establish an effective dialogue with other parts of government and provide the required evidence on returns of such investments on health and socioeconomic development.

The rational use of scarce resources to obtain more health for the money provided is essential for convincing policy makers to increase allocation to NCD prevention and control and in achieving the highest impact. Investing in the most cost-effective interventions for prevention and health care is therefore key.

Increasing taxation on tobacco, alcohol, and other unhealthy products high in sugar, salt and transfat is another potentially important source of funding for health promotion and NCD interventions provided that part of the revenue is earmarked for this purpose. Lessons learned from countries that have implemented this option will be important in guiding other countries in developing similar policies.

Additional funds for health systems strengthening could be generated through innovative financing like increasing taxes on air tickets and foreign exchange transactions.

Development Assistance for Health

As mentioned above and as stated by the World Health Report 2010, the funding shortfall in many low-income countries highlights the need for high-income countries to honour their commitments on official development assistance (ODA), and to back it up with greater effort to improve aid effectiveness. The UNGA high-level meeting in 2011 also called upon the development assistance community to increase their investments in NCDs. However, countries, particularly low- and lower middle- income countries are still not receiving any significant funding for NCDs from external donors and the development assistance community.

Data from the Institute of Health Metrics and Evaluation indicate that there has been a minimal increase in development assistance for health (DAH) for NCDs between 1990 and 2016. Of the total \$37.6 billion in DAH for 2016, only 1.7% went to NCDs, compared to almost 30% to maternal and child health and 25% to HIV/AIDS. From 2010 to 2016, funding for NCDs increased by 5.2%, but NCDs remained the health area with the smallest amount of funding by far compared to with other areas²⁸. Funding to NCDs was \$644 million in 2016. Tobacco control initiatives received \$104 million and mental health 129 million. The analysis conducted by the Institute of Health Metrics and Evaluation report that private philanthropy provided the bulk of funds in 2016. The main channels of assistance were NGOs and WHO.

²⁸ Financing Global Health 2016, IHME, 2017

Funding agencies and development partners are not highly convinced of the seriousness of the risks of NCDs and the consequences on socioeconomic development, compared to the perceived risks of pandemics and their impact on health and economy globally including their own countries. Funding decisions can also be influenced by the conflicts of interest between trade and public health policies. Some NCD policies, including best buys, may be considered by some donor countries to have a negative influence on trade and export of some of their own products. There are also opposing forces like industry interference, particularly tobacco manufacturers, which negatively influence decisions to finance effective interventions.

In general, NCD prevention is still a low priority for external funding. Lack of critical and life-saving health care also has major ethical dimensions in addition to its health and socioeconomic consequences. This is a situation that should receive priority from WHO and partners including civil society organizations. Potentially effective interventions to tackle this situation range from generating more evidence on the seriously negative impact of NCDs on sustainable development and poverty alleviation and the economic gains derived from high-impact pro-poor interventions, developing and disseminating convincing business (investment) cases, to communicating experiences to challenge impeding positions and misconceptions and counteracting unfounded and misleading claims.

There have also been repeated calls for establishing a special global financing mechanism to improve access to health care for people with serious life-threatening NCDs and strengthen health system and similar suggestions will probably continue to be proposed as a solution.

Questions

- What are the concrete and realistic strategies recommended to policy makers in LMICs to mobilize domestic resources for UHC and improvement of NCD health care and outcomes?
- Any creative ideas on raising the priority to NCDs in DAH?
- What are the views on the potential value and feasibility of a global funding mechanism?

5. Limited progress in engaging non-health sectors

Measures to promote health and prevent disease cannot be confined to the health sector alone. The NCD challenge is a prominent example where most preventive interventions require the involvement and active engagement of other sectors. Working together across sectors to improve health and influence determinants and risk factors is often known as intersectoral or multisectoral action on health²⁹.

²⁹ Annex 6, Recommended approaches to implementing effective and sustainable multisectoral action on health. Global Status Report on Noncommunicable Diseases 2010. WHO, 2011.

Sector	Tobacco	Physical inactivity	Harmful use of alcohol	Healthy diet
Agriculture (food and agriculture system)	✓		✓	✓
Communication	✓	✓	✓	✓
Education	✓	✓	✓	✓
Energy		✓	✓	✓
Environment	✓	✓	✓	✓
Finance	✓	✓	✓	✓
Food	✓		✓	✓
Health	✓	✓	✓	✓
Housing	✓	✓		
Industry		✓	✓	✓
Justice/security	✓	✓	✓	
Legislature	✓	✓	✓	✓
Transport	✓	✓	✓	✓
Social/welfare	✓	✓	✓	✓
Sports	✓	✓	✓	✓
Trade	✓	✓	✓	✓
Urban planning		✓	✓	✓

Figure 3: Examples of cross-sectoral government engagement to reduce risk factors for NCDs³⁰

Review of the progress in implementing the most cost-effective “best buys” interventions provides impressive examples of how the health sector has successfully managed to work across government sectors and with other stakeholder to reduce NCD risk factors. However, many countries are still struggling to achieve effective intersectoral action and the commitment and engagement of other sectors like finance, planning, industry and agriculture remain weak. The difficulties in achieving effective intersectoral action are often based on perceived conflicts of interest and diverging policies.

Based on a review of country experiences, through several consultations organized between 2008 and 2010, the Global Status Report 201 provides guidance on steps that policy makers can take systematically to work across sectors. The guidance is still valid but it needs to be simplified and operationalized. Of special importance is for the health sector to achieve a clear understanding of the policies and priorities of other sectors, build capacity to analyse their concerns, provide evidence to counteract misconceptions and opposing claims and develop engagement plans based on co-benefits.

It would be useful for WHO and partners to conduct an updated review of the experience across sectors over the last 5 years to update the guidance on intersectoral action for countries, learning from evidence and country best practices. Experience in the tobacco taxation area illustrates the critical importance of using successful country examples to challenge opposing claims and arguments in other countries.

Countries may also decide to focus on the interventions that will have the highest impact and are more feasible for implementation and focus on the relevant sectors like finance for implementation.

³⁰ Table 1 in document A/67/373 on page 5 available at <http://www.who.int/nmh/events/2012/20121128.pdf?ua=1>

Questions

- What other strategies should be considered to enhance a whole of government approach and strengthen active engagement of other relevant sectors?
- Of the extensive list of sectors included in figure 3, what are the most important sectors that need to be targeted?

6. Weak and sometimes opposing response from the corporate sector and limited efforts to address the commercial determinants of health

Globalization is contributing to the commercial determinants of health and in many cases leading to higher levels of NCD risk factors. In this respect, the UNGA political declaration highlights the critical importance of addressing these determinants and calls for real efforts to support the production of healthy food and to take measures to implement the recommendations on marketing for children as well as the strengthening the implementation of the international code on breast milk substitutes. It also stresses the importance of promoting access to essential and life saving medicines at affordable costs and calls for countries to make full use of the trade related aspects of intellectual property rights including TRIPS flexibilities. However, the progress since 2011 has not been encouraging and there are suggestions to a task force or commission on the commercial determinants of health to develop evidence-informed recommendations for a more serious response.

The business community is regarded as an important stakeholder by the 2000 Global Strategy and subsequent action plans. With the exception of the tobacco industry, the private sector can make a decisively important contribution to addressing NCD prevention challenges. Some representatives of the multinational food industry and the pharma industry made a set of commitments or initiatives to reduce the impact of some of their health-harming products and to improve access to medicines. However, implementation of the commitments has not been monitored due to lack of an independent accountability framework and in general, apart from isolated cases, there is no evidence that these initiatives are having a significant impact.

For a meaningful contribution, the corporate sector must do more in aligning their practices with national public health strategies and be accountable in fulfilling their commitment in reformulation, responsible marketing, and improving affordability and access to medicines. The government has a responsibility of encouraging health promoting actions of the industry and monitoring their contribution and implementation of commitments.

It is also important for WHO and other partners to develop a framework or mechanism to monitor the contribution of private sector and other stakeholders in support of NCDs. The need for such mechanism was emphasized in the outcome document of the 2014 high-level meeting of the General Assembly which requested the development, before the end of 2015, an approach that can be used to register and publish contributions to the achievement of the nine voluntary targets for noncommunicable diseases³¹. This task has to be completed as soon as possible.

³¹ 3 Paragraph 37 of United Nations General Assembly resolution 68/300 refers to “the private sector, philanthropic entities and civil society”. However, for the purpose of discussions at the World Health Assembly, it is assumed that all non-State actors identified in paragraph 8 of WHO’s Framework of Engagement with Non-State Actors are included in the scope of this approach (i.e. nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions).

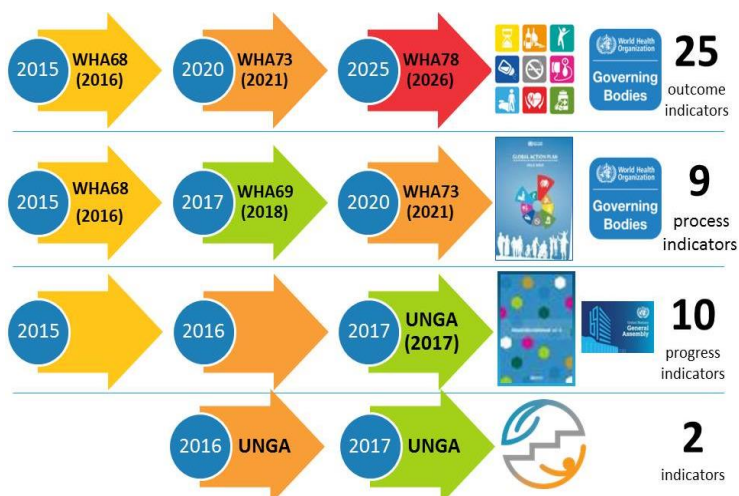
Questions

- What are the priorities for addressing the commercial determinants for health? Is there a need for a special commission to assess opportunities for a more effective response?
- How can the private sector learn from some isolated achievements to play a more effective role in NCD prevention?
- What is the role of the relevant government departments?
- What are the next steps to develop a mechanism to monitor the contribution of the private sector and other stakeholders to NCD prevention?

7. Cumbersome and demanding monitoring framework to assess NCD trends and evaluate progress

NCD surveillance remains inadequate and fragmented in many countries. As mentioned before, the three key components of NCD surveillance (monitoring risks and determinants, assessing outcomes-morbidity and cause specific mortality, and evaluating health system performance,) need considerable strengthening. Risk factors surveys need to be conducted at regular intervals to determine trends, reliable cause specific mortality data, which are not currently reported by the majority of countries, need to be strengthened and the response of health system must be assessed by establishing a small set of reliable indicators. These challenges need to be addressed by most countries as part of the strengthening the structure, functions and capacity of national health information and vital statistics systems.

A more pressing priority is to simplify the monitoring requirements for countries. In order to report on meeting the 2011 and 2014 UNGA commitments and the achievements of the nine voluntary targets and the SDG target 3.4, countries currently have a cumbersome and highly demanding scheme which is overwhelming the capacity of already weak information systems. The figure below shows the reporting commitments which are currently required from countries: 25 outcomes indicators, 9 process indicators, 10 progress indicators and 2 SDGs indicators (a total of 37 indicators). In addition to the fact that very few countries have the capacity to report regularly on this large set of indicators, the scheme has become confusing and frustrating to countries and other stakeholders.



Monitoring of progress should focus on two types of indicators: a manageable set of process indicators to assess the implementation of commitments and highest priority interventions and

another set of longer term indicators to monitor outcomes and voluntary targets including the overarching target of reduction of premature mortality.

At the same time, a priority for all stakeholders is to provide technical assistance to LMICs in strengthening their capacity to strengthen NCD surveillance and generate reliable data to report on the indicators.

Questions

- What are the key indicators that should be included in a manageable set of monitoring requirements?

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