

Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013-2020 (NCD-GAP)

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This report is supported by a separate volume of six annexes the content of which is as follows:

Annexes (separate volume)

Annex 1: Terms of reference

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Annex 3: Respondents

Annex 4: Detailed methodological description

Annex 5: Review of progress indicator and other secondary data in relation to objectives of NCD-GAP

Annex 6: Comparison of NCD-GAP and SDG targets and indicators

List of acronyms

ACTIVE	A technical package to promote physical activity
ADG	Assistant Director-General
AFR	WHO African Region
AIDS	Acquired Immunodeficiency Syndrome
AMR	WHO Region of the Americas
AP	Action Plan Implementation Progress Indicator
CEO	Chief Executive Officer
CHOICE	Choosing Interventions that are Cost-Effective
COM	Commitment Fulfilment Progress Indicator
COVID	Coronavirus Disease
CSO	Civil Society Organization
DAH	Development Assistance for Health
DALY	Disability-Adjusted Life Year
ECHO	Ending Childhood Obesity
ECOSOC	United Nations Economic and Social Council
EML	Essential Medicines List
EMR	WHO Eastern Mediterranean Region
EMRO	WHO Regional Office for the Eastern Mediterranean
EUR	WHO European Region
EURO	WHO Regional Office for Europe
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
FENSA	Framework of Engagement with Non-State Actors
GAP	Global Action Plan
GCM/NCD	Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases
GISAH	Global Information System on Alcohol and Health
GNI	Gross National Income
GPW13	WHO Thirteenth General Programme of Work, 2019-2023
GSM	WHO Global Management System
HEARTS	A technical package to promote cardiovascular health
HIC	High-Income Countries
HIV	Human Immunodeficiency Virus
IAEA	International Atomic Energy Agency
IARC	International Agency for Research on Cancer
IFBA	International Food and Beverages Association
IHME	Institute of Health Metrics and Evaluation
ILO	International Labour Organization
IOM	International Organization for Migration
IPCHS	Integrated People Centred Health Services
I\$	International Dollar ¹
iTFA	Industrially-Produced Trans-Fatty Acids
LIC	Low-Income Countries
LMIC	Lower-Middle-Income Countries
MCH	Maternal and Child Health
MPOWER	A technical package to reduce tobacco use
MS	Member State

¹ A hypothetical unit of currency that has the same purchasing power parity that the U.S. dollar had in the United States at a given point in time

NCCP	National Cancer Control Plan
NCD	Noncommunicable Disease
NGO	Non-Governmental Organization
OECD	Organization for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEN	Package of Essential NCD Interventions
REPLACE	A technical package to eliminate industrially-produced trans fats
SAFER	A technical package to reduce the harmful use of alcohol
SDG	Sustainable Development Goal
SEAR	WHO South-East Asia Region
SHAKE	A technical package to reduce population salt intake
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SRH	Sexual and Reproductive Health
STEPS	STEPwise Approach to NCD Risk Factor Surveillance
TB	Tuberculosis
TFA	Trans-Fatty Acids
TOR	Terms of Reference
UHC	Universal Health Coverage
UICC	Union for International Cancer Control
UMIC	Upper-Middle-Income Countries
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNIATF	United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
US\$	United States Dollar
WASH	Water, Sanitation and Hygiene for All
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WIN	WHO Internal Horizontal Network
WIPO	World Intellectual Property Organization
WPR	WHO Western Pacific Region

Executive summary

1. In 2013, the Sixty-sixth World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 (NCD-GAP). The NCD-GAP provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, local to global, to attain the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025. In addition to the nine voluntary global targets, there are 25 health outcome indicators within a global monitoring framework, a further nine action plan implementation progress (AP) indicators and 10 commitment fulfilment progress (COM) indicators. The Seventy-second World Health Assembly extended the period of the global action plan to 2030 to ensure alignment with the 2030 Agenda for Sustainable Development.
2. The mandate to conduct a mid-point evaluation of the progress achieved in the implementation of the NCD-GAP derives from paragraph 1(1) of resolution WHA66.10 (2013) which endorsed the NCD-GAP. Paragraph 60 of the NCD-GAP requests the WHO Secretariat to convene a representative group of stakeholders, including Member States and international partners, to conduct an evaluation at the mid-point of the NCD-GAP. An Evaluation Advisory Group was established for this purpose, consisting of a representative of a Member State from each WHO region and nine international experts.
3. The purpose of the mid-point evaluation was to assess the accomplishments of the six objectives of the NCD-GAP (see Box 1), as well as the lessons learned through implementation of the NCD-GAP in Member States, by international partners and non-State actors, and at the three levels of WHO (country offices, regional offices and headquarters).

Box S1: NCD-GAP objectives

Objective 1: to raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.

Objective 2: to strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs.

Objective 3: to reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments.

Objective 4: to strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage.

Objective 5: to promote and support national capacity for high-quality research and development for the prevention and control of NCDs.

Objective 6: to monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

4. The objective of the evaluation has three elements, namely:
 - to document successes, challenges and gaps in the implementation of the NCD-GAP since 2013;
 - to provide lessons learned and recommendations to improve the implementation of the NCD-GAP until 2030;
 - to provide inputs for the next WHO global status report on noncommunicable diseases (NCDs), as well as other reports, including on contributions to reducing premature mortality from NCDs by promoting mental health, reducing air pollution and strengthening health systems.

5. It is not usual for mid-point evaluations to assess outcomes or impact. Consequently, this evaluation has focused on progress in implementation of the planned actions in the NCD-GAP. The main value of the evaluation relates to its objectives and includes:
 - documenting progress made over time including by Member States, the WHO Secretariat and international partners/non-State actors. Analysis of this progress has included consideration of how different stakeholders have used the NCD-GAP. Key metrics in this regard included the agreed AP and COM indicators;
 - allowing opportunity to “step back” and take an overview of what has happened since 2013, including focusing on why things happened as they did and how things can be improved;
 - providing input into future NCD-GAP work (i.e. until 2030). This input seeks to be relevant to each stakeholder group (Member States, WHO, international partners/non-State actors), covers areas needing correction or adjustment and/or further investment and support, and seeks to maintain momentum and focus;
 - allowing lessons to be learned for the recalibration of the NCD-GAP in terms of policy options, oversight and coordination between WHO, Member States and international partners.
6. The scope of the evaluation was implementation of the NCD-GAP and not of the entire, wider NCD agenda. The evaluation focused on the themes covered in the NCD-GAP, namely four types of NCD (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) and four shared behavioural risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol). However, the political declaration in 2018 called to embrace other NCDs (e.g. mental health conditions) and other risk factors (e.g. air pollution), so these were also considered. The evaluation had a technical focus and did not cover strategic issues, such as possible new policy actions. The evaluation covered the time period from 2013 to 2020. Given the amount of data already collected and the constraints of the COVID-19 pandemic, the evaluation relied heavily on secondary data. Where the evaluation did collect primary data, these were qualitatively different from data collected routinely. The evaluation looked not only at how particular actors worked individually but also at the partnerships and networks that had been developed.
7. Five main evaluation questions were identified based on the evaluation’s objectives:
 - To what extent has the implementation of the NCD-GAP been successful across each of the six NCD-GAP objectives, in particular implementation by Member States; international partners and non-State actors; and the WHO Secretariat across the three levels of the Organization?
 - What have been the challenges and gaps in the implementation of the NCD-GAP across each of the six NCD-GAP objectives?
 - What lessons have been learned to improve the implementation of the NCD-GAP?
 - What recommendations can be made to improve implementation of the NCD-GAP in relation to the agreed objectives and actions?
 - To what extent is the NCD-GAP set up to identify its contributions to expected outcomes? How could this be strengthened in the future?

Methodology

8. The overall process and methodological approach followed the principles set forth in the WHO evaluation practice handbook and the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation. The initial inception phase of the evaluation focused on refining the evaluation’s design and was concluded by June 2020 following review of the inception report by the Evaluation Advisory Group. Data collection focused on identifying and reviewing existing secondary data which involved reviewing more than 360 documents. Particular attention was focused on reviewing data reported by Member States in

relation to two indicator sets: the AP and COM indicators. Additional primary data were collected through the use of structured questionnaires and semi-structured interviews with key informants. National NCD focal points in all Member States were invited to complete a structured questionnaire and 39 responses were received. In addition, all non-State actors in official relations with WHO and WHO collaborating centres working in relevant areas were asked if they wished to receive and complete a questionnaire. A total of 60 non-State actors and 37 WHO collaborating centres requested and received the questionnaire and 18 non-State actors and 12 WHO collaborating centres completed this. Key informants were identified from a range of stakeholder groups. More than 100 interviews were carried out. All interviews were conducted remotely.

Key findings

NCD-GAP objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

9. One of the key successes of the NCD-GAP, and the actions that flowed from it, has been to raise the profile of NCDs internationally. Some mechanisms which have contributed to this include (a) United Nations high-level meetings focused on NCDs; (b) the establishment of an independent High-level Commission on NCDs by the WHO Director-General; (c) the appointment of a Global Ambassador for NCDs and Injuries; (d) the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases (UNIATF); and (e) the establishment of a global coordination mechanism on the prevention and control of NCDs (GCM/NCD). In addition, greater national and regional attention contributed to many of these initiatives, including particularly the high-level meetings. The expectation of this raised international profile is that NCDs will be given higher priority within regions and in-country. Based on the selected metric for this objective – the number of countries with an operational, multisectoral NCD policy, strategy or action plan – there has been some progress. Less than one quarter of countries (24%) had such a policy, strategy or action plan in 2013 and, by 2019, this had risen to more than half (57%). However, almost half of countries still did not have such a policy, strategy or action plan in 2019. There is no statistically significant association between this indicator and country income level.
10. Having an NCD policy, strategy or action plan does not necessarily mean that appropriate actions to prevent and control NCDs are taken. But, evaluation evidence shows a statistically significant association between having an NCD policy, strategy or action plan and an adjusted implementation score based on the extent to which other COM indicators have been achieved. However, this association is not seen in low-income countries and any improvement may be short-lived. Comparison of countries that introduced an NCD policy, strategy or action plan between 2013 and 2019 showed that performance, between 2015 and 2019, improved most in countries where the policy, strategy or action plan had been introduced more recently. These findings suggest that some level of resourcing may be required to turn policies, strategies and plans into action and that the effects of introducing such policies, strategies and plans may be short-lived.
11. While it is good that NCDs have a higher profile and many countries have developed a policy, strategy or action plan to address NCDs, progress will be limited unless there is a substantial increase in the level of resources available. Data from the Institute for Health Metrics and Evaluation on development assistance for health show that, in 2018, NCDs received only 2% of development assistance for health despite representing almost two thirds (62%) of the global disease burden. The Institute also notes that, although development assistance for health for NCDs rose from less than US\$ 600 million per year in 2012 to almost US\$ 800 million in 2013, it has plateaued since. This means that the raised profile given to NCDs internationally since 2013 has not yet translated into increased international funding.

NCD-GAP objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs

12. Progress measures of national capacity to accelerate country NCD responses include whether countries have an operational NCD unit, branch or department within the Ministry of Health and an operational national coordination mechanism for the prevention and control of NCDs. In 2013, just over half of countries (51%) had an NCD unit, branch or department and this rose to more than three quarters of countries (76%) by 2019. Less than one third of countries (31%) had a national NCD coordination mechanism in 2015 and this rose to just under half of countries (46%) by 2019. Both these measures are strongly associated with country income level. For example, in 2019, less than one quarter of low-income countries (21%) had a national NCD coordination mechanism as compared to more than half of high-income countries (55%). There is a statistically significant association between having an operational NCD unit, branch or department and having an operational national NCD coordination mechanism. For example, in 2019, more than half of countries (57%) with an NCD unit, branch or department had a national NCD coordination mechanism as compared to 12% without an NCD unit, branch or department. This provides some evidence that establishing and running a national NCD coordination mechanism requires financial, human and organizational resources, for example as provided by an NCD unit. There is little evidence that having a national coordination mechanism results in more progress in areas beyond the health service, for example in areas relating to risk factors. This may reflect the composition and functioning of some of these mechanisms. One exception is tobacco taxation. Countries with a national NCD coordination mechanism are statistically more likely to have reduced the affordability of tobacco by increasing excise taxes and prices than countries without such a mechanism.

13. From 2013 to 2019, there was considerable improvement in some AP indicators, for example AP2 (NCD unit) and AP3a–d (NCD risk factor policies). For AP1 (NCD policies, strategies and action plans), AP5 (research policies), AP6 (monitoring and surveillance systems) and APx (national coordination mechanisms), despite some progress, overall performance remains at a low level. There has been little progress in developing guidelines, protocols and standards for NCD management through a primary care approach (AP4) (see Table S1).

14. Table S2 presents a similar table for the COM indicators. While 14 indicators show improvement in terms of countries fully achieving these between 2015 and 2019, the improvements are modest and overall performance levels remain low. In 2019, only three indicators were fully achieved by more than half of countries. If countries which have at least partially achieved a measure are considered, performance levels are much stronger, with 13 indicators being at least partially achieved by half of countries in 2019. Fifteen indicators showed improvement between 2015 and 2019 in terms of being at least partially achieved.

15. There is a statistically significant positive association between performance on many progress indicators and country income group. For all AP indicators, apart from one (AP1), performance is statistically positively associated with country income group. This is true for more than half (58%) of the COM indicators (marked with an asterisk in Table S2). There is also a positive association between performance on the COM indicators as a set, termed “implementation score”, and country income group (see Figure S1).

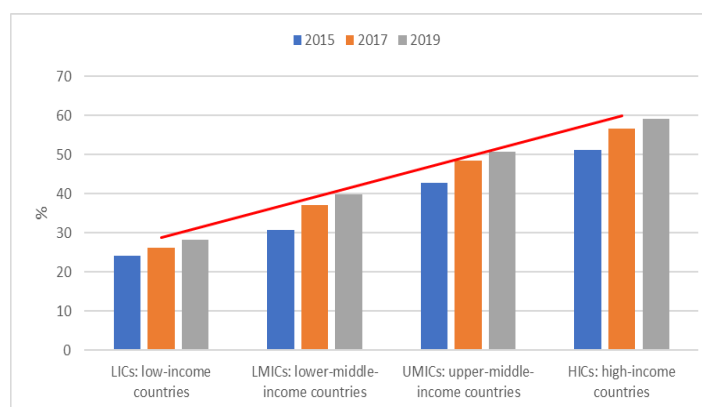
Table S1: Progress against action plan implementation progress (AP) indicators based on disaggregated data for 194 countries (colour codes show level of performance: dark green if >80%, light green if 60–79%, yellow if 40–59% and amber if <40%)

Indicator	2013	2015	2017	2019
AP1: National action plan	24%	37%	51%	57%
AP2: NCD unit	51%	60%	66%	76%
AP3a: Policy on harmful use of alcohol	48%	61%	71%	74%
AP3b: Policy on physical activity	52%	64%	77%	79%
AP3c: Tobacco policy	63%	73%	83%	79%
AP3d: Policy on healthy diet	55%	66%	78%	80%
AP4: Clinical guidelines	49%	38%	46%	48%
AP5: NCD research policy	n/a	22%	28%	33%
AP6: NCD surveillance system	23%	26%	38%	42%
APx: National coordination mechanism	n/a	31%	37%	46%

Table S2 Percentage of countries in which commitment fulfilment progress indicators (COM) are fully achieved and at least partially achieved: 2015, 2017 and 2019 (colour codes show level of performance: dark green if >80%, light green if 60–79%, yellow if 40–59% and amber if <40%)

Indicator	Fully achieved			At least partially achieved		
	2015	2017	2019	2015	2017	2019
COM1: National NCD targets	30%	48%	57%	45%	62%	68%
COM2: Mortality data*	36%	38%	40%	62%	62%	61%
COM3: Risk factor surveys*	28%	19%	27%	79%	89%	85%
COM4: National action plan	33%	51%	57%	45%	62%	66%
COM5a: Tobacco tax*	2%	16%	19%	36%	52%	51%
COM5b: Smoke-free places	25%	28%	31%	64%	69%	72%
COM5c: Graphic warnings*	22%	40%	47%	70%	74%	78%
COM5d: Tobacco advertising bans	15%	19%	25%	70%	74%	78%
COM5e: Tobacco mass media*	n/a	22%	20%	n/a	35%	41%
COM6a: Alcohol sales restrictions	15%	14%	16%	90%	84%	87%
COM6b: Alcohol advertising ban	20%	23%	27%	63%	38%	38%
COM6c: Alcohol tax	22%	17%	24%	73%	87%	68%
COM7a: Salt policies*	32%	26%	20%	32%	44%	44%
COM7b: Fat policies*	21%	35%	30%	21%	35%	39%
COM7c: Child food marketing*	22%	30%	31%	n/a	n/a	n/a
COM7d: Breast milk code	37%	20%	18%	37%	69%	70%
COM8: Physical activity mass media*	61%	52%	52%	61%	52%	65%
COM9: Clinical guidelines*	26%	46%	48%	50%	77%	78%
COM10: Drug therapy and counselling*	14%	27%	34%	20%	31%	41%

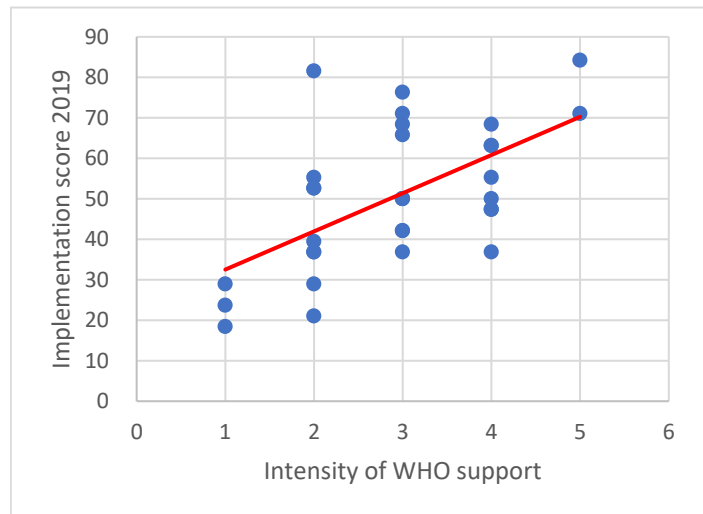
Figure S1: Mean implementation score for Member States overall by country income group: 2015, 2017 and 2019



16. Data on NCD spending, broken down by domestic and external sources, are available for 2015 to 2017 for 44 countries in the Global Health Expenditure Database. Of these, more than two thirds (68%) were in the WHO African Region. Overall, spending on NCDs across all 44 countries accounted for a total of US\$ 12.2 billion over three years, that is approximately US\$ 4 billion per year. Of this, almost all (95%) came from domestic sources. In comparison, spending on infectious diseases in the same countries over the same period was US\$ 35.9 billion, of which less than half (49%) was from domestic sources. Overall, domestic spending on NCDs accounted for an average of US\$ 23 per person per year in low-income countries, US\$ 214 in lower-middle-income countries and US\$ 527 in upper-middle-income countries.

17. Some countries perform better than expected based on country income group alone. In 2020, Allen et al.² reported anecdotal evidence from one country that explanations for this might include high-level political commitment and intense support from WHO. The evaluation presents some evidence to support these hypotheses (for high-level political commitment, see paragraph 9 above). Based on assessment by WHO regional staff from two regions, there was a positive association between intensity of WHO support and the calculated implementation score for 2019 (see Figure S2). A range of other contributing factors have been suggested and these are discussed in the main report.

Figure S2: Comparison of implementation score for 2019 and assessed intensity of WHO support: Eastern Mediterranean and South-East Asia Regions

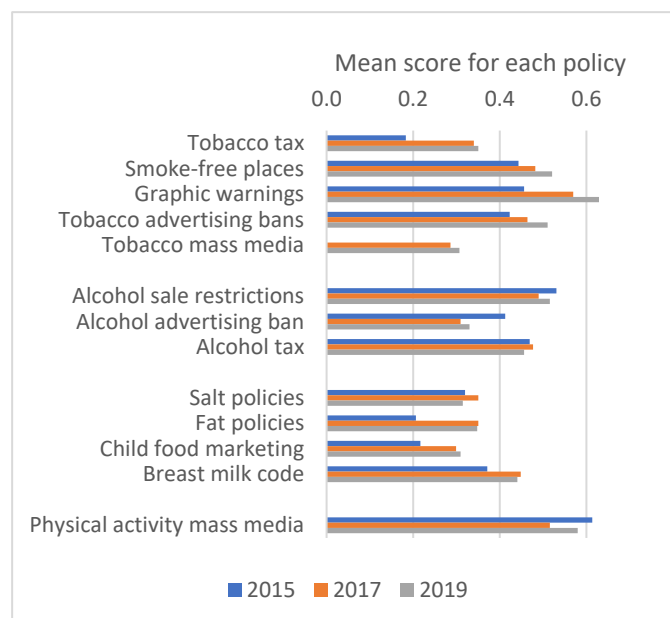


NCD-GAP objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments

18. Overall, countries have made good progress in introducing national policies on the four main risk factors (see Table S1). For example, the percentage of countries with a policy on harmful use of alcohol rose from 48% in 2013 to 74% in 2019, for physical activity from 52% to 79%, for tobacco use from 63% to 79% and for healthy diet from 55% to 80%. There was a statistically significant association between having each of these policies and country income level.

19. Progress on risk factor actions is more mixed (see Table S2) depending on whether indicators are fully achieved or at least partially achieved. Combining these into an implementation score for each indicator (see Figure S3) shows that there has been some year-on-year progress for actions on tobacco but little progress in relation to harmful use of alcohol or physical activity. There is a mixed picture on actions relating to healthy diet with, for example, steady progress in relation to food marketing aimed at children but little if any progress on policies to reduce salt content. One possible explanation for this is that there are strong frameworks in place for tobacco (WHO Framework Convention on Tobacco Control) and breast-milk substitutes which limit industry interference.

Figure S3: Mean implementation score for key actions on risk factors: 2015, 2017 and 2019



² Allen, L N, Nicholson, B D, Yeung, B Y T, Goiana-da-Silva, F. Implementation of Non-Communicable Disease Policies: A Geopolitical Analysis of 151 Countries, Lancet Global Health, 2020; 8:e50-58 ([https://doi.org/10.1016/S2214-109X\(19\)30446-2](https://doi.org/10.1016/S2214-109X(19)30446-2), accessed 20 November 2020).

20. In most cases, adopting a policy on a particular risk factor is associated with countries implementing actions in relation to those risk factors (see Table S3) However, this is not the case for the harmful use of alcohol. For example, less than one quarter of countries (23%) with a policy on harmful use of alcohol achieved the action on alcohol taxation, whereas one third of countries (33%) without a policy did. There is an association between having a policy on tobacco use and some actions, particularly on packaging, but not on others, such as pricing and smoke-free environments.

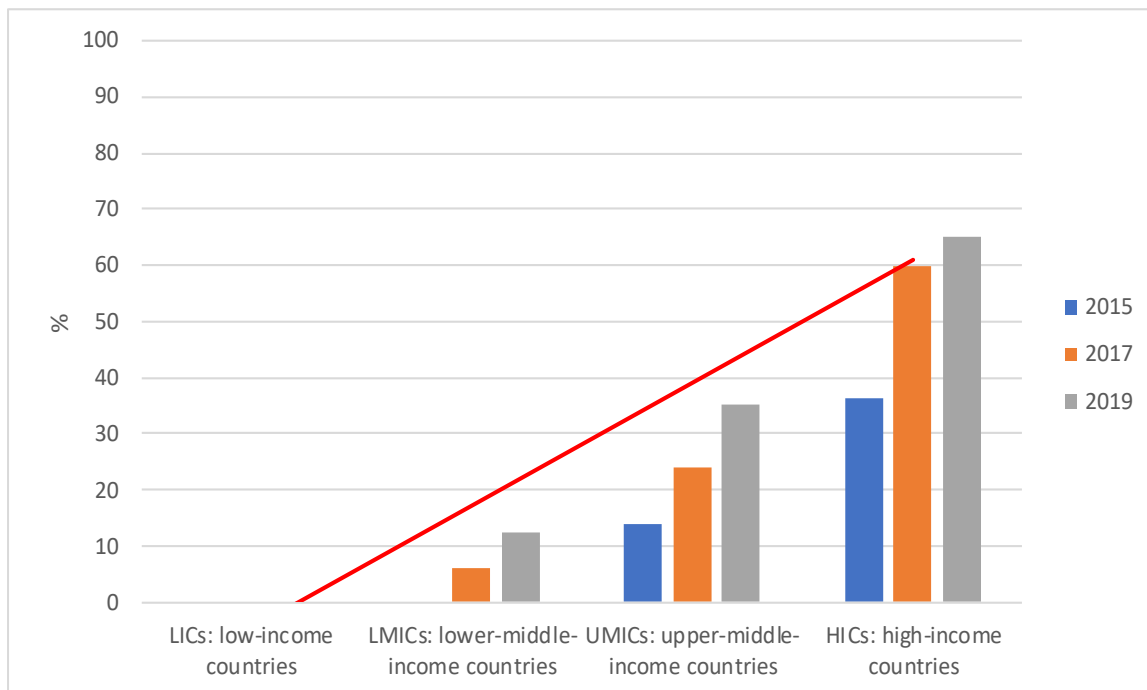
Table S3: Is having policies associated with implementation of key NCD actions?

Policy	Action	Significant association?	p-value	Percentage (%) of countries fully achieving action		Percentage (%) of countries partially achieving action	
				with policy	without policy	with policy	without policy
Harmful use of alcohol (AP3a)	Availability (COM6a)	No	.35	15%	20%	93%	95%
	Advertising (COM6b)	No	.70	31%	33%	46%	38%
	Taxes (COM6c)	No	.72	23%	33%	77%	71%
Tobacco use (AP3c)	Pricing (COM5a)	No	.06	21%	18%	59%	33%
	Smoke-free (COM5b)	No	.40	32%	31%	74%	64%
	Packaging (COM5c)	Yes	<.001	54%	26%	86%	51%
	Advertising (COM5d)	Yes	.03	24%	28%	84%	54%
Healthy diet (AP3d)	Campaigns (COM5e)	Yes	.04	27%	6%	53%	27%
	Salt (COM7a)	Yes	<.001	25%	0%	52%	11%
	Fats (COM7b)	Yes	<.001	37%	9%	48%	11%
	Marketing to children (COM7c)	Yes	<.001	38%	6%	n/a	n/a
Physical activity (AP3b)	Breast-milk code (COM7d)	Yes	.04	18%	14%	74%	54%
	Mass media (COM8)	Yes	<.001	60%	23%	75%	31%
Clinical guidelines (AP4)	Drug therapy and counselling (COM10)	Yes	<.001	50%	23%	59%	30%

NCD-GAP objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage

21. Countries have made little progress in introducing evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach (see Table S1). In 2013, less than half of countries (49%) had such guidelines/protocols/standards and this remained less than half (48%) in 2019. Some progress has been made on the percentage of countries able to provide drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level. The percentage rose from 14% in 2015 to 34% in 2019 (see Table S2) but around two thirds of countries are still unable to offer such drug therapy and counselling. In addition, there is no measure as to whether people with NCDs (e.g. hypertension and diabetes) are being diagnosed, treated and having their conditions controlled in practice. There is a particularly strong association between a country being able to provide such drug therapy and counselling and country income group (see Figure S4). In 2019, no low-income country had fully achieved this indicator as compared with almost two thirds of high-income countries (65%).

Figure S4: Percentage of Member States by country income group that have fully achieved having provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level: 2015, 2017 and 2019



NCD-GAP objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs

22. Little progress has been made on this objective. In 2015, when data began to be collected on this objective's indicator, just over one fifth of countries (22%) had an operational policy and plan on NCD research. By 2019, this figure had risen to just one third of countries (33%). So, around two thirds of countries still lack such a policy. In 2019, only four low-income countries had such a policy as compared to more than half of high-income countries (58%). There is no indicator on research in the COM indicator set. Although there is such an indicator in the AP indicator set, there was no reporting on this indicator to the Seventy-second World Health Assembly by the WHO Secretariat in 2019.

NCD-GAP objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

23. There has been some improvement in the proportion of countries that have set time-bound national NCD targets and indicators. This rose from less than one third of countries (30%) in 2015 to more than half of countries (57%) in 2019. There is no association between this indicator and country income group. But, there is a statistically significant association between this indicator and having a national NCD policy, strategy or action plan. It appears that those countries that develop such a policy, strategy or plan usually develop national targets as well. For example, of countries with a national policy, strategy or action plan, more than three quarters (78%) had set targets. However, of those without a national policy, strategy or action plan, less than one quarter (22%) had set targets. A similar statistically significant association was seen between having a national NCD policy, strategy or action plan and having conducted a risk factor survey (such as STEPS) in the past five years. However, only around one quarter of countries (27%) fully achieved this and there was no improvement between 2015 and 2019. There was an association between whether a country conducted a risk factor survey and country income group, and whether a country has a functioning system for generating reliable cause-specific mortality is largely related to country income group. For example, in 2019, no low-income country had such a system as compared to more than three quarters of high-income countries (78%). There are concerns that STEPS surveys

are expensive and unsustainable. Surveys embedded in national capacity-building and related to broader health issues may be more sustainable.

24. The indicators on risk factor surveys and cause-specific mortality system are combined to give an assessment of the extent to which a country will be able to report against the voluntary global NCD targets. While the proportion of countries that would be able to do this rose from 23% in 2013 to 42% in 2019, more than half of countries (58%) are not yet considered able to report against these targets according to these data.
25. WHO has established a system whereby countries provide data on progress indicators every two years and attempts are made to verify reported data, for example by requesting and checking supporting documentation. However, there is no in-country or external verification of data although civil society has produced shadow reports in a few countries. The progress indicators only track actions taken by Member States and there are no similar indicators for WHO, international partners or non-State actors. In terms of the AP indicators, the indicator on research was not reported to the Seventy-second World Health Assembly in 2019. However, the WHO Secretariat has confirmed that it remains part of the set and will be included in formal reporting in future. Definitions for the AP indicators need updating and it is unclear whether the WHO Secretariat is using 2010 or 2013 as the baseline for progress reporting to the Health Assembly. In general, the data sets for these indicators are not readily available publicly, for example online. Greater access to the data could increase the ability of external researchers and civil society to analyse the data and could potentially provide more support to the WHO Secretariat to analyse this extensive data set in a collaborative manner.

Cross-cutting issues

26. In terms of principles of the NCD-GAP, the primary role and responsibility of governments has been recognized. Member States have been assisted by complementary contributions from multiple actors including WHO (see Box S2), international partners and non-State actors (see Box S3). However, there has been no increase in international funding for NCD responses since 2013. There are also concerns that conflicts of interest are not being handled effectively with many examples of industry interference hampering progress in prevention and control of NCDs. While there has been some success in promoting multisectoral action (e.g. across the United Nations through the work of UNIATF), the response to NCDs continues to be seen largely as a health issue. While the issues of facilitating multistakeholder engagement and cross-sectoral collaboration remain of critical importance, the final evaluation of the GCM/NCD identified advancing multisectoral action as one of three GCM/NCD functions where there was less evidence of tangible outputs. At the country level, it has proved difficult to establish effective coordination mechanisms beyond ministries of health. To date, NCD responses have not emphasized the needs of vulnerable groups or identified specific barriers and risks that affect them. While progress has been made, more could be done to align responses to NCDs to broader health and development agendas, for example as articulated in terms of universal health coverage and the Sustainable Development Goals.

Box S2: WHO has played a substantive role in assisting Member States to implement the NCD-GAP

WHO has been active and successful in its leading and convening role in raising the profile of NCDs internationally and with Member States through mechanisms including high-level meetings, the WHO Independent High-level Commission on NCDs and UNIATF.

In their feedback, Member States identified a wide range of ways in which WHO had provided technical support tailored to the country context, including support to develop national NCD plans, to develop investment cases (through UNIATF), to respond to specific risk factors and to carry out surveys of risk factors. This support was provided through engagement of all levels of WHO, country offices (where relevant), regional offices and headquarters, and through UNIATF.

WHO has provided valued policy advice across the NCD-GAP as a whole, for example through the identification and prioritization of a number of cost-effective best buys and through the development of packages for NCDs as a whole (e.g. PEN) and for particular NCDs and risk factors (e.g. HEARTS, MPOWER, SAFER and SHAKE).

27. The COVID-19 pandemic has disproportionately affected people with NCDs. People living with some NCDs are at greater risk of severe illness and, in many communities, services relating to NCDs have been scaled back, at least temporarily, to allow health systems to respond to the pandemic. In addition, human and financial resources have been diverted away from NCD responses. The economic effects of the pandemic on NCDs are likely to be substantial but these have not yet developed fully. However, there is an opportunity for COVID-19 to be a new lens through which to see NCDs and mental health, particularly when seeking to build back better in the recovery from the pandemic.

Box S3: International partners and non-State actors have contributed to the NCD-GAP in a variety of ways

An active and diverse civil society exists in relation to NCDs internationally, regionally and in many countries including some organizations of people with lived experiences of NCDs. There is scope for greater engagement between WHO and civil society, for example to ensure that the NCD-GAP is implemented in ways which promote key NCD-GAP principles relating to human rights, equity and empowerment of people and communities.

United Nations agencies and other multilateral organizations globally, regionally and nationally are able to engage with aspects of the NCD-GAP which require multisectoral engagement and may be beyond the mandate and reach of WHO. Their approach is captured in the 2019 document "*Stronger Collaboration, Better Health*"¹ which presents a global action plan to accelerate country progress on the health-related SDGs. There are many examples of United Nations agencies engaging in this way, internationally, regionally and in countries. However, more still needs to be done, particularly in countries where the United Nations country team sees NCDs as largely a health issue for WHO.

While many academic and government research institutions are actively conducting research related to NCDs, there is little sense of this being coordinated by or contributing to the implementation of the NCD-GAP. While there are isolated incidences of support to national research capacity, there is scope for this to be done much more systematically.

The contribution of the private sector to the NCD-GAP has been mixed. There are many examples of industry interference, particularly relating to tobacco and including alcohol, highly processed food and breast-milk substitutes. However, there are also some examples of effective collaboration, for example over reformulation of some food products. There is potential for greater and more effective collaboration with the private sector in many areas, including improving governance and support to Member States to ensure that commercial factors do not undermine public health policies.

¹ Stronger Collaboration, Better Health: Global Action Plan for Health Lives and Well-Being for All, Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/9789241516433>, accessed 20 November 2020).

28. The scope of the international NCD agenda was broadened, with the 2018 political declaration, to include mental health and air pollution. There are strong arguments for this. Air pollution has been recognized as an important risk factor for a number of NCDs. In the case of mental health, there are often co-morbidities between people with NCDs and with mental health conditions. In addition, management of these conditions in countries at the primary care level is often by the same people in the same facilities. For WHO country offices, many NCD staff are working on both NCDs and mental health. However, there are reservations, particularly among those working on mental health. It is not clear what moving from "4 x 4" to "5 x 5" means in practice for the NCD-GAP, particularly as the current global action plans on both mental health and NCDs have already been extended to 2030.
29. It is too early to assess the extent to which the recent transformation has produced the WHO structure and capacity needed to effectively support national NCD responses. The evaluation has produced some evidence to support the suggestion that intense WHO support may be helpful to some countries seeking to respond to NCDs. The restructuring provides an opportunity to embed management of NCDs more fully in broader health responses including the global agenda on universal health coverage. However, it will be important to ensure effective coordination between measures to support prevention of NCDs and those to support diagnosis and

management. It is clear that, in general, WHO lacks sufficient human and financial resources at the country level to effectively support country responses to NCDs and mental health particularly given rising demands from Member States for technical support for NCD responses including as a result of COVID-19 response, recovery and future preparedness.

Conclusions and lessons learned

30. The evaluation has drawn a number of conclusions and identified a number of lessons learned. These are summarized here and are the basis for recommendations in the section that follows:
- C1. Overall, the NCD-GAP has contributed to raising the profile of NCDs internationally and in many countries and this has contributed to an increase in the number of countries that have adopted a national NCD policy, strategy or action plan. However, there is a pressing need to accelerate implementation of those plans and international and domestic financial resources are needed for this delivery.
 - C2. The identification by WHO of what it terms NCD best buys has provided Member States with a menu of policy options they can consider when looking for cost-effective mechanisms based on current best evidence. Overall, progress in implementing the NCD-GAP has been slow and incremental rather than the kind of rapid acceleration to which the high-level processes associated with the NCD-GAP aspired.
 - C3. Incremental progress has been made in addressing tobacco use but similar progress has not yet been seen with other risk factors including harmful use of alcohol, healthy diet and physical activity. A key factor in this regard may be the WHO Framework Convention on Tobacco Control (WHO FCTC) and the monitoring of its implementation.
 - C4. The crucial importance of not solely focusing on a single NCD has been recognized. While some progress has been made on developing protocols and ensuring essential NCD medicines are available, these are still lacking in many countries. More is needed to ensure NCDs are managed effectively through primary care so that people with NCDs, such as hypertension and diabetes, are diagnosed, treated and have their conditions controlled. There is a need to ensure that vulnerable groups, different age groups and those in emergency settings are included in this provision.
 - C5. Investment in and support for research has been suboptimal despite the recognition that there are still many evidence gaps, for example, in terms of what constitutes best buys in different contexts and how best to promote implementation of interventions found to be highly effective, depending on the contexts. Overwhelmingly, research has been the weakest NCD-GAP objective in terms of implementation.
 - C6. There are two sets of progress indicators, with one focused on action plan implementation and the other focused on commitment fulfilment. There is some overlap between indicator sets. Data are reported regularly by almost all Member States but there is scope for much greater use and analysis of data.

Cross-cutting issues

- C7. WHO lacks adequate financial and human resources to provide technical support to implementation of the NCD agenda, particularly at the country level especially given increasing country demands for technical support. Work across risk factors in WHO is fragmented and lacks clear leadership.
- C8. Multisectoral engagement, for example beyond the health sector and with the private sector, requires people with appropriate private sector, political, diplomatic and networking skills and experience. There has been little clear guidance from WHO as to how countries can establish effective multisectoral responses, involving other United Nations agencies, civil society, private sector organizations, etc.,

including how to manage and avoid commercial conflicts of interest. The role of civil society in supporting the NCD response has not been fully harnessed. People with lived experiences of NCDs are largely absent from decision-making processes.

- C9. Member State NCD-GAP implementation and WHO technical support have generally not emphasized the needs of vulnerable groups or identified specific barriers and risks that affect them. Disaggregated data on prevalence of NCDs and their risk factors in different segments of the population are limited, hindering the identification and design of targeted interventions. There could be more focus on health literacy both for NCD prevention and management. Key elements needing greater emphasis are patient-centred communication and easy-to-understand and easy-to-act-on material to support self-management.
- C10. While there has been an in-principle decision to include mental health and air pollution in the international NCD agenda, that is to move from “4 x 4” to “5 x 5”, it is unclear how this will work in practice within the NCD-GAP.
- C11. UNIATF has effectively convened and supported coordination between United Nations agencies globally, regionally and in-country, including through high-profile country visits which have raised the profile of NCDs with national governments and with United Nations agencies in-country. Progress on joint action has been hampered by lack of buy-in at all levels and adequate resourcing for the NCD agenda across the United Nations sector.
- C12. The GCM/NCD is, to date, the first and currently the only formal Member State-led mechanism within the WHO Secretariat aimed at facilitating multistakeholder engagement and cross-sectoral collaboration in the area of NCDs. Its unique mandate rests primarily in its engagement capacity and its potential to create links between multisectoral actors, including Member States, non-State actors, United Nations actors and other technical programmes, at the global, regional and national levels. As the functions originally envisaged for the GCM/NCD remain valid and relevant contributions to the NCD-GAP, the Thirteenth General Programme of Work, 2019–2023, and the Sustainable Development Goal targets to 2030, these functions should be continued. However, the mechanism needs to evolve towards, or possibly be replaced by, a more targeted and action-oriented model, or alternative approach, in closer collaboration with relevant internal and external actors.³

Recommendations

31. The evaluation has identified the following recommendations:

NCD-GAP objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

- R1. **WHO Secretariat and Member States to find sustainable funding mechanisms to allow for a dramatic acceleration of NCD implementation.** Specifically:
- WHO Secretariat to develop specific proposals as to how NCD funding can be incorporated into plans to build back better.
 - UNIATF, WHO and international partners to continue with plans to introduce a Catalytic/Multi-Partner Trust Fund for NCDs.
 - Bilateral funders, multilateral funders, philanthropies and other funding agencies to provide additional funds for NCD responses, including through the Catalytic/Multi-Partner Trust Fund for NCDs.

³ The full report of the final evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases is available on the website of the WHO Evaluation office (www.who.int/evaluation).

- WHO Secretariat to continue to work with Organisation for Economic Co-operation and Development to introduce a purpose code to track spending on NCDs within official development assistance.

NCD-GAP objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs

- R2. **WHO Secretariat and Member States to consider how best to use limited financial resources available for NCDs by focusing on the most cost-effective options based on available evidence.** Specifically:
- Member States to identify ways in which they can provide, identify and leverage the domestic financial resources needed to respond effectively to NCDs including, as appropriate, as part of national COVID-19 responses and recovery action plans.
 - Member States to focus their financial resources on those actions which will be most cost-effective based on best available evidence.
 - WHO Secretariat to update the best buys based on latest evidence, particularly from a diverse range of regional and national settings.
 - Member States to adapt the best buys to their context with WHO Secretariat technical support if necessary.
 - WHO Secretariat to consider if further guidance can be given on total funding needed to implement the most cost-effective NCD interventions.
 - WHO Secretariat and Member States to seek ways to collect and report more data on levels of in-country expenditure on NCDs.

NCD-GAP objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments

- R3. **WHO Secretariat and Member States to explore why progress seen in relation to addressing tobacco use has not yet been seen in relation to other risk factors.** Specifically:
- WHO Secretariat and Member States to explore why the steady progress being seen in relation to tobacco control is not being seen for other risk factors.
 - WHO Secretariat and Member States to explore why, in particular, policies on harmful use of alcohol are not associated with implementation of identified cost-effective actions on harmful use of alcohol.
 - WHO Secretariat and Member States to explore what the barriers are to implementation of actions, that are not showing a positive association with income group, in high-income countries.
 - WHO Secretariat to review (as part of any review of the best buys) whether the range of cost-effective interventions for physical activity can be expanded.
 - Member States to develop and strengthen appropriate regulatory frameworks for all risk factors with WHO Secretariat technical support.

NCD-GAP objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage

- R4. **WHO Secretariat and Member States to do more to ensure those affected by NCDs are diagnosed, receiving treatment and having their condition controlled.** Specifically:
- WHO Secretariat and Member States to identify practical ways in which responses to NCDs can be better integrated into primary health care and universal health coverage.
 - WHO Secretariat to develop more concrete guidance on NCD management in primary care.
 - WHO Secretariat and Member States to improve monitoring of the number and proportion of people receiving essential medicines in primary health care settings, particularly to reduce cardiovascular risk, ensuring that the needs of particular groups are addressed.

- WHO Secretariat, Member States, international partners and non-State actors to recognize and emphasize that it is important not to focus solely on a single NCD.

NCD-GAP objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs

R5. **WHO Secretariat and Member States to determine how the priority of NCD research can best be raised.**

Specifically:

- WHO Secretariat and Member States to determine if lack of sufficient funding or an efficient funding mechanism might be an underlying reason why little progress has been made on NCD research and if so how this can be resolved.
- WHO Secretariat to develop a clear plan as to how it will support this area of work including identifying current research priorities and needs and how these will be addressed.
- WHO Secretariat to identify respective roles and responsibilities for this objective, particularly given the establishment of a Science Division.
- WHO Secretariat with the involvement of the WHO collaborating centres to identify ways in which WHO collaborating centres working on NCDs can contribute to this objective.

NCD-GAP objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

R6. **WHO Secretariat and Member States to consider ways in which the monitoring and surveillance of NCD responses can be further strengthened.** Specifically:

- WHO Secretariat and Member States to identify how to conduct risk factor surveys in a more cost-effective and sustainable manner that builds local capacity and is coherent with other national data systems.
- WHO Secretariat to ensure that future reporting to Member States on the AP indicator set includes the indicator on research (AP5).
- WHO Secretariat to revise and update the AP indicator definitions and to clarify the baseline year for progress reporting to the Health Assembly, and then report on these to Member States.
- WHO Secretariat to make data more readily available publicly, for example online, and to use the available data more, for example through in-house analysis in collaboration with partners.
- WHO Secretariat, Member States, international partners and non-State actors to develop metrics for actors other than Member States, that is WHO, international partners and non-State actors.
- WHO Secretariat and Member States to strengthen mechanisms for validation of country-reported data, for example through civil society and in-county verification.
- WHO Secretariat to brief Member States on what monitoring and reporting implications there are of extending the NCD-GAP to 2030, including what will be reported in 2025 and what in 2030.
- WHO Secretariat and Member States to ensure that the final evaluation of the NCD-GAP is able to assess progress at the outcome level as specified in the global monitoring framework. This will require having an appropriate framework in place, for example a theory of change, and exploring and analysing associations between documented progress and observed changes in outcomes. The evaluation should also explore why some countries perform above levels expected based on country income group through case studies.

Cross-cutting issues

R7. **WHO Secretariat to undertake a functional review to consider the extent to which its structure and capacity are optimal for providing technical support to NCD responses.** Specifically:

- WHO Secretariat to develop an NCD resource plan which outlines human and financial resources needed and available for providing technical support for the prevention and control of NCDs, particularly at the country level. This to be based on focusing WHO resources on the biggest causes of death and disease faced by countries.
- WHO Secretariat to assess the extent to which the current structures for NCDs are optimal, particularly in terms of a coherent approach to risk factors and ensuring maximal input relating to NCD management within universal health coverage.
- WHO Secretariat to review the coordination mechanisms across WHO departments and teams that are available to senior leadership and others to ensure coherence of the different elements of the NCD response.

R8. **WHO Secretariat and Member States to consider how they can more effectively promote and support multisectoral engagement on NCDs.** Specifically:

- WHO Secretariat to recruit people with a more diverse skills set, for example relating to multisectoral engagement.
- WHO Secretariat to continue to effectively implement the Framework of Engagement with Non-State Actors as a guide to engaging non-State actors.
- WHO Secretariat to support Member States to engage appropriately and effectively with the private sector by producing examples of effective engagement with the private sector, offering guidance on how Member States might protect themselves from undue industry interference drawing on WHO experience in this area (e.g. the WHO FCTC).
- WHO Secretariat to provide technical support on procurement of medicines and medical technology in line with the NCD-GAP target (no. 9) of 80% availability of the affordable basic technologies and essential medicines.
- WHO Secretariat to better engage, and to support Member States to better engage, with civil society, including producing evidence of good practice on civil society engagement, supporting civil society to monitor contributions to the NCD-GAP and issuing guidelines on civil society involvement in the multisectoral response, including strengthening accountability of NCD reporting and ensuring that people living with NCDs are involved in decision-making and monitoring processes.

R9. **Member States and WHO Secretariat to increase their focus on how NCDs differentially affect different groups** including children, youth, disabled people, people living with HIV, older persons, indigenous peoples, refugees, internally displaced persons and migrants, as specified in the 2030 Agenda for Sustainable Development. Specifically:

- WHO Secretariat to support countries in conducting disaggregated data collection and analysis of NCD prevalence and risk factors in vulnerable groups.
- WHO Secretariat and Member States to design interventions addressing determinants of health including gaps and barriers that affect identified groups in line with the principles embedded in the Sustainable Development Goals of leaving no one behind and reaching the furthest behind first.
- WHO Secretariat and Member States to identify ways in which they can promote health literacy for both NCD prevention and management including greater focus on patient-centred communication and on easy-to-understand and easy-to-act-on material to support self-management.

R10. **There is a need to work out how including mental health and air pollution can be incorporated in practice into the NCD-GAP.** Specifically:

- WHO Secretariat and Member States to consider developing a joint operating model.
- WHO Secretariat to propose to Member States the adjustments needed to current monitoring systems. Reviewing and refreshing the monitoring framework would be one way of linking the current NCDs and risk factors with mental health and air pollution while also ensuring greater alignment with major developments in the fields of international health and development since 2013, such as the Sustainable Development Goals and their targets and indicators.

- R11. **UNIATF and the United Nations Economic and Social Council (ECOSOC) to consider how they can provide further support to countries, promote joint activities between United Nations agencies and further build support for NCD responses among the senior leadership of United Nations agencies.** Specifically:
- UNIATF and ECOSOC to quantify and identify necessary resources and options for how to respond to country requests including for ongoing support and follow-up, including NCDs in the context of national COVID-19 response and recovery plans.
 - UNIATF and ECOSOC to identify ways in which more joint actions can be conducted.
 - UNIATF and ECOSOC to identify ways in which support for NCDs can be built at senior levels across the United Nations.
- R12. **WHO Secretariat and Member States to consider implementing the recommendations of the final evaluation of the GCM/NCD.**⁴ The principal recommendation of the final evaluation of the GCM/NCD was that, as options going forward, (a) a strengthened, more focused approach to the delivery of the vital GCM functions through the GCM/NCD or (b) the discontinuation of the mechanism and establishment of a new operating model within WHO to ensure the functions are effectively carried forward, needed to be considered. In addition, the final evaluation contained four additional recommendations, based on the recommendations of the preliminary evaluation, which were generally not implemented. These covered developing a medium-term strategic plan, enhancing country reach, formulating a clear engagement strategy and rationalizing approaches to resource mobilization. More details of these are available in the summary report on the final evaluation of the GCM/NCD.⁵

⁴ The full report of the final evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases is available on the website of the WHO Evaluation office (www.who.int/evaluation).

⁵ The summary report of the final evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases is available on the website of the WHO Evaluation office (www.who.int/evaluation).

1. Introduction

1. In 2013, the Sixty-sixth World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 (NCD-GAP). The NCD-GAP provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, local to global, to attain the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025. In addition to the nine voluntary global targets, there are 25 health outcome indicators within a global monitoring framework, a further nine action plan implementation progress (AP) indicators and 10 commitment fulfilment progress (COM) indicators. The Seventy-second World Health Assembly extended the period of the global action plan to 2030 to ensure alignment with the 2030 Agenda for Sustainable Development.
2. The mandate to conduct a mid-point evaluation of the progress achieved in the implementation of the NCD-GAP derives from paragraph 1(1) of resolution WHA66.10 (2013) which endorsed the NCD-GAP. Paragraph 60 of the NCD-GAP requests the WHO Secretariat to convene a group of representative group of stakeholders, including Member States and international partners, to conduct an evaluation at the mid-point of the NCD-GAP. An Evaluation Advisory Group was established for this purpose, consisting of a representative of a Member State from each WHO region and nine international experts.
3. The purpose of the mid-point evaluation was to assess the accomplishments of the six objectives of the NCD-GAP (see Box 1), as well as the lessons learned through implementation of the NCD-GAP in Member States, by international partners and non-State actors, and at the three levels of WHO (country offices, regional offices and headquarters).

Box 1: NCD-GAP objectives

Objective 1: to raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.

Objective 2: to strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs.

Objective 3: to reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments.

Objective 4: to strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage.

Objective 5: to promote and support national capacity for high-quality research and development for the prevention and control of NCDs.

Objective 6: to monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

4. The objective of the evaluation has three elements, namely:
 - to document successes, challenges and gaps in the implementation of the NCD-GAP since 2013;
 - to provide lessons learned and recommendations to improve the implementation of the NCD-GAP until 2030;
 - to provide inputs for the next WHO global status report on NCDs, as well as other reports, including on contributions to reducing premature mortality from NCDs by promoting mental health, reducing air pollution and strengthening health systems.

5. It is not usual for mid-point evaluations to assess outcomes or impact. Consequently, this evaluation has focused on progress in implementation of the planned actions in the NCD-GAP. The main value of the evaluation relates to its objectives and includes:
 - documenting progress made over time including by Member States, the WHO Secretariat and international partners/non-State actors. Analysis of this progress has included consideration of how different stakeholders have used the NCD-GAP. Key metrics in this regard included the agreed AP and COM indicators;
 - allowing opportunity to “step back” and take an overview of what has happened since 2013, including focusing on why things happened as they did and how things can be improved;
 - providing input into future NCD-GAP work (i.e. until 2030). This input seeks to be relevant to each stakeholder group (Member States, WHO, international partners/non-State actors), covers areas needing correction or adjustment and/or further investment and support, and seeks to maintain momentum and focus;
 - allowing lessons to be learned for the recalibration of the NCD-GAP in terms of policy options, oversight and coordination between WHO, Member States and international partners.

6. The scope of the evaluation was implementation of the NCD-GAP and not of the entire, wider NCD agenda. The evaluation focused on the themes covered in the NCD-GAP, namely four types of NCD (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) and four shared behavioural risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol). However, it also recognized that the political declaration in 2018 called to embrace other NCDs (e.g. mental health conditions) and other risk factors (e.g. air pollution), so these were also considered. The evaluation had a technical focus and did not cover strategic issues, such as possible new policy actions. The evaluation covered the time period from 2013 to 2020. Given the amount of data already collected, and the constraints of the COVID-19 pandemic, the evaluation relied heavily on secondary data. Where the evaluation did collect primary data, these were qualitatively different from data collected routinely. The evaluation looked not only at how particular actors worked individually but also at the partnerships and networks that had been developed.

7. Five main evaluation questions were identified based on the evaluation’s objectives:
 - To what extent has the implementation of the NCD-GAP been successful across each of the six NCD-GAP objectives, in particular implementation by Member States; international partners and non-State actors; and the WHO Secretariat across the three levels of the Organization?
 - What have been the challenges and gaps in the implementation of the NCD-GAP across each of the six NCD-GAP objectives?
 - What lessons have been learned to improve the implementation of the NCD-GAP?
 - What recommendations can be made to improve implementation of the NCD-GAP in relation to the agreed objectives and actions?
 - To what extent is the NCD-GAP set up to identify its contributions to expected outcomes? How could this be strengthened in the future?

2. Methodology

8. The mandate for the evaluation specified that the WHO Secretariat should convene a representative group of stakeholders, including Member States and international partners, in order to evaluate progress on implementation of this action plan at the mid-point of the plan's time frame. An Evaluation Advisory Group was established for this purpose consisting of a representative of a Member State from each WHO region and nine international experts. The Evaluation Advisory Group was supported in carrying out the evaluation by an Evaluation Support Team, led by WHO's Evaluation Office's Director, Elil Renganathan and made up of two consultants, Roger Drew and Florianne Gaillardin.
9. The overall process and methodological approach followed the principles set forth in the WHO evaluation practice handbook⁶ and the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation.⁷ The evaluation was divided into three phases (inception; data collection; analysis and reporting). The initial inception phase focused on refining the evaluation's design and was concluded by June 2020 with the production of an inception report.
10. Data collection focused on identifying and reviewing existing secondary data. This involved reviewing more than 360 documents (see Annex 2). Particular attention was focused on reviewing data reported by Member States in relation to two indicator sets – the AP indicators and the COM indicators. Progress was tracked against individual indicators and the COM indicators as a whole using the implementation score described by Allen et al⁸ (see Annex 4). A detailed report of this work is available (see Annex 5). Additional primary data were collected through the use of structured questionnaires and semi-structured interviews with key informants.
11. Structured questionnaires were administered to three stakeholder groups – Member States, organizations in official relations with WHO and WHO collaborating centres. In July 2020, emails were sent to identified national NCD focal points in each Member State, in the languages routinely used with them for communications about data collection for country capacity surveys (English, French, Russian, Spanish and Portuguese), asking them to respond to a short structured questionnaire. Initial deadlines were extended to allow the maximum number of Member States to respond. 39 Member State responses were received. All non-State actors in official relations with WHO and WHO collaborating centres working in relevant areas (health promotion and education; NCDs; and risk factors) were asked if they wished to receive a questionnaire. Requests were received from 60 non-State actors in official relations with WHO and from 37 WHO collaborating centres. Completed questionnaires were received from 18 non-State actors in official relations with WHO and from 12 WHO collaborating centres. A summary of responses from each stakeholder group was generated to inform report compilation.
12. A number of key informants were also identified and interviewed. Because of constraints of the COVID-19 pandemic, all interviews were conducted remotely. Full details of all those interviewed or responding to structured questionnaires are available in Annex 3 and full methodological details are available in Annex 4.
13. As with all evaluations of this nature, there were some limitations. These are explained in detail in Annex 4 but included issues relating to the evaluation's timing, availability and quality of data, and lack of country case studies. Nevertheless, the Evaluation Advisory Group considers that these limitations were mitigated effectively resulting in a robust, rigorous and high-quality evaluation of the NCD-GAP.

⁶ WHO (2013) *WHO Evaluation Practice Handbook* available on http://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=B9451D6A553A070BADE75ED7E874F623?sequence=1 (accessed 24 September 2020)

⁷ United Nations Evaluation Group (2016) *Norms and Standards for Evaluation* available on <http://www.unevaluation.org/document/download/2787> (accessed 24 September 2020) and United Nations Evaluation Group (2008) *UNEG Ethical Guidelines for Evaluation* available on <http://www.unevaluation.org/document/detail/102> (accessed 24 September 2020)

⁸ Allen, L.N., Nicholson, B.D., Yeung, B.Y.T and Goiana-da-Silva, F. (2020) *Implementation of Non-Communicable Disease Policies: A Geopolitical Analysis of 151 Countries* Lancet Glob Health 2020, 8: e50-58 [https://doi.org/10.1016/S2214-109X\(19\)30446-2](https://doi.org/10.1016/S2214-109X(19)30446-2) (accessed 26 July 2020).

3. Findings

14. This section is structured according to the NCD-GAP's six objectives. Each objective sub-section seeks to answer questions 1 and 2 of the evaluation, namely (1) "To what extent has the implementation of the NCD-GAP been successful across each of the six NCD-GAP objectives, in particular implementation by Member States and the WHO Secretariat across the three levels of the Organization?" and (2) "What have been the challenges and gaps in the implementation of the NCD-GAP across each of the six NCD-GAP objectives?" In general, these sub-sections start by an overall assessment of progress in relation to that objective. They then consider actions taken by Member States focusing on the progress indicators relevant to that objective followed by reviewing contributions made by WHO, international partners and non-State actors. There is some variation depending on the objective being considered and this is indicated with the use of sub-headings. A final sub-section seeks to answer the same two evaluation questions for a number of cross-cutting issues. Relevant conclusions and recommendations are included as text boxes at the end of each objective section and at the end of the section on cross-cutting issues.

3.1 Objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

Overall progress

15. One of the main achievements and successes of the NCD-GAP has been to further raise the profile of NCDs internationally. However, this has not yet been translated into increased levels of international funding to support responses to NCDs.

International meetings and dialogue

16. A timeline of major milestones for the NCD-GAP is presented in Figure 1.⁹ From 2009, there was growing acknowledgement among governments that the global burden and threat of NCDs constituted one of the major challenges for development in the 21st century. This was considered to undermine socioeconomic development throughout the world and to threaten the achievement of internationally-agreed development goals. In September 2011, a first high-level meeting of the United Nations General Assembly was held in New York. This resulted in the adoption of a political declaration on the Prevention and Control of NCDs.¹⁰ A second high-level meeting of the United Nations General Assembly was held in New York in July 2014 to review progress made in terms of prevention and control of NCDs. This resulted in the adoption of an outcome document.¹¹ In September 2018, a third high-level meeting of the United Nations General Assembly was held in New York to further review global and national progress made regarding NCDs. This resulted in a further political declaration endorsing the concept of *Time to Deliver*.¹² These meetings engaged high-level leaders internationally on the issues relating to NCDs. Having three high-level meetings of the UN General Assembly in under ten years represents the highest level of focus on a health-related issue with the possible exception of HIV.

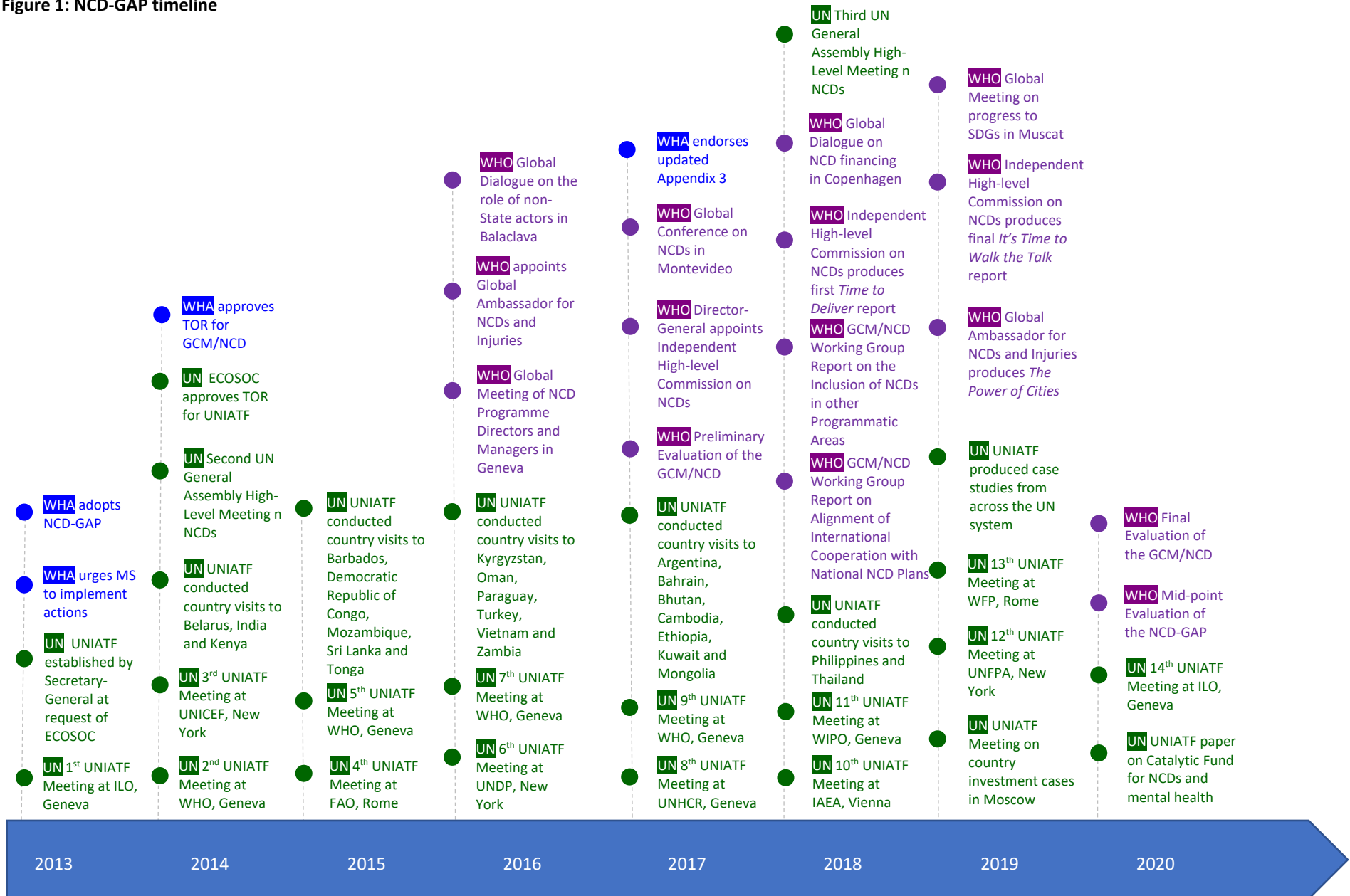
⁹ A longer timeline from 2000 is available in the WHO booklet produced for the Muscat conference in 2019

¹⁰ United Nations General Assembly (2011) *Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* UNGA A/66/L.1 available on <https://undocs.org/en/A/66/L.1> (accessed 16 September 2020)

¹¹ United Nations General Assembly (2014) *Outcome Document of the High-Level Meeting of the General Assembly of the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-Communicable Diseases* UNGA A/68/L.53 available on <https://digitallibrary.un.org/record/774662?ln=en> (accessed 16 September 2020)

¹² United Nations General Assembly (2018) *Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* UNGA A/RES/73/2 available on https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2 (accessed 16 September 2020)

Figure 1: NCD-GAP timeline



17. In addition, WHO has convened a number of international technical meetings focused on NCDs. In October 2016, a global dialogue meeting was held, in Balaclava, under the auspices of the GCM/NCD, focused on the role of non-State actors in supporting Member States in their national efforts to tackle NCDs as part of the 2030 Agenda for Sustainable Development.¹³ In October 2017, a global conference on NCDs was held in Montevideo with the intention of enhancing policy coherence to prevent and control NCDs. This produced the *Montevideo Roadmap 2018-2030 on NCDs as a Sustainable Development Priority* which was a contribution to the preparatory process for the UN General Assembly high-level meeting in 2018. Themes identified in this roadmap included reinvigorating political action, enabling health systems to respond more effectively to NCDs, increasing significantly the financing of national NCD responses and international cooperation, increasing efforts to engage sectors beyond health, seeking measures to address the negative impact of products and environmental factors harmful for health, strengthening the contribution and accountability of the private sector, reinforcing the role of non-State actors, continuing to rely on WHO's leadership and key role in the global response to NCDs, and acting in unity.¹⁴ In April 2018, a global dialogue was held in Copenhagen on financing for prevention and control of NCDs which stressed the need for actions to be taken to increase financial resources available for the prevention and control of NCDs.¹⁵ In December 2019, a global meeting was held in Muscat to accelerate progress on SDG target 3.4¹⁶ on NCDs and mental health. This meeting examined progress on NCDs and mental health through the lens of the SDGs and recognised the need for the so-called *5 x 5 agenda* incorporating NCDs, mental health conditions and environmental pollution.¹⁷

High-level Commission

18. In October 2017, WHO's Director-General established a new Independent High-level Commission on NCDs with the aim of issuing bold recommendations on how countries can accelerate progress towards SDG target 3.4 on the prevention and treatment of NCDs and the promotion of mental health and well-being. The High-Level Commission had five co-chairs and 21 Commissioners¹⁸ drawn from all WHO regions, and with experience and expertise from across government sectors, organizations of the UN system, NGOs, the private sector, philanthropy, and academia. The Commission produced two reports (see Box 2).¹⁹ Some challenges

Box 2: Reports of the WHO Independent High-level Commission on NCDs

In 2018, the High-Level Commission produced its first report *Time to Deliver*. This identified that *"the challenge is not only to gain political support but also to guarantee implementation..."* It identified the burden and impact of NCDs and mental disorders, policies and programmes that have best driven progress and global commitments to prevent and treat NCDs. However, it also commented that progress towards delivering those commitments had been disappointing. It identified seven challenges to implementation and made six overarching recommendations.

In 2019, the Commission produced their final report entitled *It's Time to Walk the Talk*. This made eight recommendations. Some of these recommendations covered a range of topics including strategic leadership, linking NCDs to mental health, addressing both NCDs and mental health through universal health coverage, promoting social protection, and increased and meaningful engagement with both the private sector and civil society. There were also some specific recommendations, such as establishing a multi-donor trust fund for NCDs and mental health conditions.

¹³ WHO (2016) *Working Together to Tackle Noncommunicable Diseases GCM/NCD Global Dialogue Meeting on the Role of Non-State Actors in Supporting Member States in their National Efforts to Tackle Noncommunicable Diseases (NCDs) as Part of the 2030 Agenda for Sustainable Development Balaclava, Mauritius, 19-21 October 2016: Final Report* available on <https://www.who.int/global-coordination-mechanism/dialogues/global-dialogue-meeting-report-oct2016.pdf?ua=1> (accessed 17 September 2020)

¹⁴ WHO (2017) *Highlights from the WHO Global Conference on NCDs: Enhancing Policy Coherence to Prevent and Control Noncommunicable Diseases 18-20 October 2017, Montevideo, Uruguay Meeting Report* available on <https://www.who.int/conferences/global-ncd-conference/montevideo-report.pdf?ua=1> (accessed 16 September 2020)

¹⁵ WHO (2018) *WHO Global Dialogue on Partnerships for Sustainable Financing of NCD Prevention and Control: Meeting Report* available on <https://www.who.int/global-coordination-mechanism/activities/dialogues/copenhagen-report.pdf?ua=1> (accessed 17 September 2020)

¹⁶ By 2030, reduce by one third premature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing.

¹⁷ WHO (2019) *WHO Global Meeting to Accelerate Progress on SDG Target 3.4 on Non-communicable Diseases and Mental Health, 9-12 December 2019, Muscat, Oman* available on https://www.who.int/docs/default-source/ncds/2556-ncd-global-meeting-booklet-14-11-19.pdf?sfvrsn=1e819c3f_3 (accessed 16 September 2020)

¹⁸ Details of the Commissioners are presented in Annex 1 of their first *Time to Deliver* report and in Annex 2 of their final *It's Time to Walk the Talk* report.

¹⁹ WHO (2018) *Time to Deliver: Report of the WHO Independent High-level Commission on Noncommunicable Diseases* and WHO (2019) *WHO Independent High-level Commission on Noncommunicable Diseases: Final Report: It's Time to Walk the Talk*

facing the Commission were acknowledged in their reports. For example, while the first report recognised that the Commissioners brought “*rich and diverse views and perspectives*”, it also noted that that diversity had meant that agreement could not be reached on some important topics, such as taxation of sugar-sweetened beverages and accountability of the private sector. Others have commented that the Commission’s final report lacked sufficient focus on addressing the issues of inequalities in NCDs, including ensuring functioning and fully-supported health systems, access to medicines and addressing NCDs in humanitarian settings.²⁰

Global Ambassador for NCDs and Injuries

19. In 2016, WHO appointed Michael R. Bloomberg as its Global Ambassador for NCDs and Injuries. The Ambassador’s work focused on strengthening the NCD response in low- and middle-income countries through two strands of work (see Box 3).

Box 3: Strands of work Conducted under the Global Ambassadorship

The Partnership for Healthy Cities (<https://partnershipforhealthycities.bloomberg.org/>) brings together a global network of 70 participating cities on the basis that cities are uniquely placed to transform the fight against NCDs and injuries. The Partnership works across fourteen intervention areas including creating a smoke-free environment, banning tobacco advertising, raising tobacco taxes or levies/fees, taxing sugary drinks, setting nutrition standards for foods served and sold in public institutions, regulating food and drink marketing, and enhancing public health data and monitoring systems. The intervention area on promoting active mobility focuses on increasing cycling which would be expected to have benefits in terms of air pollution. In 2019, through this strand, the Ambassador produced a report on *The Power of Cities*.²¹ Case studies have also been produced for a number of cities including Accra, Balanga City, Bangalore, Bangkok, Beijing, Bogor, Bogotá, Cape Town, Cotonou, Fortaleza, Hoi Am, Howrah City, Indore, Kuwait City, London, New York, Mumbai, Phnom Penh and Vienna.²²

The Return on Investment for NCDs project produced a Global Business plan for NCDs called *Saving Lives Spending Less*,²³ highlighting the health and economic benefits of implementing the best buys in low- and lower-middle-income countries. It calculated that an additional US\$ 1.27 per person per year was needed to implement the best buys in low- and lower-middle-income countries and that each US\$ 1 spent would return US\$ 7 by 2030. It also identified a series of financing options to implement the best buys including: raising excise taxes on tobacco and alcohol, impact investment, innovative financing, catalytic funding, ‘plus one’ policies, divestment and tracking investment. Some of these options are explored in more detail in Box 7 (p14).

Global Coordination Mechanism

20. In 2014, WHO established a Global Coordination Mechanism on the Prevention and Control of NCDs (GCM/NCD) the purpose and scope of which was to “*facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the WHO Global NCD Action Plan 2013-2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding the World Health Organization (WHO) and public health from undue influence by any form of real, perceived or potential conflict of interest*”. The GCM/NCD had a preliminary evaluation in 2017²⁴ and a final evaluation was conducted concurrently with this mid-point evaluation of the NCD-GAP. The final evaluation of the GCM/NCD identified that, in the period 2018-2020, a sizeable proportion of its activities related to two of its five functions – advocacy and awareness raising; and disseminating knowledge and sharing information. Functions where there was less evidence of tangible outputs

²⁰ Perone, S.A., Bausch, F.J., Boule, P., Chappuis, F., Miranda, J.J. and Beran, D. (2020) *Report of the WHO Independent High-level Commission on NCDs: Where is the Focus on Addressing Inequalities?* BMJ Global Health 2020; :e002820 doi:10.1136/bmjgh-2020-002820

²¹ WHO (2019) *The Power of Cities: Tackling Noncommunicable Diseases and Road Traffic Injuries* available on <https://apps.who.int/iris/bitstream/handle/10665/329429/WHO-NMH-PND-2019.9-eng.pdf?ua=1> (accessed 16 September 2020)

²² For more details see <https://www.who.int/ncds/publications/tackling-ncds-in-cities/en/> (accessed 16 September 2020)

²³ WHO (2018) *Saving Lives Spending Less: A Strategic Response to Noncommunicable Diseases* available on <https://apps.who.int/iris/bitstream/handle/10665/272534/WHO-NMH-NVI-18.8-eng.pdf?sequence=1&isAllowed=y> (accessed 16 September 2020)

²⁴ WHO (2017) *Preliminary Evaluation of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases* available from https://www.who.int/docs/default-source/documents/evaluation/preliminary-evaluation-ncds.pdf?sfvrsn=b5737024_2 (accessed 16 September 2020)

included innovation and identifying barriers; advancing multisectoral action; and advocating for the mobilization of resources.

United Nations Interagency Task Force

21. In July 2013, The United Nations Economic and Social Council (ECOSOC) requested the UN Secretary-General to establish the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases (UNIATF).²⁵ This was done and the UNIATF terms of reference were approved by ECOSOC in July 2014. These expanded the mandate of the then United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control and highlighted the division of tasks and responsibilities of its members in contributing to each objective of the NCD-GAP. The UNIATF is led and hosted by WHO and provides a platform for cooperation among more than 40 UN agencies, development banks and other intergovernmental organizations. Its purpose is to support the realization of commitments made in the political declaration of the 2011 high-level meeting through the implementation of the NCD-GAP. Key achievements of the UNIATF and some challenges facing it are presented in Box 4.

²⁵ ECOSOC (2013) *United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases* E/RES/2013/12 available on <https://www.who.int/nmh/ncd-task-force/tf-2013.pdf?ua=1> (accessed 16 September 2020)

²⁶ WHO (2019) *Investing in Prevention and Control of Non-communicable Diseases for Sustainable Development: Countries Discussed the Role of Investment Cases* available on <https://www.who.int/ncds/un-task-force/october2019-investment-case/en/> (accessed 17 September 2020)

²⁷ WHO (2019) *Non-communicable Diseases and Mental Health: Case Studies from across the United Nations System* available from <https://apps.who.int/iris/bitstream/handle/10665/326627/WHO-UHC-CD-NCD-19.88-eng.pdf?ua=1> (accessed 16 September 2020)

Box 4: Key achievements of the UNIATF and some challenges facing it

The UNIATF has:

- Held regular meetings twice per year hosted by different UN agencies (see Figure 1)
- Provided technical assistance to almost 30 countries including through support to development of investment cases and high-profile country missions. These missions were delivered jointly by several UN agencies and were considered effective in raising the profile of NCDs in countries visited. The visits sought to establish UN thematic groups and to identify next steps required for countries to make progress on multisectoral and multistakeholder action. Examples of progress achieved through joint country missions included on cervical cancer prevention and management, healthy foods in schools, and tobacco legislation. Some countries wish greater engagement of UNIATF at the country level, including for follow-up and evaluation of visits. UNIATF reviewed the role of country investment cases in a meeting in Moscow in 2019.²⁶
- Developed global joint programmes including:
 - Developing country investment cases with UNDP – these investment cases, developed in-country were valued by many respondents not least for bring UN agencies together in a coordinated way
 - The Artificial Intelligence for Quitting Tobacco Initiative
 - SAFER, a WHO-led roadmap to prevent and reduce alcohol-related harms
 - The Global Regulatory and Fiscal Capacity-Building Programme with the International Development Law Organization
 - FCTC2030, Strengthening WHO FCTC implementation to achieve the SDGs
 - UN Joint Action on Cervical Cancer gathering seven UN agencies to improve human papillomavirus immunization, screening, diagnosis and treatment of cervical cancer
 - The Mobile Health for NCDs Initiative *Be he@lthy, Be mobile* supporting use of mobile technologies to tackle NCDs with the International Telecommunication Union
 - Joint Global Programme on Access to Controlled Drugs for Medical Purposes While Preventing Diversion and Abuse with UNODC
 - Joint Programme for Drug Dependence Treatment and Care with UNODC

One challenge identified in this regard is that UN agencies mostly lack any specific budget for work on NCDs so this reduces the possibility of developing joint programmes. These can also be hampered by UN agencies having very different business models from each other.

- Documented examples of what different agencies are doing on NCDs across the UN system.²⁷
- Established several thematic groups that allow Task Force members to pool and align their existing resources more effectively at the global and country levels. The areas covered include nutrition, NCDs and the environment, tobacco control, physical activity, mental health and emergencies. Despite these achievements, there are some concerns that the response to NCDs remains too “*medical*” or “*health-focused*”. There are some areas where the UNIATF could focus more, for example, on the issue of NCDs in emergencies, and securing a continuum of care for NCD patients in refugee or displaced situations. A working group was established but to date no concrete progress has been made.
- Established a strong governance mechanism with a clear mandate and reporting mechanism. It has a results framework and an explicit theory of change. Annually, the WHO Director-General updates ECOSOC on the progress of the work of the Task Force through a report transmitted by the UN Secretary-General. However, respondents identified that support from other UN agencies for the UNIATF was often from technical experts in particular organizations. They identified the need for more work to engage whole agencies on the NCD agenda as this can result in a lack of alignment between commitments made in the UNIATF and programmes conducted by some of the member agencies.
- Established a supportive and effective Secretariat within WHO. However, this is constrained by only having two staff and one full-time consultant.
- Global health agencies and programmes have created siloes that have failed to integrate NCDs despite potential to do so in many areas.
- There are concerns that different agencies have different approaches and standards in terms of partnerships with health-harming industries.

22. The GCM/NCD final evaluation recognized the efforts that had been made to bring the GCM/NCD and the UNIATF together within the Global NCD Platform but it noted that it was too early to assess the effectiveness of this move. Nevertheless, the evaluation commented that the relationship between the GCM/NCD and UNIATF lacked synergy. In addition, the GCM/NCD evaluation also documented that some non-State actors reported unclear delineation of roles between the GCM/NCD, UNIATF and WHO technical departments which had led to misunderstandings and lost opportunities and had contributed to delays, overlaps and duplication of efforts. One specific area of potential overlap highlighted by the GCM/NCD final evaluation was plans to establish a pooled fund for the GCM/NCD and the intention to establish a Multi-Partner Trust Fund under the auspices of UNIATF.

WHO, international partners and non-State actors

23. Boxes 5 and 6 briefly summarize the respective contributions of WHO and non-State actors to this objective.

Box 5: WHO contributions to the NCD-GAP objective 1 - to raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

WHO worked successfully to raise the priority accorded to the prevention and control of NCDs at the global level, and in internationally-agreed development goals, and played a leading role in promoting NCDs as a global agenda.

In terms of its leading and convening role, WHO undertook a series of actions to build momentum around NCDs in the period leading up to the NCD-GAP development, through disseminating evidence for policy makers on the relationship between NCDs poverty and development, and securing political buy-in for NCDs through the first Global Ministerial Conference on Healthy Lifestyles and NCD Control leading to the 2011 Moscow Declaration on NCDs.²⁸ This prepared the ground for the series of high-level meetings described in paragraph 16 (p4). Respondents considered that WHO had played a leading role in these processes with one describing them as a “*tremendous effort*”.

WHO also worked to integrate NCDs in key development agendas such as the SDGs and universal health coverage. It provided technical input and guidance in the Future We Want which launched the process to develop the set of SDGs. This process recognized the importance of NCDs and UHC, reflected in the inclusion of NCDs in SDG target 3.4, to reduce by one-third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being by 2030.

In September 2019, at the high-level meeting on UHC, a commitment was made to cover progressively one billion additional people with essential health services and medicines for the early detection, screening and appropriate treatment of NCDs and mental health conditions by 2023.

WHO has offered technical assistance at the global, regional and national levels to enhance multistakeholder partnerships to scale up NCD policies and mobilize resources. A series of special global initiatives were launched: The Special Initiative for Mental Health, the Global Hearts Initiative, the Global Initiative to Eliminate Cervical Cancer, the Global Initiative for Childhood Cancer, the Global Initiative to Eliminate Industrially-produced Trans-fat from the Global Food Supply and the Global Strategy to Accelerate Tobacco Control 2019–2025.

In terms of its role in policy advice and dialogue, WHO has worked to secure resources and advocate for Member States and the donor community to translate political commitments into action. This includes through the international meetings highlighted in paragraph 17 (p6).

Work was also done, to some extent, to raise public awareness about the links between NCDs and sustainable development, although this did not fully reach out beyond the public health sector and policy making circles. One example of this was the Global Communications Campaign on NCDs, launched in July 2016, which included a web-based platform NCDs&me (see <https://apps.who.int/ncds-and-me/>).

Box 6: Contributions of non-State actors to the NCD-GAP objective 1 - to raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

Non-State actors have played an important role in raising the priority of NCDs internationally. For example, in 2016, the WHA recognized the contribution of non-State actors as a “powerful engine” in raising the priority accorded to the prevention and control of NCDs in national and international agendas. These non-State actors were considered to include civil society, such as the NCD Alliance, philanthropic foundations, such as the Bill and Melinda Gates Foundation and Bloomberg Philanthropies, and academia, such as the Lancet series on NCDs. That same year, the GCM/NCD convened a Global Dialogue Meeting focused on the role of non-State actors (see paragraph 17, p6).

In terms of civil society, WHO established a civil society working group on NCDs in 2017, focused on preparations for the 2018 high-level meeting. The need for meaningful civil society engagement, and for the voices of those living with and affected by NCDs to have their voices amplified, was recognized in the 2018 UN political declaration on NCDs. In responses to this evaluation, respondents from civil society:

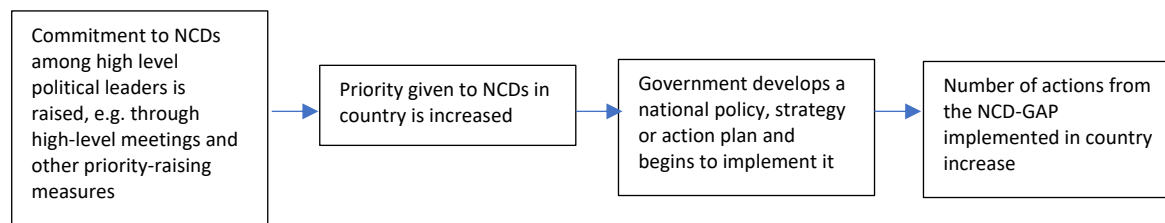
- Welcomed the NCD-GAP as a robust framework for advocacy efforts and that the role of non-State actors in the NCD response had been highlighted in political declarations
- Expressed their satisfaction at the increasing recognition of civil society in the global arena. One commented that, “the dialogue with WHO is improving, the role of civil society is better taken into account. There has been great progress at the WHO in the last 15 years on this.”

A number of challenges were identified that affect civil society. The availability of funding is limited and some funding sources, e.g. pharmaceutical companies and foundations, may present risks of conflicts of interest. Civil society respondents considered that the lack of sustainable funding hampered the ability of civil society organizations to play a stronger role. In addition, the composition of the NCD civil society movement itself is historically skewed towards representation of professional associations, with fewer organizations that have emerged from a grassroots movement of people with lived experiences of NCDs or mental health issues. One respondent commented that, “many NCD civil society organizations did not come out of patients, but professional organizations. Efforts to bring in patients’ voice is an afterthought, it has been very top down. The table is already set before the patients are invited. NCDs do not have a people-led movement”.

Progress indicator: Countries have an NCD policy, strategy or action plan

24. The metric in this objective in the AP indicator set is whether countries have a national NCD policy, strategy or action plan. This appears to be based on the implicit assumption that this indicator can act as a proxy of government commitment. For the purpose of this evaluation, these assumptions have been made explicit in the simple model shown in Figure 2.²⁹ Essentially, this states that as commitment to NCDs rises among political leaders as a result of international events, the priority given to NCDs in-country rises and this is manifested by the government developing a national policy, strategy or action plan and this then results in actions from the NCD-GAP being implemented. This model has been tested throughout the evaluation.

Figure 2: Possible causal pathways through which high-level political commitment might lead to greater action on NCDs in countries



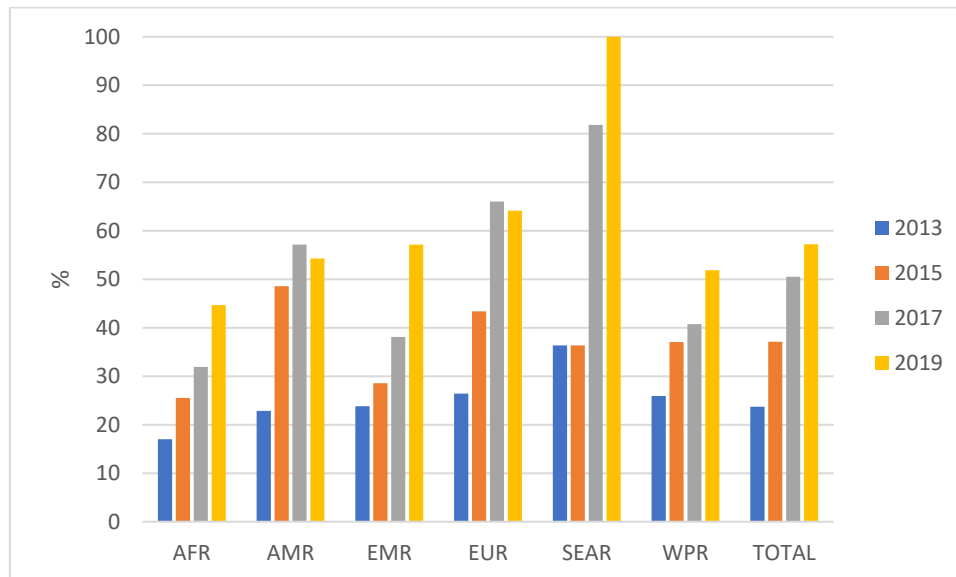
²⁸ WHO (2011) *First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control Moscow, 28-29 April 2011*

https://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/moscow_declaration_en.pdf?ua=1 (accessed 17 September 2020)

²⁹ This is not intended to be a theory of change for the NCD-GAP. Rather, it is intended to make explicit some of the assumptions within the NCD-GAP and how it is being monitored

25. There has been some progress on this indicator. In 2013, less than one quarter of countries (24%) had such a policy, strategy or action plan and, by 2019, this had risen to more than half (57%). There was improvement between 2013 and 2019 in each of WHO regions and, by 2019, all countries in SEAR reported having such a policy, strategy or action plan (see Figure 3). Globally, almost half of countries still did not have such a policy, strategy or action plan in place in 2019 and this was more than half the countries in AFR. There was no statistically significant association between this indicator and country income level in 2019 ($p=.63$).

Figure 3: Percentage of Member States by region that have an operational, multisectoral national NCD policy, strategy or action plan that integrates several NCDs and their risk factors: 2013, 2015, 2017 and 2019



Links between having an NCD policy, strategy and action plan and actions on NCDs

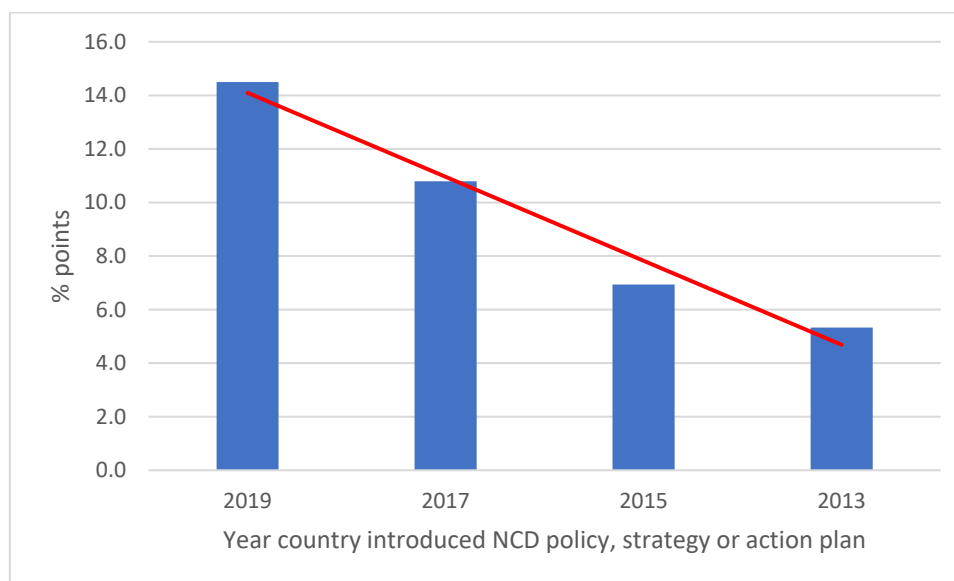
26. One criticism of the NCD-GAP, in general, and this indicator, in particular, is that much of the focus is on having policies, strategies and plans and these may not necessarily translate into needed actions. The evaluation compared the extent to which countries having an NCD policy, strategy or action plan was associated with the extent to which COM indicators have been achieved (as measured through the adjusted implementation score³⁰). There was an extremely significant statistical association ($p<.001$), that is, countries with an NCD policy, strategy or action plan are more likely to score highly in terms of implementing the actions measured through the COM indicators which correspond closely to the identified best buys. While this does provide support for the hypothesis in Figure 2, i.e. that a country develops an NCD policy, strategy or plan and then implements actions from the NCD-GAP, this does not establish a causal link definitively. Something else could be causing both findings. However, this is unlikely to be country income level as there is no association between country income level and whether a country has an NCD policy, strategy or plan. In addition, there is a statistically significant association between having an NCD policy, strategy or plan and adjusted implementation score among individual country groups (LMIC, $p<.001$; UMIC, $p<.001$; HIC, $p=.03$) with the exception of low-income countries ($p=.07$). One possible explanation for this is that having an NCD policy, strategy and action plan in place (and the political commitment that this implies) will result in other NCD policies and actions provided a country has some level of resources to do this.

27. There is also some evidence that the effect of having an NCD policy, strategy or action plan on NCD-GAP implementation may be short-lived. There was a statistically significant negative association ($p=.002$) between when a country adopted an NCD policy, strategy or action plan and the adjusted implementation score (see Figure 4) i.e. more improvement was seen in those countries who had had the NCD policy, strategy or action

³⁰ That is the overall implementation score with the score for COM 4 (having an NCD policy, strategy or action plan) removed.

plan in place for a shorter period. So, there was a mean improvement of just over five points in countries that had had a policy, strategy or action plan in place since 2013 while this rose to over 14 points in countries that introduced the policy, strategy or action plan between 2017 and 2019. One possible explanation of this is that developing a national NCD policy, strategy or action plan gives a short-term boost to actions on NCDs but this may not be maintained without other actions.

Figure 4: Comparison of mean improvement in adjusted implementation score between 2015 and 2019 and the time when an NCD policy, strategy or action plan was introduced (scores were allocated as follows – for countries with an NCD policy, strategy or action plan in place as of 2013 they were allocated the score of 4; for countries with an NCD policy, strategy or action plan in place as of 2015 but not in 2013 they were allocated the score of 3; for countries with an NCD policy, strategy or action plan in place as of 2017 but not in 2015 they were allocated the score of 2; and for countries with an NCD policy, strategy or action plan in place as of 2019 but not in 2017 they were allocated the score of 1)



International funding

28. While it is good that NCDs have a higher profile and many countries have developed a policy, strategy or action plan to address NCDs, progress will be limited unless the level of resources available is sufficient and it is widely recognised that this is not the case despite high-level political commitments made in 2011, 2014 and 2018. For example, in 2020, the NCD Alliance documented that there was still a significant financing gap for NCDs globally.³¹ One Member State respondent commented that “*funding mechanisms must be sourced before plans are launched*”.
29. In recent years, various suggestions have been made^{32 33 34 35 36} as to how this gap could be bridged and some of these are shown in Box 7. There has been particular interest in establishing a Catalytic Fund that could be administered as a multi-donor trust fund. An outline business plan for such a fund was developed for one of the

³¹ NCD Alliance (2020) *Bridging the Gap on NCDs: From Global Promises to Local Progress* available on <https://ncdalliance.org/resources/bridging-the-gap-on-ncds-from-global-promises-to-local-progress-policy-brief> (accessed 17 September 2020)

³² Norwegian Ministry of Foreign Affairs (2019) *Better Health, Better Lives: combating Non-Communicable Diseases in the Context of Norwegian Development Policy (2020-2024): Summary* available from https://www.regjeringen.no/globalassets/departementene/ud/vedlegg/utvikling/betterhealth_summary.pdf (accessed 17 September 2020)

³³ WHO GCM/NCD (undated) *Final Report and Recommendations from the Working Group on Ways and Means of Encouraging Member States and Non-State Actors to Realize the Commitment Included in Paragraph 45(d) of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases* available from <https://www.who.int/global-coordination-mechanism/working-groups/wg-final-report-comments/en/> (accessed 17 September 2020)

³⁴ WHO (2018) *Saving Lives Spending Less: A Strategic Response to Noncommunicable Diseases* available on <https://apps.who.int/iris/bitstream/handle/10665/272534/WHO-NMH-NVI-18.8-eng.pdf?sequence=1&isAllowed=y> (accessed 16 September 2020)

³⁵ WHO (2019) *WHO Independent High-level Commission on Noncommunicable Diseases: Final Report: It's Time to Walk the Talk* available on <https://apps.who.int/iris/handle/10665/330023> (accessed 17 September 2020)

³⁶ WHO (2018) *WHO Global Dialogue on Partnerships for Sustainable Financing of NCD Prevention and Control: Meeting Report* available on <https://www.who.int/global-coordination-mechanism/activities/dialogues/copenhagen-report.pdf?ua=1> (accessed 17 September 2020)

working groups of the High-Level Commission.³⁷ This is now being taken forward by WHO, the World Bank, UNDP, UNICEF and UNFPA under the auspices of UNIATF. Plans have been developed and presented to ECOSOC. Terms of reference have been drafted. The Catalytic Fund would aim to mobilize at least US\$ 200 million for disbursement over five years, to support up to 25 countries in accelerating country-level actions towards achieving national and global NCD targets.³⁸ While the intention is not to establish “a Global Fund for NCDs”, the scale of financing planned and experience of similar catalytic financing facilities in other sectors, e.g. nutrition,³⁹ suggests that this would likely develop an organizational identity of its own. Nevertheless, many respondents highlighted the potential of a multi-partner trust fund to unlock funding for specific NCD programmes. For example one respondent noted “it would be a good opportunity to have an NCD financial instrument. It is not about being more vertical but about being more operational”.

Box 7: Suggested mechanisms for bridging the international NCD funding gap

There is recognition that funding for responses to NCDs needs to come from domestic resources supplemented by the international community in some cases, e.g. in low-income countries. Options for domestic resourcing include:

- Ensuring NCD responses are included in national budgets for health
- Taxation of unhealthy products including tobacco, alcohol and foods high in fat, sugar or salt
- Phasing out of subsidies for unhealthy products
- Promote and incentivize private sector financing - this could be both from domestic and international sources. It could include forms of impact investment which delivers a financial return to external investors

Options for greater international funding include:

- Greater focus on NCDs by bilateral donors – for example, Norway has developed a specific strategy for combating NCDs in the context of its development policy - including by covering NCDs through existing aid instruments. This could include catalytic funding aimed at stimulating greater public or private investment
- Innovative funding mechanisms, e.g. the use of an airline ticket tax to fund UNITAID
- Adding NCDs to an existing health programme or funding instrument, referred to as “plus one” policies
- Not funding activities or actors that would have effects contrary to the aims of the NCD-GAP. This might include divestment in industries such as the tobacco industry
- Establishing a multi-donor trust fund focused on NCDs and mental health conditions

30. Although WHO has done work to identify purpose codes for NCD financing that could be used to track NCD spending as a component of official development assistance,⁴⁰ it does not appear that these are yet being used by OECD in their tracking of this⁴¹ but it is reported, by the NCD Alliance, that this code will start to be used from 2020.³¹ Data from the Institute for Health Metrics and Evaluation (IHME) on development assistance for health (DAH)⁴² show that, in 2018, NCDs received only 2% of DAH despite representing almost two thirds (62%) of global disease burden. IHME also notes that, although DAH for NCDs rose from less than US\$ 600 million per year in 2012 to almost US\$ 800 million in 2013, it has plateaued since. The main channels of international funding for NCDs, identified by IHME, were US NGOs and WHO. Relatively little financial support for responses to NCDs is provided through direct bilateral aid. In their report, IHME identified the countries that were the top

³⁷ Health Finance Institute (undated) *Outline Business Plan for a Catalytic Multi-Donor Trust Fund for the Prevention and Control of Noncommunicable Diseases and Mental Health* available on <https://www.who.int/ncds/governance/high-level-commission/MDTF-4-business-plan-HFI.pdf> (accessed 17 September 2020)

³⁸ UNIATF (2020) *United Nations Multi-Partner Trust to Catalyze Country Action for Non-Communicable Diseases and Mental Health*

³⁹ In nutrition, the catalytic financing facility became the organization, The Power of Nutrition – see <https://www.powerofnutrition.org/who-we-are/> (accessed 17 September 2020)

⁴⁰ In 2016, details were presented to WHA69 of a proposed purpose code that could be used by the OECD DAC to track the amount of ODA spent on NCDs. In 2018, a report was provided to WHA71 that developing this purpose code (through the OECD DAC) was one of a set of assignments given to WHO and that this had been completed in June 2017.

⁴¹ The OECD web page on Aid to Health (see <https://www.oecd.org/dac/stats/aidtohealth.htm> [accessed 21 July 2020]) gives codes for health (120), health general (121), basic health (122) and population policies/programmes and reproductive health (130) but not the proposed NCD code (123)

⁴² IHME (2019) *Financing Global Health 2018: Countries and Programs in Transition* available on http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf (accessed 17 September 2020)

20 recipients of DAH for NCDs and noted that these are not the countries with the highest burden of NCDs. Three quarters of these were middle-income countries (12 LMIC and 3 UMIC).

31. In summary, this means that the raised profile given to NCDs internationally since 2013 and the various ideas, suggestions and recommendations as to how funding could be increased have not yet translated into increased international funding.

Conclusions and recommendations for objective 1

Overall, the NCD-GAP has contributed to raising the profile of NCDs internationally and in many countries and this has contributed to an increase in the number of countries that have adopted a national NCD policy, strategy or action plan. However, there is a pressing need to accelerate implementation of those plans and international and domestic financial resources are needed for this delivery.

WHO Secretariat and Member States to find sustainable funding mechanisms to allow for a dramatic acceleration of NCD implementation. Specifically:

- WHO Secretariat to develop specific proposals as to how NCD funding can be incorporated into plans to build back better.
- UNIATF, WHO and international partners to continue with plans to introduce a Catalytic/Multi-Partner Trust Fund for NCDs.
- Bilateral funders, multilateral funders, philanthropies and other funding agencies to provide additional funds for NCD responses, including through the Catalytic/Multi-Partner Trust Fund for NCDs.
- WHO Secretariat to continue to work with Organisation for Economic Co-operation and Development to introduce a purpose code to track spending on NCDs within official development assistance.

3.2 Objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs

Overall progress

32. In general, the raised profile given to NCDs internationally, regionally and nationally has only resulted in modest levels of progress in terms of country responses to NCDs. Most countries have not yet seen the type of dramatic acceleration envisaged by the NCD-GAP.

Progress indicators

33. Progress measures of national capacity to accelerate country NCD responses include whether countries have an operational NCD unit, branch or department within the Ministry of Health and an operational national coordination mechanism for the prevention and control of NCDs. In 2013, just over half of countries (51%) had an NCD unit, branch or department and this rose to more than three quarters of countries (76%) by 2019. Less than one third of countries (31%) had a national NCD coordination mechanism in 2015 and this rose to just under half of countries (46%) by 2019. Both these measures are strongly associated with country income level (see Figures 5 and 6). For example, in 2019, less than one quarter of low-income countries (21%) had a national NCD coordination mechanism as compared to more than half of high-income countries (55%) (see Figure 6).

34. There is a statistically significant association between the two indicators, that is, having an operational NCD unit, branch or department and having an operational national NCD coordination mechanism ($p < .001$). For example, in 2019, more than half of countries (57%) with an NCD unit, branch or department had a national NCD coordination mechanism as compared to 12% without an NCD unit, branch or department. This provides some evidence that establishing and running a national NCD coordination mechanism requires financial, human and organizational resources, e.g. as provided by an NCD unit.

Are national coordination mechanisms effective?

35. In principle, it might be expected that countries with national NCD coordination mechanisms might perform better than other countries, particularly on actions beyond the health sector which might require multisectoral action, e.g. on risk factors. However, there is little evidence that this is the case. In general, there was little difference in performance on most actions between countries that had an NCD policy, strategy or action plan and those that had a national coordination mechanism. There was, however, one exception where there was a statistically significant association with having a national coordination mechanism ($p = .03$) but not with having a national NCD policy, strategy or plan ($p = .69$) and that is the area of tobacco taxation. However, in the case of

Figure 5: Percentage of Member States by country income group that have an operational NCD unit(s), branch(es) or department(s) within the Ministry of Health, or equivalent: 2013, 2015, 2017 and 2019

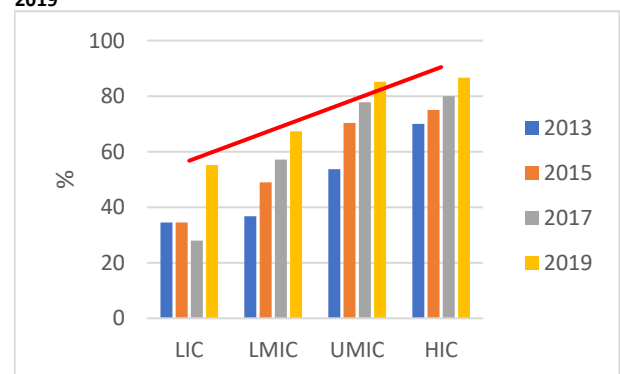
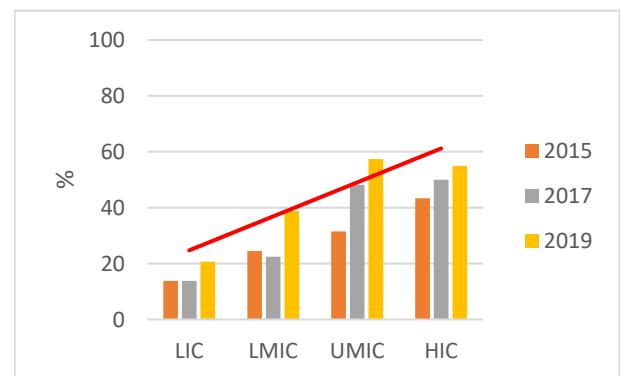


Figure 6: Percentage of Member States by country income group that have an operational national coordination mechanism in place for the prevention and control of noncommunicable diseases: 2015, 2017 and 2019



both tobacco packaging and tobacco advertising, the reverse was true. There was a statistically significant association with having a national NCD policy, strategy or action plan (packaging $p=.008$ and advertising $p=.002$) but not with having a national coordination mechanism (packaging $p=.08$ and advertising $p=.38$).

36. The evidence concerning national NCD coordination mechanisms is very disappointing. As of 2019, less than half of all countries had such mechanisms and, where they are in place, they do not seem to be associated with the benefits expected. However, this may not mean that there is a problem with the concept of these mechanisms. Qualitative feedback suggests there may be issues with the composition and functioning of these groups (see Box 11, p27).

Progress on national NCD responses as a whole

37. In addition to looking at specific indicators of national capacity, it is possible to look across the indicator sets to assess the extent to which expected actions of the NCD-GAP are being implemented. From 2013 to 2019, there was considerable improvement in some AP indicators, e.g. AP2 (NCD unit) and AP3a-d (NCD risk factor policies). For AP1 (NCD policies, strategies, and action plans), AP5 (research policies), AP6 (monitoring and surveillance systems) and APx (national coordination mechanisms), despite some progress overall performance remains at a low level. There has been little progress in developing guidelines, protocols and standards for NCD management through a primary care approach (AP4) (see Table 1).

Table 1: Progress against action plan implementation progress (AP) indicators based on disaggregated data for 194 countries (colour codes show level of performance: dark green if >80%, light green if 60–79%, yellow if 40–59% and amber if <40%)

Indicator	2013	2015	2017	2019	Association with country income level?	p
AP1: National action plan	24%	37%	51%	57%		.63
AP2: NCD unit	51%	60%	66%	76%		<.001
AP3a: Policy on harmful use of alcohol	48%	61%	71%	74%		0.006
AP3b: Policy on physical activity	52%	64%	77%	79%		<.001
AP3c: Tobacco policy	63%	73%	83%	79%		<.001
AP3d: Policy on healthy diet	55%	66%	78%	80%		<.001
AP4: Clinical guidelines	49%	38%	46%	48%		.02
AP5: NCD research policy	n/a	22%	28%	33%		<.001
AP6: NCD surveillance system	23%	26%	38%	42%		.004
APx: National coordination mechanism	n/a	31%	37%	46%		.002

38. Table 2 presents a similar table for the COM indicators. While 14 indicators show improvement in terms of countries fully achieving these between 2015 and 2019, the improvements are modest and overall performance levels remain low. In 2019, only three indicators were fully achieved by more than half of countries. These were indicators relating to having a policy (COM4) and targets (COM1) and mass media campaigns on physical activity (COM8). If countries which have at least partially achieved a measure are considered, performance levels are much stronger with 13 indicators being at least partially achieved by half of countries in 2019. Indicators that did not achieve this were mass media activities on tobacco (COM5e), alcohol advertising bans (COM6b), salt policies (COM7a), fat policies (COM7b), marketing of food to children (COM7c) and availability of drug therapy and counselling (COM10). Fifteen indicators showed improvement between 2015 and 2019 in terms of being at least partially achieved.

Table 2: Percentage of countries in which commitment fulfilment progress (COM) indicators are fully achieved and at least partially achieved: 2015, 2017 and 2019 (colour codes show level of performance: dark green if >80%, light green if 60–79%, yellow if 40–59% and amber if <40%)

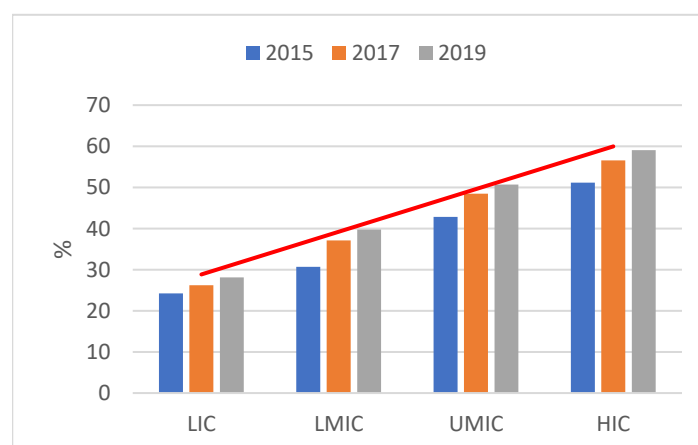
Indicator	Fully achieved			At least partially achieved			p
	2015	2017	2019	2015	2017	2019	
COM1: National NCD targets	30%	48%	57%	45%	62%	68%	.82
COM2: Mortality data	36%	38%	40%	62%	62%	61%	<.001
COM3: Risk factor surveys	28%	19%	27%	79%	89%	85%	.02
COM4: National action plan	33%	51%	57%	45%	62%	66%	.29
COM5a: Tobacco tax	2%	16%	19%	36%	52%	51%	<.001
COM5b: Smoke-free places	25%	28%	31%	64%	69%	72%	.14
COM5c: Graphic warnings	22%	40%	47%	70%	74%	78%	<.001
COM5d: Tobacco advertising bans	15%	19%	25%	70%	74%	78%	.60
COM5e: Tobacco mass media	n/a	22%	20%	n/a	35%	41%	.001
COM6a: Alcohol sales restrictions	15%	14%	16%	90%	84%	87%	.23
COM6b: Alcohol advertising ban	20%	23%	27%	63%	38%	38%	.35
COM6c: Alcohol tax	22%	17%	24%	73%	87%	68%	.14
COM7a: Salt policies	32%	26%	20%	32%	44%	44%	<.001
COM7b: Fat policies	21%	35%	30%	21%	35%	39%	<.001
COM7c: Child food marketing	22%	30%	31%	n/a	n/a	n/a	<.001
COM7d: Breast milk code	37%	20%	18%	37%	69%	70%	.47
COM8: Physical activity mass media	61%	52%	52%	61%	52%	65%	<.001
COM9: Clinical guidelines	26%	46%	48%	50%	77%	78%	.001
COM10: Drug therapy and counselling	14%	27%	34%	20%	31%	41%	<.001

Association with country income level?

The level of national response to NCDs is associated with country income level

39. There is a statistically significant association between performance on many progress indicators and country income group. For all AP indicators, apart from one (on NCD policies - AP1), performance is statistically associated with country income group (see Table 1). This is true for more than half (58%) of the COM indicators (see Table 2). There is also an association between performance on the COM indicators as a set, termed implementation score, and country income group ($p<.001$ and see Figure 7). This Figure shows that implementation score is higher in countries with higher income. It also shows that there were modest increases in mean implementation score in each country income group over the period from 2015 to 2019.

Figure 7: Mean implementation score for Member States overall by country income group: 2015, 2017 and 2019

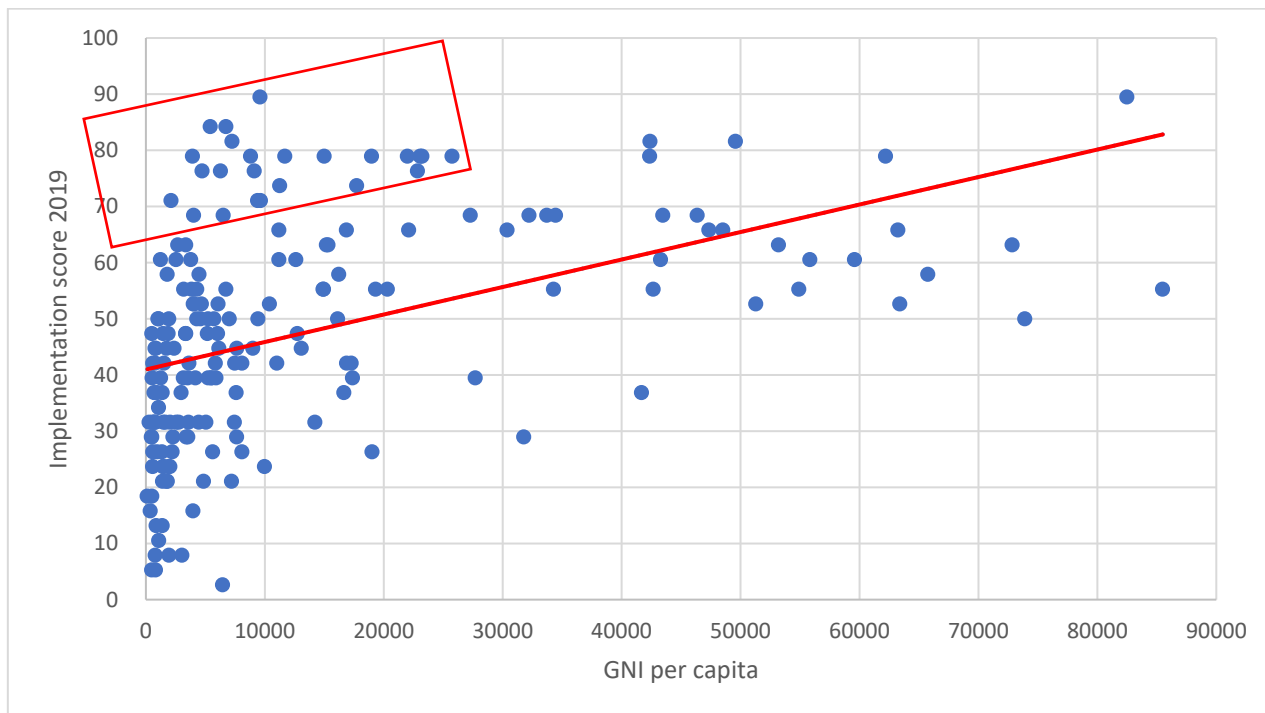


Some countries perform better than might be expected on income level alone

40. Some countries perform better than expected based on country income group alone. This is illustrated in Figure 8 which compares countries' implementation scores for 2019 with gross national income (GNI) per capita. There is a statistically significant association between these variables ($p<.001$). In general, countries with higher income have higher implementation scores than countries with lower income. However, there is substantial variation at the country level. Two countries with the same GNI per capita may have highly divergent implementation scores. Countries above the red trend line have higher implementation scores than might be

expected based on GNI levels. This is particularly the case for countries in the red rectangle shown in Figure 8. Understanding the reasons for these countries' success could be crucial for understanding what factors support and impede implementation progress. Case studies which explored success factors in those countries could be very informative but these were not included in the method of this evaluation. Of course, this higher "performance" could be a reporting artefact and it might be important to understand what processes these countries have in place to verify the results reported.

Figure 8: Comparison of 2019 implementation score with GNI per capita

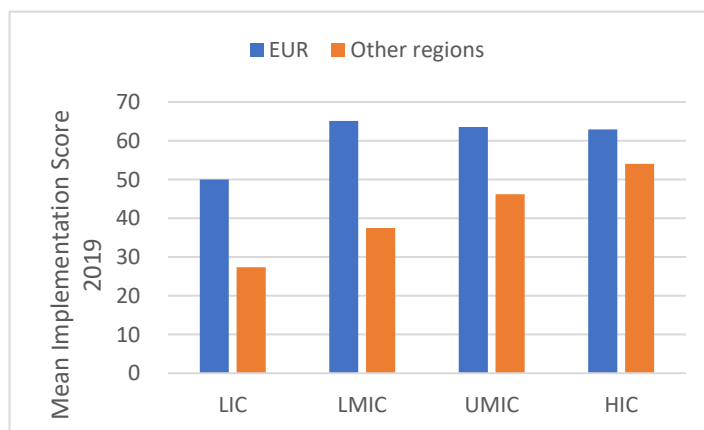


41. There are other explanatory factors that could influence the extent of implementation of the NCD-GAP, including regional variations not explained by income variations, the presence of an active civil society or a particularly well-developed or equitable healthcare system.

Countries in EUR perform better than countries in other regions even accounting for variation in income level

42. In terms of regional variation, of the 23 countries within the red rectangle in Figure 8, more than half (12, 52%) are in EUR as compared to just over one quarter (53, 27%) overall. Figure 9 shows the mean implementation score 2019 for all countries distinguished by EUR and other regions. This shows that for each income group, mean scores are higher for countries in EUR than in other regions. These differences are statistically significant (LIC, $p=.04$; LMIC, $p<.001$; UMIC, $p=.001$; HIC, $p=.02$). Figure 9 also shows that middle-income countries (LMIC and UMIC) in EUR have equivalent or higher mean implementation scores than high-income countries.

Figure 9: Mean implementation score 2019 for countries in European Region (EUR) and other regions by country income group



43. It appears that there may be a factor other than income level which is contributing to higher implementation scores in countries of EUR than other regions. One possible explanation is that there may be common standards across the region which influence country performance. It does appear that there may be some factor which means that a country in EUR has a higher implementation score than a country in the same country income group in another region.

There is evidence of the importance of high level political commitment for effective NCD responses

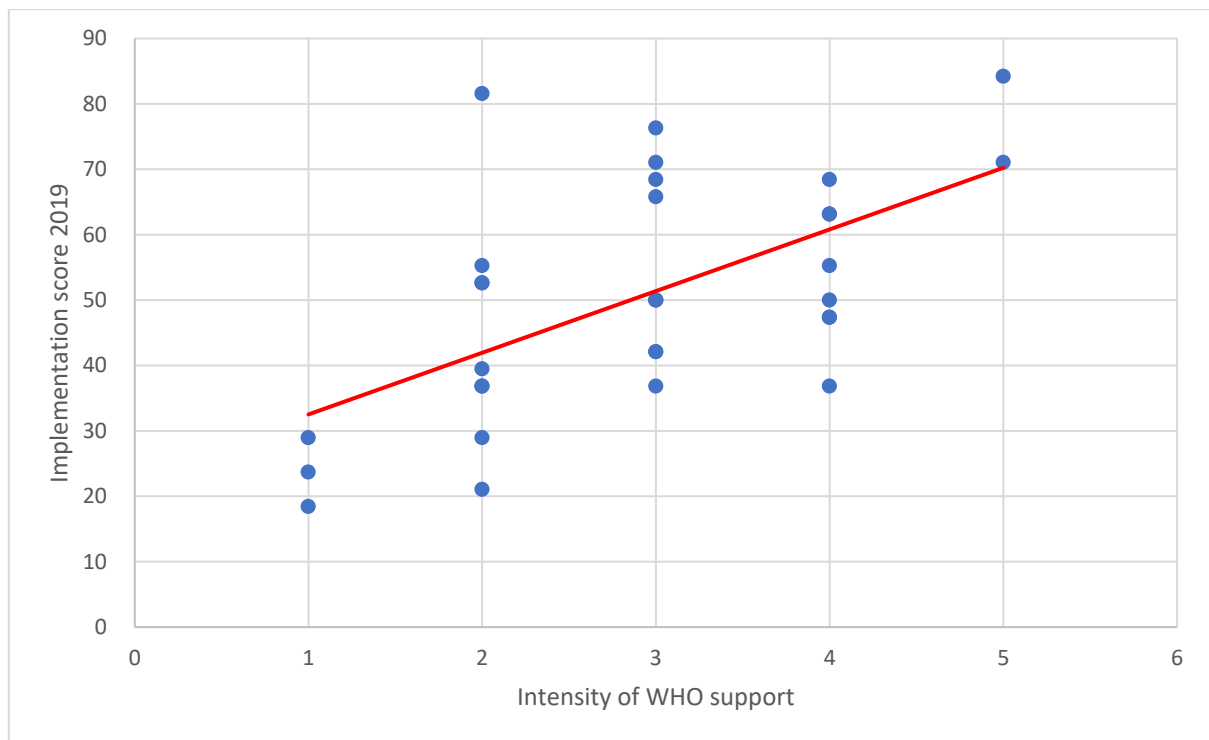
44. In 2020, Allen et al.⁴³ reported anecdotal evidence from one country that possible explanations for the relatively high performance of this country might be high-level political commitment and intense support from WHO. The evaluation presents some evidence to support these hypotheses. Evidence relating to high-level political commitment has been presented under objective 1 (see Figure 2 and paragraphs 24-25, from p11). If it is accepted that having an NCD policy, strategy or action plan is a valid proxy of domestic political commitment to preventing and controlling NCDs, the evaluation has shown an association between a measure of domestic political commitment and an NCD implementation score. This association is not seen in low-income countries and it appears to fade over time.

There is qualitative and some quantitative evidence of the importance of WHO support to national NCD responses

45. There is no existing metric available to assess the intensity of WHO support to countries on NCDs. So, the evaluators asked NCD leads in Regional Offices to grade the intensity of support provided to countries on a 0-4 scale. This generated a great deal of discussion about what intensity of WHO support meant and how this could be assessed given:
- That NCDs comprise a wide range of diseases and risk factors with support provided by different technical officers
 - That WHO provides a wide range of different types of technical support
 - That different regions and different people within regions would assess this differently particularly in the absence of clear criteria
 - Concerns about appearing to criticise colleagues or countries
46. Nevertheless, two regions (EMR and SEAR) were able to conduct this rapid assessment. Figure 10 maps absolute implementation scores for all commitment fulfilment progress indicators for 2019 against assessed intensity of WHO support in two regions. This shows there is a statistically significant positive association between these two factors (shown as the red trend line in Figure 10, $p < .001$).

⁴³ Allen, L.N., Nicholson, B.D., Yeung, B.Y.T and Goiana-da-Silva, F. (2020) *Implementation of Non-Communicable Disease Policies: A Geopolitical Analysis of 151 Countries* Lancet Glob Health 2020, 8: e50-58 ([https://doi.org/10.1016/S2214-109X\(19\)30446-2](https://doi.org/10.1016/S2214-109X(19)30446-2) accessed 26 July 2020).

Figure 10: Comparison of implementation score for 2019 and assessed intensity of WHO support: Eastern Mediterranean and South-East Asia Regions



47. This does not mean that there is necessarily a causal link between intensity of WHO support and implementation of NCD actions by countries. Other explanations could be that WHO provides more intense support to countries that are doing better on NCDs. This seems unlikely. However, there could be a common factor affecting both WHO intensity of support and NCD implementation, such as availability of resources, enabling environment etc. There could also potentially be grading issues. These assessments are subjective and presumably the Regional Officers involved would have known which countries are performing well on NCDs and this could have consciously or unconsciously affected their grading. However, the anecdotal evidence cited by Allen et al. and the qualitative feedback received from Member States during this evaluation (see paragraphs 56-59 and Boxes 9 & 10, from p25) are all supportive of the hypothesis that WHO support could be a factor in improving implementation score, particularly among lower-middle-income countries.

There are many other factors which can support or hinder national NCD responses

48. The evaluation received a large number of suggestions of factors that might facilitate or hinder NCD-GAP implementation. Some of those suggested by Member States are included in Table 3. Many of the factors identified lend themselves better to qualitative analysis, e.g. through country case studies. In other cases, where quantitative analysis might be possible, it is hindered by the lack of metrics and/or data. In a few cases, e.g. on political commitment, intensity of WHO support, the evaluation succeeded in obtaining some quantitative data to allow a degree of analysis.

Table 3: Facilitating and hindering factors affecting NCD-GAP implementation: Member State feedback

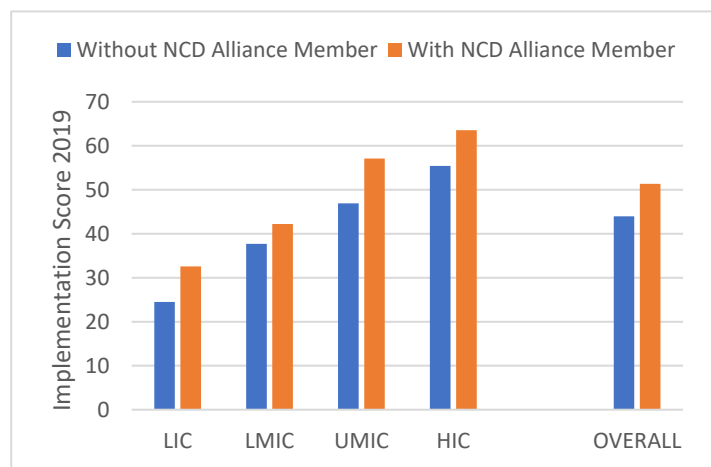
Facilitating factors	Hindering factors
<p>General level of development – including, for example, sanitation, housing and other infrastructure</p> <p>Political will – for example, in one country, in 2015, the government and MOH mentioned NCDs as a public priority for the first time. The importance of Ministries of Health was mentioned in some countries. Having political champions of some issues is important in some countries</p> <p>Cross-country agreements, e.g. at the European Union level on tobacco</p> <p>Good governance including leadership often from within the Ministry of Health and intersectoral coordination where this works well</p> <p>Having a dedicated team working on NCDs in MOH but it is also important to have functioning systems at sub-national level, particularly in large and federal countries</p> <p>Active partner involvement including from other ministries (e.g. Education), UN agencies (e.g. UNICEF), other countries (e.g. their development agencies), civil society (e.g. Santé Diabète, Santé Sud, World Diabetes Federation), clinicians and clinical institutions (e.g. for cancer screening) and the private sector. One country identified the creation of a national NCD network as a positive – having members from relevant ministries and major NCD related NGOs.</p> <p>Participation in international meetings which has increased knowledge and understanding</p> <p>External funding support, where available, e.g. from the World Bank in some countries</p> <p>Having a clear national NCD plan or strategy that is time bound and has clear indicators – it is particularly helpful if this is in line with the national health strategy, the national economic vision and SDGs. It is helpful to have NCD objectives in the overall health policy and strategic plan</p> <p>Having clear quantified objectives with precise indicators and targets</p> <p>Enthusiastic and educated workforce(s) (in clinical, health promotion, information technology and surveillance)</p> <p>Countries having a strong and functioning health system or being able to develop this – including a focus on primary care and family medicine that includes NCDs</p> <p>Availability of relevant information and data, e.g. through risk factor and other surveys. Having comparable monitoring instruments at the regional level has been useful particularly for advocacy. Periodic monitoring of the progress of NCD control at the level of each Member State by WHO through the publication of global reports that allows the country to better visualize its situation vis-à-vis similar countries is also helpful. This also encourages the adoption of the best national policies regarding NCDs.</p> <p>Having appropriate and supportive legislation in place, e.g. on alcohol, mental health</p>	<p>A gap between policy declarations and the provision of sustainable resources and support. One respondent noted that many programmes lack a budget line. Even in high-income countries, there may not be coordinated provision of resource for NCDs. One respondent commented that <i>“funding mechanisms must be sourced before plans are launched”</i>. In some countries, their national NCD plans do include a <i>“financial framework”</i>. Another commented – <i>“It is not enough for presidents and ministers of health to sign international agreements on NCDs, they need to raise awareness and support them in practice”</i></p> <p>Positioning NCDs among other health and non-health priorities – particularly vis a vis communicable diseases and epidemics which are seen as more urgent. In most countries, national public health authorities must position NCDs in relation to other government policy priorities.</p> <p>Difficulties in promoting intersectoral cooperation and weak engagement from non-health sectors. There is also a lack of a way for monitoring this. One respondent commented that although an inter-sectoral committee had been established in 2015 under the control of the Prime Minister, it had not functioned.</p> <p>There may be a lack of specific technical knowledge and skills e.g. on taxation of sugar-sweetened beverages.</p> <p>In some countries, failure to mobilize decisionmakers has been a key challenge – while in others high turnover of decisionmakers has been a problem</p> <p>There may be a lack of supportive laws and legal frameworks – and insufficient implementation of laws that exist</p> <p>Some countries have failed to integrate NCDs into national health and development plans and programmes</p> <p>Industry interference including particularly through marketing and advertising. In some cases, conflicts of interest have delayed decisions in public policy. The influence of vested commercial interests in implementing and enforcing laws is considered problematic. One country commented - Implementing of health-based alcohol policies has been somewhat complicated by increased visibility and involvement of alcohol industry in policy making. Another commented - there is opposition from very powerful sectors, from the private sector, which have blocked efforts to have an effective regulatory legal framework on tobacco, alcohol and healthy eating issues.</p> <p>There is limited availability of partners to work on and support NCD responses – and a lack of focus on partner development by some governments. In some countries, poor organization of civil society has been a factor.</p> <p>In some countries, there is low public awareness of NCDs.</p> <p>It has been hard to establish local structures for NCD control – including at sub-national level</p> <p>Some of the targets are not considered practical and mechanisms to measure them are weak</p> <p>Some countries have weak health systems, particularly at PHC level and there are difficulties in integrating NCDs into them. Some countries lack experience and any tradition of implementing a public health system.</p> <p>A lack of monitoring and evaluation of the implementation of the plan. Some countries commented that there was a lack of a practical framework for monitoring of progress and that NCD surveillance remains inadequate and fragmented</p> <p>There have been specific issues associated with the delay in getting basic documents available in languages other than English, e.g. Spanish</p> <p>There have been some difficulties in applying a single, coordinated approach in a federal country. Where health is decentralized, sub-national entities may have different priorities – and different levels of funding</p> <p>Smaller countries may have experienced difficulties in accessing equipment and medicines, e.g. HPV vaccines and HPV testing kits</p> <p>Emergencies and epidemics, e.g. COVID 19 – and unstable security situation in some contexts</p>

There is some evidence of the value of civil society in supporting national NCD responses

49. One specific suggestion made was that the presence of strong civil society on NCD might facilitate NCD-GAP implementation in a country. In the absence of a recognized metric of civil society strength, the evaluation identified countries that did or did not have an NCD Alliance member organization in their country.⁴⁴ There was a statistically significant association between this measure and NCD implementation score in 2019 ($p=.01$). There was no association between having an NCD Alliance member in a country and country income group ($p=.90$). Mean implementation scores were higher in countries with NCD Alliance members than in countries without them and this pattern was seen across all income groups (see Figure 11).

50. This does not establish a causal link. It is possible that NCD Alliance members are being established in countries because they are making good progress on NCDs but this seems implausible, not least because many NCD Alliance members have been around for decades. More plausible is perhaps the possibility that a common factor is contributing to NCD Alliance members being established and progress on NCDs. It does not seem that this is country income level as the presence of an NCD Alliance member is not associated with country income level. However, it is possible that strong governance mechanisms and conducive civic space for civil society to develop could potentially explain both growth of NCD civil society and higher rates of NCD implementation in a particular country.

Figure 11: Mean implementation score for 2019 by country income group for countries with and without NCD Alliance members



51. However, there could be a causal link and perhaps this could be operating through a similar model as the one for political commitment, i.e. having an active civil society (as measured through having an NCD Alliance member in-country) means a country is more likely to have an NCD policy, strategy or action plan and that in turn leads to appropriate actions on NCDs. However, there is no association between having an NCD Alliance member in-country and having an NCD policy, strategy or action plan ($p=.90$). There are, however, statistically significant associations with certain actions including tobacco packaging ($p=.046$), salt reduction ($p=.02$), availability of NCD management guidelines ($p=.04$) and, in particular, actions on breastfeeding substitutes ($p=.002$). These findings support the hypothesis that while having a policy, strategy or plan is associated with action on NCDs, some actions can take place without being mediated through having such a policy, strategy or plan. There are also some countries, including some high-income countries, that might not have a national NCD policy, strategy or action plan but are implementing many key actions so have high implementation scores.

52. These findings also resonate with civil society actions on tobacco and healthy diet and with civil society's long history of struggling against inappropriate promotion of breast-milk substitutes. It is perhaps unsurprising that the association of civil society with action on breastfeeding substitutes is particularly strong in LMIC ($p<.001$) and in AFR ($p=.05$) and in SEAR ($p=.001$). What is perhaps more surprising is that the association between presence of NCD Alliance members and overall implementation score was only of statistical significant in one region, AMR, where it was highly significant ($p<.001$). In addition to the association with overall implementation

⁴⁴ It is recognized that this is not a perfect indicator and there are many other civil society organizations at the country level that are not reflected in the NCD Alliance's membership

score, there was an association between having an NCD Alliance member in countries in AMR and a number of individual actions related to tobacco – smoke-free environments ($p=.003$) and tobacco packaging ($p=.01$) – and healthy diet – salt reduction ($p=.009$), marketing to children ($p=.003$) and especially fat reduction ($p<.001$). There was also an association with having risk surveys ($p=.03$). While these findings do not establish causality, they do resonate with a qualitative assessment of civil society actions in AMR (see Box 8).

Box 8: Civil society and NCDs in AMR: Qualitative assessment

There have been advances on tobacco control and nutrition in the region with support from civil society in collaboration with supportive individual decision makers and legislators. These actions have been supported by strong global and regional plans on specific topics, e.g. FCTC globally and PAHO’s Action Plan on Childhood Obesity⁴⁵ and PAHO’s Rio de Janeiro declaration on the elimination of trans fats.⁴⁶ These plans have provided important guidance to country and a firm basis for civil society advocacy.

National NCD responses are hindered by lack of resources

53. One of the recurring themes of the evaluation, particularly at the country level, was the lack of financial and human resources to implement something as ambitious as the NCD-GAP even when distilled down to a smaller number of best buys. One challenge was a lack of readily available information as to what the costs of responding effectively to NCDs would be. The NCD-GAP itself did have some estimates of costs. It estimated that the overall costs of the NCD-GAP would be US\$ 940.26 million and that at the country level the costs would be between 1-4% of current health spending. One of the strands of work of the WHO Global Ambassador for NCDs and Injuries (see Box 3, p7) was to develop an investment case for NCDs. This used a method that had been used to cost the SDGs⁴⁷ and was applied in 78 low- and lower-middle-income countries. They concluded that to implement a package of 16 best buys in those countries would cost an additional US\$ 1.27 per person per year and would yield a financial return of US\$ 7 for every US\$ 1 invested. As this is the additional amount required, it is not possible use this to assess or benchmark countries’ current spending on NCDs.
54. It is also not possible to assess funding needed in terms of budgets attached to NCD policies, strategies or action plans. It is unclear how many of these are costed or what those costings mean. Often such budgets are aspirational and may be compiled on the basis that it is necessary to ask for more than needed as requests will always be reduced in the finalisation process. For this reason, such budgets, even if they were available would not provide a reliable basis for estimating financial resources needed as a basis of comparing this with funds available.
55. Data on NCD spending, broken down by domestic and external sources, are available for 2015 to 2017 for 44 countries in the Global Health Expenditure Database.⁴⁸ Of these, more than two thirds (68%) were in AFR. More than three quarters (80%) were from low- (34%) or lower-middle-income countries (46%). One sixth (16%) were from upper-middle-income countries with only two high-income countries included. Overall, spending on NCDs across these countries accounted for a total of US\$ 12.2 billion over three years, that is approximately US\$ 4 billion per year. Of this, almost all (95%) came from domestic sources.⁴⁹ In comparison, spending on infectious diseases in the same countries over the same period was US\$ 35.9 billion,⁵⁰ of which less than half (49%) was

⁴⁵ PAHO (2014) *Plan of Action for the Prevention of Obesity in Children and Adolescents* available from https://iris.paho.org/bitstream/handle/10665.2/49138/obesity-plan-of-action-child_eng_2015.pdf?sequence=1&isAllowed=y (accessed 17 September 2020)

⁴⁶ PAHO (2008) *Trans Fat Free Americas: Declaration of Rio de Janeiro* available from <https://www.paho.org/en/documents/trans-fat-free-americas-declaration-rio-janeiro-2008> (accessed 17 September 2020)

⁴⁷ Stenberg, K., Hanssen, O., Tan-Torres Edejer, T., Bertram, M., Brindley, C., Meshreky, A., Rosen, J.E., Stover, J., Verboom, P., Sanders, R. and Soucat, A. (2017) Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries. *Lancet Global Health* 2017; published online July 17 ([http://dx.doi.org/10.1016/S2214-109X\(17\)30263-2](http://dx.doi.org/10.1016/S2214-109X(17)30263-2))

⁴⁸ WHO (2020) *Global Health Expenditure Database*

⁴⁹ This varied from 81% in low-income countries to 97% in lower-middle-income countries to 99% in both upper-middle-income countries and high-income countries

⁵⁰ This means that, overall, spending on NCDs was 34% of spending on infectious diseases. This figure was 16% for low-income countries, 28% for lower-middle income countries, 168% for upper-middle-income countries and 488% for high-income countries.

from domestic sources.⁵¹ Overall, domestic spending on NCDs accounted for an average of US\$ 23 per person per year in low-income countries, US\$ 214 in lower-middle-income countries and US\$ 527 in upper-middle-income countries.⁵²

WHO support to national NCD responses

56. WHO has contributed to this objective by providing policy guidance and dialogue through providing the NCD-GAP overall and, in particular, by providing a set of best buys as a revised Appendix 3 to the NCD-GAP (see Box 9). In terms of the NCD-GAP as a whole, respondents considered that this had provided a policy framework that was flexible enough to guide policy development at the country level. One respondent noted, *“a good success for WHO was to create an action plan that is globally relevant, it was a very good template that was largely translated at the country level”*.

Box 9: What are the NCD best buys?

The NCD-GAP contained five appendices. Appendix 1 explained synergies between major NCDs and other conditions, Appendix 2 presented the global monitoring framework, Appendix 4 gave examples of a division of labour within the UN and Appendix 5 gave examples of cross-sectoral government engagement to reduce risk factors. Appendix 3 presented a menu of policy options across all objectives of the NCD-GAP. The NCD-GAP recognized that the appendix would need to be updated as new evidence became available and the WHO Director-General was asked to propose this as appropriate.

Appendix 3 was updated in 2017 and forms a stand-alone document known as best buys.⁵³ This document covers 88 interventions within which 16 are considered best buys as the most cost-effective and feasible for implementation. The document reflects emergence of new evidence of cost-effectiveness, new WHO recommendations and lessons learnt from the use of the first version of Appendix 3. Interventions were assessed for cost-effectiveness using the WHO CHOICE model.⁵⁴ Non-financial considerations were also included. Those with an average cost-effectiveness ratio of \leq I\$100/DALY averted, in low- and lower-middle-income countries, were considered the most cost-effective and feasible for implementation.

Best buys were considered particularly useful as an exercise in prioritization, guiding countries to the most cost-effective interventions out of the comprehensive list of actions in the NCD-GAP. Respondents considered that the best buys helped progress NCD-GAP objectives. Several respondents identified them as the shining achievement of the NCD-GAP. A typical comment was, *“we find the best buys to be the most important technical and supportive document in the NCD work.”*

While the value of the best buys is recognized, concerns have been raised that the evidence is now somewhat dated and in large part was not derived from low-income settings. The importance of local context in making decisions about implementing interventions for preventing NCDs has been highlighted by some authors.⁵⁵ Some evaluation respondents considered that the best buys remained too broad and needed to be made more specific, particularly for different country contexts. The best buys may lack sufficient detail to be useful for some high-income countries. For example, one respondent highlighted that there was need not just to look at whether there was food labelling or not but which type of labelling was most effective. There were also concerns that the best buys document could be used in way that was too prescriptive and did not always recognize the need for countries to adapt such guidance to their own specific context. While progress in the implementation of many of the best buys can be tracked through the COM indicators, there is no explicit monitoring framework for them. One respondent commented that they would have liked the best buys available in their own language.

⁵¹ This varied from 29% in low-income countries to 55% in lower-middle-income countries to 79% in upper-middle-income countries and to 93% in high-income countries

⁵² The figure for the two high-income countries was US\$ 298 per person per year.

⁵³ WHO (2017) *‘Best Buys’ and other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases: Updated (2017) Appendix 3 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases* available from https://www.who.int/ncds/management/WHO_Appendix_BestBuys.pdf (accessed 17 September 2020)

⁵⁴ WHO (undated) *WHO-CHOICE* available on <https://www.who.int/news-room/questions-and-answers/item/who-choice-frequently-asked-questions> (accessed 18 September 2020)

⁵⁵ Isaranuwatthai, W., Teerawattananon, Y., Archer, R.A., Luz, A., Sharma, M., Rattanavipapong, W., Anothaisintawee, T., Bacon, R.L., Bhatia, T., Bump, J., Chalkidou, K., Elshaug, A.G., Kim, D.D., Reddiar, S.K., Nakamura, R., Neumann, P.J., Shichijo, A., Smith, P.C. and Culyer, A.J. (2020) *Prevention of Non-communicable Disease: Best Buys, Wasted Buys and Contestable Buys* BMJ 2020;368:m141 <http://dx.doi.org/10.1136/bmj.m141>

57. WHO has also provided capacity-building support to Member States through a range of activities at the global, regional and national levels. This has included involving country representatives in global meetings (see Figure 1, p5). Respondents highlighted that WHO capacity to provide tailored support to countries either through regional or country offices has been uneven. Respondents from WHO at different levels explained that increasing demands on country offices had not been reflected in increased human resources and capacity in-country offices. Consequently, while WHO country offices are providing capacity-building support to countries, more could be done with more resources. One respondent commented, “*WHO support has been quite fragmented and patchy. NCDs are unfunded. The biggest disease burden is the least funded. We keep saying the right things in Assemblies, but the resources haven’t come, even within WHO architecture. Internally, we need to walk the talk in terms of the WHO budget*”.

58. Member States identified a number of specific ways in which WHO has provided technical assistance to their national NCD responses (see Box 10). In many cases, countries provided long lists of areas where they had been supported by WHO. Areas included:

Box 10: WHO support is valued highly by Member States

One respondent commented, “*WHO plays an important role in building capacity at the regional and country level by mobilizing partnerships, providing technical expertise, and maximizing its geographic reach, particularly into vulnerable places in order to implement the NCD-GAP... One of WHO’s strengths as the leading global public health agency is its role as a convener, bringing together arrays of multi-sectoral partners to address complex problems... WHO also plays a critical role in the development of normative work to guide country-level responses to NCDs and their risk factors in a range of domains*”.

- Assistance in developing and renewing national plans for the prevention and control of NCDs. The NCD-GAP was considered to have provided useful ideas and scientific rationale. Respondents commented that their national plans often mirrored the NCD-GAP.
- Technical cooperation, advice and the generation of knowledge through documents, research, studies, (regional and national) workshops, webinars and regional meetings.
- Access to specific knowledge on laws in different areas affecting NCDs enabling development of better laws and policies addressing NCDs.
- Limited financial support for consultations and technical assistance in drafting laws and policies.
- In-country advocacy and influence with Ministry of Health.

59. However, Member States identified a number of areas in which WHO support could be strengthened. These included:

- Some countries commenting that in-country capacity-building activities have been limited. One respondent noted that while good support was received from 2013 to 2015, this dramatically reduced after 2015.
- One respondent commented that they did not always get documents and tools directly from WHO but sometimes heard about them from other countries.
- Observing that the human resources available to WHO on NCDs at the country level were inadequate.
- On occasions, there has been a disconnect between technical support provided by WHO, e.g. at provincial level, and governmental national initiatives. Also, sometimes some decisions were considered to have been made by WHO without consulting the Member State.
- While WHO has a long-standing record of accomplishment in coordinating technical expertise that could be deployed to Member States experiencing an infectious disease outbreak, e.g. Ebola, this type of mobilization has not been replicated for NCDs. It was suggested that WHO could consider establishing a programme that matches national governments needing specific technical expertise with Member States or civil society organizations who could provide such expertise.
- Providing more guidance at the country level on how to coordinate partners or convene multisectoral actors and forums.
- More guidance would be welcomed in relation to delivering NCD programmes during emergencies
- Insufficient support to allow follow-up surveys.

60. Support from international partners and non-State actors is crucial to national NCD responses and this is recognized in the basic principles of the NCD-GAP. Various global meetings have considered how best this support can be harnessed. The WHO GCM/NCD dialogue meeting in 2016 focused on how different types of non-State actors could best engage with government.⁵⁶ The most recent WHO Global Meeting in Muscat included a Global Multistakeholder Partners' Forum focused on engagement with non-State actors.⁵⁷ However, respondents identified this as an area where more support from WHO would be welcomed including on how to manage relationships with the private sector, such as engaging the private sector in policy implementation through relevant partnerships, and managing conflict of interest with industries that potentially affect the prevention of risk factors (tobacco, alcohol and food and beverages companies) or that are engaged in the provision of medicines and commodities needed for the health response to NCDs (pharmaceutical and medical technology companies). Civil society organizations play a variety of roles in supporting multisectoral responses to NCDs (see Box 11).

Box 11: Civil Society Organizations (CSOs) and their role in supporting national NCD responses

CSOs play different roles in supporting national responses to NCDs. As noted in the Balaclava meeting⁵⁶, *“NGOs are not only important advocates and watchdogs that help hold governments and other stakeholders accountable to their commitments, they are also increasingly supporting governments as service providers in NCD prevention and control.”* In 2015, civil society committed itself to be at the centre of the response to NCDs playing important roles in advocacy, accountability, knowledge exchange and service delivery.⁵⁸ The NCD Alliance summarises the role of CSOs in the national NCD response as *“the Four As”* - advocacy, awareness, access, and accountability.

To some extent, civil society has been engaged in holding governments to account and monitoring the implementation of commitments and policies at the national level through shadow reporting, benchmarking and producing NCD scorecards. Four Civil Society Status Reports have so far been published on the website of the NCD Alliance.⁵⁹ An example of civil society accountability initiative is the framework developed by the Healthy Caribbean Coalition to track and promote progress on governments' commitments in tackling the region's childhood obesity. The initiative includes an online policy-tracking platform and scorecard, CSO training, public involvement in accountability initiatives and technical support for managing conflicts of interest.⁶⁰

However, involvement of CSOs is hampered by the absence of mechanisms to involve them in many countries. As of 2019, less than half of countries had a national NCD coordination mechanism (see paragraph 32, p16) and it is reported that in countries that did, almost one third (30%) of these did not involve civil society.⁶⁰ As one respondent commented, *“At the country level, countries may have multisectoral coordination mechanisms but they are dominated by the government sector. Some academic experts may be included but not on an equal footing and there is little if any role for civil society”*.

CSOs that are formed by peer-support networks provide a unique insight to policymakers of the lived experiences of those affected by NCDs, and are an important channel to promote their participation in national NCD responses. The 2018 UN political declaration on NCDs specifically includes a commitment to *“promote meaningful civil society engagement and amplify the voices of and raise awareness about people living with and affected by NCDs”*. Although some progress has been made, there are concerns that the involvement of people with lived experiences of NCDs is still often tokenistic. One respondent commented, *“We are still at the beginning of making governments and WHO understand how to meaningfully engage with people living with NCDs”*. The need to address this has been recognised, for example, *“People living with NCDs are there to support Governments in making these difficult choices. We need to act now to provide people living with NCDs with a seat at the decision-making table in the Ministries of Health when decisions need to be made about on how to balance the demands on the health system during the [COVID-19] pandemic”*.⁶¹

⁵⁶ WHO (2016) *Working Together to Tackle Noncommunicable Diseases GCM/NCD Global Dialogue Meeting on the Role of Non-State Actors in Supporting Member States in their National Efforts to Tackle Noncommunicable Diseases (NCDs) as Part of the 2030 Agenda for Sustainable Development Balaclava, Mauritius, 19-21 October 2016: Final Report* available on <https://www.who.int/global-coordination-mechanism/dialogues/global-dialogue-meeting-report-oct2016.pdf?ua=1> (accessed 17 September 2020)

⁵⁷ WHO (2019) *WHO Global Meeting to Accelerate Progress on SDG Target 3.4 on Non communicable Diseases and Mental Health, 9-12 December 2019, Muscat, Oman* available on https://www.who.int/docs/default-source/ncds/2556-ncd-global-meeting-booklet-14-11-19.pdf?sfvrsn=1e819c3f_3 (accessed 16 September 2020)

Conclusions and recommendations for objective 2

The identification by WHO of what it terms NCD best buys has provided Member States with a menu of policy options they can consider when looking for cost-effective mechanisms based on current best evidence. Overall, progress in implementing the NCD-GAP has been slow and incremental rather than the kind of rapid acceleration to which the high-level processes associated with the NCD-GAP aspired.

WHO Secretariat and Member States to consider how best to use limited financial resources available for NCDs by focusing on the most cost-effective options based on available evidence. Specifically:

- Member States to identify ways in which they can provide, identify and leverage the domestic financial resources needed to respond effectively to NCDs including, as appropriate, as part of national COVID-19 responses and recovery action plans.
- Member States to focus their financial resources on those actions which will be most cost-effective based on best available evidence.
- WHO Secretariat to update the best buys based on latest evidence, particularly from a diverse range of regional and national settings.
- Member States to adapt the best buys to their context with WHO Secretariat technical support if necessary.
- WHO Secretariat to consider if further guidance can be given on total funding needed to implement the most cost-effective NCD interventions.
- WHO Secretariat and Member States to seek ways to collect and report more data on levels of in-country expenditure on NCDs.

⁵⁸ NCD Alliance (2015) *Sharjah Declaration on NCDs: Civil Society United Towards 2030* available on https://ncdalliance.org/sites/default/files/rfiles/Sharjah%20Declaration_FV_eng.pdf (accessed 18 September 2020)

⁵⁹ These are : Healthy Caribbean Coalition Civil Society Regional Status Report - Responses to NCDs in the Caribbean Community, South African Civil Society Status Report 2010- 2015, Civil Society Report on the Situation of Chronic Non-Communicable Diseases in Brazil, and a civil society benchmark report - Responses to NCDs in East Africa

⁶⁰ NCD Alliance (2020) *NCD Atlas Bridging the Gap on NCDs through Civil Society Action: Initiatives of National and Regional NCD Alliances* see <https://ncdalliance.org/resources/ncd-atlas-bridging-the-gap-on-ncds-through-civil-society-action#:~:text=To%20showcase%20NCD%20civil%20society,of%20National%20and%20Regional%20NCD> (accessed 10 September 2020)

⁶¹ Mikkelsen, B. (2020) *Now is the Time for a 'Great Reset' of the NCD Agenda* Personal Blog by @MikkelsenBente_ available on <https://www.ncd.one/blog> (accessed 18 September 2020)

3.3 Objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments

Overall progress

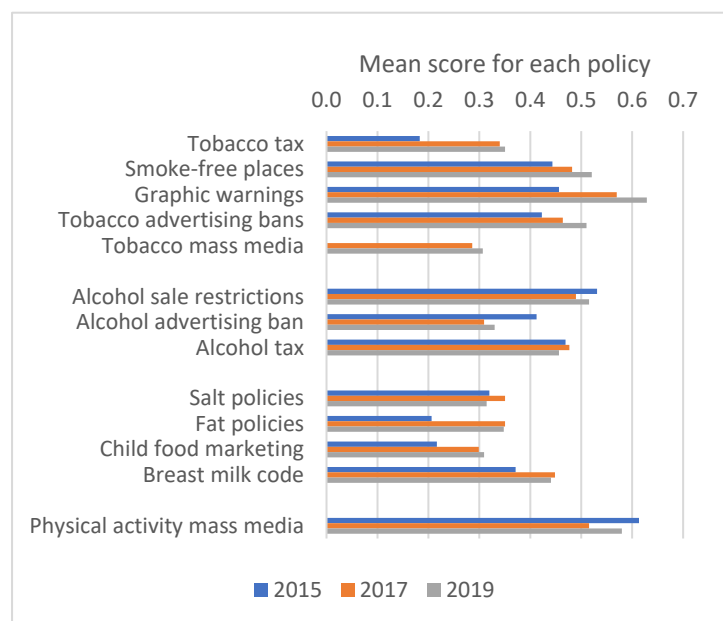
61. Countries have made good progress in introducing national policies on the four main NCD risk factors. In the case of tobacco use, healthy diet and physical activity, introduction of these policies has been associated with progress in key action areas. However, this is not the case with respect to the harmful use of alcohol. Overall, steady progress has been seen in relation to tobacco use with more mixed results in relation to other areas. Countries have yet to see the kind of dramatic acceleration of progress envisaged in the NCD-GAP

Progress indicators

62. Overall, countries have made good progress in introducing national policies on the four main risk factors (see Table 1, p17). For example, the percentage of countries with a policy on harmful use of alcohol rose from 48% in 2013 to 74% in 2019, for physical activity from 52% to 79%, for tobacco use from 63% to 79% and for healthy diet from 55% to 80%. There was a statistically significant association between having each of these policies and country income level (see Table 1).

63. Progress on risk factor actions is more mixed (see Table 2, p18) depending on whether indicators are fully achieved or at least partially achieved. Combining these into an implementation score for each indicator (see Figure 12) shows that there has been some year-on-year progress for actions on tobacco but little progress in relation to harmful use of alcohol or physical activity. There is a mixed picture on actions relating to healthy diet with, for example, steady progress in relation to food marketing aimed at children but little if any progress on policies to reduce salt content.

Figure 12: Mean implementation score for key actions on risk factors: 2015, 2017 and 2019



Does having a policy on a risk factor lead to actions on that risk factor?

64. The same criticism that has been levelled at the NCD-GAP, in general, (see paragraph 26, p12), namely that developing policies, strategies and action plans does not necessarily lead to implementation of the needed actions, can also be levelled at the NCD-GAP in terms of policies relating to risk factors. Does having a policy on a specific risk factor mean that a country then implements the actions needed to address that risk factor? The evaluation sought to address this by exploring the extent to which adopting a policy on a particular risk factor is associated with countries implementing actions in relation to those risk factors (see Table 4). In most cases, there is a statistically significant association (green shading in Table 4). However, this is not the case for the harmful use of alcohol. In this case, there is a negative association between having a policy and implementing key actions although these associations are not statistically significant. For example, less than one quarter of countries (23%) with a policy on harmful use of alcohol fully achieved the action on alcohol taxation whereas one third of countries (33%) without a policy fully achieved this. There is an association between having a policy on tobacco use and some actions, particularly on packaging, but not on others, such as pricing and smoke-free

environments. In relation to healthy diets, there is a statistical association between the policies and the actions and to each of the actions individually. These associations are very strong with the possible exception of the action on the breast milk code.

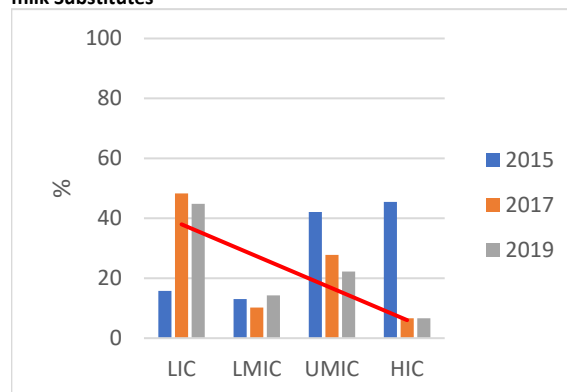
Table 4: Is having policies associated with implementation of key NCD actions?

Policy	Action	Significant association?	p-value	Percentage (%) of countries fully achieving action		Percentage (%) of countries partially achieving action	
				with policy	without policy	with policy	without policy
Harmful use of alcohol (AP3a)	Availability (COM6a)	No	.35	15%	20%	93%	95%
	Advertising (COM6b)	No	.70	31%	33%	46%	38%
	Taxes (COM6c)	No	.72	23%	33%	77%	71%
Tobacco use (AP3c)	Pricing (COM5a)	No	.06	21%	18%	59%	33%
	Smoke-free (COM5b)	No	.40	32%	31%	74%	64%
	Packaging (COM5c)	Yes	<.001	54%	26%	86%	51%
	Advertising (COM5d)	Yes	.03	24%	28%	84%	54%
	Campaigns (COM5e)	Yes	.04	27%	6%	53%	27%
Healthy diet (AP3d)	Salt (COM7a)	Yes	<.001	25%	0%	52%	11%
	Fats (COM7b)	Yes	<.001	37%	9%	48%	11%
	Marketing to children (COM7c)	Yes	<.001	38%	6%	n/a	n/a
	Breast-milk code (COM7d)	Yes	.04	18%	14%	74%	54%
Physical activity (AP3b)	Mass media (COM8)	Yes	<.001	60%	23%	75%	31%

In general, actions on risk factors are associated with country income level but there are exceptions

65. In general, there was a positive association between country income group and performance on the COM indicators related to risk factors, i.e. high-income countries tend to have higher scores than low-income countries. However, there are a few exceptions. These include indicators related to tobacco and alcohol advertising, smoke-free environment, indicators related to alcohol availability and taxation and the indicator related to the breast-milk code. Indeed, in some of these cases, there are negative trends in which low-income countries have higher scores than high-income countries (see for example Figure 13). While these trends are not statistically significant (see Table 4), they are in marked contrast to the overall performance trend (see Figure 7, p18). These indicators are all in areas where there are significant economic and/or commercial interests that might be affected by introduction of these policies.

Figure 13: Percentage of Member States by country income group that have fully achieved legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes



WHO support to countries to address risk factors

66. WHO has conducted extensive policy advice and dialogue on tobacco control, reflecting both that tobacco is the largest preventable cause of death and disease globally and the extensive body of evidence on effective interventions to curb tobacco demand. The WHO Framework Convention on Tobacco Control (WHO FCTC)⁶² adopted by the World Health Assembly in 2003, and coming into force in 2005, was a major achievement. The FCTC is widely ratified, including 180 signatory countries, and provides a legally-binding framework that commits governments to implementing a comprehensive, evidence-based approach to tobacco control. WHO

⁶² WHO (2003) WHO Framework Convention on Tobacco Control available on <https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf?sequence=1> (accessed 18 September 2020)

and the FCTC Secretariat have contributed very substantially to the prominence given to tobacco control in the global development agenda, as reflected in the SDG target 3.A, *Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate*. The NCD-GAP fully supports FCTC implementation. The nine interventions included in the best buys and other recommended interventions on tobacco control align to the measures contemplated in the Convention. The FCTC has an established monitoring framework and the WHO report on the global tobacco epidemic published every two years provides data towards indicators COM5a-e. Other key actions by WHO in support of FCTC implementation include the development of the Protocol to Eliminate Illicit Trade in Tobacco Products⁶³ and the Global Strategy to Accelerate Tobacco Control.⁶⁴ WHO has also provided on-going technical cooperation on tobacco control, with the MPOWER.⁶⁵ The 2019 report on the global tobacco epidemic highlights that “*the number of people protected by at least one MPOWER measure has more than quadrupled since 2007, representing 136 countries covering 5 billion people*”.⁶⁶ WHO has engaged with finance ministries in different Member States to provide technical assistance on tobacco taxation and on elimination of illicit trade in tobacco products. WHO has also supported Member States in developing policies related to the supply of tobacco, such as alternative livelihoods to tobacco growing. Progress on tobacco control has been possible, despite documented evidence of tobacco industry interference,⁶⁷ ⁶⁸ because of efforts by WHO and the FCTC Secretariat based on robust provisions in the FCTC.

67. Prior to the development of the NCD-GAP, WHO developed the Global Strategy to Reduce the Harmful Use of Alcohol⁶⁹ and there are plans to update this in 2022. WHO monitors effects of alcohol on health globally and has published six editions of a Global Status Report on Alcohol and Health.⁷⁰ Actions on the harmful use of alcohol included in the best buys relate to the availability, advertising and taxation of alcohol products. WHO has also promoted reducing the harmful use of alcohol as a global development agenda and tracks the contribution of this alcohol control to the SDGs through WHO’s Global Information System on Alcohol and Health (GISAH).⁷¹ ⁷² WHO produced the SAFER initiative,⁷³ a technical package based on five high-impact strategies to help governments reduce the harmful use of alcohol and related health, social and economic consequences. According to respondents, alcohol industry lobbying and interference have hampered progress on reducing the harmful use of alcohol. The harmful use of alcohol is not controlled at the international level by a legally-binding regulatory framework, e.g. as with tobacco, and the alcohol industry has been actively involved in the initiatives addressing the harmful use of alcohol, for example through awareness-raising activities, despite substantial evidence that industry-funded initiatives are unlikely to be effective, influencing

⁶³ WHO FCTC (2013) *Protocol to Eliminate Illicit Trade in Tobacco Products* available on https://www.who.int/fctc/protocol/illicit_trade/protocol-publication/en/ (accessed 18 September 2020). Although this protocol was adopted in November 2012, it entered into force in September 2018 following a lengthy period of negotiation

⁶⁴ WHO FCTC (2019) *Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019-2025* available from <https://apps.who.int/iris/bitstream/handle/10665/325887/WHO-CSF-2019.1-eng.pdf?ua=1> (accessed 18 September 2020)

⁶⁵ MPOWER is based on monitoring tobacco use and prevention policies, protecting people from tobacco smoke, offering help to quit tobacco use, warning about the dangers of tobacco, enforcing bans on tobacco advertising, promotion and sponsorship, and raising taxes on tobacco - see <https://www.who.int/tobacco/mpower/publications/en/> (accessed 18 September 2020)

⁶⁶ WHO (2019) *WHO Report on the Global Tobacco Epidemic, 2019: Offer Help to Quit Tobacco Use* available on <https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf?ua=1>

⁶⁷ Committee of Experts on Tobacco Company Documents (2000) *Tobacco Company Strategies to Undermine Tobacco Control activities at the World Health Organization* available on https://www.who.int/tobacco/en/who_inquiry.pdf?ua=1 (accessed 18 September 2020)

⁶⁸ WHO (2008) *Tobacco Industry Interference with Tobacco Control* available on https://apps.who.int/iris/bitstream/handle/10665/83128/9789241597340_eng.pdf?sequence=1 (accessed 18 September 2020)

⁶⁹ WHO (2010) *Global Strategy to Reduce the Harmful Use of Alcohol* available on <https://www.who.int/publications/i/item/9789241599931> (accessed 18 September 2020)

⁷⁰ In 1999, 2001 (on young people), 2004 (including on alcohol policy), 2011, 2014 and 2018 – see https://www.who.int/substance_abuse/activities/gsr/en/ (accessed 18 September 2020)

⁷¹ WHO (2020) Global Information System on Alcohol and Health (GISAH) – see <https://www.who.int/gho/alcohol/en/> (accessed 18 September 2020)

⁷² Data for COM indicators on the harmful use of alcohol are collected through this tracking process

⁷³ WHO (2018) *SAFER : Preventing and Reducing Alcohol-Related Harms: Harmful Use of Alcohol: A Health and Development Priority* available on https://www.who.int/docs/default-source/alcohol/safer-framework.pdf?sfvrsn=3d085e49_4 (accessed 18 September 2020). SAFER is based on strengthening restrictions on alcohol availability, advancing and enforcing drink-driving measures, facilitating access to screening, brief interventions and treatment, enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion, and raising prices on alcohol through excise duties and pricing policies.

research and alcohol industry interference with policymaking. Documented types of interference with policy-making include industry presence during legislative meetings and legal challenges to alcohol policies.⁷⁴

68. WHO's work on healthy diet is guided by the Global Strategy on Diet, Physical Activity and Health⁷⁵ and the joint WHO and UNICEF Global Strategy for Infant and Young Child Feeding.⁷⁶ Work on nutrition has been closely coordinated with other UN agencies, and with the FAO in particular, with the Rome Declaration on Nutrition of 2014⁷⁷ and the development of SMART commitments within the UN Decade of Action on Nutrition.⁷⁸ WHO policy advice and dialogue on the promotion of a healthy diet has included the production of technical guidelines for regulation, reformulation and labelling such as:

- The REPLACE framework on the elimination of trans fats globally by 2023⁷⁹
- The salt reduction package SHAKE⁸⁰
- The Ending Inappropriate Promotion of Foods for Infants and Young Children Guidelines⁸¹
- Regional nutrient profile models to protect children from food marketing^{82 83 84 85 86 87}
- Guidelines on sugar intake for adults and children⁸⁸

69. WHO reports on healthy diet as an NCD risk factor through the Global Nutrition Policy Review produced every five years.⁸⁹ Respondents' views relating to industry involvement in relation to healthy diet were more mixed than in relation to tobacco and harmful use of alcohol. They recognized the key role played by the private sector

⁷⁴ WHO (2018) *Global Status Report on Alcohol and Health* available on <https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1> (accessed 18 September 2020)

⁷⁵ WHO (2004) *Global Strategy on Diet, Physical Activity and Health* available on https://apps.who.int/iris/bitstream/handle/10665/43035/9241592222_eng.pdf?ua=1 (accessed 18 September 2020)

⁷⁶ WHO and UNICEF (2003) *Global Strategy for Infant and Young Child Feeding* available on <https://apps.who.int/iris/bitstream/handle/10665/42590/9241562218.pdf?sequence=1> (accessed 18 September 2020)

⁷⁷ FAO and WHO (2014) *Second International Conference on Nutrition: Rome, 19-21 November 2014, Conference Outcome Document: Rome Declaration on Nutrition* available on <http://www.fao.org/3/a-ml542e.pdf> (accessed 18 September 2020)

⁷⁸ FAO and WHO (undated) *UN Decade of Action on Nutrition 2016-2025* available on https://www.un.org/nutrition/sites/www.un.org.nutrition/files/general/pdf/1-nutrition_decade_flyer_intro_for_web.pdf (accessed 18 September 2020)

⁷⁹ WHO (2019) *REPLACE Trans Fat: An Action Package to Eliminate Industrially Produced Trans-Fatty Acids* available on <https://www.who.int/docs/default-source/replace-transfat/1-replace-framework-updated-june-2019-ke.pdf> (accessed 18 September 2020). REPLACE is based on reviewing dietary sources of industrially produced TFA and the landscape for required policy change, promoting the replacement of industrially produced TFA with healthier oils and fats, legislating or enacting regulatory actions to eliminate industrially produced TFA, assessing and monitoring TFA content in the food supply and changes in TFA consumption in the population, creating awareness of the negative health impact of TFA among policy-makers, producers, suppliers and the public, and enforcing compliance with policies and regulations.

⁸⁰ WHO (2016) *Shake the Salt Habit: The SHAKE Technical Package for Salt Reduction* available on <https://apps.who.int/iris/bitstream/handle/10665/250135/9789241511346-eng.pdf?sequence=1> (accessed 18 September 2020). SHAKE is based on surveillance to measure and monitor salt use, harnessing industry to promote the reformulation of food and meals to contain less salt, adopting and implementing standards for labelling and marketing, Knowledge by educating and communicating to empower individuals to eat less salt, and environment – supporting settings to promote healthy eating.

⁸¹ WHA (2016) *Ending Inappropriate Promotion of Foods for Infants and Young Children* available on https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf?ua=1 (accessed 18 September 2020)

⁸² WHO (2015) *WHO Regional Office for Europe: Nutrient Profile Model* available on https://www.euro.who.int/_data/assets/pdf_file/0005/270716/Nutrient-children_web-new.pdf (accessed 18 September 2020)

⁸³ PAHO (2016) *Pan American Health Organization Nutrient Profile Model* available on https://iris.paho.org/bitstream/handle/10665.2/18621/9789275118733_eng.pdf (accessed 18 September 2020)

⁸⁴ WHO (2016) *WHO Nutrient Profile Model for the Western Pacific Region A Tool to Protect Children from Food Marketing* available on <https://apps.who.int/iris/bitstream/handle/10665/252082/9789290617853-eng.pdf;jsessionid=C3BBF778743CB91DF552ED0EDBCC5303?sequence=1> (accessed 18 September 2020)

⁸⁵ WHO (2017) *Nutrient Profile Model for the Marketing of Food and Non-Alcoholic Beverages to Children in the WHO Eastern Mediterranean Region* available on https://applications.emro.who.int/dsaf/EMROPUB_2017_en_19632.pdf?ua=1 (accessed 18 September 2020)

⁸⁶ WHO (2017) *Nutrient Profile Model for South-East Asia Region: To implement the Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children* available on http://applications.emro.who.int/dsaf/EMROPUB_2017_en_19632.pdf?ua=1 (accessed 18 September 2020)

⁸⁷ WHO (2019) *Nutrient Profile Model for the African Region: A Tool for Implementing WHO Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children* available on <https://apps.who.int/iris/bitstream/handle/10665/329956/9789290234401-eng.pdf?sequence=1&isAllowed=y> (accessed 18 September 2020)

⁸⁸ WHO (2015) *Guideline: Sugars Intake for Adults and Children* available on <https://www.who.int/publications/i/item/9789241549028> (accessed 18 September 2020)

⁸⁹ WHO (2018) *Global Nutrition Policy Review 2016-2017* available on <https://apps.who.int/iris/rest/bitstreams/1161738/retrieve> (accessed 18 September 2020)

in relation to healthy diet, as an NCD risk factor, highlighting both negative influences on policymaking, regulation and health outcomes and the potential for positive influences in progressing this agenda.

70. In terms of policy advice and dialogue on physical activity, this is also based on the Global Strategy on Diet, Physical Activity and Health.⁷⁵ Physical activity is recognised as an independent risk factor in the NCD-GAP and one of the best buys relates to this risk factor. WHO has developed a Global Action Plan on Physical Activity for 2018–2030⁹⁰ which aims to reduce global levels of physical inactivity by 10% by 2025 and by 15% by 2030. WHO provided norms and standards on physical activity through Physical Activity Guidelines.⁹¹ WHO has supported UNESCO in developing the Quality Physical Education policy package.⁹² The ACTIVE⁹³ package on physical activity supports the implementation of the Global Action Plan on Physical Activity. Campaigns such as Walk the Talk, Walk for Health have sought to promote awareness of physical activity as an NCD risk factor globally.⁹⁴ Despite these developments, some respondents expressed concern that physical activity still received less focus than other risk factors. Physical activity is an area where opportunities exist for productive engagement with the private sector, as there is a strong alignment between the sports industry's interest and the objective to reduce physical inactivity. One respondent commented that on physical activity, *“there is much more common interest with WHO and engagement is much less problematic...”* One example of such collaboration is UNESCO's Quality Physical Education policy package which included involvement from the International Olympic Committee and Nike.

The role of international partners and non-State actors

71. One of the topics which came up frequently with respondents, and WHO has grappled with, is the extent to which engagement with the private sector is constructive or unhelpful when addressing NCD risk factors. On the one hand, there may be opportunity for productive dialogue with some industries on some topics but there are real, and well-documented risks, of industry interference and undue influence on other topics. One example of where industry engagement is considered to have worked well is presented in Box 12.
72. Civil society organizations have been active in advocating on NCD risk factors globally, for example, on tobacco control, inappropriate promotion of breast-milk substitutes and the harmful use of alcohol. The NCD-GAP provides common ground for movements in these areas. Civil society actors, in particular, under the umbrella of the NCD Alliance, refer to the risk factors as a common agenda. One respondent commented, *“usually, when we talk about NCDs, people focus on health services and management, rather than on the whole picture of the NCDs. Although prevention is much more efficient. You need to fight for the space of the risk factors”*.

⁹⁰ WHO (2018) *Global Action Plan on Physical Activity 2018–2030: More Active People for a Healthier World* available on <https://apps.who.int/iris/bitstream/handle/10665/272722/9789241514187-eng.pdf?ua=1> (accessed 18 September 2020)

⁹¹ WHO (2010) *Global Recommendations on Physical Activity for Health* available on https://apps.who.int/iris/bitstream/handle/10665/44399/9789241599979_eng.pdf?sequence=1 (accessed 18 September 2020)

⁹² UNESCO (2020) *Promoting Quality Physical Education Policy* available on <https://en.unesco.org/themes/sport-and-anti-doping/sports-education/gpe#revision> (accessed 18 September 2020)

⁹³ WHO (2018) *ACTIVE – A Technical Package for Increasing Physical Activity* available on <https://apps.who.int/iris/bitstream/handle/10665/275415/9789241514804-eng.pdf?ua> (accessed 18 September 2020). ACTIVE is based on Active Societies, Active Environments, Active People and Active Systems

⁹⁴ WHO (2020) *Global Walk the Talk: The Health for All Challenge* see <https://www.who.int/news-room/events/global-walk-the-talk> (accessed 18 September 2020)

Box 12: Engaging the private sector on product reformulation to eliminate trans fats

Considerable work has been done with the private sector on reformulating foods to replace industrially-produced trans-fatty acids (TFA) with healthier oils and fats. This has been possible because this can be done without changing taste or cost and because the health benefits of doing this are well-recognized.

Progress on the global objective of trans fat elimination has been facilitated by partnering with the food industry to develop a road map for achieving the target of eliminating TFA from the food supply. The REPLACE framework acknowledges that eliminating industrially-produced TFA requires the involvement of manufacturers of foods, edible oils and fats. One private sector respondent commented, *“We understand our consumers, our industry and the market. We are part of the system, so if you make policy decisions without the industry they may fail, because we know our consumers the best. Our input is helpful to understand the reality of business, and the scale we can reach is massive.”*

Engagement took place through the GCM/NCD and regular CEO-level dialogues on trans fat elimination between WHO and the food industry. In April 2019, the Director-General of WHO issued a statement calling on fats, oils and food, and food service industries to reformulate foods to eliminate industrially-produced TFA and increase replacement with alternatives low in saturated fat.⁹⁵ In May 2019, the IFBA published the Enhanced Commitment to Phase out Industrially Produced Trans-Fatty Acids⁹⁶ in which its members commit to not exceed 2g iTFA per 100g fat/oil in their products worldwide by 2023, in line with the WHO’s overall objective of phasing out iTFA from the global food supply by that date.

One respondent commented that, although the IFBA represents around 15% of the global packaged food sales, it has leant further support to the 2023 target by providing technical support from 2019 to small- and medium-sized food producing companies to reformulate product lines without industrially-produced TFA. This has been done with the Scaling Up Nutrition Business Network.

Lessons can be learned from this example. In this case, a combination of open dialogue between WHO and private sector representatives, and alignment between WHO’s and the industry’s objectives, has made a positive collaboration possible. WHO and private sector stakeholders can learn from this experience to take advantage of such opportunities for partnership when they arise. A civil society respondent working on nutrition commented, *“The anxiety about whether to engage or not with the private sector has been a distraction. There is a role for the private sector, and WHO should work to develop accountable, transparent relationship with the food industry sector”*.

⁹⁵ WHO (2019) *Fats, Oils and Food Service Industries should Join the Global Effort to Eliminate Industrial Trans Fat from Processed Food by 2023* available on <https://www.who.int/news-room/detail/23-04-2019-fats-oils-food-and-food-service-industries-should-join-global-effort-to-eliminate-industrial-trans-fat-from-processed-food-by-2023> (accessed 18 September 2020)

⁹⁶ IFBA (2019) *International Food and Beverage Alliance (IFBA) Enhanced Commitment to Phase Out Industrially Produced Trans-Fatty Acids* available on https://ifballiance.org/uploads/press/pdf/5ccc4b8061475_IFBA%20iTFA%20Enhanced%20Commitment%202002.05.2019.pdf (accessed 18 September 2020)

Conclusions and recommendations for objective 3

Incremental progress has been made in addressing tobacco use but similar progress has not yet been seen with other risk factors including harmful use of alcohol, healthy diet and physical activity. A key factor in this regard may be the WHO Framework Convention on Tobacco Control (WHO FCTC) and the monitoring of its implementation.

WHO Secretariat and Member States to explore why progress seen in relation to addressing tobacco use has not yet been seen in relation to other risk factors. Specifically:

- WHO Secretariat and Member States to explore why the steady progress being seen in relation to tobacco control is not being seen for other risk factors.
- WHO Secretariat and Member States to explore why, in particular, policies on harmful use of alcohol are not associated with implementation of identified cost-effective actions on harmful use of alcohol.
- WHO Secretariat and Member States to explore what the barriers are to implementation of actions, that are not showing a positive association with income group, in high-income countries.
- WHO Secretariat to review (as part of any review of the best buys) whether the range of cost-effective interventions for physical activity can be expanded.
- Member States to develop and strengthen appropriate regulatory frameworks for all risk factors with WHO Secretariat technical support.

3.4 Objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage

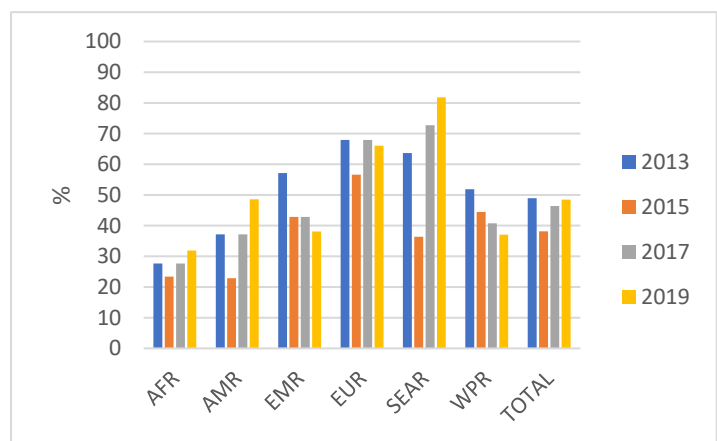
Overall progress

73. Relatively little progress has been made in terms of effectively managing NCDs through primary health care in most countries. In general, countries' health system responses to NCDs remain focused on secondary and tertiary care.

Progress indicators

74. The AP indicator for this objective is the percentage of Members States that have evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach. Countries have made little progress in introducing evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach. In 2013, less than half of countries (49%) had such guidelines/protocols/standards and this remained less than half (48%) in 2019 (see Table 1, p17 and Figure 14). This indicator is measured in both the AP and COM sets (AP4 and COM9). Although the figures for 2017 and 2019 are the same, there is quite a discrepancy between the figures for 2015 (38% for AP4 and 26% for COM8 – see Tables 1 and 2, from p17). The main explanation for this seems to be that the COM8 calculations were based on earlier or preliminary data. For this reason, the evaluation has placed more store on the AP data.

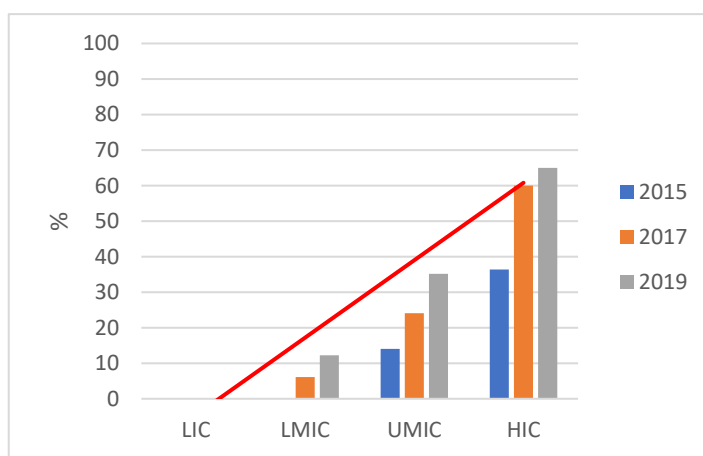
Figure 14: Percentage of Member States by region that have evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities: 2013, 2015, 2017 and 2019



75. There is substantial regional variation for this indicator. Overall, performance levels were higher in EUR and SEAR and lower in AFR. There was a statistically significant association between this indicator and country income group ($p=.001$). Between 2013 and 2019, there was improvement in AFR, AMR and SEAR but performance worsened in EMR, EUR and WPR.

76. Some progress has been made on the percentage of countries able to provide drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level. The percentage who fully achieved this rose from 14% in 2015 to 34% in 2019 (see Table 2, p18). There is a particularly strong association between a country being able to provide such drug therapy and country income group (see Figure 15). In 2019, no low-income country provided such therapy compared with almost two thirds of high-income countries (65%).

Figure 15: Percentage of Member States by country income group that have fully achieved having provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level: 2015, 2017 and 2019



77. Similar to the findings concerning risk factor policies (see paragraph 64, p29), there is a statistically significant association between having NCD management guidelines/protocols/standards and provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent heart attacks and strokes, with emphasis on the primary care level ($p < .001$ and see Table 5). Of countries with guidelines/protocols/standards, half (50%) report having fully achieved the action on drug therapy whereas this is less than one quarter (23%) in the absence of guidelines/protocols/standards.

Table 5: Is having NCD management guidelines/protocols/standards associated with having drug therapy available?

Policy	Action	Significant association?	p-value	Percentage (%) of countries fully achieving action		Percentage (%) of countries partially achieving action	
				with policy	without policy	with policy	without policy
Clinical guidelines (AP4)	Drug therapy and counselling (COM10)	Yes	<.001	50%	23%	59%	30%

78. Overall, in 2019, this meant that around two thirds of countries (66%) were still unable to fully offer these treatments. In addition, there is no measure as to whether people with NCDs, e.g. hypertension and diabetes, are being diagnosed, treated and having their conditions controlled in practice. Qualitative feedback received indicated that there is still a tendency in-country to focus on management of NCDs mainly with a focus of specialist care at secondary or tertiary level. Relatively limited progress has been made in embedding the management and care of NCDs in practical delivery of primary health care and universal health coverage. In 2018, a GCM/NCD working group published a report focused on including NCDs in other programmatic areas, particularly primary health care and human resources for health.⁹⁷ This report made some recommendations which remain relevant including:

- Governments should assess existing national health policies with a view to develop and/or strengthen strategies to ensure integration of the prevention and control of NCDs with other health programmes, with a particular emphasis on HIV, TB, MCH, and SRH (GCM/NCD Working Group Recommendation 1)
- Governments must build adequate and sustainable health workforce that has the resources and capacities to manage and integrate NCDs (GCM/NCD Working Group Recommendation 5)

⁹⁷ WHO (2018) *Final Report: Working Group on the Inclusion of NCDs in Other Programmatic Areas: WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (Working Group 3.1, 2016-2017)* available on <https://www.who.int/global-coordination-mechanism/activities/working-groups/3-1-report.PDF?ua=1> (accessed 16 September 2020)

- Governments should incorporate and integrate NCD services at all levels of health care, with a particular focus in primary and community care services, applying an integrated people-centred approach (GCM/NCD Working Group Recommendation 6)

WHO support to country health systems

79. This objective corresponds to the WHO Secretariat's core area of expertise and capacity. However, concerns were raised that the needs of people living with NCDs, in terms of diagnosis and treatment, have sometimes been overshadowed by the attention paid to risk factors and prevention covered under objective 3 of the NCD-GAP. In the best buys, 13 interventions relate to objective 3 while only three relate to objective 4. One respondent commented, *"Yes, it is good to work on risk factors through regulation but there is need for basic treatment of hypertension, diabetes and cancer. We need facility level action."* While the focus on risk factors has been important, respondents identified the need for increased focus on management of NCDs through primary care in the next implementation period. As one respondent commented, *"People living with NCD have not seen themselves addressed through the NCD agenda. There has not [been] enough resources put in access to medicine, and including the management in the UHC package. During the COVID-19 crisis it became clear that there is no understanding of what the minimum services package on NCD is. There is now need to balance better risk factors prevention with disease specific management"*.
80. The World Health Assembly has passed resolutions that strengthen WHO's mandate on NCD management and control, for example, on cancer prevention and control in the context of an integrated approach⁹⁸ and on rheumatic fever and rheumatic heart disease.⁹⁹ WHO Secretariat's technical cooperation has largely focussed on supporting the implementation of the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN)¹⁰⁰ in primary health care services. The PEN package, introduced in 2010 and updated in 2013, aims to support countries to improve the coverage of essential NCD interventions in low-resources settings by defining a set of minimum interventions. Implementation tools enable early detection and management of cardiovascular diseases, diabetes, chronic respiratory diseases and cancer to prevent life threatening complications (e.g. heart attacks, stroke, kidney failure, amputations, blindness). Implementation of the PEN and its contribution to NCD health outcomes have not been reviewed systematically, although several country-level studies have been produced.¹⁰¹ A Joint Programme on Cervical Cancer¹⁰² was launched under the auspices of the UNIATF, gathering seven UN agencies¹⁰³ and working in six countries, and a toolkit for cervical cancer prevention and control programmes was produced in 2019.¹⁰⁴ In 2016, WHO Secretariat and partners produced the HEARTS technical package to support governments in strengthening the prevention and control of cardiovascular disease with a focus on hypertension and diabetes as part of the Global Hearts initiative.¹⁰⁵ EMRO led the development of an NCD kit in 2016 that identifies the set of medications, equipment and renewables needed for a population of 10 000 people over a period of three months following disruption of normal medical services.¹⁰⁶ Some concerns were raised that WHO's technical cooperation had remained quite high-level

⁹⁸ WHA (2017) *Cancer Prevention and Control in the Context of an Integrated Approach* available on

https://apps.who.int/iris/bitstream/handle/10665/275676/A70_R12-en.pdf?sequence=1&isAllowed=y (accessed 19 September 2020)

⁹⁹ WHA (2018) *Rheumatic Fever and Rheumatic Heart Disease* available on https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_25-en.pdf?ua=1 (accessed 19 September 2020)

¹⁰⁰ WHO (2013) *Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings: Implementation Tools* available on

https://apps.who.int/iris/bitstream/handle/10665/133525/9789241506557_eng.pdf;jsessionid=E8FE818A2FD1B3234821017B474512DE?sequence=1 (accessed 19 September 2020)

¹⁰¹ See some country examples and publications at https://www.who.int/ncds/management/pen_tools/en/

¹⁰² UNIATF (2016) *UN Joint Global Programme on Cervical Cancer Prevention and Control* available on <https://www.who.int/ncds/un-task-force/un-joint-action-cervical-cancer-leaflet.pdf> (accessed 19 September 2020)

¹⁰³ WHO, IAEA, IARC, UNAIDS, UNFPA, UNICEF and UNWomen

¹⁰⁴ WHO (2019) *Improving Data for Decision-making: A Toolkit for Cervical Cancer Prevention and Control Programmes* available on

<https://apps.who.int/iris/bitstream/handle/10665/279420/9789241514255-eng.pdf?ua=1> (accessed 19 September 2020)

¹⁰⁵ WHO (2016) *HEARTS: Technical Package for Cardiovascular Management in Primary Health Care* available on

<https://apps.who.int/iris/bitstream/handle/10665/252661/9789241511377-eng.pdf?sequence=1> (accessed 19 September 2020)

¹⁰⁶ WHO (2016) *Noncommunicable Diseases Kit* available on https://www.who.int/docs/default-source/documents/emergencies/ncd-2016-content-list-rev-nov2017.pdf?sfvrsn=70538d1e_2 (accessed 19 September 2020)

meaning that some important areas were not fully developed, such as workforce competencies for NCDs at primary health care level and NCD services quality monitoring.

81. The WHO Secretariat also supported countries in identifying gaps at primary health care level, training health care workers and implementing the PEN package. The WHO Secretariat organized global technical and strategic meetings on the management of the four main NCDs and held regional consultations on NCD management issues, including the integration of NCD management into primary health care, palliative care, cancer care and the total risk approach to cardiovascular disease. The WHO Secretariat supported countries on procurement of NCD medicines and commodities in order to fulfil the target of attaining 80% availability of the affordable basic technologies and essential medicines. Country surveys on prices, availability, affordability and price components of medicines for NCDs were conducted. While WHO Secretariat provided technical guidance on NCD management, respondents commented that the health strengthening aspect within objective 4 lagged behind, a key issue being the lack of funding in low resources settings. During the NCD-GAP implementation period, subsequent developments have taken place in relation to this issue, with the UHC/PHC agenda in the context of the SDGs and the UHC declaration in 2019. WHO Secretariat respondents considered that the implementation of the NCD-GAP had not fully engaged with those developments meaning that, at times, there had been a disjointed approach, as work to improve NCD services delivery had not been integrated into the broader agendas of UHC/PHC. *“Different work streams continued in parallel to NCDs, such as the IPCHS [WHO Framework on integrated people centred health services]. There was no robust dialogue with other global processes... we lack understanding of how NCDs fit in the broader global dialogue”*. Without promoting ‘vertical’ or ‘siloed’ NCD programming, it is important that NCDs are taken on board and prioritized within the UHC/PHC agenda in order for specific NCD-related services, competencies and indicators not to be sidelined. This risk was identified by several respondents, for example, *“WHO drives people centred care agenda, but there is nothing specific on NCDs that was not subsumed in global health agenda, PHC fully exists in parallel, UHC/PHC are a shared narrative, but NCDs are not part of it”*. The GPW13 and the integration of NCD management and control within the UHC billion¹⁰⁷ constitute an opportunity to remedy the chronic lack of resources for NCDs at PHC level, as well as to improve patient-centred care for people living with NCDs. Importantly, WHO is working on integrating NCD services, commodities and competencies within the Compendium of Essential Services.

International partners and non-State actors

82. Non-state actors have supported the WHO Secretariat’s work on NCD management and control. Foundations and private initiatives have contributed important resources to cancer research and services. For example, the WHO Global Initiative for Childhood Cancer, which aims to increase child cancer survival rates to at least 60% by 2030,¹⁰⁸ has received funding from the WHO collaborating centre St. Jude Children’s Research Hospital among other partners. The initiative Resolve to Save Lives¹⁰⁹ has supported WHO’s work on cardiovascular diseases and diabetes through programmes including trans fat elimination, salt reduction and hypertension control. Civil society organizations, especially peer networks of people with lived experiences of NCDs, have advocated for the right to access NCD care and treatment services.¹¹⁰ However according to civil society respondents the engagement of people living with NCDs in improving equity and access to health care services is still in its infancy in the NCD sector.
83. In order to attain the of 80% availability of the affordable basic technologies and essential medicines, WHO and countries are involved in discussions with private providers of medicines and commodities for supply and procurement. The PAHO Strategic Fund is an example of successful brokering role played by the WHO. The Fund

¹⁰⁷ UHC Target: 1 billion more people benefitting from universal health coverage without financial hardship in WHO (2019) *Thirteenth General Programme of Work 2019-2023: Promote Health, Keep the World Safe, serve the Vulnerable* available on <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf> (accessed 19 September 2020)

¹⁰⁸ WHO (2020) *Global Initiative for Childhood Cancer* available on <https://www.who.int/cancer/childhood-cancer/en/> (accessed 19 September 2020)

¹⁰⁹ See <https://resolvetosavelives.org/> (accessed 19 September 2020)

¹¹⁰ NCD Alliance (2020) *NCD Atlas Bridging the Gap on NCDs through Civil Society Action: Initiatives of National and Regional NCD Alliances* see <https://ncdalliance.org/resources/ncd-atlas-bridging-the-gap-on-ncds-through-civil-society-action#:~:text=To%20showcase%20NCD%20civil%20society,of%20National%20and%20Regional%20NCD> (accessed 10 September 2020)

includes long-term agreements for a unique price for each medication with prequalified manufacturers, accessible by all countries in the region. Respondents commented that WHO had been slow to engage with the industry on NCD medicines and commodities procurement, production, distribution and quality control. The Access Accelerated programme,¹¹¹ formed by twenty pharmaceutical companies has contributed to developing public private partnerships on supply chain, digital health and primary care services delivery programmes. The programme works with a number of partners including City Cancer Challenge, PATH, World Heart Foundation, the NCD Alliance and the World Bank but engagement of WHO with this programme has been minimal. Several respondents from the private sector highlighted the need for the WHO Secretariat to drive the coordination of the private sector's contribution more clearly, by providing a clear steer on how philanthropies and private sector actors can collaborate. For example, one of the respondents mentioned that *"It would be such benefit if WHO put their asks in a catalogue, and give legitimacy to the non-State actors response. If that happens, we will see bigger contribution from the private sector. Companies would respond to those calls. We could do so much more if we could bring the private sector investment closer to public health programme implementation, but we need normative work to frame it"*. Respondents from the private sector as well as civil society called for WHO to further support countries in conducting discussions with the industry so as to best direct their input in the national health care system. Respondents felt that WHO Secretariat was reticent to engage in dialogue with pharmaceutical companies because of the risk of conflict of interest. One respondent commented, *"It is a little bit chaotic right now, there is an unclear panorama of conflict of interest. The better things are organised, the better the industry can contribute legitimately"*.

Conclusions and recommendations for objective 4

The crucial importance of not solely focusing on a single NCD has been recognized. While some progress has been made on developing protocols and ensuring essential NCD medicines are available, these are still lacking in many countries. More is needed to ensure NCDs are managed effectively through primary care so that people with NCDs, such as hypertension and diabetes, are diagnosed, treated and have their conditions controlled. There is a need to ensure that vulnerable groups, different age groups and those in emergency settings are included in this provision.

WHO Secretariat and Member States to do more to ensure those affected by NCDs are diagnosed, receiving treatment and having their condition controlled. Specifically:

- WHO Secretariat and Member States to identify practical ways in which responses to NCDs can be better integrated into primary health care and universal health coverage.
- WHO Secretariat to develop more concrete guidance on NCD management in primary care.
- WHO Secretariat and Member States to improve monitoring of the number and proportion of people receiving essential medicines in primary health care settings, particularly to reduce cardiovascular risk, ensuring that the needs of particular groups are addressed.
- WHO Secretariat, Member States, international partners and non-State actors to recognize and emphasize that it is important not to focus solely on a single NCD.

¹¹¹ See <https://accessaccelerated.org/> (accessed 19 September 2020)

3.5 Objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs

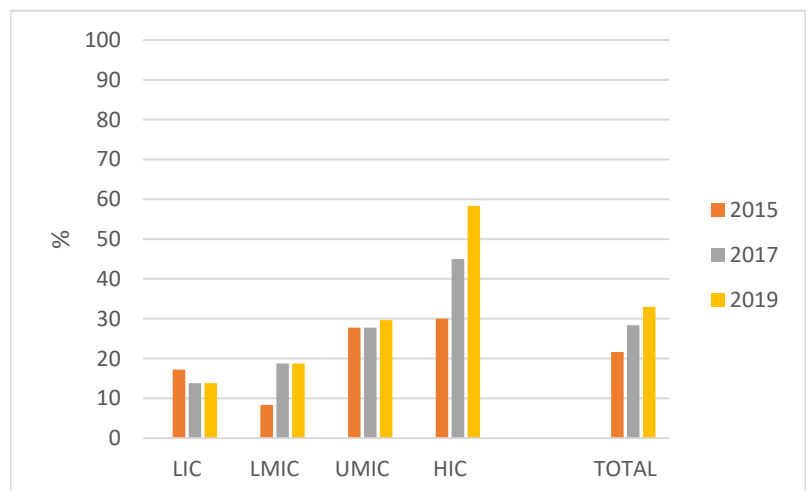
Overall progress

84. Very little progress has been made on this objective. This was reported by respondents and confirmed by performance against the agreed indicator. What progress there has been has been largely limited to high-income countries.
85. Respondents from all stakeholder groups identified research as a weak area in NCD-GAP implementation. Research on NCDs has often been driven by funding rather than aligning with public health priorities, as underlined in the World Health Report in 2013,¹¹² “Investments in health research and development... are still insufficiently aligned with global public health demands and needs”. WHO respondents commented, “WHO should help set the research agenda, we should do more on this. Low-income countries struggle to have locally designed and funded research”. Different areas of research have received uneven attention. The best-funded area remains cancer with the support of organizations like the Union for Cancer Control (UICC) that has conducted, in partnership with WHO, a review of national cancer control plans covering 158 countries.^{113 114}

Progress indicator

86. In 2015, when data began to be collected on this objective’s indicator, just over one fifth of countries (22%) had an operational policy and plan on NCD research. By 2019, this figure had risen to just one third of countries (33%) (see Figure 16). So, around two thirds of countries still lack such a policy. In 2019, only four low-income countries had such a policy as compared to more than half of high-income countries (58%). Indeed, the situation worsened in low-income countries between 2015 and 2019. Most of the improvement that occurred between 2015 and 2019 was in high-income countries.

Figure 16: Percentage of Member States by country income group and overall that have an operational national policy and plan on noncommunicable disease-related research, including community-based research and evaluation of the impact of interventions and policies: 2015, 2017 and 2019



87. There is no indicator on research in the COM indicator set. Although there is such an indicator in the AP set, this indicator was omitted from the data reported to WHA72 by the WHO Secretariat in 2019 (see Tables 6 and 7).

¹¹² WHO (2013) *The World Health Report 2013: Research for Universal Health Coverage* available on https://apps.who.int/iris/bitstream/handle/10665/85761/9789240690837_eng.pdf?sequence=2 (accessed 19 September 2020)

¹¹³ International Cancer Control Partnership (undated) *Achieving Measurable Progress Towards the NCD Targets: The Importance of National Cancer Control Plans (NCCPs)* available on https://www.uicc.org/sites/main/files/atoms/files/180927_NCCP_Review-2Pager_EN_Final_WEB.pdf (accessed 19 September 2020)

¹¹⁴ Romero, Y., Trapani, D., Johnson, S., Tittenbrum, Z., Given, L., Hohman, K., Stevens, L., Torode, J.S., Boniol, M. and Ilbawi, A.M. (2018) *National Cancer Plans: A Global Analysis* The Lancet Oncology, Volume 19, Issue 10, E546-E555 [https://doi.org/10.1016/S1470-2045\(18\)30681-8](https://doi.org/10.1016/S1470-2045(18)30681-8)

Table 6: Report on AP indicators to World Health Assembly in 2016

Annex 1

A69/10

Number	Global action plan indicator ²	2010	2015	Trend
3c	Number of countries with an operational policy, strategy or action plan, in line with the WHO Framework Convention on Tobacco Control, to reduce the burden of tobacco use.	109/166 (66%)	135/166 (81%)	↑
3d	Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets.	99/166 (60%)	123/166 (74%)	↑
4	Number of countries that have evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities.	125/166 (75%)	61/166 (37%) ^a	N/A ^c
5	Number of countries that have an operational national policy and plan on noncommunicable disease-related research, including community-based research and evaluation of the impact of interventions and policies.	NO DATA	60/166 (36%)	N/A ^c
6	Number of countries with noncommunicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global noncommunicable disease targets.	60/166 (36%)	48/166 (29%) ^b	N/A ^c

^a The 2010 questionnaire only included guidelines on diabetes, while the 2015 questionnaire included guidelines for the four major noncommunicable diseases.

^b In the 2010 questionnaire, the wording of the mortality question was different: it simply asked whether cause-specific mortality related to noncommunicable diseases was included in the national health reporting system. In addition, salt was not included in risk factor surveillance.

^c Not applicable.

^d Not applicable.

A72/19

Table 4. Progress in strengthening national capacities for the prevention and control of noncommunicable diseases between 2010 and 2017

Indicator	2010	2015	2017
Number of countries with at least one operational multisectoral national policy, strategy or action plan. ¹	32/169 (19%)	69/169 (41%)	89/169 (53%)
Number of countries that have operational noncommunicable disease unit(s)/branch(es)/department(s) within the health ministry.	90/169 (53%)	113/169 (67%)	116/169 (69%)
Number of countries with an operational policy, strategy or action plan to reduce the harmful use of alcohol, as appropriate, within the national context.	82/169 (49%)	114/169 (67%)	127/169 (75%)
Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity.	93/169 (55%)	120/169 (71%)	137/169 (81%)
Number of countries with an operational policy, strategy or action plan, in line with the WHO Framework Convention on Tobacco Control, to reduce the burden of tobacco use.	112/169 (66%)	138/169 (82%)	146/169 (86%)
Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets.	101/169 (60%)	124/169 (73%)	139/169 (82%)
Number of countries that have evidence-based national guidelines/protocols/standards for the management of major noncommunicable diseases through a primary care approach, recognized/approved by government or competent authorities.	No data	74/169 (42%)	84/169 (50%)
Number of countries with noncommunicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global noncommunicable disease targets.	67/169 (39%)	51/169 (30%)	70/169 (41%)
Number of countries with an operational national coordination mechanism in place for the prevention and control of noncommunicable diseases.	No data	57/169 (34%)	65/169 (38%)

88. The explanation for this omission given by the Secretariat was because no data were available for this indicator and there was recognition of the importance of national coordination mechanisms in relation to NCD-GAP implementation. So, this switch was made but the Secretariat report that this was a one-off, ad hoc arrangement which will not be repeated. This indicator (AP5) will be included in future reporting on the official GAP progress indicator set.

WHO support to research

89. One of the six core functions of WHO Secretariat is shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.¹¹⁵ The GPW13 identifies two approaches for WHO to fulfil its research function, namely WHO conducts research drawing upon a wide range of disciplines from the social sciences to implementation research and WHO uses its comparative advantage to identify needs and translate knowledge in order to facilitate research best conducted in research institutions. The Global Action Plan on SDG 3¹¹⁶ identifies research and development, innovation and access as one of seven key accelerators relating to progress on health-related SDGs. Respondents from WHO highlighted the strategic importance of research for identifying successful or innovative models for NCD interventions, supporting evidence-based advocacy work and demonstrating to potential funders that countries are able to successfully implement NCDs programmes in low resources settings.
90. Despite this, the Secretariat's reporting to WHA on objective 5 has been quite limited. In 2016, they reported on an ad hoc meeting in May 2015 and that the outputs of that meeting would be used to develop a research workplan for 2016 to 2018. It is not clear if that happened. WHO did produce a guide to implementation research in the prevention and control of NCDs¹¹⁷ and this was reported to WHA in 2018. The Secretariat also reported that it had organized a workshop in strengthening national capacity for implementation research for six countries with Oxford University. WHO's Regional Office for Europe held a similar workshop in Moscow in 2019.¹¹⁸ One of the country offices interviewed had had a strong focus on supporting research but this appears to have been the exception rather than the rule. The GCM/NCD-led Knowledge Action Portal¹¹⁹ promotes exchanges within the scientific community on key research topics such as digital health, accountability, people living with NCDs, scaling-up action, industry interference, youth, health systems, financing, and collaborations and partnerships. Although WHO has developed strong data collection processes to periodically gather country level data on NCDs, their risk factors and countries' interventions on NCDs, in-house research making use of these data appears limited.
91. The Secretariat could drive research on NCDs to provide needed evidence, for example in areas such as access to and prequalification of medicines in the framework of UHC and research into the implementation of NCD policies and programmes to identify successful intervention models. Respondents commented, "*we need to update the research agenda which is now outdated. There could be a focus on implementation research and interdisciplinary research for determinants and risk factors sitting in other sectors.*" and "*There has not been much investment into research on basic technologies, medicines and access*". The WHO transformation process, as part of the GPW13, offers opportunities to address the gap on NCD research, with the creation of a Division of Science and of the role of Chief Scientist. However, it is too early to assess this fully. The Global Observatory on Health Research and Development is also a key instrument with potential to disseminate NCD research.¹²⁰

International partners and non-State actors

92. WHO has an extensive network of collaborating centres. However, those that responded to the evaluation, while they were doing research on topics related to NCDs, largely did not conceptualize this in terms of the NCD-GAP. In some cases, it was part of other work of their parent institution and not specifically organized as part of the WHO collaborating centre.

¹¹⁵ Recalled in the 13th Global Programme of Work <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>

¹¹⁶ WHO (2019) *Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All* available on <https://apps.who.int/iris/rest/bitstreams/1250381/retrieve> (accessed 20 September 2020)

¹¹⁷ WHO (2016) *A Guide to Implementation Research in the Prevention and Control of NCDs* available on <https://apps.who.int/iris/bitstream/handle/10665/252626/9789241511803-eng.pdf> (accessed 19 September 2020)

¹¹⁸ WHO (2019) *Strengthening Capacity for Noncommunicable Disease Implementation Research in the WHO European Region* available on https://www.euro.who.int/_data/assets/pdf_file/0018/416502/NCD-res-cap-5.pdf?ua=1 (accessed 19 September 2020)

¹¹⁹ See <https://www.knowledge-action-portal.com/> (accessed 19 September 2020)

¹²⁰ See https://www.who.int/research-observatory/why_what_how/en/index1.html (accessed 19 September 2020)

93. One risk of this fairly limited engagement by WHO with research is that this leaves a bit of a vacuum and this is currently being filled by private companies, e.g. pharmaceutical and food industry who do have resources and who are interested in conducting or funding research. While there is a place for this, this could raise concerns about conflict of interest particularly as some sectors, e.g. tobacco, have used research to seek to gain undue influence.

Conclusions and recommendations for objective 5

Investment in and support for research has been suboptimal despite the recognition that there are still many evidence gaps, for example, in terms of what constitutes best buys in different contexts and how best to promote implementation of interventions found to be highly effective, depending on the contexts. Overwhelmingly, research has been the weakest NCD-GAP objective in terms of implementation.

WHO Secretariat and Member States to determine how the priority of NCD research can best be raised. Specifically:

- WHO Secretariat and Member States to determine if lack of sufficient funding or an efficient funding mechanism might be an underlying reason why little progress has been made on NCD research and if so how this can be resolved.
- WHO Secretariat to develop a clear plan as to how it will support this area of work including identifying current research priorities and needs and how these will be addressed.
- WHO Secretariat to identify respective roles and responsibilities for this objective, particularly given the establishment of a Science Division.
- WHO Secretariat with the involvement of the WHO collaborating centres to identify ways in which WHO collaborating centres working on NCDs can contribute to this objective.

3.6 Objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

Overall progress

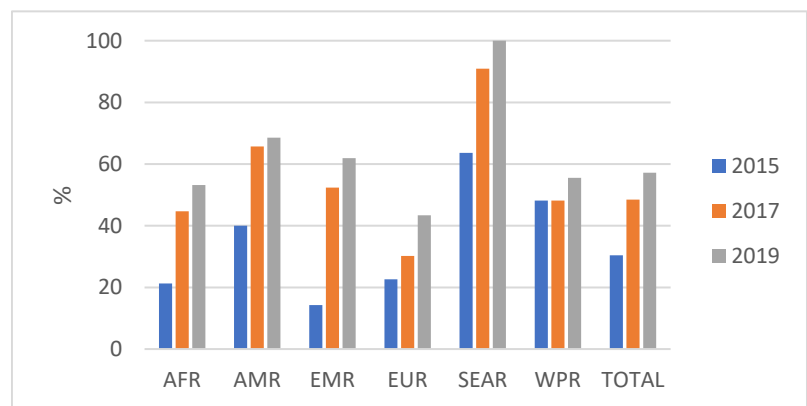
94. A system has been established through which Member States report on the progress they are making in implementing their national NCD responses. Similarly, many countries have conducted surveys of the trends and determinants of NCDs but there have been difficulties in conducting these surveys regularly, sustainably and in ways which align with the broader national health system. Relatively few countries are able to report effectively against the NCD-GAP's global monitoring framework.

Progress indicators

95. The COM indicator set contains three indicators that are related to this objective (COM1-3, see Table 2, p18).

96. There has been some improvement in the proportion of countries that have set time-bound national NCD targets and indicators. This rose from less than one third of countries (30%) in 2015 to more than half of countries (57%) in 2019. There is no association between this indicator and country income group. However, there was substantial regional variation with highest levels of performance in 2019 in SEAR and the lowest in EUR (see Figure 17).

Figure 17: Percentage of Member States by region that have fully achieved having set time-bound national targets and indicators based on WHO guidance: 2015, 2017 and 2019



97. There is a statistically significant association between this indicator (having targets) and having a national NCD policy, strategy or action plan ($p < .001$). This is perhaps unsurprising as presumably those countries that develop such a policy, strategy or plan would usually develop national targets as well. This seems to be the case as, of countries with a national policy, strategy or action plan, more than three quarters (78%) had set targets. However, of those without a national policy, strategy or action plan, less than one quarter (22%) had set targets.

98. A similar statistically significant association was seen between having a national NCD policy, strategy or action plan and having conducted a risk factor survey (such as STEPS) in the past five years ($p < .001$). However, only around one quarter of countries (27%) fully achieved this and there was no improvement between 2015 and 2019. There was an association between whether a country conducted a risk factor survey and country income group. Based on data from the WHO website,¹²¹ 114 countries and territories conducted a STEPS survey between 2001 and 2019.¹²² The mean number of surveys conducted was 1.5 and this varied by region and income group. Overall, more than two thirds of countries and territories (79 of 114, 69%) only conducted one STEPS survey during this period. Figure 18 shows when these surveys were conducted. There was a peak in 2005 with another peak between 2011 and 2014. It could be that the high-level meetings and launch of the NCD-GAP contributed to that peak. However, the peak was not very large and it was not sustained. Based on these data, only five countries (4.4%) were able to sustain the cycle of STEPS surveys, i.e. they had one survey in each of

¹²¹ <https://www.who.int/ncds/surveillance/steps/en/> (accessed 25 July 2020)

¹²² This does not include equivalent surveys. Data is based on the dates reported on the website. In some cases, these are consecutive years.

the five year periods (2003-2007, 2008-2012 and 2013-2017). There are concerns that STEPS surveys are expensive and unsustainable and alternatives should be considered that are embedded in national capacity and which link to broader health issues.

99. In terms of whether a country had a functioning system for generating reliable cause-specific mortality, only just over one third of countries (36%) had achieved this in 2015 and this rose modestly to 40% by 2019. However, most countries did not have such a system in place as of 2019. Whether they did is largely related to country income group. For example, in 2019, no low-income country had such a system as compared to more than three quarters of high-income countries (78%) (see Figure 19).

Are countries able to report against the voluntary global NCD targets?

100. The indicators on risk factor surveys and cause-specific mortality system are combined to give an assessment of the extent to which a country will be able to report against the voluntary global NCD targets.¹²³ While the proportion of countries that would be able to do this rose from 23% in 2013 to 42% in 2019, more than half of countries (58%) are not yet considered able to report against these targets according to this data. This could be problematic for any final evaluation of the NCD-GAP which is expected to look at any association between progress on the NCD-GAP and improvement of outcomes. However, what this mid-point evaluation has done is shown that there are ways of quantifying country performance across the NCD-GAP and this would mean that comparisons could be made if outcome data are available.

101. By way of illustration, this evaluation compared country implementation scores for 2019 with the percentage reduction in probability of dying age 30-70 from four NCDs for the period for which data were available, i.e. 2010 to 2016 (see Figure 20). There is a highly statistically significant association ($p<.001$). So, those countries that performed well in terms of NCD best buys in 2019 also did well in terms of reduction of premature mortality in the period 2010 to 2016. Of course, this does not indicate causality. This could be an effect of country income

Figure 18: Numbers of STEPS surveys conducted per year: 2001-2019

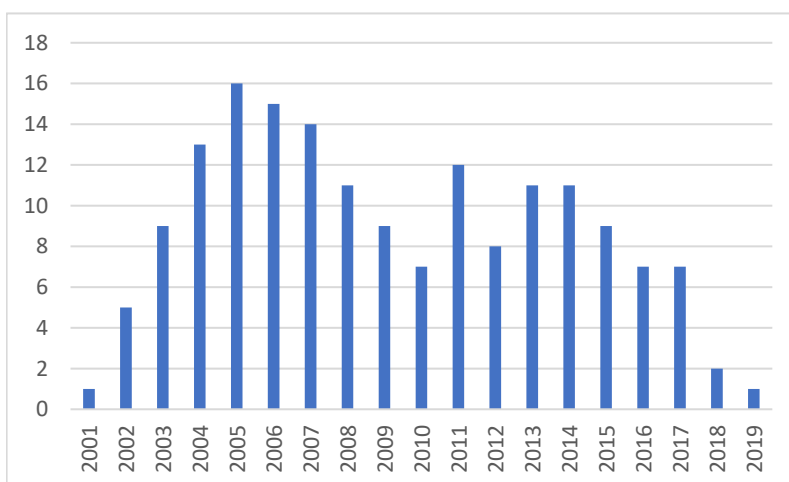
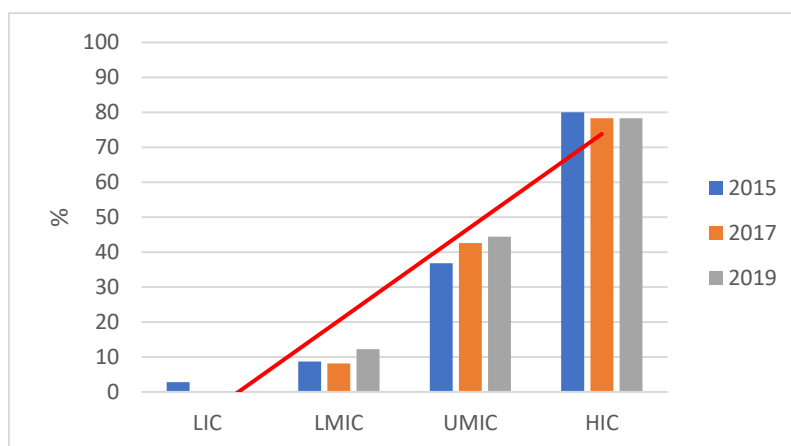


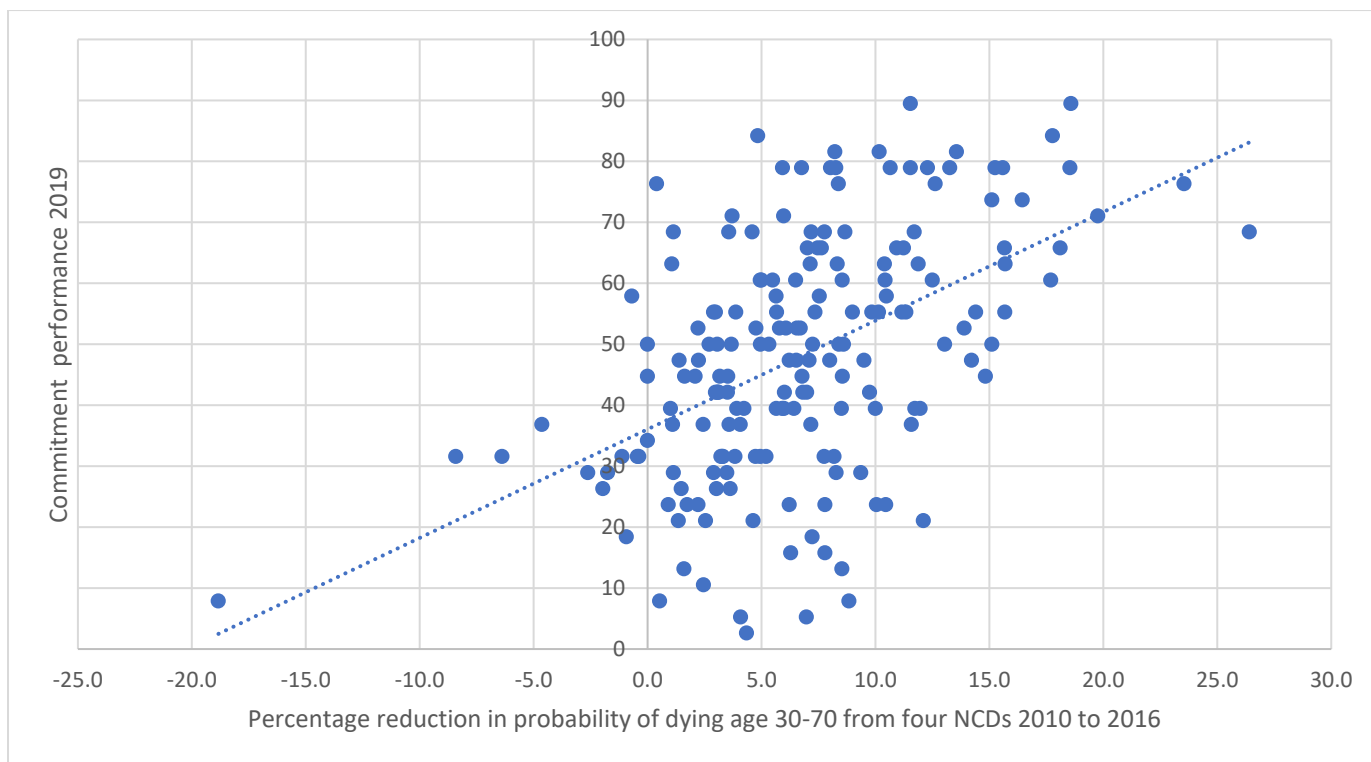
Figure 19: Percentage of Member States by country income group that have fully achieved having a functioning system for generating reliable cause-specific mortality data on a routine basis: 2015, 2017 and 2019



¹²³ These are 1. 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases; 2. At least 10% relative reduction in the harmful use of alcohol as appropriate, within the national context; 3. A 10% relative reduction in prevalence of insufficient physical activity; 4. 30% relative reduction in mean population intake of salt/sodium; 5. A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years; 6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances; 7. Halt the rise in diabetes & obesity; 8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes; 9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.

group, i.e. high-income countries perform well on NCD implementation score and they also perform well on reducing NCD mortality. Looking at country income groups, there is no statistically significant association between performance score and reduction in mortality among low- and lower-middle-income countries ($p=.18$ and $.06$ respectively) but there is among high-income countries ($p=.02$) and particularly among upper-middle-income countries ($p<.001$).

Figure 20: Comparison of countries' commitment performance in 2019 and percentage reduction in NCD mortality between 2010 and 2016.



WHO support to surveillance and monitoring

102. WHO has established a system whereby countries provide data on progress indicators every two years and attempts are made to verify reported data, e.g. by requesting and checking supporting documentation which is stored in an extensive document repository.¹²⁴ However, there is no in-country or external verification of data although civil society has produced shadow reports in a few countries (see Box 11, p27). The progress indicators only track actions taken by Member States and there are no similar indicators for WHO, international partners or non-State actors. In terms of the AP indicators, the indicator on research was not reported on to WHA72 in 2019 but the WHO Secretariat advise that it will be included in future formal reporting. The Secretariat also report that the indicator on national coordination mechanisms has not been formally added to the AP indicator set although this may be tracked and reported outside this set. Definitions for the AP indicators are out-of-date and it is unclear whether the WHO Secretariat is using 2010 or 2013 as the baseline for progress reporting to WHA. In general, the data sets for these indicators are not readily available, e.g. online. It was not possible for the evaluation to obtain the complete data set from the country capacity surveys, for example. This lack of access restricts the ability of external researchers and civil society to analyse the data and more analysis of the data could be carried out by the WHO Secretariat. Issues relating to surveillance data are considered in more detail in Annex 4.

¹²⁴ See <https://extranet.who.int/ncdccc/documents/> (accessed 10 September 2020)

103. There is currently no established system to involve civil society in Member State reporting against the AP or COM indicators. In a small number of cases, civil society has produced their own reports on the status of NCD responses. For example, these were done in Brazil,¹²⁵ the Caribbean,¹²⁶ East Africa¹²⁷ and South Africa.¹²⁸ These were all done in 2014/15 so perhaps could have been part of a funded project.

Conclusions and recommendations for objective 6

There are two sets of progress indicators, with one focused on action plan implementation and the other focused on commitment fulfilment. There is some overlap between indicator sets. Data are reported regularly by almost all Member States but there is scope for much greater use and analysis of data.

WHO Secretariat and Member States to consider ways in which the monitoring and surveillance of NCD responses can be further strengthened. Specifically:

- WHO Secretariat and Member States to identify how to conduct risk factor surveys in a more cost-effective and sustainable manner that builds local capacity and is coherent with other national data systems.
- WHO Secretariat to ensure that future reporting to the Member States on the AP indicator set includes the indicator on research (AP5).
- WHO Secretariat to revise and update the AP indicator definitions and to clarify the baseline year for progress reporting to the Health Assembly, and then report on these to Member States.
- WHO Secretariat to make data more readily available publicly, for example online, and to use the available data more, for example through in-house analysis in collaboration with partners.
- WHO Secretariat, Member States, international partners and non-State actors to develop metrics for actors other than Member States, that is WHO, international partners and non-State actors.
- WHO Secretariat and Member States to strengthen mechanisms for validation of country-reported data, for example through civil society and in-county verification.
- WHO Secretariat to brief Member States on what monitoring and reporting implications there are of extending the NCD-GAP to 2030, including what will be reported in 2025 and what in 2030.
- WHO Secretariat and Member States to ensure that the final evaluation of the NCD-GAP is able to assess progress at the outcome level as specified in the global monitoring framework. This will require having an appropriate framework in place, for example a theory of change, and exploring and analysing associations between documented progress and observed changes in outcomes. The evaluation should also explore why some countries perform above levels expected based on country income group through case studies.

¹²⁵ Aliança de Controle de Tabagismo + Saúde and the NCD Alliance (2014) *Civil Society Report on the Situation of Chronic Non-communicable Diseases in Brazil* available on https://ncdalliance.org/sites/default/files/resource_files/Civil%20Society%20Report%20on%20NCDs%20in%20Brazil_EN.pdf (accessed 18 September 2020)

¹²⁶ Healthy Caribbean Coalition (2014) *Responses to NCDs in the Caribbean Community* available on https://ncdalliance.org/sites/default/files/resource_files/HCC%20NCDA%20RSR%20FINAL.pdf (accessed 18 September 2020)

¹²⁷ East Africa NCD Alliance Initiative (2014) *A Civil Society Benchmark Report: Responses to NCDs in East Africa: The East Africa NCD Alliance Initiative* available on https://ncdalliance.org/sites/default/files/resource_files/East%20Africa%20NCD%20Alliance%20Civil%20Society%20Survey%20Report.pdf (accessed 18 September 2020)

¹²⁸ South African NCD Alliance (2015) *Civil Society Status Report 2010-2015: Mapping South Africa's Response to the Epidemic of Non-Communicable Diseases* available on https://ncdalliance.org/sites/default/files/resource_files/SA%20NCD%20Alliance%20CSR%2015%20Sept%2024%20-%20SCREEN.pdf (accessed 18 September 2020)

3.7 Cross-cutting Issues

3.7.1 Principles of the NCD-GAP

Multisectoral action

104. Material relevant to these principles has been covered under some of the objectives, e.g. objective 1 (Section 3.1, p4) and objective 2 (section 3.2, p16). The need for multisectoral action was recognized as a principle at the heart of the NCD-GAP acknowledging that this required engagement and action, not only across government, but also partnership with civil society and private sector partnerships. Efforts have been made by WHO at the country level and during UNIATF joint-missions to engage other government ministries, e.g. finance and trade, in relation to taxation and regulation of the industry. Progress has been limited and governmental NCD responses often go little further than ministries of health. Little attention has been given to the role of local government, e.g. municipalities although there are some exceptions (see Box 3, p7). The United Nations Inter-Agency Task Force has been effective in coordinating international partners within the UN and, to some extent beyond, e.g. including development banks.
105. Progress regarding coordination with civil society and the private sector has been fairly limited despite WHO having a framework in place for this.¹²⁹ Throughout this report, there are many examples of areas where civil society organizations have made a valuable contribution to NCD-GAP implementation. There are fewer examples in relation to the private sector (see Box 12, p34). Private sector respondents highlighted the difficulty in being recognised as a legitimate interlocutor by WHO because of the risk of perceived or real conflict of interest, although most noted an improvement over time as rules of engagement have become clearer. For example, one noted *“It has been very difficult for the private sector to engage with WHO before the FENSA was published. WHO has been very adverse to discuss with the private sector. There is a notable change in the past few years”*. Efforts are underway to improve the engagement of WHO with private entities as outlined at the Seventy-third World Health Assembly.¹³⁰ The private sector is extremely diverse. One respondent commented, *“we need to differentiate the private sector in general from specific industries that are causing a great deal of harm, especially targeting young people and children...”* Responding to NCDs can be seen as a pro-business proposal, improving workforce productivity, reducing the disease burden impact on the economy and offering business opportunities for many sectors, including sports, farming, pharmaceutical and medical technologies.
106. Against this backdrop, feedback from countries indicated challenges in this area and a desire for more guidance and support. As of 2019, more than half of countries still did not have a national NCD coordination mechanism (see paragraph 33, p16). The evaluation was unable to demonstrate that countries with such mechanisms in place were making greater progress than countries that only had an NCD policy, strategy or action plan, with the possible exception of tobacco taxation (see paragraph 24, p11). Feedback from civil society to the evaluation expressed concern that often countries’ national coordination mechanisms were only focused on coordination across government without the partnership with civil society and private sector envisaged in the NCD-GAP (see Box 11, p27).

Management of real, perceived or potential conflicts of interest

107. This principle in the NCD-GAP is focused on ensuring that public health policies, strategies and multisectoral action for the prevention and control of NCDs must be protected from undue influence by any form of vested interest. Respondents reported substantial efforts from some industries, particularly tobacco and alcohol, to exert the kind of undue influence prohibited in the NCD-GAP. These efforts are hindering country responses to

¹²⁹ WHO (2016) *Framework of Engagement with Non-State Actors* available on https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_r10-en.pdf (accessed 19 September 2020)

¹³⁰WHA (2020) *WHO’s Engagement with Private Sector Entities for the Prevention and Control of Noncommunicable Diseases* contained as Annex 5 of *Consolidated Report by the Director-General* available https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_5-en.pdf (accessed 24 September 2020)

NCD. At the country level there is a litany of examples of industry interference, particularly in relation to tobacco and the harmful use of alcohol. Tobacco industry tactics^{131 132} have been particularly problematic, such as the use of front groups to act on their behalf. In summary, *“despite active implementation of the Framework Convention on Tobacco Control (FCTC), the tobacco, alcohol and unhealthy food industries use similar tactics to aggressively interfere in policies, with the tobacco industry being the most aggressive. Policy interference by industries are effective in the context of poor governance, rampant corruption, conflict of interest among political and government actors, and regulatory capture in all levels of countries from low- to high-income. In addressing these interferences, government requires the practice of good governance, effective mechanisms to counteract conflict of interests among political and policy actors, and prevention of regulatory capture.”*¹³³ Civil society has highlighted the risk of COVID-19 exacerbating potential conflicts of interest as companies step in with corporate social responsibility actions.¹³⁴

108. Participants in a GCM dialogue proposed that private sector entities should not be included in policymaking processes but rather in technical discussions on implementation.¹³⁵ Civil society has been playing a role in tracking the implementation of regulations by the industry and documenting undue interference.¹³⁶ Efforts by the private sector to self-regulate have been disappointing. External accountability, protecting consumers against NCD risk factors through regulation and raising revenues for public health promotion through taxation of tobacco and unhealthy food products have generally been more effective.¹³⁷

109. WHO has longstanding experience in managing conflict of interest, exemplified by the FCTC and the FENSA. As the leading agency on NCD-GAP implementation and SDG target 3.4, WHO is well placed to promote a coherent approach to private sector engagement on NCDs across the UN system. An example of this work was documented at the Sixty-ninth World Health Assembly¹³⁸ when the UNIATF identified and addressed cases of conflict of interest affecting its work. More can be done to support countries in managing undue influence by industries through the provision of a clear engagement framework for the private sector and accountability mechanisms involving civil society to ensure that commitments are upheld. For example a private sector stakeholders commented, *“there is a large gap in terms of support to the Member States in engaging with the private sector. Member States trust WHO, so WHO could help them not be vulnerable to interactions with private sectors that may not be beneficial to them”* and *“rather than not engage with potential conflict of interest, it is better to engage and manage the conflict of interest transparently. Invite private sector actors and guide them to behave better”*.

¹³¹ Committee of Experts on Tobacco Industry Documents (2000) *Tobacco Company Strategies to Undermine Tobacco Control Activities* at the World Health Organization available on https://www.who.int/tobacco/en/who_inquiry.pdf?ua=1 (accessed 24 September 2020)

¹³² WHO (2008) *Tobacco Industry Interference with Tobacco Control* available on https://apps.who.int/iris/bitstream/handle/10665/83128/9789241597340_eng.pdf?sequence=1 (accessed 24 September 2020)

¹³³ Tangcharoensathien, V., Chandraisai, O., Kunpeuk, W., Markchang, K. and Pangkariya, N. (2019) *Addressing NCDs: Challenges from Industry Market Promotion and Interferences* Int J Health Policy Manag 2019, 8 (5), 256-260 doi 10.15171/ijhpm.2019.02

¹³⁴ NCD Alliance and SPECTRUM (2020) *Signalling Virtue, Promoting Harm: Unhealthy Commodity Industries and COVID-19* available on https://ncdalliance.org/sites/default/files/resource_files/Signalling%20Virtue%2C%20Promoting%20Harm_Sept2020_FINALv.pdf (accessed 24 September 2020)

¹³⁵ WHO (2016) *Working Together to Tackle Noncommunicable Diseases GCM/NCD Global Dialogue Meeting on the Role of Non-State Actors in Supporting Member States in their National Efforts to Tackle Noncommunicable Diseases (NCDs) as Part of the 2030 Agenda for Sustainable Development Balaclava, Mauritius, 19-21 October 2016: Final Report* available on <https://www.who.int/global-coordination-mechanism/dialogues/global-dialogue-meeting-report-oct2016.pdf?ua=1> (accessed 17 September 2020)

¹³⁶ See for example Vital Strategies (undated) *Fool me Twice* available on https://www.vitalstrategies.org/wp-content/uploads/2019/06/FoolMeTwice_Report.pdf (accessed 24 September 2020) and World Cancer Research Fund International (2020) *Building Momentum: Lessons on Implementing Evidence-Informed Nutrition Policy* available on <https://www.wcrf.org/int/policy/our-publications/building-momentum-lessons-implementing-evidence-informed-nutrition> (accessed 24 September 2020)

¹³⁷ See for example Buse, K., Tanaka, S. and Hawkes, S. (2017) *Healthy People and Healthy Profits? Elaborating a Conceptual Framework for Governing the Commercial Determinants of Non-Communicable Diseases and Identifying Options for Reducing Risk Exposure* Globalization and Health, 13, Article number:34 available at <https://doi.org/10.1186/s12992-017-0255-3> (accessed 24 September 2020)

¹³⁸ WHA (2016) *Conflict of Interest in Report on Progress made between April 2015 and March 2016 by United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases* available on https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_10-en.pdf (accessed 24 September 2020) ‘There have been examples of the tobacco industry associating itself with some members of the Task Force, sometimes without the knowledge of members themselves.(...) The Task Force is also aware that the alcohol industry has lobbied at least one Member State ahead of Task Force meetings.’

110. A structured approach to private sector involvement in policy implementation, centred on specific terms of engagement, principles of transparency, protection from undue influence, measurable goals and shared interests is possible and can result in real public health wins.¹³⁹

National action and international cooperation and solidarity.

111. This principle in the NCD-GAP, of particular relevance to objectives 1 and 2 (Sections 3.1, p4 and section 3.2, p16), emphasizes the need for recognition of the primary role and responsibility of governments in responding to the challenge of NCDs with international cooperation assisting Member States in a complementary way. Broadly, this has been the case although some respondents questioned the extent to which governments were fully shouldering this responsibility or the extent to which international cooperation was fully supporting countries, particularly low- and lower-middle-income countries.

112. One of the GCM/NCD working groups produced a report focused on the alignment of international cooperation with national plans.¹⁴⁰ This focused on a number of key themes including development assistance and aid effectiveness, universal health coverage for NCDs, a paradigm shift from foreign aid to development cooperation and national NCD plans as tools for development cooperation. The report made six recommendations for governments including promoting and enhancing cooperation with non-State actors including CSOs.

Human rights approach, equity-based approach and empowerment of people & communities

113. These principles of the NCD-GAP recognize the right to the highest attainable standard of health for all and the need for actions on social determinants of health which are distributed inequitably. NCD-GAP implementation has supported these principles by:

- Raising awareness about the burden of NCDs including in low and middle income countries (see Section 3.1, p4).
- Promoting UHC and the focus on including affordable services at primary health care level in low-resources settings. As a result, NCD-GAP implementation has the potential to reduce catastrophic out-of-pocket expenditures and promote access for all to NCD prevention and care services.
- Promoting health literacy on NCDs, relying on easily understandable messages such as high impact, pictorial health warnings on tobacco products or traffic light coding on food products.
- Addressing commercial, social and cultural determinants of health rather than focusing only on individual responsibility and behaviour change. This approach is highly coherent with an equity-based approach to health.

114. However, some have questioned the extent to which these principles have been at the forefront of NCD-GAP implementation.¹⁴¹ Prioritizing four main diseases and focusing on selected best buys risks conflict with the SDG principle of “leaving no-one behind” which is the central, transformative promise of the 2030 Agenda and its

¹³⁹ WHO (2016) *Working Together to Tackle Noncommunicable Diseases GCM/NCD Global Dialogue Meeting on the Role of Non-State Actors in Supporting Member States in their National Efforts to Tackle Noncommunicable Diseases (NCDs) as Part of the 2030 Agenda for Sustainable Development Balaclava, Mauritius, 19-21 October 2016: Final Report* available on <https://www.who.int/global-coordination-mechanism/dialogues/global-dialogue-meeting-report-oct2016.pdf?ua=1> (accessed 17 September 2020)

¹⁴⁰ WHO (2018) *WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases: Final Report: WHO GCM/NCD Working Group on the Alignment of International Cooperation with National NCD Plans (Working Group 3.2, 2016-2017)* available on <https://www.who.int/global-coordination-mechanism/activities/working-groups/3-2-report.PDF?ua=1> (accessed 16 September 2020)

¹⁴¹ See, for example, Perone, S.A., Bausch, F.J., Bouille, P., Chappuis, F., Miranda, J.J. and Beran, D. (2020) *Report of the WHO Independent High-level Commission on NCDs: Where is the Focus on Addressing Inequalities?* *BMJ Global Health* 2020; :e002820 doi:10.1136/bmjgh-2020-002820 and Bukhman, G., Mocumbi, A.O., Atun, R., Becker, A. E., Bhutta, Z., Binagwaho, A., Clinton, C., Coates, M.M., Dain, K., Ezzati, M., Gottlieb, G., Gupta, I., Gupta, N., Hyder, A.A., Jain, Y., Kruk, M.E., Makani, J., Marx, A., Miranda, J.J., Norheim, O.F., Nugent, R.F., Roy, N., Stefan, C., Wallis, L. and Mayosi, B. for the Lancet NCDI Poverty Commission Study Group (2020) *The Lancet NCDI Poverty commission: Bridging a Gap in Universal Health Coverage for the Poorest Billion* *Lancet* Vol 396 No. 10256 available on [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(20\)31907-3.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)31907-3.pdf) (accessed 16 October 2020)

SDGs.¹⁴² Respondents highlighted that this aspect risked being overlooked in NCD-GAP implementation. For example, one commented, “rights based approaches in NCDs are very weak. The extent to which national NCD plans are taking into account human rights is pretty limited. These principles are seen as a nice to have, but non-essential”. Respondents considered that little had been done on key rights issues such as addressing social stigma associated with some NCDs, such as obesity, mental health conditions or cervical cancer, and the right to treatment for disabled people enshrined in the 2006 UN Convention on the Rights of Persons with Disabilities (CPRD).¹⁴³

115. NCD responses need to include humanitarian and emergency settings, including for displaced, refugees and host populations.¹⁴¹ Work in this area, conducted through the UNIATF, including by IOM and UNHCR, included the development of a policy brief on NCDs in emergencies.¹⁴⁴ This highlights the need to further focus on this area in the next NCD-GAP implementation period.

116. Respondents raised concerns that there was little analysis available of how NCDs affect different groups within the populations. For example, “equity, and rights principles are cross-cutting, but what is missing is the analysis. Not only on what WHO is doing, but on how countries are addressing NCDs for vulnerable populations. That kind of analysis is lacking on access to treatment. Although the country plan says treatment is free, finer analysis can show what geographical areas or income groups do not have access to treatment country by country. Vulnerable groups are lost within global estimates”. These concerns included lack of disaggregated data for specific population groups to allow responses to better focus on their needs.

117. There could be greater focus on the ‘empowerment of people and communities’ principle by ensuring that people living with or affected by NCDs have a seat at the table when decisions are made.¹⁴⁵ The 2018 high-level meeting political declaration referred to the need to “promote meaningful civil society engagement and amplify the voices of and raise awareness about people living with and affected by NCDs”. However, the empowerment of people living with NCDs and their communities in terms of advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation, as stated in the NCD-GAP, is still in its infancy. Civil society organizations and the WHO Secretariat have key roles to play to guide NCD-GAP implementation towards better addressing health inequalities and including people living with NCDs at all levels in the NCD response.

Life-course approach

118. This principle emphasises that opportunities to prevent and control NCDs occur at multiple stages of life and interventions focused on early life may offer the best chance for primary prevention. It also emphasises taking account of health and social needs at all stages of the life course. WHO emphasises the importance of a life course approach to health and NCDs.¹⁴⁶ The European Region of WHO made life course approaches a major part of Health 2020 and the regional framework for prevention and control of NCDs.¹⁴⁷ There are also examples of interventions for particular age groups, including for women before and during pregnancy, during infancy, childhood, adolescence, adulthood and for older people.

¹⁴² United Nations Sustainable Development Group (2019) *Leaving No One Behind: A UNSDG Operational Guide for UN Country Teams* available on <https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams-interim-draft> (accessed 20 September 2020)

¹⁴³ UN Human Rights Office of the High Commissioner (2020) *Convention on the Rights of Persons with Disabilities* available on <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#1> (accessed 20 September 2020)

¹⁴⁴ UNIATF and WHO (2016) *Noncommunicable Diseases in Emergencies* available on https://apps.who.int/iris/bitstream/handle/10665/204627/WHO_NMH_NVI_16.2_eng.pdf?sequence=1 (accessed 19 September 2020)

¹⁴⁵ Mikkelsen, B. (2020) *Now is the Time for a ‘Great Reset’ of the NCD Agenda* Personal Blog by @MikkelsenBente_ available on <https://www.ncd.one/blog> (accessed 18 September 2020)

¹⁴⁶ Jacob, C.M., Baird, J., Barker, M., Cooper, C. and Hanson, M. (undated) *The Importance of a Life Course Approach to Health: chronic Disease Risk from Preconception through Adolescence and Adulthood* available on <https://www.who.int/life-course/publications/life-course-approach-to-health.pdf> (accessed 19 September 2020)

¹⁴⁷ Mikkelsen, B., Williams, J., Rakovac, I., Wickramasinghe, K., Hennis, A., Shin, H-R., Farmer, M., Weber, M., Berdzuli, N., Borges, C., Huber, M. and Breda, J. (2019) *Life Course Approach to Prevention and Control of Non-communicable Diseases* BMJ 2019 Jan 28:364:l257 doi: 10.1136/bmj.l257.

119. However in terms of management and care there are concerns that the NCD-GAP focuses on part of the adult population, as the premature mortality indicator includes only those aged 30 to 70. The rationale for this age range as described in the Global Health Observatory indicator definition relates to the economic impact of NCDs in the 'most productive age span'. Similarly, STEPS surveys generally cover those aged 18 to 69. There are concerns that the disease burden in children and young adults may be overlooked, consequently. NCD Child, while noting the paucity of data, provides a low-estimate of two million children affected by cancer, asthma, diabetes and cardiovascular diseases in 2017.¹⁴⁸ Also, the needs of older people in relation to NCDs may be overlooked. Dementia is particularly relevant in this regard. While some argue that dementia might be included in an expanded NCD-GAP that includes mental health conditions, others argue that neurological conditions do not fully fit under the banner of mental health. Dementia shares many risk factors with NCDs such as harmful use of alcohol, smoking, obesity, physical inactivity and hypertension.¹⁴⁹ Another important area of concern is continuum of care for NCD patients and access to palliative care. So far, it does not appear that there has been an assessment of NCD-GAP interventions using a life-course lens.

Evidence-based strategies

120. This principle in the NCD-GAP emphasises that strategies and practices for the prevention and control of NCDs need to be based on latest scientific evidence and/or best practice, cost-effectiveness, affordability and public health principles, taking cultural considerations into account. The WHO Secretariat has sought to do this, including through the production of guidance on cost-effective options in the form of best buys (Box 9, p25). However, this needs to be reviewed and revised to make sure it is based on latest evidence with, wherever possible, evidence also being collected from low- and lower-middle income countries.

121. There is evidence that countries are endeavouring to implement actions in the NCD-GAP including identified best buys. The main constraint in doing this more effectively seems to be available resources. However, there are a small number of indicators where performance is no better in higher-income countries and may be worse (see paragraph 65, p30). These indicators relate to tobacco and alcohol advertising, smoke-free environments, alcohol taxation and availability, and breastfeeding substitutes. Assuming the evidence base for these is sound, why are higher-income countries not pursuing these more vigorously? Could there be a tension between economic and commercial considerations and the evidence base?

122. It is surprising, given the focus on evidence-based strategies, that objective 5 has not been pursued more vigorously (see Section 3.5, p41). The NCD-GAP would likely be based more firmly on latest scientific evidence if there were greater efforts to identify and expand that evidence base.

Universal health coverage

123. The principle of universal health coverage in the NCD-GAP states that *"all people should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines. At the same time it must be ensured that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor and populations living in vulnerable situations"*. The importance of not focusing on a single cause of death on the pathway to reducing the global burden of NCDs was emphasized in a recent Lancet article.¹⁵⁰

¹⁴⁸ NCD Child (2019) *Children and Noncommunicable Disease: Global Burden Report* available on http://www.ncdchild.org/media/1526/ncdchild_global_final_light_final_2309.pdf (accessed 24 September 2020)

¹⁴⁹ Livingston, G., Huntley, J., Sommerlad, A., Ames, D., Ballard, C., Banerjee, S., Brayne, C., Burns, A., Cohen-Mansfield, J., Cooper, C., Costafredo, S.G., Dias, A., Fox, N., Gitlin, L.N., Howard, R., Kales, H.C., Kivimäki, M., Larson, E.B., Ogunniyi, A., Orgeta, V., Ritchie, K., Rockwood, K., Sampson, E.L., Samus, Q., Schneider, L.S., Selbæk, G., Teri, L. and Mukadam, N. (2020) *Dementia Prevention, Intervention, and Care: 2020 Report of the Lancet Commission* available on [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(20\)30367-6.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30367-6.pdf) (accessed 24 September 2020)

¹⁵⁰ NCD Countdown 2030 collaborators (2020) *NCD Countdown 2030: Pathways to Achieving Sustainable Development Goal Target 3.4* The Lancet available on <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931761-X> (accessed 20 September 2020)

124. While the NCD-GAP, through its Appendix 1, does emphasize the importance of synergies between major NCDs and other conditions, such as other modifiable risk factors, mental disorders, communicable diseases, demographic change and disabilities, and violence and unintentional injuries, NCD-GAP implementation and monitoring has not yet fully addressed these. For example, the PEN package only provides technical guidance on the prevention and treatment of each of the four main diseases without focusing on co-morbidities. Monitoring systems, including progress and outcome indicators, focus on the four main NCDs and four main risk factors without considering the synergies identified in NCD-GAP Appendix 1.

125. In terms of funding NCD management and care, there is still strong reliance on out-of-pocket financing in many contexts. While part of the focus of the universal health coverage agenda has been to strengthen financial protection and reduce further impoverishment of the poorest households as a result of catastrophic health expenditures, linkages between these developments and NCD-GAP implementation have been limited. Some steps have been taken to ensure that NCDs are integrated into the basic primary health care packages offered in different contexts. WHO's strong focus on universal health coverage, for example as encapsulated in GPW13, provides an opportunity to further embed NCDs within PHC and UHC.

3.7.2 Effects of the COVID-19 pandemic

126. The COVID-19 pandemic, which occurred in 2020, has had a range of effects on NCDs and responses to them. These include:

- *People affected by some NCDs experienced worse health outcomes relating to COVID-19¹⁵¹* – in Italy, of those dying in hospital, more than two thirds (68%) had hypertension and just under one third had type 2 diabetes.¹⁵² In Spain, 43% of patients with severe COVID-19 disease had existing cardiovascular diseases.¹⁵² Exposure to risk factors for NCDs and particular NCDs may increase vulnerability to COVID-19.¹⁵³ In responses to this evaluation, Member States noted that people with hypertension, diabetes and obesity were more vulnerable to COVID-19. As a result of this vulnerability, some people with NCDs were fearful of using health services and became unwilling to do so. There is also some evidence of longer-term cardiovascular and respiratory complications among people surviving COVID-19.¹⁵⁴
- *Health services and access to care for people with NCDs were disrupted¹⁵⁵* – in some countries, health services were overwhelmed. There were reported to be shortages of medical supplies and some medicines. In many, NCD activities and services were delayed. This included patient treatment services, particularly for cancer.¹⁵⁶ There were some reports of health care staff refusing to treat people if they could not be tested for COVID-19.

¹⁵¹ Expressed as “NCDs and their metabolic, behavioural and environmental risk factors are associated with greater susceptibility to COVID-19 infection and increased risks of severe disease and death from COVID-19” in UNIATF, WHO and UNDP (2020) *Responding to Non-communicable Diseases During and Beyond the COVID-19 Pandemic* available on https://www.who.int/publications/i/item/WHO-2019-nCoV-Non-communicable_diseases-Actions-2020.1 (accessed 19 September 2020)

¹⁵² WHO (2020) *Rapid Assessment of Service Delivery for Noncommunicable Diseases (NCDs) during the COVID-19 Pandemic: Final Results* available on <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic> (accessed 19 September 2020)

¹⁵³ UNIATF, WHO and UNDP (2020) *Responding to Non-communicable Diseases During and Beyond the COVID-19 Pandemic: State of the Evidence on COVID-19 and Non-Communicable Diseases: A Rapid Review* available on https://apps.who.int/iris/bitstream/handle/10665/334143/WHO-2019-nCoV-Non-communicable_diseases-Evidence-2020.1-eng.pdf?sequence=1&isAllowed=y (accessed 19 September 2020)

¹⁵⁴ UNIATF, WHO and UNDP (2020) *Responding to Non-communicable Diseases During and Beyond the COVID-19 Pandemic* available on https://www.who.int/publications/i/item/WHO-2019-nCoV-Non-communicable_diseases-Actions-2020.1 (accessed 19 September 2020)

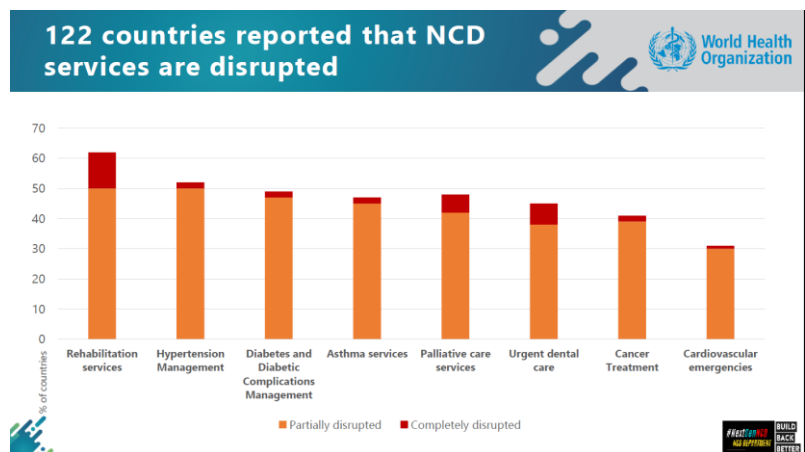
¹⁵⁵ Expressed as “The pandemic has severely disrupted diagnostic, treatment, rehabilitation and palliation services for people living with NCDs” in UNIATF, WHO and UNDP (2020) *Responding to Non-communicable Diseases During and Beyond the COVID-19 Pandemic* available on https://www.who.int/publications/i/item/WHO-2019-nCoV-Non-communicable_diseases-Actions-2020.1 (accessed 19 September 2020)

¹⁵⁶ Sharpless, N.E. (2020) *COVID-19 and Cancer* Science 368 (6497), 1290 available on <https://doi.org/10.1126/science.abd3377>

Based on survey data from 163 countries¹⁵², three quarters of countries (75%) reported that some NCD services were disrupted (see Figure 21). The report noted that the more severe the transmission phase of COVID-19 the more severe was the disruption of NCD services. Reasons given for service disruption included:

- Cancellation of elective care
- Closure of population level screening programmes
- Government or public transport lockdowns
- Deployment of NCD-related clinical staff to the COVID response
- Closure of specific outpatient services
- Insufficient personal protection equipment, medicines, equipment and staff
- Inpatient services/hospital beds not available
- Patients not attending

Figure 21: Percentage of countries reporting disruption of different NCD services



Source: WHO (2020) *Rapid Assessment of Service Delivery for Noncommunicable Diseases (NCDs) during the COVID-19 Pandemic: Final Results*

Some Member State respondents reported that COVID-19 had disrupted some NCD surveillance activities, such as STEPS surveys. Some commented that community activities, such as screening, training and campaigns, had been particularly disrupted. Others noted that international technical assistance missions had been reduced. In some countries, NGO services, based on public donations, had been disrupted by economic constraints and limited opportunities for public fundraising due to lockdowns. Member State respondents also commented that guidance provided by WHO on maintaining essential NCD services had been helpful.

- *The number of people seeking treatment for some NCDs reduced* – in India, the number of cardiac emergencies reaching health facilities in rural areas was reduced by 30% as compared to previous years.¹⁵² In the Netherlands, the number of people newly diagnosed with cancer fell by 25% as a result of lockdown.¹⁵²
- *Human and financial resources were diverted away from NCDs to responses to COVID-19* – in some cases, this happened in an already very difficult context, that is where resources available to responses to NCDs were already very low. Some respondents considered that this was another example of a communicable disease being prioritized ahead of NCDs.
- *COVID-19 occurred at a time when the response to NCDs was already precarious* - A WHO report¹⁵² noted that the COVID-19 pandemic had occurred against a backdrop of underinvestment in the prevention, early diagnosis, screening, treatment and rehabilitation for NCDs meaning that health systems were unable to meet the health-care needs of people living with and affected by NCDs. The report noted that this had occurred because momentum of progress in curbing the NCD epidemic had dwindled since 2010. One respondent commented that COVID-19 had “*aggravated a precarious position*” and a UNIATF paper described it as a “*perfect storm*”.¹⁵⁴ In some settings, the COVID-19 pandemic came on top of a number of other emergencies and emphasized the importance of preparedness. There were several examples of where preparations made for one emergency had been useful in responding to COVID-19 or vice versa.

- *COVID-19 and responses to it affected NCD risk factors* – Member State respondents noted that, in some countries, tobacco sales increased as the ability to bring in tax-free tobacco reduced. Various different effects on alcohol consumption were reported, such as reduced drinking in bars etc. but more drinking at home. There were different changes to exercise, such as less exercise in getting to and from work and patchy changes in leisure exercise. In some countries, access to healthy food, e.g. in schools and workplaces reduced. Overall, the pandemic and responses to it were considered to have increased certain risk factors, such as physical inactivity, unhealthy diet and harmful use of alcohol.¹⁵⁴ In addition, COVID-19 may have exacerbated conflicts of interest in some cases (see paragraph 107, p50).
- *The economic impact of COVID-19 and responses to it are likely to have long-term effects on NCDs* including mental ill health, suicide and death from alcohol and substance use and there is evidence that these effects are likely to increase health inequalities.¹⁵⁷
- *COVID-19 has created opportunities to better incorporate NCDs and mental health in efforts to Build Back Better* – some have argued that COVID-19 provides a new lens through which to view NCDs.¹⁵⁸ Some respondents recognized that the COVID-19 pandemic had brought a focus on the health system and highlighted the importance of prevention and control of disease. The disproportionate effects of COVID-19 on people with NCDs emphasized the need to recognize that the NCD response is fundamental to preparedness and health security and to break down siloes between communicable and non-communicable diseases. There was also a sharp focus on the effects of COVID-19 and particularly of responses to it, such as lockdown on mental health. The profile of mental health and mental health conditions was raised as a result. Lessons were also learned about facility management, infection control and the sense of urgency and mobilization that was generated by the pandemic. There was also much greater use of virtual and digital means, such as telemedicine, home delivery of medicines, Internet hospitals etc. to provide health services. However, a shift to virtual means of providing services requires staff training and may be problematic where Internet access is limited or there is a lack of electronic equipment, referred to by some as the “digital divide”.¹⁵⁴ In some contexts, there has been a greater focus on self-care training for people living with NCDs.

Recommendations made by WHO¹⁵² and UNIATF¹⁵⁴ to *Build Back Better* include:

- Involving people living with and affected by NCDs in knowledge-sharing, awareness-raising and service provision
- Building bridges between national humanitarian emergency plans and NCDs responses
- Including the prevention, early diagnosis, screening and appropriate treatment of NCDs in essential PHC services and UHC benefit packages
- Addressing the historic underinvestment in NCDs, calling for new international funding patterns, a reset of global initiatives and building new partnerships for NCDs
- Addressing the social, economic, commercial and environmental determinants of NCDs
- Implementing WHO guidance on resuming health services and activities for health and wellbeing
- Collecting better data and making better use of data
- Developing systematic approaches to digital health care solutions for NCDs

¹⁵⁷ Bamba, C., Riordan, R., Ford, J. and Mathews, F. (2020) *The COVID-19 Pandemic and Health Inequalities* J Epidemiol Community Health. 2020; <http://dx.doi.org/10.1136/jech-2020-214401> cited in UNIATF, WHO and UNDP (2020) *Responding to Non-communicable Diseases During and Beyond the COVID-19 Pandemic* available on https://www.who.int/publications/i/item/WHO-2019-nCoV-Non-communicable_diseases-Actions-2020.1 (accessed 19 September 2020)

¹⁵⁸ Lancet (2020) *COVID-19: A New Lens for Non-communicable Diseases* Volume 396, Issue 10252, p649 available on [https://doi.org/10.1016/S0140-6736\(20\)31856-0](https://doi.org/10.1016/S0140-6736(20)31856-0)

3.7.3 Mental health conditions and air pollution

127. The political declaration of the third high-level meeting on NCDs in 2018 included commitments to address air pollution and to implement measures to improve mental health and wellbeing.¹⁵⁹ Many respondents referred to this as a shift from 4 x 4 to 5 x 5.

128. Air pollution is increasingly recognized as an important risk factor for cardiovascular disease and cancer with emerging links to diabetes, dementia and mental health conditions. In terms of mental health, respondents noted many reasons for integrating mental health and non-communicable diseases including:

- There are often co-morbidities between NCDs and mental health conditions
- There are similar risk factors for NCDs and mental health conditions
- Management and treatment of NCDs and mental health conditions needs to be through a holistic approach to UHC and PHC
- Conceptually, there is a need to equalize mental and physical health
- Linking mental health to NCDs would lend it more weight
- Mental health civil society is stronger than for NCDs including longstanding and well-established grassroots' networks of people with lived experiences of mental health conditions. This offers opportunities to integrate better NCDs into those networks and for NCD civil society organizations to benefit from these linkages
- Linking NCDs and mental health makes sense politically and technically – mental health may be less contentious politically
- Mental health conditions are better understood as an NCD and would allow a broader understanding of mental health, e.g. including dementia
- Incorporating mental health may boost the interest of others outside the health sector, e.g. other members of UN country teams
- Some WHO Regional Office and Country Office staff are already covering both NCDs and mental health

129. However, a number of respondents, particularly those working on mental health raised concerns about this move. Mental health is often managed quite separately from NCDs, particularly in ministries of health in some countries. The concept of mental health is not just about the absence of disease but incorporates the concepts of health and wellbeing. While it is true that there are links between mental health and NCDs, this is also true of mental health and communicable diseases, e.g. substance use and HIV. While there are some common risk factors for NCDs and mental health conditions, risk factors related to mental health are considered by some to be more diverse and complex. They do not fully overlap with those for NCDs. It will be limiting to think of mental health as one of five NCDs. Mental health disorders are very diverse so it would be better to incorporate as 10 x 10 than 5 x 5. There are concerns that mental health may cease to exist as an entity. If the GAPS were merged, this might mean that mental health would no longer have direct access to the WHA but only as one of five NCDs. One concern raised by a broader spectrum of respondents was that there was a broader underlying issue of overall integration under PHC and UHC and, to date, progress on that within WHO had been limited with many disease specific “siloes” remaining, particularly at headquarters level. Some people working on specific elements of NCDs feared that their area might receive less focus within a 5 x 5 approach. Concerns were also raised that there were also many other NCDs that were left out by the NCD-GAP including musculoskeletal conditions and vision and hearing disorders. This issue was highlighted by a recent Lancet NCDI Poverty Commission report which highlighted specifically that a 4 x 4 or 5 x 5 approach leaves out “key NCDI priorities for the poorest billion” which they termed “NCDI poverty”.¹⁶⁰

¹⁵⁹ United Nations General Assembly (2018) *Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* UNGA A/RES/73/2 available on https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2 (accessed 16 September 2020). See paragraphs 31 and 32 concerning environmental pollution and paragraph 37 concerning mental health.

¹⁶⁰ Bukhman, G., Mocumbi, A.O., Atun, R., Becker, A. E., Bhutta, Z., Binagwaho, A., Clinton, C., Coates, M.M., Dain, K., Ezzati, M., Gottlieb, G., Gupta, I., Gupta, N., Hyder, A.A., Jain, Y., Kruk, M.E., Makani, J., Marx, A., Miranda, J.J., Norheim, O.F., Nugent, R.F., Roy, N., Stefan, C., Wallis, L. and Mayosi, B. for the Lancet

130. However, given the 2018 political declaration, the issue may not be whether the NCD agenda should include mental health and air pollution but how this could be done. This is particularly an issue given that both GAPs for NCDs and mental health have been extended to 2030. Will there be common plans globally, regionally and in countries? Will a common approach to measurement be adopted? Will neurodegenerative conditions, such as dementia, be included? How do global, regional and national structures and systems need to be revised to reflect this expanded focus?
131. Before the shift to the 5 x 5 agenda, WHO had produced guidelines relating to air pollution and NCDs, such as guidelines for indoor air quality¹⁶¹ and for eliminating asbestos-related diseases.¹⁶² In 2018, the first Global Conference on Air Pollution and Health¹⁶³ gathered stakeholders from Ministers of Health and Environment, health professionals and representatives from different sectors (e.g. transport and energy), in order to raise awareness and to share information and tools. In preparation to the 2019 UN Climate Action Summit, WHO produced the Clean Air Commitments to address air pollution and climate change together.¹⁶⁴
132. Some WHO regions (e.g. SEAR and WPR) had also already integrated targets on household air pollution into their regional NCD plans. Respondents were interested in extending the NCD-GAP to include air pollution and thought this could be influential in many countries, as countries tend to follow advice and direction given by WHO. The topic may resonate with other UN agencies, e.g. ILO who are interested in pollution in the workplace. There is also a connection with the agenda on healthy cities, particularly linked to transportation. There is a great deal of interest in this topic from young people. However, some wondered why other types of pollution were not included. Indeed, the political declaration from the high-level meeting in 2018 did specify addressing the high number of deaths from NCDs attributed to indoor and outdoor air pollution but also sought to address *“the impact of environmental determinants on non-communicable diseases, including air, water and soil pollution, exposure to chemicals, climate change and extreme weather events, as well as the ways in which cities and human settlements are planned and developed, including sustainable transportation and urban safety”*. The health-related SDG target 3.9 also refers to hazardous chemicals and air, water and soil pollution.
133. Despite enthusiasm for embracing air pollution as an additional risk factor in the NCD-GAP, respondents had questions about how integration would be achieved and what capacity would be needed. Concerns were raised that although the idea was good in theory, implementation mechanisms are very different, including departments and ministries outside of the ministry of health. One respondent suspected that although this might be adopted *“on paper”*, there would be little change in practice. Another commented that air pollution is linked to broader issues of climate change and extreme weather (which is mentioned in the NCD-GAP) and that it is not possible to remove air pollution from the area of climate change which is particularly high profile.

3.7.4 WHO structure and capacity

134. To frame WHO’s contribution to NCD-GAP implementation, a one-WHO workplan, and accompanying internal steering group, were established in 2013. The purpose was to increase the efficiency of WHO work to answer Member States’ requests for technical support more rapidly, address gaps in skills, reduce costs and meet funding challenges. However, it appears that this coordination has not functioned optimally, with some level of fragmentation and competition taking place between thematic areas. In addition, there is unclear ownership of the area of risk factors at the three levels of the organization in the context of limited resources. Reporting on

NCDI Poverty Commission Study Group (2020) *The Lancet NCDI Poverty commission: Bridging a Gap in Universal Health Coverage for the Poorest Billion* Lancet Vol 396 No. 10256 available on [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(20\)31907-3.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)31907-3.pdf) (accessed 16 October 2020)

¹⁶¹ WHO (2014) *Guidelines for Indoor Air Quality: Household Fuel Combustion* available on https://apps.who.int/iris/bitstream/handle/10665/141496/9789241548885_eng.pdf?sequence=1 (accessed 24 September 2020)

¹⁶² ILO and WHO (2007) *Outline for the Development of National Programmes for Elimination of Asbestos-Related Diseases* available on https://www.who.int/occupational_health/publications/elim_asbestos_doc_en.pdf?ua=1 (accessed 24 September 2020)

¹⁶³ See <https://www.who.int/airpollution/events/conference/en/> (accessed 24 September 2020)

¹⁶⁴ See for example <https://www.who.int/globalchange/commit/commit-to-ambitious-climate-action/en/> (accessed 24 September 2020)

WHO's work to support the implementation of the NCD-GAP was provided to a number of World Health Assemblies but no explicit reference was made to the one-WHO workplan.

135. Some concerns were raised that the restructuring that had taken place in headquarters, as part of the transformation agenda, had split NCDs into two with one part focused on prevention (and risk factors) and the other focused on management of NCDs. While most Regional Offices had then restructured along similar lines, this was not the case in EMRO or AMRO/PAHO. One respondent commented that *"the NCD agenda was sacrificed"* at least conceptually and some Member States were said to be unhappy about this. If the system is to work, there will be need for good coordination between the two Assistant Directors-General (ADG) leading these areas of work. The NCD/WIN network, composed of a Steering Committee and an Action Network, has established a format for this through weekly coordination meetings and the production of a strategic internal delivery plan covering the period 2019-23. Some respondents considered that the change had been positive in terms of the NCD management side, providing an opportunity to raise the profile of NCDs and access funding by fully integrating NCDs as a key element of UHC and PHC. The issue of how headquarters was structured was of less concern to respondents from Country Offices. One commented that there would always be issues with *"how you slice the cake"* and they would manage however it was done. They also commented that there had always been an element of fragmentation, e.g. between different risk factors.
136. Respondents were very concerned about WHO capacity at the country level to provide support on issues relating to NCDs. In most cases, even in large country offices, WHO staff have to cover multiple areas. Respondents considered that having sufficient capacity at Country Office level was essential if WHO was to provide the support needed on NCDs. Financial and human resources were identified as the main challenges facing WHO Country Offices wishing to work on NCDs. One respondent commented that without adequate human resources in Country Offices, WHO was only paying *"lip service"* to NCDs. Another commented that it is crucial to align strategy, incentives and staff but noted that WHO does not do this. Concern was raised that sometimes the only funds available were for one specific activity, e.g. a STEPS survey, but without other funds, e.g. to follow-up, they wondered about the value of using money in this way. One point raised by several respondents was that sometimes lack of human resources forces an integrated approach.
137. In order to effectively support multi-sectoral responses to NCDs, specific non-health related competencies may need to be built at the country level to engage with ministries of finance and trade or in order to support countries in managing their relationships with private sector actors active in relevant fields. Some respondents considered that WHO capacity in non-health areas at the country level needed to be strengthened to support countries adequately in tackling NCD risk factors. Attempts to mobilize sectors outside health may have fallen short because they require skills outside the core competencies of WHO. One respondent commented, *"Prevention is not health promotion, it is not only what you do in the clinic, it is a different approach. We are physicians, focussed on treating and preventing diseases in the medical sector. Tackling the enabling environment and taxation are a different skill set altogether"*. This can also relate to the way WHO presence is set up in different contexts. One respondent commented, *"The Ministry of Health treats WHO as one of its departments. If WHO wants to contact other ministries, the procedure is not well-defined"*. Some respondents in Country Offices appreciated however that it was possible to get very detailed technical support, e.g. on the economics of taxation, from headquarters.

3.7.5 Linking to the broader development agenda

138. The NCD-GAP and related high-level political commitments have raised the profile of NCDs on international and national health and development agendas (see Section 3.1, p4). This momentum contributed to the inclusion

of NCDs, as target 3.4,¹⁶⁵ in the 2030 Agenda for Sustainable Development.¹⁶⁶ Target 3.4 specifically includes reference to promoting mental health and wellbeing (see Section 3.7.3, p58). Within SDG 3,¹⁶⁷ several other targets are pertinent to NCDs covering risk factors (harmful use of alcohol, tobacco control), management of NCDs (universal health coverage and research and development on NCD vaccines and medicines) and air, water and soil pollution (see Figure 22).

Figure 22: Targets relating to NCDs within SDG 3



139. The Global Action Plan on SDG 3¹⁶⁸ guides the work of 12 multilateral organizations¹⁶⁹ to streamline their efforts to better support countries to accelerate progress on SDG 3. The plan identifies seven “accelerators” namely primary health care; sustainable financing for health; community and civil society engagement; determinants of health; innovative programming in fragile and vulnerable settings and for disease outbreak responses; research and development, innovation and access; data and digital health. In 2019, the UN General Assembly high-level meeting adopted a landmark political declaration on universal health coverage.¹⁷⁰ The declaration expands on the SDG target 3.8 of achieving universal health coverage by 2030 through a set of wide-ranging actions to support the development of UHC. It includes a mid-point target to cover one billion additional people, by 2023, with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies in line with the GPW13 target. This declaration was followed by

¹⁶⁵ By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Details of targets under SDG3 are available on <https://www.un.org/sustainabledevelopment/health/> (accessed 20 September 2020)

¹⁶⁶ United Nations General Assembly (2015) *Transforming our World: The 2030 Agenda for Sustainable Development* A/RES/70.1 available on https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf (accessed 20 September 2020)

¹⁶⁷ Ensure healthy lives and promote well-being for all at all ages

¹⁶⁸ WHO (2019) *Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All* available On <https://apps.who.int/iris/rest/bitstreams/1250381/retrieve> (accessed 20 September 2020)

¹⁶⁹ Gavi, Global Financing Facility, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UNWomen, the World Bank, World Food Programme and WHO

¹⁷⁰ United Nations General Assembly (2019) *Political Declaration of the High-Level Meeting on Universal Health Coverage* available on <https://undocs.org/en/A/RES/74/2> (accessed 20 September 2020)

the creation of the UHC2030 International Health Partnership and the Global Compact for progress towards UHC.¹⁷¹

140. In light of these major developments in the international health agenda, the World Health Assembly in 2019 confirmed the objectives of the NCD-GAP as a contribution towards achieving SDG Target 3.4 and other NCD-related goals and targets and decided to extend the period of the action plan to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.¹⁷² Concerns were raised with the evaluation support team that the implications of this decision needed further consideration, particularly in terms of whether the indicators and targets in the NCD-GAP aligned with SDG targets and indicators.¹⁷³ This matter is considered in Annex 6. This highlights a number of issues:

- Does the 2025 deadline still apply to NCD targets or has this now been shifted to 2030? Specifically, in relation to premature mortality from NCDs, is the target of 25% reduction by 2025 superseded by the SDG target of one third reduction by 2030 or does it remain as a milestone en route to that target? Another potential issue is whether these targets have a common time point from when reductions would be measured.
- The SDG targets and indicators include mental health and air pollution. Are there plans to incorporate these indicators into the NCD-GAP monitoring framework or to otherwise modify this to align better with SDG indicators?
- There seems to be a specific issue relating to age for monitoring tobacco use. The NCD-GAP specifies 18+ while the SDGs specify aged 15 years and over. Is this an issue? If yes, how will it be resolved?
- Some of the NCD-GAP indicators are potentially part of broader UHC indicators or measure elements of the same thing in a slightly different way. Are there plans to align these?

141. Regardless of whether the focus is on reducing premature NCD mortality by 25% by 2025 or 33% by 2030, current evidence is that this target is off track globally. According to the Secretariat's report to the World Health Assembly in 2019, the rate of decline of the probability of dying from cardiovascular disease, cancer, diabetes and chronic lung disease between the ages of 30 and 70 years was *"insufficient to meet Sustainable Development Goal target 3.4"*.¹⁷⁴ This was confirmed in a recent article by NCD Countdown 2030 collaborators which concluded that, at the current rate of progress, SDG target 3.4 would only be achieved by fewer than one-fifth of countries by 2030, most from the high-income group.¹⁷⁵

142. Some respondents questioned the ongoing relevance of the NCD-GAP to guide the management and control of NCDs given the changes that have occurred in relation to UHC and SDGs since 2013. One commented, *"the SDGs absorbed the GAP, there is some alignment, but there is no global monitoring mechanism, political dialogue, financing platform for the GAP as for the SDGs"*. Respondents suggested there was a need to further define specific requirements of NCD management within the UHC agenda especially in terms of workforce, medicine availability and competencies.

¹⁷¹ UHC2030 International Health Partnership (undated) *Global Compact for Progress towards Universal Health Coverage* available on https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangements_docs/UHC2030_Official_documents/UHC2030_Global_Compact_WEB.pdf (accessed 20 September 2020)

¹⁷² WHA (2019) *Resolutions and Decisions Annex: Decision WHA72(11) Follow-up to the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* available from p49 of https://apps.who.int/gb/ebwha/pdf_files/WHA72-REC1/A72_2019_REC1-en.pdf#page=25 (accessed 20 September 2020)

¹⁷³ See United Nations General Assembly (2017) *Work of the Statistical Commission Pertaining to the 2030 Agenda for Sustainable Development A/RES/71/313* available on http://ggim.un.org/documents/A_RES_71_313.pdf (accessed 20 September 2020)

¹⁷⁴ WHA (2019) *Follow-up to the High-Level Meetings of the United Nations General Assembly on Health-Related Issues* available on https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_19-en.pdf (accessed 20 September 2020) – paragraph 9, p5

¹⁷⁵ NCD Countdown 2030 collaborators (2020) *NCD Countdown 2030: Pathways to Achieving Sustainable Development Goal Target 3.4* The Lancet available on <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931761-X> (accessed 20 September 2020)

143. Respondents also questioned the extent to which the NCD-GAP is set up to link up to other NCD areas beyond the limited number of diseases specified given the context of the patient-centred approach promoted in the UHC agenda. Respondents highlighted areas such as eye health, kidney disease and dementia, for example, *“there is a need for a greater integration within UHC and a more holistic approach which accounts for the whole person and includes adequate focus on ‘non-communicable’ eye diseases and conditions”, “many diseases are not listed among the big 4 (or 5) NCDs and therefore will not be officially tracked. This is duplicating the errors of the MDGs, leaving diseases behind” and “setting priorities over such a long period of time inevitably misses out on new challenges and new opportunities that emerge. This is certainly the case with obesity, given the amount of new evidence that has surfaced since the GAP was originally formulated, particularly around the nature of obesity as a disease and its role in COVID-19 complications”.*
144. Concerns were also raised about the demands placed on countries if they have to report separately on the NCD-GAP and on the SDGs. Respondents commented, *“it would be easier if the indicators were combined” and “there is the SDG targets and indicators towards 2030 and the 2025 target and that is confusing, so there is a tendency to have a lot of process around the GAP. There is need for more alignment and simplification between what WHO and broader UN demand. Countries have to produce many reports”.*

Conclusions and recommendations for cross-cutting issues

Conclusions

WHO lacks adequate financial and human resources to provide technical support to implementation of the NCD agenda, particularly at the country level especially given increasing country demands for technical support. Work across risk factors in WHO is fragmented and lacks clear leadership.

Multisectoral engagement, for example beyond the health sector and with the private sector, requires people with appropriate private sector, political, diplomatic and networking skills and experience. There has been little clear guidance from WHO as to how countries can establish effective multisectoral responses, involving other United Nations agencies, civil society, private sector organizations, etc., including how to manage and avoid commercial conflicts of interest. The role of civil society in supporting the NCD response has not been fully harnessed. People with lived experiences of NCDs are largely absent from decision-making processes.

Member State NCD-GAP implementation and WHO technical support have generally not emphasized the needs of vulnerable groups or identified specific barriers and risks that affect them. Disaggregated data on prevalence of NCDs and their risk factors in different segments of the population are limited, hindering the identification and design of targeted interventions. There could be more focus on health literacy both for NCD prevention and management. Key elements needing greater emphasis are patient-centred communication and easy-to-understand and easy-to-act-on material to support self-management.

While there has been an in-principle decision to include mental health and air pollution in the international NCD agenda, that is to move from “4 x 4” to “5 x 5”, it is unclear how this will work in practice within the NCD-GAP.

UNIATF has effectively convened and supported coordination between United Nations Agencies globally, regionally and in-country, including through high-profile country visits which have raised the profile of NCDs with national governments and with United Nations agencies in-country. Progress on joint action has been hampered by lack of buy-in at all levels and adequate resourcing for the NCD agenda across the United Nations sector.

The GCM/NCD is, to date, the first and currently the only formal Member State-led mechanism within the WHO Secretariat aimed at facilitating multistakeholder engagement and cross-sectoral collaboration in the area of NCDs. Its unique mandate rests primarily in its engagement capacity and its potential to create links between multisectoral actors, including Member States, non-State actors, United Nations actors and other technical programmes, at the global, regional and national levels. As the functions originally envisaged for the GCM/NCD remain valid and relevant contributions to the NCD-GAP, the Thirteenth General Programme of Work, 2019–2023, and the Sustainable Development Goal targets to 2030, these functions should be continued. However, the mechanism needs to evolve towards, or possibly be replaced by, a more targeted and action-oriented model, or alternative approach, in closer collaboration with relevant internal and external actors.

Conclusions and recommendations for cross-cutting issues

Recommendations

WHO Secretariat to undertake a functional review to consider the extent to which its structure and capacity are optimal for providing technical support to NCD responses. Specifically:

- WHO Secretariat to develop an NCD resource plan which outlines human and financial resources needed and available for providing technical support for the prevention and control of NCDs, particularly at the country level. This to be based on focusing WHO resources on the biggest causes of death and disease faced by countries.
- WHO Secretariat to assess the extent to which the current structures for NCDs are optimal, particularly in terms of a coherent approach to risk factors and ensuring maximal input relating to NCD management within universal health coverage.
- WHO Secretariat to review the coordination mechanisms across WHO departments and teams that are available to senior leadership and others to ensure coherence of the different elements of the NCD response.

WHO Secretariat and Member States to consider how they can more effectively promote and support multisectoral engagement on NCDs. Specifically:

- WHO Secretariat to recruit people with a more diverse skills set, for example relating to multisectoral engagement.
- WHO Secretariat to continue to effectively implement the Framework of Engagement with Non-State Actors as a guide to engaging non-State actors.
- WHO Secretariat to support Member States to engage appropriately and effectively with the private sector by producing examples of effective engagement with the private sector, offering guidance on how Member States might protect themselves from undue industry interference drawing on WHO experience in this area (e.g. the WHO FCTC).
- WHO Secretariat to provide technical support on procurement of medicines and medical technology in line with the NCD-GAP target (no. 9) of 80% availability of the affordable basic technologies and essential medicines.
- WHO Secretariat to better engage, and to support Member States to better engage, with civil society, including producing evidence of good practice on civil society engagement, supporting civil society to monitor contributions to the NCD-GAP and issuing guidelines on civil society involvement in the multisectoral response, including strengthening accountability of NCD reporting and ensuring that people living with NCDs are involved in decision-making and monitoring processes.

Member States and WHO Secretariat to increase their focus on how NCDs differentially affect different groups including children, youth, disabled people, people living with HIV, older persons, indigenous peoples, refugees, internally displaced persons and migrants, as specified in the 2030 Agenda for Sustainable Development. Specifically:

- WHO Secretariat to support countries in conducting disaggregated data collection and analysis of NCD prevalence and risk factors in vulnerable groups.
- WHO Secretariat and Member States to design interventions addressing determinants of health including gaps and barriers that affect identified groups in line with the principles embedded in the Sustainable Development Goals of leaving no one behind and reaching the furthest behind first.
- WHO Secretariat and Member States to identify ways in which they can promote health literacy for both NCD prevention and management including greater focus on patient-centred communication and on easy-to-understand and easy-to-act-on material to support self-management.

Conclusions and recommendations for cross-cutting issues

Recommendations (continued)

There is a need to work out how including mental health and air pollution can be incorporated in practice into the NCD-GAP. Specifically:

- WHO Secretariat and Member States to consider developing a joint operating model.
- WHO Secretariat to propose to Member States the adjustments needed to current monitoring systems. Reviewing and refreshing the monitoring framework would be one way of linking the current NCDs and risk factors with mental health and air pollution while also ensuring greater alignment with major developments in the fields of international health and development since 2013, such as the Sustainable Development Goals and their targets and indicators.

UNIATF and the United Nations Economic and Social Council (ECOSOC) to consider how they can provide further support to countries, promote joint activities between United Nations agencies and further build support for NCD responses among the senior leadership of United Nations agencies. Specifically:

- UNIATF and ECOSOC to quantify and identify necessary resources and options for how to respond to country requests including for ongoing support and follow-up, including NCDs in the context of national COVID-19 response and recovery plans.
- UNIATF and ECOSOC to identify ways in which more joint actions can be conducted.
- UNIATF and ECOSOC to identify ways in which support for NCDs can be built at senior levels across the United Nations.

WHO Secretariat and Member States to consider implementing the recommendations of the final evaluation of the GCM/NCD. The principal recommendation of the final GCM evaluation was that, as options going forward, (a) a strengthened, more focused approach to the delivery of the vital GCM functions through the GCM/NCD, or (b) the discontinuation of the mechanism and establishment of a new operating model within WHO to ensure the functions are effectively carried forward, needed to be considered. In addition, the final evaluation contained four additional recommendations, based on the recommendations of the preliminary evaluation, which were generally not implemented. These covered developing a medium-term strategic plan, enhancing country reach, formulating a clear engagement strategy and rationalizing approaches to resource mobilization. More details of these are available in the summary report on the final evaluation of the GCM/NCD.

4. Conclusions and lessons learned

145. The findings section of this report considered progress within each objective of the NCD-GAP according to a number of identified indicators. The four risk factors within objective 3 are treated separately. It is possible to aggregate performance across these indicators to provide an overall assessment of progress against the objective, analysed by country income group. The detailed method for this is described in Annex 4 and the conclusions are summarized here and in Table 8.

Table 8: Performance scores by objective in 2015 and 2019 and the difference between them: Overall and by country income group (colour codes show level of performance: dark green if >80%, light green if 60–79%, yellow if 40–59% and amber if <40% - *p*-value relates to whether there is a statistical association between the objective and county income group)

Objective	LIC			LMIC			UMIC		
	2015	2019	Diff	2015	2019	Diff	2015	2019	Diff
1	29	47	+18	37	66	+29	40	65	+25
2	24	38	+14	37	53	+16	51	71	+20
3 – tobacco	24	30	+6	34	42	+8	41	48	+7
3- alcohol	45	45	0	44	42	-2	52	48	-4
3- diet	3	11	+8	16	25	+9	31	35	+4
3- activity	28	17	-11	55	30	-25	67	75	+8
4	9	22	+13	15	38	+23	34	55	+21
5	17	14	-3	8	19	+11	28	30	+2
6	20	32	+12	37	49	+12	55	65	+10

Objective	HIC			Total			<i>p</i> -value		
	2015	2019	Diff	2015	2019	Diff	2015	2019	Diff
1	45	63	+18	39	62	+23	.12	.26	.75
2	59	71	+12	46	61	+15	<.001	<.001	.75
3 – tobacco	45	57	+12	38	46	+8	<.001	<.001	.07
3- alcohol	47	41	-6	47	44	-3	.46	.63	.23
3- diet	48	57	+9	28	36	+8	<.001	<.001	.997
3- activity	78	86	+8	61	58	-3	<.001	<.001	.007
4	42	70	+28	28	50	+22	<.001	<.001	.09
5	30	58	+28	22	34	+12	.02	<.001	.005
6	62	67	+5	47	57	+10	<.001	<.001	.09

146. Overall, across all objectives, performance remains relatively low. There has been modest improvement in most objectives with the exception of, within objective 3, reducing the harmful use of alcohol and promoting physical activity. For most objectives, there was a statistically significant association between levels of performance in both 2015 and 2019 and country income level. The exceptions to this are objective 1 and, within objective 3, reducing the harmful use of alcohol. In most cases, the change between 2015 and 2019 was not statistically associated with country income level. There were two exceptions. In the case of physical activity, levels of performance declined markedly in both low- and lower-middle-income countries while there were modest improvements in upper-middle- and high-income countries. In the case of objective 5, related to research, what improvement that was seen was almost entirely in high-income countries.

147. It appears that any country is able to develop a policy, strategy or action plan to address NCDs but resource are needed to develop structures and to implement the actions needed. These resources may be available in high-income countries but they are largely lacking in countries with lower income levels. In some areas, particularly preventing the harmful use of alcohol, this expected difference is not seen suggesting that there may be factors other than resources at play in this case.

148. The evaluation has drawn a number of conclusions and identified a number of lessons learned. These are summarized here and are the basis for recommendations in the section that follows:

- C1. Overall, the NCD-GAP has contributed to raising the profile of NCDs internationally and in many countries and this has contributed to an increase in the number of countries that have adopted a national NCD policy, strategy or action plan. However, there is a pressing need to accelerate implementation of those plans and international and domestic financial resources are needed for this delivery.
- C2. The identification by WHO of what it terms NCD best buys has provided Member States with a menu of policy options they can consider when looking for cost-effective mechanisms based on current best evidence. Overall, progress in implementing the NCD-GAP has been slow and incremental rather than the kind of rapid acceleration to which the high-level processes associated with the NCD-GAP aspired.
- C3. Incremental progress has been made in addressing tobacco use but similar progress has not yet been seen with other risk factors including harmful use of alcohol, healthy diet and physical activity. A key factor in this regard may be the WHO Framework Convention on Tobacco Control (WHO FCTC) and the monitoring of its implementation.
- C4. The crucial importance of not solely focusing on a single NCD has been recognized. While some progress has been made on developing protocols and ensuring essential NCD medicines are available, these are still lacking in many countries. More is needed to ensure NCDs are managed effectively through primary care so that people with NCDs, such as hypertension and diabetes, are diagnosed, treated and have their conditions controlled. There is a need to ensure that vulnerable groups, different age groups and those in emergency settings are included in this provision.
- C5. Investment in and support for research has been suboptimal despite the recognition that there are still many evidence gaps, for example, in terms of what constitutes best buys in different contexts and how best to promote implementation of interventions found to be highly effective, depending on the contexts. Overwhelmingly, research has been the weakest NCD-GAP objective in terms of implementation.
- C6. There are two sets of progress indicators, with one focused on action plan implementation and the other focused on commitment fulfilment. There is some overlap between indicator sets. Data are reported regularly by almost all Member States but there is scope for much greater use and analysis of data.

Cross-cutting issues

- C7. WHO lacks adequate financial and human resources to provide technical support to implementation of the NCD agenda, particularly at the country level especially given increasing country demands for technical support. Work across risk factors in WHO is fragmented and lacks clear leadership.
- C8. Multisectoral engagement, for example beyond the health sector and with the private sector, requires people with appropriate private sector, political, diplomatic and networking skills and experience. There has been little clear guidance from WHO as to how countries can establish effective multisectoral responses, involving other United Nations agencies, civil society, private sector organizations, etc., including how to manage and avoid commercial conflicts of interest. The role of civil society in supporting the NCD response has not been fully harnessed. People with lived experiences of NCDs are largely absent from decision-making processes.
- C9. Member State NCD-GAP implementation and WHO technical support have generally not emphasized the needs of vulnerable groups or identified specific barriers and risks that affect them. Disaggregated data on prevalence of NCDs and their risk factors in different segments of the population are limited, hindering the identification and design of targeted interventions. There could be more focus on health literacy both for NCD prevention and management. Key elements needing greater emphasis are patient-centred communication and easy-to-understand and easy-to-act-on material to support self-management.

- C10. While there has been an in-principle decision to include mental health and air pollution in the international NCD agenda, that is to move from “4 x 4” to “5 x 5”, it is unclear how this will work in practice within the NCD-GAP.
- C11. UNIATF has effectively convened and supported coordination between United Nations agencies globally, regionally and in-country, including through high-profile country visits which have raised the profile of NCDs with national governments and with United Nations agencies in-country. Progress on joint action has been hampered by lack of buy-in at all levels and adequate resourcing for the NCD agenda across the United Nations sector.
- C12. The GCM/NCD is, to date, the first and currently the only formal Member State-led mechanism within the WHO Secretariat aimed at facilitating multistakeholder engagement and cross-sectoral collaboration in the area of NCDs. Its unique mandate rests primarily in its engagement capacity and its potential to create links between multisectoral actors, including Member States, non-State actors, United Nations actors and other technical programmes, at the global, regional and national levels. As the functions originally envisaged for the GCM/NCD remain valid and relevant contributions to the NCD-GAP, the Thirteenth General Programme of Work, 2019–2023, and the Sustainable Development Goal targets to 2030, these functions should be continued. However, the mechanism needs to evolve towards, or possibly be replaced by, a more targeted and action-oriented model, or alternative approach, in closer collaboration with relevant internal and external actors.¹⁷⁶

¹⁷⁶ The full report of the final evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases is available on the website of the WHO Evaluation office (www.who.int/evaluation).

5. Recommendations

149. The evaluation has identified the following recommendations:

NCD-GAP Objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

R1. **WHO Secretariat and Member States to find sustainable funding mechanisms to allow for a dramatic acceleration of NCD implementation.** Specifically:

- WHO Secretariat to develop specific proposals as to how NCD funding can be incorporated into plans to build back better.
- UNIATF, WHO and international partners to continue with plans to introduce a Catalytic/Multi-Partner Trust Fund for NCDs.
- Bilateral funders, multilateral funders, philanthropies and other funding agencies to provide additional funds for NCD responses, including through the Catalytic/Multi-Partner Trust Fund for NCDs.
- WHO Secretariat to continue to work with the Organisation for Economic Co-operation and Development to introduce a purpose code to track spending on NCDs within official development assistance.

NCD-GAP objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs

R2. **WHO Secretariat and Member States to consider how best to use limited financial resources available for NCDs by focusing on the most cost-effective options based on available evidence.** Specifically:

- Member States to identify ways in which they can provide, identify and leverage the domestic financial resources needed to respond effectively to NCDs including, as appropriate, as part of national COVID-19 responses and recovery action plans .
- Member States to focus their financial resources on those actions which will be most cost-effective based on best available evidence.
- WHO Secretariat to update the best buys based on latest evidence, particularly from a diverse range of regional and national settings.
- Member States to adapt the best buys to their context with WHO Secretariat technical support if necessary.
- WHO Secretariat to consider if further guidance can be given on total funding needed to implement the most cost-effective NCD interventions.
- WHO Secretariat and Member States to seek ways to collect and report more data on levels of in-country expenditure on NCDs.

NCD-GAP objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments

R3. **WHO Secretariat and Member States to explore why progress seen in relation to addressing tobacco use has not yet been seen in relation to other risk factors.** Specifically:

- WHO Secretariat and Member States to explore why the steady progress being seen in relation to tobacco control is not being seen for other risk factors.
- WHO Secretariat and Member States to explore why, in particular, policies on harmful use of alcohol are not associated with implementation of identified cost-effective actions on harmful use of alcohol.
- WHO Secretariat and Member States to explore what the barriers are to implementation of actions, that are not showing a positive association with income group, in high-income countries.

- WHO Secretariat to review (as part of any review of the best buys) whether the range of cost-effective interventions for physical activity can be expanded.
- Member States to develop and strengthen appropriate regulatory frameworks for all risk factors with WHO Secretariat technical support.

NCD-GAP objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage

R4. WHO Secretariat and Member States to do more to ensure those affected by NCDs are diagnosed, receiving treatment and having their condition controlled. Specifically:

- WHO Secretariat and Member States to identify practical ways in which responses to NCDs can be better integrated into primary health care and universal health coverage.
- WHO Secretariat to develop more concrete guidance on NCD management in primary care.
- WHO Secretariat and Member States to improve monitoring of the number and proportion of people receiving essential medicines in primary health care settings, particularly to reduce cardiovascular risk, ensuring that the needs of particular groups are addressed.
- WHO Secretariat, Member States, international partners and non-State actors to recognize and emphasize that it is important not to focus solely on a single NCD.

NCD-GAP objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs

R5. WHO Secretariat and Member States to determine how the priority of NCD research can best be raised. Specifically:

- WHO Secretariat and Member States to determine if lack of sufficient funding or an efficient funding mechanism might be an underlying reason why little progress has been made on NCD research and if so how this can be resolved.
- WHO Secretariat to develop a clear plan as to how it will support this area of work including identifying current research priorities and needs and how these will be addressed.
- WHO Secretariat to identify respective roles and responsibilities for this objective, particularly given the establishment of a Science Division.
- WHO Secretariat with the involvement of the WHO collaborating centres to identify ways in which WHO collaborating centres working on NCDs can contribute to this objective.

NCD-GAP objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

R6. WHO Secretariat and Member States to consider ways in which the monitoring and surveillance of NCD responses can be further strengthened. Specifically:

- WHO Secretariat and Member States to identify how to conduct risk factor surveys in a more cost-effective and sustainable manner that builds local capacity and is coherent with other national data systems.
- WHO Secretariat to ensure that future reporting to Member States on the AP indicator set includes the indicator on research (AP5).
- WHO Secretariat to revise and update the AP indicator definitions and to clarify the baseline year for progress reporting to the Health Assembly, and then report on these to Member States.
- WHO Secretariat to make data more readily available publicly, for example online, and to use the available data more, for example through in-house analysis in collaboration with partners.
- WHO Secretariat, Member States, international partners and non-State actors to develop metrics for actors other than Member States, that is WHO, international partners and non-State actors.

- WHO Secretariat and Member States to strengthen mechanisms for validation of country-reported data, for example through civil society and in-county verification.
- WHO Secretariat to brief Member States on what monitoring and reporting implications there are of extending the NCD-GAP to 2030, including what will be reported in 2025 and what in 2030.
- WHO Secretariat and Member States to ensure that the final evaluation of the NCD-GAP is able to assess progress at the outcome level as specified in the global monitoring framework. This will require having an appropriate framework in place, for example a theory of change, and exploring and analysing associations between documented progress and observed changes in outcomes. The evaluation should also explore why some countries perform above levels expected based on country income group through case studies.

Cross-cutting issues

R7. **WHO Secretariat to undertake a functional review to consider the extent to which its structure and capacity are optimal for providing technical support to NCD responses.** Specifically:

- WHO Secretariat to develop an NCD resource plan which outlines human and financial resources needed and available for providing technical support for the prevention and control of NCDs, particularly at the country level. This to be based on focusing WHO resources on the biggest causes of death and disease faced by countries.
- WHO Secretariat to assess the extent to which the current structures for NCDs are optimal, particularly in terms of a coherent approach to risk factors and ensuring maximal input relating to NCD management within universal health coverage.
- WHO Secretariat to review the coordination mechanisms across WHO departments and teams that are available to senior leadership and others to ensure coherence of the different elements of the NCD response.

R8. **WHO Secretariat and Member States to consider how they can more effectively promote and support multisectoral engagement on NCDs.** Specifically:

- WHO Secretariat to recruit people with a more diverse skills set, for example relating to multisectoral engagement.
- WHO Secretariat to continue to effectively implement the Framework of Engagement with Non-State Actors as a guide to engaging non-State actors.
- WHO Secretariat to support Member States to engage appropriately and effectively with the private sector by producing examples of effective engagement with the private sector, offering guidance on how Member States might protect themselves from undue industry interference drawing on WHO experience in this area (e.g. the WHO FCTC).
- WHO Secretariat to provide technical support on procurement of medicines and medical technology in line with the NCD-GAP target (no. 9) of 80% availability of the affordable basic technologies and essential medicines.
- WHO Secretariat to better engage, and to support Member States to better engage, with civil society, including producing evidence of good practice on civil society engagement, supporting civil society to monitor contributions to the NCD-GAP and issuing guidelines on civil society involvement in the multisectoral response, including strengthening accountability of NCD reporting and ensuring that people living with NCDs are involved in decision-making and monitoring processes.

R9. **Member States and WHO Secretariat to increase their focus on how NCDs differentially affect different groups** including children, youth, disabled people, people living with HIV, older persons, indigenous peoples, refugees, internally displaced persons and migrants, as specified in the 2030 Agenda for Sustainable Development. Specifically:

- WHO Secretariat to support countries in conducting disaggregated data collection and analysis of NCD prevalence and risk factors in vulnerable groups.

- WHO Secretariat and Member States to design interventions addressing determinants of health including gaps and barriers that affect identified groups in line with the principles embedded in the Sustainable Development Goals of leaving no one behind and reaching the furthest behind first.
- WHO Secretariat and Member States to identify ways in which they can promote health literacy for both NCD prevention and management including greater focus on patient-centred communication and on easy-to-understand and easy-to-act-on material to support self-management.

R10. **There is a need to work out how including mental health and air pollution can be incorporated in practice into the NCD-GAP.** Specifically:

- WHO Secretariat and Member States to consider developing a joint operating model.
- WHO Secretariat to propose to Member States the adjustments needed to current monitoring systems. Reviewing and refreshing the monitoring framework would be one way of linking the current NCDs and risk factors with mental health and air pollution while also ensuring greater alignment with major developments in the fields of international health and development since 2013, such as the Sustainable Development Goals and their targets and indicators.

R11. **UNIATF and the United Nations Economic and Social Council (ECOSOC) to consider how they can provide further support to countries, promote joint activities between United Nations agencies and further build support for NCD responses among the senior leadership of United Nations agencies.** Specifically:

- UNIATF and ECOSOC to quantify and identify necessary resources and options for how to respond to country requests including for ongoing support and follow-up, including NCDs in the context of national COVID-19 response and recovery plans.
- UNIATF and ECOSOC to identify ways in which more joint actions can be conducted.
- UNIATF and ECOSOC to identify ways in which support for NCDs can be built at senior levels across the United Nations.

R12. **WHO Secretariat and Member States to consider implementing the recommendations of the final evaluation of the GCM/NCD**¹⁷⁷. The principal recommendation of the final evaluation of the GCM/NCD was that, as options going forward, (a) a strengthened, more focused approach to the delivery of the vital GCM functions through the GCM/NCD, or (b) the discontinuation of the mechanism and establishment of a new operating model within WHO to ensure the functions are effectively carried forward, needed to be considered. In addition, the final evaluation contained four additional recommendations, based on the recommendations of the preliminary evaluation, which were generally not implemented. These covered developing a medium-term strategic plan, enhancing country reach, formulating a clear engagement strategy and rationalizing approaches to resource mobilization. More details of these are available in the summary report on the final evaluation of the GCM/NCD.¹⁷⁸

¹⁷⁷ The full report of the final evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases is available on the website of the WHO Evaluation office (www.who.int/evaluation).

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