World Health Organization

INFORMATION NOTE

Dialogue on how to encourage the continued inclusion of noncommunicable diseases (NCDs) in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies (Geneva, 20-21 April 2015)

Introduction

1. This paper aims to provide background for the Dialogue on how to encourage the continued inclusion of noncommunicable diseases (NCDs) to be held on 20-21 April 2015 in Geneva. It intends to build on current knowledge, highlight new developments and evidence, as well as uniting stakeholders around a common agenda and accelerating implementation of the Global action plan for the prevention and control of NCDs 2013-2020 .

2. This information note summarizes the developments since 2011 in the area of addressing NCDs, in particular with regard to the role of development cooperation, economic development policies, sustainable development frameworks and poverty reduction strategies. It draws on the latest research and lessons learnt from implementation in affected countries.

3. NCDs constitute one of the major challenges for development in the twenty-first century. These diseases undermine social and economic development throughout the world, threaten the achievement of internationally agreed development goals and may lead to increasing inequalities within and between countries and populations.

4. NCDs and their risk factors worsen poverty, while at the same time poverty contributes to the increasing rates of NCDs. This situation poses a serious threat to sustainable development, and a proposed target for NCDs in the post-2015 sustainable development goals is currently under discussion.

5. Pursuant to action 1.1 included in the WHO GCM/NCD work plan 2014-2015, the WHO Global Coordination Mechanism on NCDs (GCM) is conducting a Dialogue which will explore mechanisms to encourage the inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

6. NCDs act as barriers to poverty alleviation and to sustainable development, and it is essential to move from political commitment to action. Government commitments around this topic are substantial. They include setting national targets in 2015 and developing national plans to attain these targets; implementation of WHO's best buys in 2016; establishing structures and processes for multisectoral and intersectoral collaboration; and increasing and prioritizing domestic budgetary allocations for addressing NCDs. Throughout all of these commitments, it is important to remember that prevention needs to be the cornerstone of any national NCD response and that investments in health systems are critical for improving NCD outcomes.

Context

Epidemiology:

7. NCDs include cardiovascular diseases (CVD), diabetes, cancer and chronic respiratory diseases, and are linked to four key risk factors: tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol. Aside from these four 'major' NCDs, mental, neurological and substance use disorders, musculoskeletal disorders and sensory disorders also contribute massively to the global burden of disease. NCDs kill an estimated 38 million people each year. Almost three quarters of NCD deaths (28 million) occur in low- and middle-income countries. Cardiovascular diseases account for most NCD deaths (17.5 million people annually), followed by cancers (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million).

8. Sixteen million NCD deaths occur before the age of 70 and 82% of these "premature" deaths occurred in low- and middle-income countries.[1] Most premature deaths from NCDs are largely preventable by influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol—and by strengthening health systems to enable them to respond to the health care needs of people with NCDs.

9. Premature deaths from NCDs reduce productivity, curtail economic growth and trap populations in poverty. The underlying determinants of these diseases and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required to prevent and control NCDs.[2]

Economic impact:

10. The cumulative lost output in low- and middle-income countries associated with the four major NCDs is estimated at US$7 trillion over the period 2011-2025 through spiralling health-care costs and productivity losses according to a 2011 study conducted by the Harvard School of Public Health and the World Economic Forum.

11. Macroeconomic simulations predict that over the period 2011-2025, the cumulative global economic losses due to the four main NCDs will surpass US$ 51 trillion. Relative to the size of their economies, low- and middle-income countries will be disproportionately affected. These countries' projected losses amount to an average of nearly US$ 500 billion per year, equivalent to approximately 4% of their gross domestic product in 2010.[3] In India, the current GDP loss from NCDs is estimated to be 4-10 percent per year.[4] Losses from NCDs (including mental health) are estimated to be $6.2 trillion between 2012 and 2030. These economic costs are even higher in China. The total losses associated with the four major non-communicable diseases and mental health in China are US$ 18.4 trillion and US$ 9.4 trillion, respectively, over the period 2012-2030. These estimates equate to more than eight times India's total health expenditure over the previous 19-year period, and more than twelve times China's total health expenditure in the 19 years prior to 2012.[5]

NCDs and poverty:

12. NCD´s have significant macroeconomic and poverty impact, and there is good evidence that reducing adult NCD mortality promotes poverty reduction.[6] Higher rates of NCDs impede poverty reduction initiatives in low-income countries, particularly by increasing household costs associated with health care and loss of productivity. Also, tobacco expenditure can constitute a significant portion of household expenditure leaving less money for food, education, housing, and clothing

particularly for the poor households who have competing needs. Vulnerable and socially disadvantaged people get sicker and die sooner than people of higher social positions, especially because they are at greater risk of being exposed to harmful products, such as alcohol, tobacco or unhealthy food, and have lower health literacy and limited access to health services. The poorest 20% of people get sicker and die sooner than people in higher income quintiles of higher social positions, especially because poor people are afforded much lower levels of protection from the risks and consequences of NCDs than people in high income quintiles. Additionally, most NCDs are chronic diseases which require repeated interactions with the health system. These continuous medical expenditures can be catastrophic for household budgets. For instance, studies have shown that in low- and middle-income settings more than 70% of stroke survivors could experience catastrophic out-of–pocket expenditure and more than 35% of patients and families were pushed below the poverty line.[7] A study conducted in India showed that 40% of CVD patients lost their income secondary to their illness and 13% could not continue the medication due to factors related to cost. [8] As a consequence, NCDs make it difficult for the "bottom billion" to break free from the cycle of poverty.

13. In low- and middle-income countries, treatment for cardiovascular disease, cancer, diabetes or chronic lung disease can quickly drain household resources, driving families into impoverishment. Health and economic outcomes are mutually dependent. The poor are more vulnerable to disease and the resulting direct and indirect costs of ill-health, such as out-of-pocket costs, reduced or even lost employment. Furthermore, others in the household are adversely affected by loss of schooling and savings which could have improved the household's opportunities if not spent on health care. In a vicious cycle, these losses can worsen the effects of disease through stress and efforts to adapt, such as non-adherence to treatment.[9] As development goals are ultimately aimed at reducing poverty, illness-related poverty puts the achievement of these goals further out of reach.

14. NCDs exacerbate social inequity because most payments for health care in low- and middle-income countries are private and out-of-pocket; such costs weigh more heavily on those least able to afford them, increasing their risk of impoverishment. The economic burden of NCD care is consistently higher for the poor than the higher income groups. Catastrophic spending for cardiovascular diseases occurred among more than 90 percent of patients in Tanzania and India, more than 70 percent of patients in China, and for more than 60 percent of cancer patients in Iran. The odds of incurring catastrophic hospitalization expenditures are nearly 160 percent higher with cancer than the odds of incurring catastrophic spending when hospitalization is due to a communicable condition. By comparison, the odds of incurring catastrophic hospital spending due to CVD or injuries are about 30 percent greater compared to communicable conditions that result in hospital stays.[10] The chronic nature of NCDs, and the projected increase in prevalence, means that the economic impact may grow cumulatively over many years and have dramatic economic impacts.[11]

Political commitment:

15. In 2011, the World Health Organization (WHO) was assigned a leadership and coordination role in supporting national efforts to address no communicable diseases by the *Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*.[12] Three years later, there is a global road map in place based on nine concrete global targets for 2025, organized around the WHO *Global action plan for the prevention and control of NCDs 2013–2020*. The global action plan, when implemented collectively by Member States, international partners and WHO, will help to attain a global target of a 25% reduction in premature deaths from NCDs by 2025[13]. The United Nations Interagency Task Force on NCDs, which the United Nations Secretary-General established in July 2013 and placed under the

leadership of WHO, has started to provide support to national efforts to build solutions to address NCDs. The WHO Global Coordination Mechanism on NCDs, established in May 2014, aims to facilitate and enhance the coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global level to prevent and control NCDs in line with the WHO Global NCD Action Plan 2013-2020.

16. Progress within countries matters most. Some striking achievements emerge from a survey conducted by WHO in 2013. Of the 172 countries reporting data, 95% have a unit or department in the Ministry of Health responsible for NCDs. Half now have an integrated operational plan with a dedicated budget. The number of countries conducting recent surveys of risk factors jumped from 30% in 2011 to 63% in 2013. In other words, more countries are getting the basics in place.

17. However, in July 2014 at the United Nations General Assembly, ministers from across the world found that overall progress is insufficient and highly uneven. The United Nations review saw no lack of commitment, but witnessed a lack of capacity to act, especially in low- and middle-income countries, due to a lack of access to expertise which is only available through international cooperation. To move forward, the outcome document adopted by the United Nations review presents a highly focused agenda for strengthening international cooperation.

18. The outcome document also contains next priorities in clear steps that will guide action until 2018, when the United Nations General Assembly will convene a third high-level meeting on NCDs. These include five commitments from Member States[14] setting national NCD targets for 2025, developing national multisectoral plans and implementing the WHO Global Action Plan for the prevention and control of NCDs 2013–2020 to reduce risk factors and strengthen health systems.

19. WHO has three major assignments; the first is to prepare a framework for country action aimed at supporting national efforts to improve health through action across sectors on risk factors for NCDs. The second is to develop an approach to register and publish contributions of non-State actors to the achievement of the nine global targets and the third is to submit a progress report to the United Nations General Assembly.

20. In July 2014, ministers in New York also agreed to give due consideration to addressing NCDs in the elaboration of the post-2015 development agenda, taking into account that NCDs constitute one of the major challenges for development in the twenty first century.[15] A proposed target to reduce premature mortality from NCDs by one third by 2030 was considered by Member States in September 2014 at the United Nations General Assembly. This milestone will provide critical guidance to the September 2015 United Nations Summit, which will adopt the post-2015 agenda. The discussions in July 2014 provided a timely opportunity for rallying political support for bolder measures in the post-2015 era.

Policy options to address NCDs and poverty link

21. A multisectoral approach is important, since sectors such as trade, finance, education, agriculture and food, and urban development all impact risk factors for NCDs at the population level. Within the health sector, supply and production of pharmaceuticals, diagnostics, devices and equipment must be considered. Different exposures to risk and barriers access to care and treatment are responsible for major inequalities in the occurrence and outcome of NCDs.

22. Social economic and environmental determinants of health are highly complex. However, they provide a clear roadmap for the ways in which policies in low- and middle-income countries receiving UN assistance can narrow the disparities in health outcomes. Integrating NCDs into broader and non-health specific social, economic and environmental policies and programmes is a

challenge. Effective NCD prevention and control requires political leadership, coordinated multi-stakeholder engagement and multisectoral action at the national level, as well as across the UN and other development partners.

23. Though a majority of countries see international donors as an important source of funding for NCDs, country requests for donor assistance are largely unmet. NCDs receive the smallest amount of donor funding of all major global health areas, accounting for only 1.23%, US$377 million, of all donor assistance for health (DAH) in 2011 and, while funding sources for NCDs are diversifying, to date, bilateral donors have been largely absent. Furthermore, NCD donor funding has been skewed toward general health services and tobacco control. At this point, some development agencies have committed to include NCDs into their bilateral and multilateral policies. Bilateral donors are the dominant funding source in global health, providing 52% of overall DAH; however, bilateral donors provided only US$40 million or 11% of DAH for NCDs in 2011. The World Bank and WHO each provide 9%. In sharp contrast, USA-based NGOs as a group provide US$100 million for NCDs -- almost as much as multilateral organizations provide, and far more than bilateral donors. This category includes organizations that receive funding from the USA government, as well as individual charitable giving.[16]

24. Approaching NCDs in low- and middle-income countries is largely centred on four main NCDs—cardiovascular diseases, diabetes, chronic respiratory diseases, and some cancers— and four risk factors—tobacco, poor diet, physical inactivity, and the harmful use of alcohol. The main approach to these conditions is preventive, through steps raising the price of tobacco, but also through simple treatments for conditions such as hypertension. The United Nations has ratified this approach, and WHO has set a target of reducing deaths under 70 from NCDs by 25% by 2025, the 25 x 25 target. Addressing the underlying determinants of NCDs and the four NCDs risk factors requires multisectoral, whole-of-government and whole-of-society responses to prevent and control NCDs.

25. There are a number of cost-effective and multisectoral policy options which thus contribute to poverty reduction. A number of these are included in Appendix 3 of the Global Action Plan for NCDs 2013-2020. These include tobacco control and alcohol reduction measures through policies such as tax and price increases. Such options are already part of the existing technical guidance available for health and development actors alike. In addition, work in this area could be informed by technical guidance on the integration of NCDs into work on Universal Health Coverage and improved primary health care. Recent analysis suggests that many of these measures can be implemented at a high benefit (e.g. number of life years saved) to cost ratio. A combined package of interventions to achieve five of the WHA targets – and nearly meet the goal of reducing NCD mortality by 1/3 – will provide between US$ 9-44 in economic benefit for every dollar spent.[17]

26. Additionally, there are already sound existing resources on interventions. A number of "best buys" are included in Appendix 3 of the Global Action Plan for NCDs 2013-2020. These are highly cost-effective, inexpensive, feasible and culturally acceptable actions that governments should undertake immediately to prevent NCDs save lives and reduce health care costs.

Box 1

'Best buys' have been identified for the four risk factors. Some highlights from this list include:

- Tobacco use: protecting people from tobacco smoke, warning about the dangers of tobacco, enforcing bans on tobacco advertising and raising taxes on tobacco;

- Harmful use of alcohol: regulating commercial and public availability of alcohol, restricting access to retailed alcohol, enforcing restrictions or banning alcohol advertising and promotions and using pricing policies such as excise tax increases on alcoholic beverages;
- Unhealthy diet: reduce salt intake, replacing trans-fat with polyunsaturated fat, promoting public awareness about diet;
- Physical inactivity: Promoting physical activity through the mass media.

'Best buys' have also been identified for health care interventions for the four major NCDs. These include:

- Cardiovascular disease and diabetes: (i) counseling and treatment (including glycaemic control for diabetes mellitus) for people (≥30 years), with 10-year risk of fatal or nonfatal cardiovascular events ≥ 30% and (ii) aspirin therapy for acute myocardial infarction;
- Cancer: cervical cancer screening and treatment of pre-cancerous lesions to prevent cervical cancer.

27. Within these, the average yearly cost of implementing a core set of high- impact, cost-effective NCD interventions in all low- and middle-income countries is estimated to be US$11.4 billion (an overall cost of US$170 billion over the period 2011- 2025). This represents an annual investment of under US$1 per capita in low-income countries, US$1.50 in lower middle-income countries, and US$3 in upper middle-income countries. Expressed as a proportion of current health spending, the cost of implementing such a package amounts to 4% in low-income countries, 2% in lower middle-income countries and less than 1% in upper middle-income countries.

28. Existing population-based tobacco control policy is pro-poor, and tobacco prevention contributes to eliminating extreme poverty. Reductions in tobacco use can avoid high health care costs associated with treating tobacco-related diseases, and prevent families from losing income through tobacco-related deaths or disability. Policies that raise tobacco taxes and prices are particularly effective for reducing tobacco use among the poor as low income people are more responsive to increases in tobacco prices than people with higher income.[18] Higher tobacco taxes will assist poor people to quit smoking and/or reduce quantities consumed, reducing the burden tobacco disproportionately imposes on the poor. Illicit trade in tobacco products is also a serious global concern because it increases the accessibility and affordability of tobacco products and undermines national economies and the tobacco-control policies of governments. The best available data suggest that globally one out of nine cigarettes (11.6%) is illicit. If the global illicit trade were eliminated, governments would gain at least US$31 billion in income and from 2030 onwards over 160 000 lives a year would be saved.

29. Tobacco-caused disease also drains valuable resources that could otherwise go for health care and other important basic needs. Particular measures as set out in the WHO FCTC constitute effective population-based intervention to reduce tobacco use. In April 2011 a report published in The Lancet identified tobacco control as "the most urgent and immediate priority" for combating NCDs, estimating that implementation of FCTC policies would prevent 5.5 million deaths over 10 years in 23 low- and middle-income countries with a high burden of NCDs — and cost less than 20 cents per person per year in countries such as China and India.[19]

30. There exists an extensive and well-documented evidence base for what works in tobacco control through the WHO FCTC, including through the MPOWER technical package provides guidance for and assistance. Guidance is also available from intergovernmental organizations such as WHO and the World Bank, and numerous NGOs, and documented in a technical assistance database

managed by the FCTC Secretariat. Experiences from low- and middle-income countries in tobacco control, shared through technical exchanges and study tours supported through a variety of inter-governmental organizations, NGOs and country governments, can be expanded within development initiatives.

31. There is an existing extensive and well-documented evidence base for what works to reduce harmful use of alcohol. Alcohol use is an integral part of many cultures; consequently effective interventions to reduce alcohol-related harm and inequities often meet with considerable resistance. Despite the large health, social and economic burden associated with harmful use of alcohol, it has remained a relatively low priority in public policy, including in public health policy. However, recent international policy frameworks and action plans, such as the WHO Global strategy to reduce the harmful use of alcohol and the WHO Global action plan for the prevention and control of noncommunicable diseases (NCDs) 2013–2020, have shifted the political compass towards an increased focus on the harmful use of alcohol.

32. The global strategy to reduce the harmful use of alcohol represents a collective commitment by WHO Member States to reduce the global burden of disease caused by harmful use of alcohol. The strategy includes evidence-based policies and interventions that can protect health and save lives if adopted, implemented and enforced. The strategy also contains a set of principles to guide the development and implementation of policies; it sets priority areas for global action, recommends target areas for national action and gives a strong mandate to WHO to strengthen action at all levels.

33. Alcohol consumption rates are markedly lower in poorer than in wealthier societies. However, within society differences in alcohol-related health outcomes by socioeconomic status (SES) tend to be more pronounced than differences in alcohol consumption. In other words, for a given amount of consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm. Such nuances in the relationships between alcohol and inequity demand further empirical exploration, particularly in low- and middle-income countries.[20]

34. Inequities stemming from the harmful use of alcohol can be reduced by interventions directly targeting socioeconomic context and differential vulnerability and exposure. While many existing alcohol interventions have proved effective to prevent and reduce alcohol related harm and as showed above, may even be pro-poor, few have focused on directly reducing health disparities or the negative consequences of alcohol on the poor, New approaches are required alongside the already established approaches, e.g. while poor consumers do often change their drinking habits in the face of regressive alcohol taxation, there may well be adverse effects on family income and well-being if they do not. This negative effect can be neutralized by earmarking some tax receipts from increased alcohol taxation for purposes that benefit poor people with alcohol use disorders and their families (e.g. cessation support).

35. The ongoing work on alcohol, health and development has identified several challenges for low- and middle-income countries:

- Because alcohol is a commodity that requires disposable income to obtain, the poorest segments of the population are usually the least likely to drink. This opens up the possibility that otherwise beneficial decreases in socioeconomic inequity can lead to an increased burden of alcohol-attributable health problems in low-income populations.
- Alcohol use among women has been increasing steadily in line with economic development and changing gender roles. In addition, the high growth rate of the adolescent and adult population in low- and middle-income countries increases the number of potential consumers.

Consequently, the total amount of drinkers and of alcohol consumed in low- and middle-income countries might substantially increase.

- Market liberalization and increasing affluence have increased the availability of alcohol to lower SES groups in growing economies.

36. Concerted and bold actions at all levels of government are needed to tackle alcohol-related inequities worldwide. This will require increased awareness and acceptance of the public health issues and of the effectiveness of strategies already available and the need to develop additional measures to tackle inequities in societies among policy-makers and in public discourse.

37. Alcohol production and consumption is on the rise in Africa and Asia, aided by minimal regulation and the increasing purchasing power resulting from economic development. Alcohol production is seen by many governments as a means to increasing the population's economic participation, ignoring the fact that the economic costs far outweigh the benefits. Alcohol abuse severely affects those who drink, and especially their families, through increased risk of domestic violence and child abuse and neglect. Measures to address harmful use of alcohol - such as tax increases, restricted access to retailed alcohol and bans on alcohol advertising - should be included in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

38. Policies on diet and physical activity can similarly address poverty. Socioeconomic status has a profound impact on diet and lifestyles, both in terms of the quality of food available, the "obesogenic environment", and the availability and safety of outdoor activity in the places where people live and work.[21 22]

39. The WHO Global Strategy on Diet, Physical Activity and Heath aimed to promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity. These actions complemented by the actions in the Global NCD Action Plans support the United Nations Millennium Development Goals and have immense potential for public health gains worldwide. Programmes aimed at promoting healthy diets and physical activity for the prevention of disease are key instruments in policies to achieve development goals. For example, a physical activity campaign based on promoting netball in Tonga has increased participation particularly in rural areas of women who are relatively more obese than men. Population based obesity prevention and salt reduction measures help prevent cardiovascular diseases including hypertension and stroke leading to healthier lifestyle and potential cost saving for the poor who can least afford treatment and care costs.

40. For all risk factors, there are valuable strategic lessons learned from mobilizing global health initiatives in other areas (e.g. AIDS, TB) that could be applied to the NCD prevention and control. These include demonstrating evidence, agreeing on messaging and communication, focusing on the emerging epidemic, actively seeking synergies, promoting multi-sectoral engagement, and supporting civil society activism[23]

What is the role of development cooperation in supporting national efforts to address NCDs?

41. Three-quarters of NCD-related mortality takes place in low- and middle-income countries, and poverty is both a determinant and a consequence of NCDs. NCD interventions delivered so as to benefit the poor and to contribute to poverty reduction will support productivity and healthy economies within low- and middle-income countries. Furthermore, economic growth is not only

about poverty reduction, but is clearly linked to economic development and a means to expand freedoms associated with improvements in general living standards, such as greater opportunities for people to become healthier, eat better and live longer.[24]

42. One important aspect of this work is the integration of NCDs into the post-2015 sustainable development goals. As the Millennium Development Goals end, negotiations are ongoing about precise targets to be included in the post-2015 Sustainable Development Goals which will drive the international development agenda until 2030. The current working draft of the SDGs includes a target to "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being."

43. Similarly, the work of development agencies to support national NCDs response is important. The potential benefits of integrating NCDs into development programmes include improving outcomes of development programmes; addressing social, economic and environmental determinants of health and implications of NCDs; and targeting interventions to high-risk, difficult-to-reach populations.

44. As NCDs are closely related to inequity and inequality in both rich and poor countries, the global discussion on NCDs should emphasize the role of broader social and environmental drivers of NCDs. In the area of tobacco control population-based interventions, taxes have been demonstrated to reduce tobacco use across income groups but especially benefit the poor.

45. In the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs, Heads of State and Government expressed a commitment to a world free of the avoidable burden of NCDs, an issue that the Millennium Development Goals (MDGs) did not address. Heads of State and Government committed themselves to a whole-of-government and whole-of-society approach to tackle NCDs and to integrate NCD policies and programmes into health-planning processes and the national development agenda of each Member State. In 2013, the World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020. This Action Plan provides Member States, international partners and WHO with a road map and menu of policy options which, when implemented, collectively between 2013 and 2020, will contribute to progress on nine voluntary global NCD targets to be attained by 2025, including a 25% relative reduction in premature mortality from NCDs by 2025. The Plan also stresses the need for the UN system to work together with governments to reduce NCDs, including by integrating NCDs into the United Nations Development Assistance Framework (UNDAF).

46. In 2013, the Economic and Social Council (ECOSOC) established the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs (UNIATF) and in 2014 endorsed its terms of reference, including a division of tasks and responsibilities for UN agencies, funds and programmes and other international organizations. The UNIATF is led by WHO and coordinates the activities of its members in support of the 2011 Political Declaration on NCDs and the WHO Global NCD Action Plan 2013–2020. The Task Force has six objectives to enhance and coordinate systematic support to Member States, focusing efforts at the national level (summarised in Box 1).

Box 1: Summarised Objectives of the Task Force

- To increase support to Member States in their efforts to prevent and control NCDs;
- To facilitate systematic and timely information exchange across Task Force members on strategies, programmes and activities;

- To facilitate information on resources to support national efforts and undertake resource mobilization;
- To strengthen advocacy efforts;
- To ensure that tobacco control is prioritized;
- To strengthen international cooperation to support national, regional and global NCD plans.

47. The magnitude of NCDs, their socio-economic and development impacts and, in particular, their multisectoral nature, gives the UN system a significant comparative advantage in supporting governments in preventing and controlling NCDs. To this effect, in 2012 a joint letter from the Administrator of the United Nations Development Programme and the Director-General of WHO proposed that UN Country Teams work with government counterparts to integrate NCDs into UNDAF design processes and implementation. A second joint letter in 2014 reiterated the importance of mainstreaming NCDs into UNDAF roll-out processes and encouraged UNCTs to scale up their capacities to support governments in implementing these priority actions.[25]

48. One means of assessing this integration of tobacco control is through the representation of WHO's Framework Convention on Tobacco Control (FCTC) within UNDAFs. The WHO FCTC is an international treaty developed in response to the globalization of the tobacco epidemic; it entered into force in 2005. States Parties agree to take specific steps for governments addressing tobacco use, including both demand reduction and supply reduction measures addressing inter alia protection from exposure to tobacco smoke; regulation of the contents of tobacco products; packaging and labelling of tobacco products; demand reduction measures concerning tobacco dependence and cessation; taxation; and sales to and by minors. Concerned that FCTC implementation is crucial in meeting the World Health Assembly target of a 25 percent reduction in premature mortality from NCDs by 2025, a UNDP and the Convention Secretariat prepared a 2014 report to assess the integration of FCTC obligations into the UNDAFs for FCTC parties. Overall, the sample (48 countries) showed little integration of tobacco control in the development planning documents, with 30% of the development plans supporting action on tobacco control, and less than 25% of the including any commitments to support WHO FCTC implementation or tobacco control. Only four countries had included commitments to tobacco control in both their NDPs and UNDAFs. [26]

49. A 2013 report looks specifically at the extent to which non-communicable diseases (NCDs) have been successfully integrated into the UNDAFs during the period when the WHO Global Action Plan on NCDs 2008-2013 was implemented. [27] Of 56 UNDAFs selected for analysis, only 20 were found to have followed the UNDAF guidelines and planned for NCDs sufficiently; with the highest score in the Asia pacific region at 0.17% of countries reviewed and the lowest score at 0.06% for Latin America and the Caribbean region. The report concluded with several conditions for a successful integration of NCDs into the UNDAF process should include: high national awareness on NCDs and their risk factors; the development of policies and plans on NCDs and their risk factors; the implementation of the WHO FCTC and the use of the committee recommendations and observations for planning purposes; the application of a multi-sectoral and human rights based approach in planning for NCDs in the WHO CCS and other sectoral plans; the development of NCD guidelines and tools and their inclusion in the UNDG guidelines for preparing an UNDAF; the use of the UNDAF guidelines to plan for NCDs during the UNDAF process and national prioritisation of NCDs in the development planning process.[28]

Getting to scale: How to increase the priority assigned to NCDs in development cooperation?

50. Scaling up technical assistance is critical to addressing NCDs. One issue in this endeavour involves effective scaling up service and financial coverage and national policy implementation without creating competition with other health and development priorities. Key themes include:

51. Estimates of costs for scaling up population-based measures is low (for tobacco, this is US$0.11 per person per year, or US$0.05 per person per year in low-income countries), with limited potential of detracting from other priorities. For instance, the World Economic Forum reports that the return on investment from implementing WHO's best buys will be many millions of avoided premature deaths and billions of dollars of additional output. While such return on investment will in the long run free capacities which can be assigned to other health and development priorities, the effect of ageing populations on the future demand for NCD care and treatment must also be taken into account.

52. It will also be key to provide strengthened policy guidance/technical assistance and advocacy on multisectoral approaches to NCDs and development. Here, it will be necessary to demonstrate the benefits of health-sensitive policy-making through showing for example that the consideration of reducing obesogenic environments in policy negotiations can be supportive of foreign policy, diminish preventable health costs to countries, and improve health outcomes.

53. Another direct method to reduce competition is by creating new resources for health and development efforts. Accelerated implementation of effective tobacco tax and price interventions to reduce tobacco use is a best buy as it both reduces tobacco use and NCDs (thus reducing the resources needed to address tobacco use) and generates revenue that can be used to either self-fund tobacco control efforts and/or address other health and development challenges facing low- and middle-income countries. Increasing tobacco taxes provides a potential win- win source of revenue to scale up technical assistance on NCDs.

54. As explained in paragraph 2, on 20-21 April 2015 WHO's Global Coordination Mechanism is hosting a Dialogue on how to encourage the continued inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies. This Dialogue can serve as a useful forum to address both financial and non-financial means of implementation for NCDs, and should do so within the context of the on-going debate around means of implementation and financing for development taking place at the global political level. Currently, NCDs receive less than two per cent of all Development Assistance for Health (DAH). The Dialogue should dedicate specific attention to the ways in which international, bilateral and multilateral assistance for NCDs can be scaled up, and how official development assistance (ODA) can be maximized and used efficiently to address NCDs while still considerate of other health priorities and from a systems-based approach. It is also essential to develop the capacity of to finance a greater share of the health budget, by exploring viable and innovative health financing mechanisms. Non-financial means of implementation for NCDs, including technology, capacity building, and trade are important, particularly for issues related to access to treatment and care, and should also be a focus at the Dialogue.

55. The discussion described above should be informed by the on-going work of the WHO GCM/NCD Working Group on financing. The 2011 UN Political Declaration on NCDs acknowledged that the global burden of NCDs constitutes one of the major challenges for development in the 21st century, an issue that the MDGs did not address. Heads of State and Government agreed in 2011 on a road map of commitments to reduce premature mortality from

NCDs, including a commitment to explore the provision of resources through domestic, bilateral and multilateral channels.

56. Taking into account that the UN General Assembly concluded in July 2014 that many countries were struggling to move from commitment to action, and bearing in mind that the proposed SDGs include a target to reduce by one third premature mortality from NCDs by 2030, Member States requested the WHO Global Coordination Mechanism on NCDs to establish a Working Group to recommend ways and means of encouraging Member States to provide financing for NCDs. The Working Group commenced its work in February 2015 and will submit its recommendations to WHO/DG in December 2015, covering the same areas set out as in the zero draft of the Addis Ababa Accord, i.e. (1) domestic public finance; (2) domestic and international private business and finance; (3) international public finance; (4) international trade; (5) debt and debt sustainability; (6) systemic issues; (7) technology, innovation and capacity building; and (8) data, monitoring and follow-up. An interim report of the Working Group may recommend that Member States consider the Solidarity Tobacco Contribution, a new international health-financing concept prepared by WHO and considered by the G20 Cannes Summit 2011.

57. Scaling up technical assistance on NCDs and strengthening national capacity without creating competition within health should be informed by existing technical work, specifically that on integrating NCDs into universal health coverage (UHC) and improved primary health care. The 2010 World Health Report on Health Systems Financing provides a menu of options for raising sufficient resources and removing financial barriers to access, especially for the poor, to move towards a path to universal health coverage.

Objectives of the Dialogue:

58. The Dialogue has the following objectives:

- Highlight the current scientific knowledge, available evidence and information on the relationship between NCDs, poverty and development, and identify evidence gaps, and articulate a road map of how these gaps could be addressed
- Review international experience in incorporating the prevention and control of NCDs explicitly in poverty-reduction strategies and in relevant social and economic policies.
- Take stock of which international development agencies have integrated NCDs into their bilateral and multilateral international development policies, and to which extent, and identify lessons learned
- Promote discussions on the role of philanthropic foundations, NGOs and private sector entities in addressing NCDs in development cooperation agendas.
- Assess to which extent NCDs are included in the ongoing discussions in New York on the post-2015 development agenda.
- Explore options in the post-2015 development era for the continued inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

59. A concise report will document the outcomes of the Dialogue.

= = =

DISCLAIMER

This WHO Information Note does not represent an official position of the World Health Organization. It is a tool to explore the views of interested parties on the subject matter. References to international partners are suggestions only and do not constitute or imply any endorsement whatsoever of this Information Note.

The World Health Organization does not warrant that the information contained in this Information Note is complete and correct and shall not be liable for any damages incurred as a result of its use.

The designations employed and the presentation of the material in this information note do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this information note. However, this information note is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the presentation lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

[1] World Health Organization, Global Status Report on Noncommunicable Diseases. Geneva: WHO, 2014.
[2] Guidance note on the integration of noncommunicable diseases into the United Nations Development Assistance Framework. Geneva: World Health Organization (WHO); 2015. Available at: http://www.who.int/nmh/ncd-task-force/en/
[3] Guidance note on the integration of noncommunicable diseases into the United Nations Development Assistance Framework. Geneva: World Health Organization (WHO); 2015. Available at: http://www.who.int/nmh/ncd-task-force/en/
[4] Mahal, Ajay; Karan, Anup; Engelgau, Michael. 2010. The Economic Implications of Non-Communicable Disease for India. Washington, DC: World Bank, 2010. Available at: https://openknowledge.worldbank.com/handle/10986/13649
[5] Bloom, David E., et al. *The economic impact of non-communicable disease in China and India: estimates, projections, and comparisons*. No. w19335. National Bureau of Economic Research, 2013.
[6] Stuckler D, Basu S, McKee M. Drivers of inequality in Millennium Development Goal progress: a statistical analysis. *PLoS Med 7*(3):e1000241. doi:10.1371/journal.pmed.1000241
[7] E Heeley, CS Anderson, Y Huang et al. Role of health insurance in averting economic hardship in families after acute stroke in China. *Stroke* 2009: 40 (6), 2149-2156
[8] Engelgau MM, Karan A, Mahal A. The economic impact of Non-Communicable Diseases on households in India. *Globalization and Health* 2012; 8(9).
[9] Hanratty B, Holland P, Jacoby A, Whitehead M. Financial stress and strain associated with terminal cancer--a review of the evidence. *Palliative medicine* 2007; 21(7): 595-607.
[10] Engelgau, Michael, et al. The economic effect of noncommunicable diseases on households and nations: a review of existing evidence. *Journal of health communication* 16.sup2 (2011): 75-81.
[11] Guidance note on the integration of noncommunicable diseases into the United Nations Development Assistance Framework. Geneva: World Health Organization (WHO); 2015. Available at: http://www.who.int/nmh/ncd-task-force/en/
[12] Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (Document A/RES/66.2). In: 2011 High Level Meeting on Prevention and Control of Non-communicable Diseases, New York, 19–20 September 2011. New York: United Nations; 2011.
[13] Follow-up to the Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (Resolution WHA66/10). In: Sixty-sixth World Health Assembly, Geneva, 27 May 2013. Geneva: World Health Organization; 2013.
[14] Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases (Resolution A/RES/68/300). In: Sixty-eighth United Nations General Assembly documentation. New York: United Nations; 2014.
[15] Note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on the prevention and control of non-communicable diseases (Document A/68/650). In: Sixty-eighth United Nations General Assembly documentation. New York: United Nations; 2014.
[16] Nugent R. Policy Brief: Bilateral and multilateral financing for NCDs, prepared for the Working Group on how to realize governments' commitment to provide financing for NCDs (Geneva, 23-24 February, 2015).
[17] Nugent, R. 2015. Benefits and Costs of the NonCommunicable Disease Targets for the Post-2015 Development Agenda. Copenhagen Consensus Post-2015 Consensus, available at http://www.copenhagenconsensus.com/sites/default/files/health_perspective_ncd_-_nugent.pdf
[18] Verguet, Stéphane, et al. "The consequences of tobacco tax on household health and finances in rich and poor smokers in China: an extended cost-effectiveness analysis." *The Lancet Global Health* 3.4 (2015): e206-e216
[19] Beaglehole R et al. Lancet. Priority actions for the non-communicable disease crisis. 2011 Apr 23;377(9775):1438-47. doi: 10.1016/S0140-6736(11)60393-0. Epub 2011 Apr 5.
[20] Sassi, F., A. Belloni and C. Capobianco (2013), "The Role of Fiscal Policies in Health Promotion". OECD Health Working Paper No. 66, OECD Publishing, Paris, http://dx.doi.org/10.1787/5k3twr94kvzx-en

[21] Sassi, F. Obesity and the economics of prevention: fit not fat. Paris, OECD Publishing: 2010.
[22] Shemilt I, Hollands GJ, Marteau TM et al. Economic instruments for population diet and physical activity behaviour change: a systematic scoping review. *PLoS One*. 2013 Sep 24;8(9):e75070. 2013.
[23] Framework Convention Alliance. "Strategies for accelerated implementation of the global tobacco control treaty".
[24] Building Jobs and Prosperity in Developing Countries. London: DFID, 2008. Available at: http://www.oecd.org/derec/unitedkingdom/40700982.pdf
[25] Bell R, Lutz B, Webb D, Small R. Addressing the Social Determinants of Noncommunicable Diseases. New York: UNDP, 2013.
[26] Development Planning and Tobacco Control: Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments. New York: UNDP, 2014.
[27] Lifanda K, Stanley T, Webb, D. Planning for the Prevention and Control of Non-Communicable Diseases in the UN Development Assistance Framework (UNDAF), New York: UNDP/WHO FCTC 2013.
[28] Lifanda K, Stanley T, Webb, D. Planning for the Prevention and Control of Non-Communicable Diseases in the UN Development Assistance Framework (UNDAF), New York: UNDP/WHO FCTC 2013.