
Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020

Executive summary

Report by the Secretariat

1. The Sixty-sixth World Health Assembly, in resolution WHA66.10 (2013), endorsed the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020.¹ In accordance with paragraph 60 of the global action plan,² in 2019 the Secretariat convened a representative group of stakeholders, including Member States and international partners, to conduct a mid-point evaluation of progress on the implementation of the global action plan.

2. In accordance with the modalities of this mid-point evaluation, the Evaluation Office is submitting the executive summary of the mid-point evaluation to the Seventy-fourth World Health Assembly (see Annex).³ The Executive Board at its 148th session noted this report;⁴ it also adopted decision EB148(7).

ACTION BY THE HEALTH ASSEMBLY

3. The Health Assembly is invited to adopt the draft decision recommended by the Executive Board in decision EB148(7).

¹ The Seventy-second World Health Assembly extended the period of the global action plan to 2030 in order to ensure its alignment with the 2030 Agenda for Sustainable Development; see document WHA72/2019/REC/1, decision WHA72(11).

² See document WHA66/2013/REC/1, resolution WHA66.10 and Annex 4.

³ The full report on the mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 is available on the website of the Evaluation Office (www.who.int/evaluation, accessed 1 April 2021).

⁴ Document EB148/7 Add.1; see also the summary records of the Executive Board at its 148th session, eighth meeting.

ANNEX

MID-POINT EVALUATION OF THE IMPLEMENTATION OF THE WHO GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020

EXECUTIVE SUMMARY

Background

1. In 2013, the Sixty-sixth World Health Assembly endorsed the WHO global action plan for the prevention and control of noncommunicable diseases 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 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 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 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
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%

14. 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. 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.

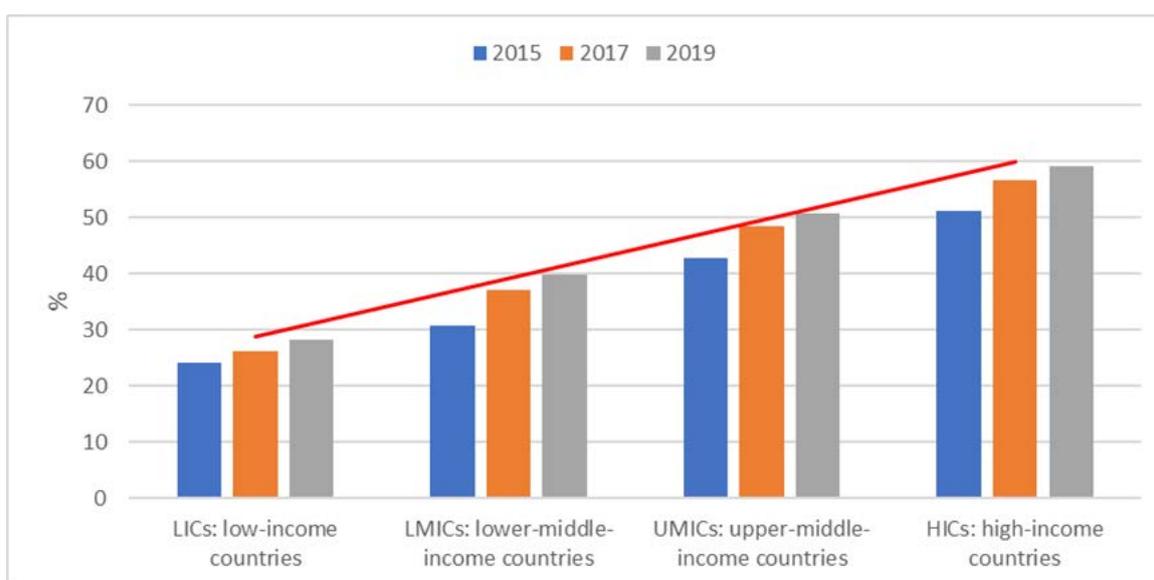
15. There is a statistically significant positive association between performance on many progress indicators and country income group. For all AP indicators, apart from one (AP1), performance is statistically positively associated with country income group. This is true for more than half (58%) of the COM indicators (marked with an asterisk in Table 2). There is also a positive association between performance on the COM indicators as a set, termed “implementation score”, and country income group (see Fig. 1).

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		
	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%

Indicator	Fully achieved			At least partially achieved		
	2015	2017	2019	2015	2017	2019
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%

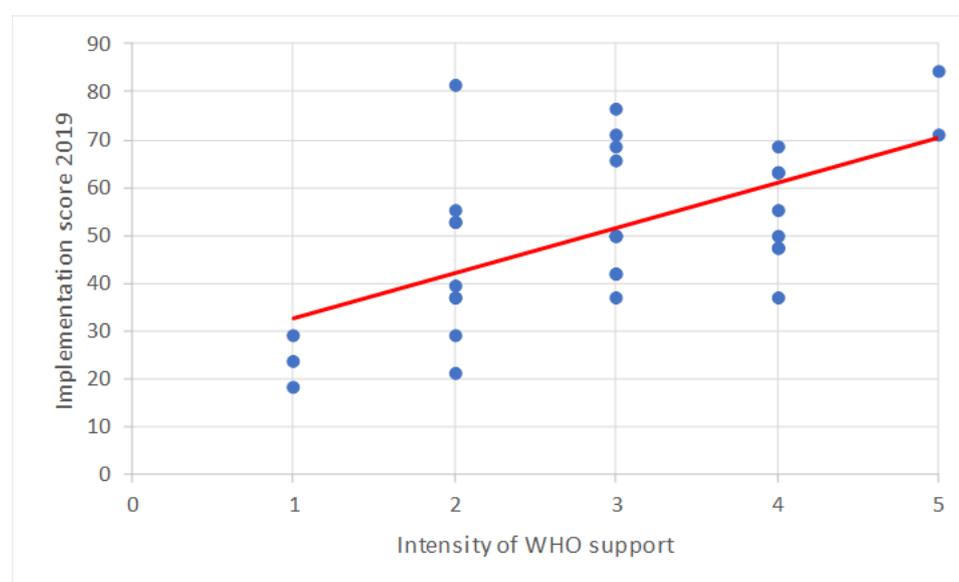
Fig. 1. Mean implementation score for Member States overall by country income group: 2015, 2017 and 2019



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.¹ 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 Fig. 2). A range of other contributing factors have been suggested and these are discussed in the main report.

Fig. 2. 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

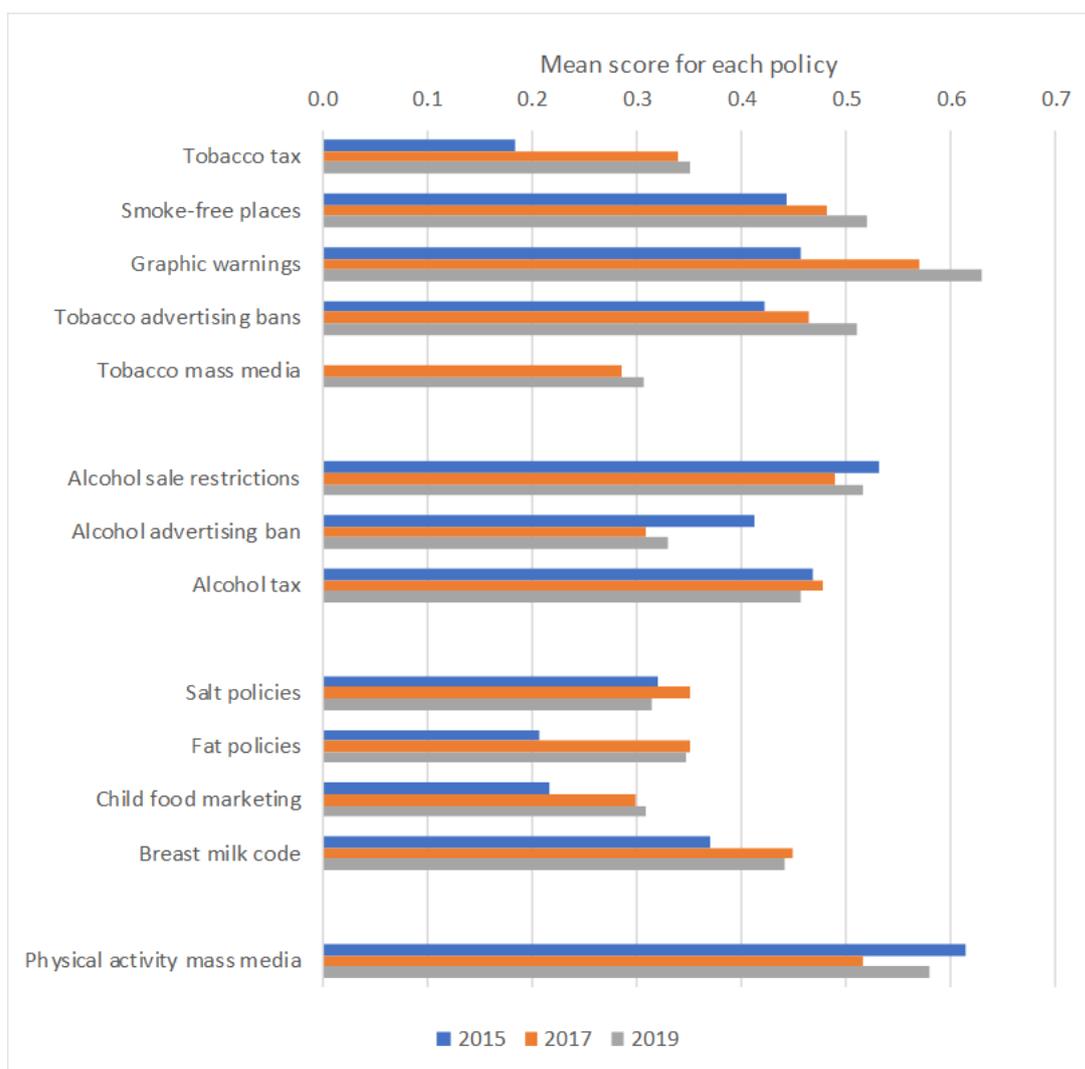
18. Overall, countries have made good progress in introducing national policies on the four main risk factors (see Table 1). For example, the percentage of countries with a policy on harmful use of alcohol rose from 48% in 2013 to 74% in 2019, for physical activity from 52% to 79%, for tobacco use from 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 2) depending on whether indicators are fully achieved or at least partially achieved. Combining these into an implementation score for each indicator (see Fig. 3) 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

¹ 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).

that there are strong frameworks in place for tobacco (WHO Framework Convention on Tobacco Control) and breast-milk substitutes which limit industry interference.

Fig. 3. Mean implementation score for key actions on risk factors: 2015, 2017 and 2019



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 3). 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.

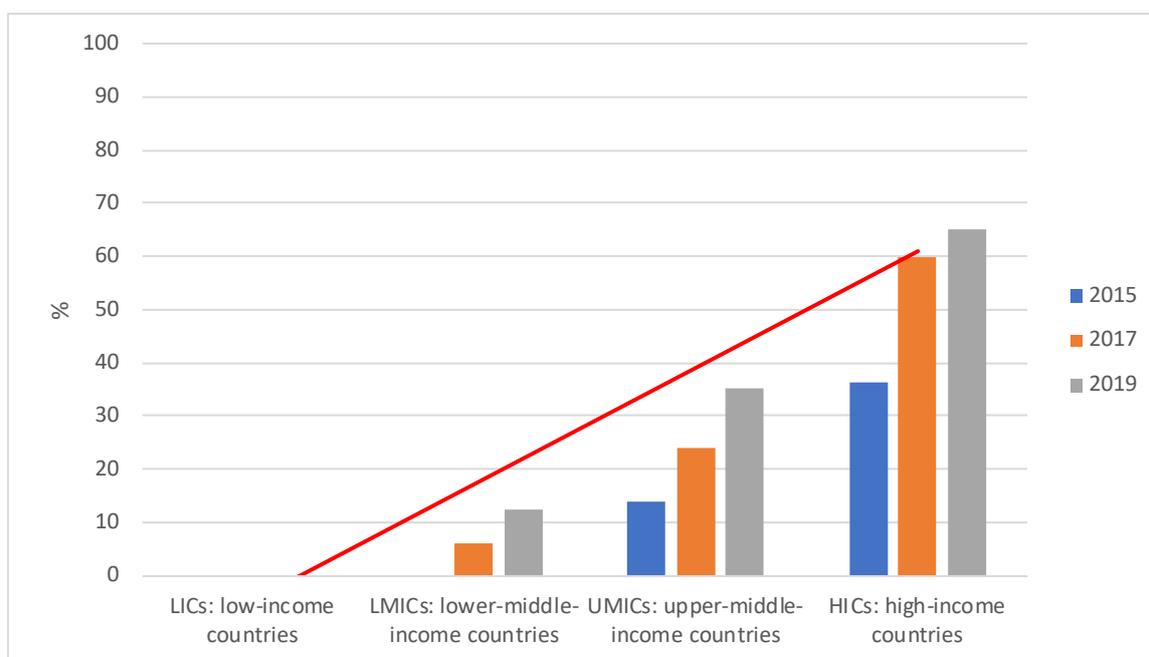
Table 3. Is having policies associated with implementation of key NCD actions?

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%
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 1). 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 2) but around two thirds of countries are still unable to provide 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 Fig. 4). In 2019, no low-income country had fully achieved this indicator as compared with almost two thirds of high-income countries (65%).

Fig. 4. 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 systems 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 2), international partners and non-State actors (see Box 3). 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 2. 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 3: 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 Sustainable Development Goals. 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 foods 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.¹

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.
- 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.

¹ See document EB148/6 Add.2.

- 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-country 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.**¹ 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.¹

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¹ See document EB148/7 Add.2.