WHO GLOBAL COORDINATION MECHANISM ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

FINAL REPORT

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WHO GCM/NCD WORKING GROUP ON THE ALIGNMENT OF INTERNATIONAL COOPERATION WITH NATIONAL NCD PLANS

(WORKING GROUP 3.2, 2016–2017)
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABBREVIATIONS</td>
<td>7</td>
</tr>
<tr>
<td>CONTRIBUTORS</td>
<td>8</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>10</td>
</tr>
<tr>
<td>Introduction</td>
<td>10</td>
</tr>
<tr>
<td>Development assistance and aid effectiveness for NCDs</td>
<td>11</td>
</tr>
<tr>
<td>Universal health coverage for NCDs</td>
<td>13</td>
</tr>
<tr>
<td>Paradigm shift: from foreign aid to development cooperation</td>
<td>13</td>
</tr>
<tr>
<td>National NCD plans as tools for development cooperation</td>
<td>14</td>
</tr>
<tr>
<td>Key recommendations to governments</td>
<td>14</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>16</td>
</tr>
<tr>
<td>2. BACKGROUND NONCOMMUNICABLE DISEASES: A GLOBAL DEVELOPMENT CHALLENGE OF THE 21ST CENTURY</td>
<td>19</td>
</tr>
<tr>
<td>2.1 Health, economic and political arguments for addressing NCDs</td>
<td>20</td>
</tr>
<tr>
<td>2.2 Paradigm shift: from foreign aid to development cooperation and partnerships</td>
<td>24</td>
</tr>
<tr>
<td>3. DEVELOPMENT ASSISTANCE FOR HEALTH: ACTORS AND TRENDS</td>
<td>30</td>
</tr>
<tr>
<td>3.1 Evolving global health financing landscape and the need for coordination</td>
<td>30</td>
</tr>
<tr>
<td>3.2 Discrepancies between burden of disease and resource allocation</td>
<td>36</td>
</tr>
<tr>
<td>3.3 Actors: major sources and channels of development funding</td>
<td>39</td>
</tr>
<tr>
<td>3.4 From MDGs to SDGs: capitalizing on momentum for collaborative action on universal health coverage and NCDs</td>
<td>41</td>
</tr>
<tr>
<td>4. DAH FUNDING FOR NCDs AND TRACKING RESOURCE FLOWS: UNDERSTANDING THE CHALLENGES</td>
<td>45</td>
</tr>
<tr>
<td>4.1 Categorization and definition of NCDs</td>
<td>45</td>
</tr>
<tr>
<td>4.2 Methodological challenges</td>
<td>45</td>
</tr>
<tr>
<td>4.3 Other challenges to DAH for NCDs</td>
<td>46</td>
</tr>
<tr>
<td>5. DEVELOPMENT EFFECTIVENESS</td>
<td>53</td>
</tr>
<tr>
<td>5.1 Importance of development assistance for health</td>
<td>53</td>
</tr>
<tr>
<td>5.2 National NCD plans as a tool for cooperation</td>
<td>54</td>
</tr>
<tr>
<td>5.3 Making an investment case for NCDs</td>
<td>61</td>
</tr>
<tr>
<td>5.4 Mobilizing domestic resources for NCDs</td>
<td>65</td>
</tr>
<tr>
<td>5.5 Beyond national NCD plans: addressing alignment with government policy</td>
<td>68</td>
</tr>
<tr>
<td>5.6 Pushing traditional boundaries for effective collaboration on NCD prevention and control</td>
<td>71</td>
</tr>
<tr>
<td>5.7 Conclusions</td>
<td>77</td>
</tr>
<tr>
<td>6. RECOMMENDATIONS</td>
<td>80</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>92</td>
</tr>
</tbody>
</table>
ANNEX 1. WHO GCM/NCD WORKING GROUP 3.2 MEMBERS

ANNEX 2. EXCERPTS FROM RELEVANT POLITICAL DECLARATIONS AND RESOLUTIONS

ANNEX 3. OECD HIGH-LEVEL FORUMS ON AID EFFECTIVENESS

ANNEX 4. UNITED NATIONS INTERNATIONAL CONFERENCES ON FINANCING FOR DEVELOPMENT

ANNEX 5. SYNERGIES AMONG THE SDGS WITH A BEARING ON NCDs

ANNEX 6. DAC LIST OF RECIPIENTS OF OFFICIAL DEVELOPMENT ASSISTANCE

ANNEX 7. HIV/AIDS INVESTMENT FRAMEWORK

ANNEX 8. GCM/NCD WORKING GROUP RECOMMENDATIONS ON INTEGRATING NCDs IN OTHER PROGRAMMATIC AREAS

ANNEX 9. OECD/DAC AND NON-DAC COUNTRIES PROVIDING FINANCING FOR DEVELOPMENT

ANNEX 10. OVERARCHING RECOMMENDATIONS FROM THE GCM/NCD WORKING GROUP ON FINANCING FOR NCDs

ANNEX 11. OVERARCHING RECOMMENDATIONS FROM THE GCM/NCD WORKING GROUP ON ENGAGEMENT WITH THE PRIVATE SECTOR

FIGURES

Figure 1. High cost of NCDs to economies, health systems, households and individuals

Figure 2. Paradigm shift from foreign aid to development cooperation

Figure 3. Top 20 countries by 2015 NCD burden of disease versus average 2012–2014 DAH

Figure 4. Base technical programme areas, funding and gap

Figure 5. Breakdown of programme-specific investments across disease areas

Figure 6. Percentage of countries with funding for NCD activities by function and WHO region

Figure 7. Working framework for analysing coordination

Figure 8. The seven behaviours of development partners for effective collaboration

TABLES

Table 1. Major NCDs and their shared risk factors

Table 2. Global health financing landscape

Table 3. DAH annualized growth rates

Table 4. Flow of global DAH into selected programme areas, 2015

Table 5. Development assistance for NCDs and all health, 2000–2014

Table 6. Top donors of health policy and systems research funding, 2000–2014

Table 7. Major funding sources for NCDs: percentage of countries with funding source

Table 8. Summary of potential strategies for additional financing of HIV programmes

Table 9. Overview of South–South cooperation and triangular cooperation modalities
BOXES

Box 1. Objective 3 (action 3.2) of GCM/NCD work plan 2016–2017

Box 2. NCDs and the main risk factors defined

Box 3. Examples of economic impact of NCDs in selected countries

Box 4. “Tragic consequences will surely follow tomorrow our failure to act today”

Box 5. Partnership means dialogue with and beyond government

Box 6. Case study: Ministry of Health-led coordination at state and local levels in China

Box 7. Case study: Delivering as One: United Nations support to the health sector plan in Namibia

Box 8. Case study: WHO Global Coordination Mechanism and the United Nations Interagency Task Force

Box 9. Case study: NCD Alliance of Kenya: building networks, alliances and partnerships towards the achievement of national commitments and global targets

Box 10. Factors in developing national NCD plans

Box 11. Case study: Alignment of NCDs in sectorwide health policies and plans: cases of five countries in the WHO Western Pacific Region

Box 12. Disrupted health financing strategies in three low-income African countries

Box 13. Case study: Public health product tax in Hungary

Box 14. Case study: Innovative financing to tackle NCD risk factors in Thailand

Box 15. Development cooperation alignment strategies

Box 16. Definitions: South-South cooperation and triangular cooperation

Box 17. South-South cooperation: promoting healthy lifestyles

Box 18. Triangular cooperation: achieving universal health care and developing an effective nutrition sector

Box 19. Effective development cooperation practices in the health sector

Box 20. Policy framework for post-2015 partnerships

Box 21. Classification of donor aid for health as global and countryspecific functions and subfunctions

Box 22. Improved NCD surveillance, monitoring and evaluation in Rwanda

Box 23. Brazil’s multisectoral NCD Action Plan

Box 24. NCD investment case in Barbados

Box 25. WHO STEPS programme for NCD risk factor surveillance

Box 26. Multisectoral cooperation to reduce sugar consumption in Mexico

Box 27. Expanded NCD capacity through donor assistance in Argentina
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASEAN</td>
<td>Association of South-East Asian Nations</td>
</tr>
<tr>
<td>BRICS</td>
<td>Brazil, Russian Federation, India, China and South Africa</td>
</tr>
<tr>
<td>CSO</td>
<td>civil society organization</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DAH</td>
<td>development assistance for health</td>
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<td>DALY</td>
<td>disability-adjusted life-year</td>
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<td>GCM/NCD</td>
<td>Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GNI</td>
<td>gross national income</td>
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<tr>
<td>GNP</td>
<td>gross national product</td>
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<tr>
<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<tr>
<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NCDAK</td>
<td>NCD Alliance of Kenya</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>STEPS</td>
<td>STEPwise approach to chronic disease risk factor surveillance</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNIATF</td>
<td>United Nations Interagency Task Force</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WP-EFF</td>
<td>Working Party on Aid Effectiveness</td>
</tr>
</tbody>
</table>
Contributors

The principal contributors to this report were the members of the WHO GCM/NCD Working Group on the alignment of international cooperation with national plans on the prevention and control of noncommunicable diseases (WG 3.2), including: Hussain Abdul Rahman Al Rand, Mary Amuyunzu-Nyamongo, Nino Berdzuli, Omar Bin Mihat, Randah Ribhi Hamadeh, Eduardo Jaramillo Navarrete, Guna Raj Lohani, Deborah Malta, Eva Martos, Mohammad Reza Masjedi, Supattra Srivanichakorn, Lesley-Charles Usurua and Wen-Qiang Wei.

H.E. Ambassador Taonga Mushayavanhu, Permanent Representative to the UNOG, Zimbabwe, and Kjetil Aasland, Minister Counsellor for Health, Permanent Mission of Norway to the UNOG, co-chaired the Working Group 3.2 and provided their valuable input. The report was undertaken with the overall guidance of Oleg Chestnov, Bente Mikkelsen and Svetlana Akselrod.

The contributions of Louise Agersnap, Nicholas Banatvala, Melanie Bertram, Douglas Bettcher, Francesco Branca, Guy Fones, Sophie Genay-Diliautas, Menno Van Hilten, Etienne Krug, Alexey Kulikov, Nicoletta de Lissandri, Michael Wong, Jonathan Santos, Shekhar Saxena, Hannah Todd and Cherian Varghese, and of the stakeholders who participated in several stakeholder hearings and on-line consultations on the draft report, are also gratefully acknowledged.

Overall project management, research and writing were conducted by Téa Collins. Editorial support was provided by John Dawson. Design and layout were supplied by Blossom.
Executive summary

INTRODUCTION

- This final report is the outcome of the Working Group convened by the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) to consider the alignment of international cooperation with national NCD plans (Working Group 3.2, 2016–2017). The Working Group was formed under objective 3 (action 3.2) of the GCM/NCD work plan to provide a forum for identifying barriers to and sharing innovative solutions for the implementation of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.

- The purpose of establishing this Working Group was to inform WHO Member States and other stakeholders of the complex landscape of development cooperation and its implication for NCDs, and to develop “actionable recommendations”.

- Noncommunicable diseases, or NCDs, commonly refer to four broad categories of chronic diseases – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – due to the high disease burden they impose and their shared risk factors (tobacco use, unhealthy diets, lack of physical exercise and harmful consumption of alcohol).

- In high-income countries, NCDs have long been the leading cause of morbidity and mortality. However, it is the rapid rise of NCDs in low- and middle-income countries that makes them a major global health and development challenge.

- The devastating consequences of NCDs can be viewed from three perspectives: (a) health and epidemiological; (b) economic; and (c) political.
DEVELOPMENT ASSISTANCE AND AID EFFECTIVENESS FOR NCDs

- The era of the Millennium Development Goals (MDGs) entailed a significant increase in development assistance for the MDG-related health areas. However, NCDs were excluded from the MDGs and did not benefit much from the funding boost.

- The 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs), which include an NCD target of a one third reduction of premature mortality from NCDs through prevention and treatment and promotion of mental health and well-being (SDG 3.4), firmly embed NCDs into the development agenda. However, NCDs may have to compete for donor attention with other areas of health traditionally considered the focus of development assistance, such as HIV/AIDS, tuberculosis and malaria, and women’s and children’s health.

- Despite contributing to over half of all deaths worldwide and becoming a major challenge in low- and middle-income countries, NCDs received only 1.7% of total development assistance for health (DAH) in 2016. In addition, the amount of investment was poorly aligned with the NCD burden in countries.

- Tracking development assistance resource flows into NCDs is challenging due to (a) lack of a clear definition of NCDs (for example, what is included in terms of the risk factors and diseases); (b) methodological challenges, such as incomplete and partial data sources, and incomplete reporting.

- NCDs are still not considered part of the traditional development agenda, and are hence not a priority for development donors.

- There is a transformation happening in the sources of development assistance, with private donors, particularly the Bill & Melinda Gates Foundation, and other “non-traditional” donor countries (for example BRICS) assuming greater importance.

- Governments (bilateral donors) still remain the main source of funding for official DAH. The Governments of the United States of America and United Kingdom are the biggest funders of global health. In 2015, the United States spent US$ 13 billion on global health, of which US$ 45 million was spent on NCDs. The United Kingdom Government spent US$ 4.1 billion on global health and US$ 66 million on NCDs in the same year.
• United Nations agencies are receiving as well as channelling funds. After the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank was the second-largest multilateral channel in 2015 (US$ 2.1 billion), followed by the World Health Organization (WHO) US$ 2.2 billion in 2016).

• In 2016, the main channels of development assistance for NCDs were WHO and nongovernmental organizations (NGOs).

• In 2015, the world spent US$ 7.3 trillion on health, approximately 10% of the global gross domestic product (GDP). Domestic finances for health were the main source of health funding in all but a small number of lower-income countries. DAH was less than 0.3% of global health expenditure; however, it still constitutes an important funding source for low-income countries. For example, in 2015, the average share of external resources in health spending in the 31 low-income countries was 30%, while in the 50 lower middle-income and 57 upper middle-income countries it was 3% and less than 1%, respectively.

• In general, as country economies grow, total public health expenditure increases, while the reliance on out-of-pocket expenditure decreases as a share of total health expenditure. At the same time, access to development assistance falls and potentially threatens the financial and institutional sustainability of health systems. DAH is also essential to finance the transition costs.

• As low- and middle-income countries undergo economic growth, donor funding should be used to support “global functions” of public health, such as research and development for health, knowledge generation and sharing, disease outbreak preparedness, responses to marketing of unhealthy foods and commercial determinants of health, as well as health security and control of disease movement across borders.

• Although the focus on global functions will benefit countries in all income categories, especially the poor and vulnerable populations, many lower-income countries, particularly the fragile States, will still need external support for country-specific functions, including NCDs and health system strengthening.

• Development effectiveness is contingent upon strong government leadership, clear definition of the roles and responsibilities of participating partners, alignment with country contexts, focus on results, and joint measuring and monitoring of progress.

• Leadership needs to be built by both government and development partners through focusing on capacity-building within the development agenda.

1BRICS: Brazil, Russian Federation, India, China and South Africa.
UNIVERSAL HEALTH COVERAGE FOR NCDs

- Universal health coverage is one of the important targets of SDG 3, with major implications for NCDs. However, universal health coverage is a means to an end, not an end in itself. Moving towards universal health coverage will help countries achieve SDG target 3.4 (to reduce premature mortality from NCDs).
- The joint WHO and World Bank publication Tracking universal health coverage: 2017 global monitoring report specifies 16 tracer indicators for universal health coverage, including indicators for NCD prevention and treatment.
- The health workforce and health facilities (including the cost of technologies) will be the main cost drivers for health systems to meet the health-related SDG targets.
- The World Bank identified 71 intersectoral policies (fiscal, regulatory, infrastructural and informational) to be included in essential universal health coverage packages to address behavioural and environmental risks. Full achievement of the NCD premature mortality target (SDG target 3.4) will require increased investments in sustained intersectoral action, as well as action by ministries of finance to tax tobacco and polluting emissions and eliminate subsidies on fossil fuels.

PARADIGM SHIFT: FROM FOREIGN AID TO DEVELOPMENT COOPERATION

- Four high-level forums on aid effectiveness took place in the MDG era – in Rome (2003), Paris (2005), Accra (2008) and Busan (2011). The forums developed a set of practices for development partners (funders and recipients) to maximize development effectiveness to complement domestic financing. After a lengthy participatory negotiation process, the Busan forum concluded with an endorsement of the Busan Partnership for Effective Development Co-operation, including civil society.
- With the introduction of the 2030 Agenda for Sustainable Development, the need for development cooperation at global, regional, national and local levels became more evident. SDGs explicitly include a partnership goal (SDG 17), which the international development community has recognized as a means to achieve the SDGs.
- International cooperation is more than just financial aid. It also includes technical collaboration, knowledge exchange programmes, technology transfer and capacity-building activities through North-South, South-South and triangular cooperation.
NATIONAL NCD PLANS AS TOOLS FOR DEVELOPMENT COOPERATION

• While multisectoral NCD plans provide the basis for setting priorities and monitoring results, the true indicator of their quality from the development perspective is whether they can serve as useful tools to engage the government and development partners in the implementation of these plans.

• NCD multisectoral plans play a key role in enabling alignment and international cooperation. However, countries also have other mechanisms and tools to enhance the policy dialogue and ensure harmonization and alignment, such as joint assessments and reviews, codes of conduct, annual sector reviews and special policy events.

• Multisectoral coordination mechanisms are important to accelerate action across sectors, ensure accountability and deliver results.

KEY RECOMMENDATIONS TO GOVERNMENTS

(Note: Detailed policy actions for each recommendation are provided in the recommendations section of the report)

1. Increase investments in health information and disease surveillance, monitoring and evaluation, and research systems to provide evidence for effective interventions and advocacy, and to support resource mobilization efforts for NCDs.

2. Develop and implement high-quality, multisectoral, integrated NCD plans that are prioritized and costed, in close collaboration with relevant stakeholders, including development partners and non-State actors.

3. Develop NCD investment frameworks to communicate the urgent need for accelerated and targeted investments in NCDs as part of the 2030 Agenda for Sustainable Development.

4. Develop or expand existing and emerging forms of development cooperation beyond the traditional donor–recipient model to address NCDs through North–South, South–South and triangular cooperation.

5. Promote and enhance cooperation with non-State actors, including civil society organizations, to strengthen advocacy and mutual accountability, and ensure the implementation of national NCD plans.

6. Build their institutional capacity to engage effectively with development agencies to ensure aid coordination and efficiency, mutual accountability, and development impact of external resources to support national NCD priorities.
Introduction

Non-communicable diseases (NCDs), including cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are now the leading cause of death in all regions of the world except sub-Saharan Africa. Nearly three quarters of the NCD-related deaths in 2016 occurred in low- and middle-income countries [1]. Most of these deaths could be prevented by effective health system responses and by influencing public policies in sectors outside health to address the shared risk factors and the social and environmental determinants of NCDs [1]. Strong international cooperation will be critical for comprehensive NCD prevention and control at the global, regional and national levels to meet the nine voluntary global targets of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and the NCD-related targets of the 2030 Agenda for Sustainable Development.

The WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) was established in September 2014 with a mandate to “enhance coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the WHO Global NCD Action Plan (2013–2020).” To facilitate the process, the WHO Director-General, in consultation with Member States, established Working Groups in line with the principles and six objectives of the Global NCD Action Plan.

The WHO GCM/NCD Working Group on the alignment of international cooperation with national NCD plans (Working Group 3.2, 2016–2017) was formed under objective 3 (action 3.2) of the GCM/NCD work plan 2016–2017 to provide a forum for identifying barriers and sharing innovative solutions for the implementation of the Global NCD Action Plan (Box 1). The list of the Working Group members is provided in Annex 1.
“Establish a Working Group in 2016 to recommend ways and means of encouraging Member States and non-State actors to align international cooperation on noncommunicable diseases with national plans concerning noncommunicable diseases in order to strengthen aid effectiveness and the development impact of external resources in support of noncommunicable diseases.”

The Working Group is co-chaired by the following representatives of two Member States, one from a developed country and one from a developing country, appointed in consultation with Member States:

- H.E. Ambassador Taonga Mushayavanhu, Permanent Representative of Zimbabwe to the United Nations Office at Geneva
- Mr Kjetil Aasland, Minister Counsellor for Health, Permanent Mission of Norway to the United Nations Office at Geneva


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Box 1 Objective 3 (action 3.2) of GCM/NCD work plan 2016–2017

The overarching goal of this Working Group report is to inform Member States and other stakeholders of the complex landscape of development cooperation and its implications for NCDs, and to come up with “actionable recommendations” to support the implementation of the objectives of the Global NCD Action Plan and the 2030 Agenda for Sustainable Development. Specifically, the report aims to provide direction and guidance to government policy-makers on how to make the best use of external resources and international cooperation to address the local disease burden in line with the globally agreed targets of the Global NCD Action Plan and the 2030 Agenda for Sustainable Development.

To achieve this, the report examines the complexity of the NCD challenge through health, economic and political lenses. It also looks at the trends of development assistance for health (DAH) and investigates the suitability of national NCD plans as tools for countries to express their demand for development cooperation for NCD prevention and control.

The paper draws on a range of current data, as well as on the vast experience and knowledge of the Working Group members, who represent all six regions of WHO globally. The Working Group members contributed valuable lessons from their respective countries, which are especially important, as the recommendations need to be tailored to fit the specific circumstances of each country. The report also reflects on the role of the international community, particularly civil society, to help address NCDs as one of the major development challenges of the 21st century. Annex 2 provides excerpts from United Nations documents of particular relevance to this report.
Noncommunicable diseases, or NCDs, encompass a wide range of diseases that are chronic and characterized by slow progression. Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are commonly grouped as the main NCDs due to their shared risk factors (tobacco use, unhealthy diets, lack of physical exercise and harmful consumption of alcohol) and the substantial contribution they make to the global disease burden (Table 1 and Box 2).

### Table 1. Major NCDs and their shared risk factors

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<thead>
<tr>
<th>Four major groups of diseases under NCDs</th>
<th>Shared risk factors</th>
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<tr>
<td></td>
<td>Tobacco use</td>
</tr>
<tr>
<td>Heart disease and stroke</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>✓</td>
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Box 2. NCDs and the main risk factors defined

NCDs, also known as chronic diseases, are not passed from person to person. The four main causes of death from NCDs are from the following diseases:

- **Cardiovascular diseases**, including heart attacks, stroke, and other heart and blood vessel diseases.
- **Cancers**, including neoplasms.
- **Diabetes**, a major contributing factor to deaths from heart, circulatory, and kidney failure, though it rarely kills patients by itself.
- **Chronic respiratory diseases**, including chronic obstructive pulmonary diseases, asthma, emphysema and chronic bronchitis.

**Mental health**, including age-related dementia, is not usually included in the definition of NCDs, but it is an important factor in overall well-being. It is also a major cost driver in high-income countries.


It should be noted that NCDs are not the only chronic diseases: infectious diseases, such as HIV/AIDS, are also chronic. In addition, not all neoplasms are necessarily cancerous or malignant.

In high-income countries, NCDs have long been the leading causes of morbidity and mortality. However, it is the rapid rise of NCDs in low- and middle-income countries that makes them a major global health and development challenge. These countries are at earlier stages of development, possess fewer resources and have less time and ability to effectively mobilize adequate responses [2].

### 2.1 Health, Economic and Political Arguments for Addressing NCDs

The devastating consequences of the “NCD crisis” are felt by all societies globally. The supporting evidence for this can be grouped into three broad categories: (a) a health or epidemiological argument; (b) an economic argument; and (c) a political argument.

#### 2.1.1 Health Argument

**Increasing share of NCD deaths globally.** Of the 56 million deaths that took place worldwide in 2016, NCDs contributed to about 41 million. Globally, the leading causes of death were cardiovascular diseases (17.9 million deaths, or 44% of NCD mortality), cancers (9 million deaths, or 22% of NCD mortality), respiratory diseases, including asthma and chronic obstructive pulmonary disease (3.8 million deaths, or 9% of NCD mortality), and diabetes (1.6 million deaths, or 4% of NCD mortality). The four main groups of NCDs accounted for nearly 80% of NCD deaths globally [1].
NCD mortality among younger populations. The high level of premature mortality from NCDs, that is, deaths under the age of 70, is particularly disturbing. Even though the risk of dying from any of the four major NCDs between the ages of 30 and 70 decreased from 23% in 2000 to 19% in 2015, this improvement was mainly due to the decline in the age-standardized cardiovascular mortality rates, while mortality from other NCDs declined at a slower pace and remained much higher in low- and middle-income countries. In 2015, 15 million people still died prematurely and 47% (7 million) of these deaths took place in low- and middle-income countries [3].

Growing burden of NCDs in low-income countries. Overall, NCD-related deaths as a share of total deaths are projected to rise by over 50% in middle- and low-income countries by 2030. The change will be especially dramatic in sub-Saharan Africa, where NCDs will be responsible for 46% of all deaths by 2030, up from 28% in 2008, and in South Asia, where the share of deaths from NCDs will rise from 51% to 72% during the same time period. The morbidity data show a similar pattern. By 2030, cancer incidence is estimated to increase by 70% in middle-income countries and 82% in low-income countries [4]. In addition, low-income countries will continue to face a substantial burden of communicable diseases, resulting in a “double burden” of disease and further complicating the health and development challenges.

Population ageing and NCDs. As populations grow and live longer, annual NCD deaths will continue to rise. For example, annual mortality due to cardiovascular diseases is estimated to increase from 17.5 million in 2012 to 22.2 million in 2030. Similarly, annual cancer deaths will rise from 8.2 million to 12.6 million in the same time period [5].
2.1.2 ECONOMIC ARGUMENT

The economic argument implies that NCDs impose large and often avoidable costs on already stretched government budgets and the economy more broadly. Therefore, the NCD challenge cannot be fully understood without considering its direct and indirect effects on economies and health systems, and the impact on households and individuals (Figure 1).

Over the period 2011-2030, the total lost output from the four NCD conditions that are the focus of the UN High-Level meeting and mental health conditions is projected to be nearly US$ 47 trillion. [6] There are also significant estimates of lost economic outputs reported from low- and middle-income countries (Box 3).
Box 3. Examples of economic impact of NCDs in selected countries

**China.** Reducing cardiovascular mortality by 1% every year between 2010 and 2040 could generate an economic value equivalent to 68% of China’s real GDP in 2010 or over PPP US$ 10.7 trillion.

**Egypt.** NCDs could be leading to an overall production loss of 12% of Egypt’s GDP.

**Brazil.** Costs of NCDs between 2005 and 2009 could equal 10% of Brazil’s 2003 GDP.

**India.** Eliminating NCDs could have increased India’s 2004 GDP by 4–10%.


The impact of NCDs on health systems can also be substantial. A World Bank (2005) study in the Russian Federation found that NCDs, such as cardiovascular diseases, respiratory diseases and digestive tract diseases, accounted for over 40% of the country’s total health expenditure [7].

NCD-related health care costs can significantly affect households and increase the risk of “catastrophic” health costs (high out-of-pocket expenditure pushing households into poverty). For example, in South Asia the likelihood of facing catastrophic health expenditure due to hospitalization was 160% higher for cancer patients and 30% higher for people living with cardiovascular diseases than for those requiring hospitalization for communicable diseases [8]. In India, 25% of families with a family member requiring hospitalization from NCDs incur such catastrophic expenditures, and over 10% of these households are driven into poverty [9].

**2.1.3 POLITICAL ARGUMENT**

While public health practitioners, epidemiologists and scholars have long been pointing to the changing global distribution of the NCD burden, it is relatively recently that NCDs have been elevated to the global political agenda, when governments too expressed their concern over the rising threat at the two high-level meetings of the United Nations General Assembly on NCDs in 2011 and 2014 [10].
The outcome documents of the high-level meetings noted that comprehensive NCD prevention and control will need action beyond health systems. The NCD crisis requires whole-of-government and whole-of-society approaches to meet national and global commitments. As low-cost and highly effective solutions for the prevention and control of NCDs are available, “the failure to respond is now a political, rather than a technical issue” [11]. The political commitments made at the highest-level need to be translated into country-level actions. Decisive country leadership at the highest level to engage stakeholders across public and private sectors, along with civil society, is of utmost of importance to achieve considerable gains in preventing NCDs and mitigating their impact.

2.2 PARADIGM SHIFT: FROM FOREIGN AID TO DEVELOPMENT COOPERATION AND PARTNERSHIPS

2.2.1 EVOLVING CONCEPT OF PARTNERSHIPS FOR DEVELOPMENT: A SNAPSHOT OF HISTORY

The last 15 years have shown a change in priorities and direction in development assistance and the recurring significance of aid effectiveness. There has been a gradual but consistent push globally for the prioritization of country ownership and the need to promote good governance to implement effective health programmes. Understanding the evolution of development cooperation and gaining a better insight into the drivers behind bilateral and multilateral development agencies is paramount to finding effective, sustainable solutions and addressing NCDs.

The concept of “partnerships for development” first appeared in the 1969 Pearson Commission report. The commission was established by the then World Bank President Robert McNamara and led by former Canadian Prime Minister and Nobel Prize winner Lester Pearson. The commission provided the most comprehensive analysis of economic development of that time. The commission’s report proposed a new basis for international cooperation and spelled out the responsibilities of both donor and recipient countries (Box 4).
“Development must, in the future - even more than it has in the past - be an active and genuine partnership between rich nations and poor. It is futile to hope for the day when either side can stand off at a distance and provide or receive large quantities of aid without fully understanding and participating in the process by which their allocation and use is decided.

No country has the right to intervene in another’s policy-making, but any country or agency, which transfers resources to another country, does have a right to be heard and to be informed about decisions which basically affect the development it is helping to support.

This partnership, which must be separated as much as possible from the vagaries of day-to-day politics, is basic to a sustained relationship centered upon long-term development objectives, which is the only proper basis for a systematic approach to the problem.”


Yet, the concept of partnership for development did not gain prominence within the development community until the 1990s, when the Nordic countries started to actively explore partnership models for development assistance and cooperation [12].

In 1996, the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) put forward a publication entitled Shaping the 21st century, which set out a partnership-based vision for effective development cooperation centred on strategies led by developing-country governments and civil society organizations (CSOs). The report concluded that the basic lesson learned over the decades of development assistance efforts was that “development cooperation is only a complement, albeit often a vital one, to the efforts of the people, the institutions and the governments of developing countries”. The report also stressed that old distinctions between “North” and “South”, as well as “East” and “West”, were becoming increasingly blurred, and issues could no longer be divided into “domestic” and “international” [13].

This vision of development cooperation was further developed in the 2001 DAC Guidelines on Poverty Reduction, which set out the rights, responsibilities and obligations to be fulfilled in partnerships for development (Box 5). The report also stressed that “development effectiveness strengthens the need for a more selective, more strategic approach to aid allocations, based on objective criteria, demonstrated partner performance and a long-term timeframe” [14].
“A broad range of partners should be engaged in the policy dialogue process when poverty reduction strategies are devised. Extra effort will be required to ensure that, from the beginning, genuine participation informing policy decisions and outcomes takes place in these consultations. This means promoting local domestic structures and identifying civil society actors who can legitimately speak for the poor and be accountable to them. It also means taking care not to undermine the legitimacy of partner governments – instead respecting what partners are doing to build and consolidate their constitutional and democratic institutions.”

Source: OECD [13].

**2.2.2 HIGH-LEVEL FORUMS ON DEVELOPMENT COOPERATION**

The late 1990s marked the emergence of a new aid effectiveness agenda increasingly oriented towards achieving poverty reduction and promoting good governance. The Millennium Development Goals (MDGs) provided an even stronger focus on a global commitment to tangible target-led development results. At the core of the new aid paradigm were three important elements:

- recipient countries to take a greater ownership and responsibility for their own poverty reduction and development strategies;
- donors to align with the priorities and agendas of recipient countries, and to work within the existing administrative and accounting systems;
- donors to harmonize and coordinate their activities for aid effectiveness and development results [15].

The new paradigm included a greater reliance on a series of development targets, which were important for three reasons:

- The targets were outcome-based measures rather than a traditional donor concern with measuring inputs and short-terms effects.
- The targets expanded the concept of development beyond the focus on income poverty alone (for example, MDG targets included health and well-being measures).
- The targets acted as a means of bringing various stakeholders together in partnerships (for example, governments and non-State actors) [16].
The aid effectiveness agenda led by OECD was championed by the Working Party on Aid Effectiveness (WP-EFF). This started as a traditional donor-only group in 2003 as a subsidiary of the OECD/DAC. In 2005, it moved to a joint partnership with a growing number of developing countries as members. In 2009, the partnership included 80 members, comprising 24 recipient countries, eight countries that both provided and received aid, 51 donor countries, nine multilaterals, and six civil society and other organizations. The WP EFF continued to be hosted by the OECD/DAC. However, in 2012, the WP-EFF was transformed into the new Global Partnership (Busan Partnership) for Effective Development Cooperation. OECD and the United National Development Programme (UNDP) are providing secretariat functions drawing on their existing resources [17].

Throughout its lifespan, the WP-EFF organized a series of high-level forums, in Rome (2003), Paris (2005), Accra (2008) and Busan (2011). Two landmark international agreements were negotiated in these forums. This first was the Paris Declaration on Aid Effectiveness (2005), which promoted ownership, alignment, harmonization, results-based management and mutual accountability. The agreement was signed by 35 donor countries, 26 multilateral donors, 56 recipient countries and 14 civil society observers.

The Accra Agenda for Action followed in 2008. For the first time in development cooperation the agenda was the result of negotiations among donors, partner countries and civil society. The Accra Agenda for Action called on donors to respect local priorities while encouraging developing countries to consult with their parliamentarians and civil society.

The Fourth High-Level Forum on Aid Effectiveness, held in Busan, Republic of Korea, aimed to evaluate progress made towards achieving more effective aid and to define the new agenda. After a lengthy participatory negotiation process it concluded with the endorsement of the Busan Partnership for Effective Development Co-operation. The major themes and results of these high-level forums are summarized in Annex 3.

### 2.2.3 FINANCING FOR DEVELOPMENT: MAJOR INTERNATIONAL CONFERENCES

The Financing for Development Office was established within the Department of Economic and Social Affairs of the United Nations Secretariat on 24 January 2003, in accordance with General Assembly resolution 57/273. The mandate of the Financing for Development Office is to follow up on the outcomes and commitments reached at the International Conferences on Financing for Development, organized by the United Nations. There have been three International Conferences on Financing for Development – Monterrey, Mexico (2002), Doha, Qatar (2008) and Addis Ababa, Ethiopia (2015). The key themes and the major outcomes of the conferences are summarized in Annex 4.

Both the Monterrey Consensus on Financing for Development and the Doha Declaration on Financing for Development mentioned the importance of investing in health. However, it was not until the Third International Conference on Financing for Development, Addis Ababa, 2015, that health received more prominent attention and the
burden of NCDs in developing countries was also noted (paragraphs 77 and 32, respectively).

More specifically, in the area of health, the Addis Ababa Action Agenda:

- encouraged better alignment of multistakeholder partnerships “to improve their contribution to strengthening health systems”;
- recognized “the key role of the World Health Organization as the directing and coordinating authority on international health work”;
- committed to the enhancement of “international coordination and enabling environments at all levels to strengthen national health systems and achieve universal health coverage”; 
- committed to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries”;
- welcomed “innovative approaches to catalyse additional domestic and international private and public resources”;
- urged parties to the WHO Framework Convention on Tobacco Control to “strengthen implementation of the Convention in all countries”;
- noted “the enormous burden that non-communicable diseases place on developed and developing countries”.

Figure 2 depicts schematically the change in approach to development assistance over time as the concept has evolved from foreign aid to development cooperation and multistakeholder partnerships.

Figure 2. Paradigm shift: from foreign aid to development cooperation

OECD DAC establish the Working Party on Aid Effectiveness (successor of Task Force on Donor Practices)

Accra Agenda for Action signed highlighting the value of cooperation that reaches beyond traditional aid agreements

Rome 2003

The Paris Declaration was signed Implementation of monitoring framework with 2 progress surveys 2008 and 2010 agreed

Paris 2005

Accra 2008

Busan 2011

Busan Partnership for Effective Development agreed and Global Partnership for Effective Development Cooperation founded

Source: WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases, World Health Organization, 2018
3 Development assistance for health: actors and trends

3.1 EVOLVING GLOBAL HEALTH FINANCING LANDSCAPE AND THE NEED FOR COORDINATION

The post-MDG era has seen an unprecedented proliferation of global health actors with overlapping and often imprecise mandates. In general, these actors in the global health financing landscape can be grouped into three broad functional categories: (a) providing (sources of financing) – concerns the need to raise or generate global health funds; (b) managing (channelling funds) – refers to the management or pooling and channelling of funds; and (c) spending (receiving) – considers the consumption of global finances. In reality, the financing landscape is more chaotic, with several actors performing more than one function simultaneously. A schematic representation of the global health financing landscape is provided in Table 2.

Table 2. Global health financing landscape

<table>
<thead>
<tr>
<th>Actors</th>
<th>Providing</th>
<th>Managing</th>
<th>Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor governments</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilateral agencies (official development assistance)</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Multilateral (United Nations) agencies</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Intergovernmental organizations</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Global health partnerships</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>NGOs</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
The years between 2000 and 2010 were a golden era for DAH. During that period, the health sector saw an almost tripling of global DAH from US$ 12 billion to US$ 34 billion [19]. Since 2000, increasing numbers of MDG-related global health institutions and initiatives have been created, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi, the Vaccine Alliance, and the Global Alliance for Improved Nutrition. These vertically aligned global health partnerships illustrate three major broad trends in global health governance: (a) moving away from core or longer-term funding towards discretionary funding; (b) increased emphasis on multistakeholder governance versus more traditional government-centred decision-making; and (c) a preference for narrower, problem-focused initiatives rather than broader system goals requiring multilateral cooperation [20].

The MDG era also saw a shift in the sources of financing, with private sources and foundations playing an increasing role in the global health aid landscape. Overall, private sources contributed up to 25% of health assistance between 2000 and 2015. Amongst these sources, the Bill & Melinda Gates Foundation was the third-largest contributor of health aid during the same time period [21]. However, the private sector is not a homogeneous group of actors, and from the NCD funding perspective it will be important to differentiate between the private sector stakeholders and their impact on development.

Despite the remarkable progress the global health initiatives have achieved in terms of the rapid scale-up in service delivery for priority diseases, greater stakeholder participation, and channelling of funds to nongovernmental organizations (NGOs), they remained largely uncoordinated, focused on vertical disease-specific programmes, and lacking in rigorous assessment [22].
The institutional proliferation of the global health initiatives had two implications for NCDs. First, only a few of these actors were interested in the NCD agenda. This lack of interest was reflected in the chronic underfunding of NCDs as part of development assistance. As an example, on average, donors spent around US$ 300 for each year lost to disability from HIV/AIDS, US$ 200 for malaria, and US$ 100 for tuberculosis, but less than US$ 1 for NCDs [23]. Second, the underlying drivers of NCDs are beyond the remit of the health sector. The institutional incentive structures to engage other sectors to address NCDs are weak [24].

The increasing importance of NCDs as part of the development agenda built the political momentum to mobilize bilateral, multilateral and private flows of aid for health to address NCDs as part of countries’ universal health coverage efforts. Governments will be increasingly challenged to finance their own health priorities. However, the shifts in disease patterns and underlying determinants have been only partial in many low- and middle-income countries. As a result, many countries are now facing a triple disease burden: (a) the unfinished agenda of communicable or infectious diseases, malnutrition and reproductive health-related issues; (b) a rising burden of NCDs and their shared risk factors; and (c) the burden and risks more directly linked to globalization, such as antimicrobial resistance and the health effects of climate change and trade policies [25]. These countries will continue to rely on external assistance to support their health and development agendas.

Adding NCDs to the global health development agenda makes the aid architecture even more complex. The donors’ portfolios are growing to include infectious diseases, reproductive health, health system challenges and NCDs. The proliferation of global health actors makes their coordination challenging. Even within one government, a variety of structures, such as the ministry of health, ministry of foreign affairs, and public research funders, all have intersecting roles in fighting NCDs. Likewise, within the United Nations system, WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Program (UNDP), the United Nations Children’s Fund (UNICEF), and the United Nations Population Fund (UNFPA) have distinct missions that can each contribute to the prevention and treatment of NCDs. Governments face the significant challenge of navigating and utilizing the resources offered by the national government, the United Nations system, and the contributions of multilateral development banks, civil society, and private industry.
China has sought to address the growing burden of NCDs by advancing government-led multisectoral cooperation and by building demonstration sites for comprehensive NCD prevention and control.

**Ministries united coordination meetings**

These meetings bring together state council leadership and representatives from approximately 30 ministries or councils with far-reaching missions, including health, agriculture, finance, sport, civil affairs, economics and the environment. The implementation of these meetings can be flexible to best fit each state’s needs. The meeting can be convened regularly or sporadically, and can include some or all standing members, as well as invited guests or experts. Local and state leaders develop the meeting agenda to address pressing needs, and the results of the large group meeting are reported back to the State government. The National Plan for NCD Prevention and Control (2012–2015) was issued by a group of 15 ministries that collaborated through the ministries united coordination meetings. This meeting mechanism also led to the publication of a national Three-Year Action Plan for Cancer Prevention and Control (2015–2017), issued by 16 ministries aiming to continuously enhance effective strategies by focusing on short-term targets.

**Demonstration sites for comprehensive NCD prevention and control**

These sites adopt a multipronged approach, including primary and secondary prevention as well as linkage to surveillance and care. Through early identification and standardized management, the programme reduces the negative consequences of hypertension, diabetes and cancer. These sites also create a positive health culture through programmes such as the national fitness campaign. So far, 265 demonstration sites have been built in 30 provinces with national financial backing, and the number of sites is expected to grow in the future.
Namibia faces a significant double burden of communicable diseases, including HIV and tuberculosis, coupled with growing rates of mental health conditions, hypertension, diabetes and cancer. To address these challenges, and to help Namibia reach its goals set out in Vision 2030: A Prosperous and Industrialized Namibia, the government developed the Delivering as One platform. Namibia’s Delivering as One platform aims to employ effective coordination to lead to a more strategic and efficient United Nations system in support of international and national development goals and priorities. Delivering as One seeks to unify efforts under one common voice by streamlining a variety of United Nations efforts under four pillars:

- one United Nations leader and one United Nations team
- one United Nations programme
- one United Nations budgetary framework
- one United Nations house.

A variety of United Nations organizations, including WHO, UNAIDS, UNICEF, and UNFPA, have offered support to a cross-section of strategic initiatives in the country. By consolidating this far-reaching group of efforts into one United Nations programme, Delivering as One allows for multisectoral integration and collaboration. Through this platform, Namibia has been able to identify and prioritize several cross-cutting strategic initiatives that will simultaneously address communicable diseases, NCDs, and broader development goals alike. This integrated platform is allowing Namibia to expedite recruitment and retention of health workers, decentralize training to regions and districts, strengthen stakeholder cooperation, and improve access to and quality of health services. Ultimately, the Government of Namibia hopes this cooperation will create the basis for a strong universal health care system, with both high coverage and high quality of services, to address the growing double burden of disease in the country.
The WHO GCM/NCD was established by Member States in 2014 precisely with the aim of addressing the intersectoral nature of NCDs: to “enhance coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global levels”. The strategic foundations for the establishment of the GCM/NCD were laid by the two landmark United Nations high-level meetings on NCDs in 2011 and 2014.

Currently, the GCM/NCD participants include over 350 partners, comprising all WHO Member States, United Nations funds, programmes and agencies, other intergovernmental organizations and non-State actors (NGOs, academia, philanthropic foundations and the private sector). Those partners engage with the GCM/NCD through a variety of channels: working groups, global multistakeholder dialogue meetings, an extensive network of communities of practice, webinars, integrated country initiatives, and knowledge dissemination and advocacy at global, regional and country levels. The GCM/NCD works to accelerate action for the achievement of the nine voluntary global targets of the Global NCD Action Plan and attain SDG target 3.4 and other NCD-related targets of the 2030 Agenda for Sustainable Development.

The United Nations Interagency Task Force (UNIATF) on the Prevention and Control of NCDs, which is a component of the GCM/NCD, coordinates the activities of relevant United Nations organizations and other intergovernmental organizations to support governments to meet high-level commitments to respond to NCD epidemics worldwide. The Task Force was established by the United Nations Secretary-General in June 2013 and placed under the leadership of WHO.

WHO is the only global health body with the power to create international health law, and the agency has already demonstrated its leadership in legislating against tobacco. Similar “hard law” mechanisms for alcohol, the processed foods and other commercial determinants of health are certainly feasible as well. However, WHO and other global health agencies presently lack the resources and mechanisms to meaningfully participate in policy issues, such as trade, agriculture, food security, poverty alleviation and climate change [22]. Moving forward, it will be important to carefully consider the importance of balancing political and economic influences in order to strengthen the multistakeholder engagement platforms and coordinating mechanisms at the global and national levels if NCDs are not to be left behind again.

Box 8. Case Study: WHO Global Coordination Mechanism and the United Nations Interagency Task Force
Evidence from the MDG era suggests that high-profile global goals benefit from increased donor funding. However, NCDs have not benefited much from this goal-related funding boost. From 1990 to 1999, health spending on the MDG areas only grew at a 5.5% rate, very close to the 4.0% growth rate for the non-MDG health areas. Following the Millennium Declaration and the MDGs, there was a clear demarcation in health funding, with the MDG areas growing at a 14.8% rate, whereas the non-MDG areas grew at a 6.3% rate. Despite this boom in global health funding for the MDGs, the growth rate was uneven across the various health focus areas. For example, HIV/AIDS funding increased substantially, with a 24.1% growth rate during the 2000–2009 period, whereas funding for maternal health only grew by 4.7%. Table 3 details the DAH annualized growth rates by health focus area.

### Table 3. DAH annualized growth rates

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<thead>
<tr>
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<tbody>
<tr>
<td>Malaria</td>
<td>9.1%</td>
<td>28.3%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>11.1%</td>
<td>26.9%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>9.5%</td>
<td>24.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Child and newborn health</td>
<td>7.7%</td>
<td>9.1%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Maternal health</td>
<td>2.6%</td>
<td>4.7%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Noncommunicable diseases</td>
<td>2.5%</td>
<td>10.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other infectious diseases</td>
<td>15.4%</td>
<td>9.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Sectorwide approaches and health system strengthening</td>
<td>8.8%</td>
<td>7.0%</td>
<td>-2.3%</td>
</tr>
<tr>
<td>Other</td>
<td>2.2%</td>
<td>5.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Unallocable</td>
<td>2.2%</td>
<td>14.3%</td>
<td>-17.3%</td>
</tr>
<tr>
<td>MDG areas</td>
<td>5.5%</td>
<td>14.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Non-MDG areas</td>
<td>4.0%</td>
<td>6.3%</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.6%</strong></td>
<td><strong>11.3%</strong></td>
<td><strong>1.2%</strong></td>
</tr>
</tbody>
</table>

Beyond growth rates are the absolute numbers indicating the spending in DAH by disease burden. These numbers highlight even more the differences in funding between MDG and non-MDG areas of health. Table 4 provides the DAH spending for 2015 by health focus areas as an absolute number and as a percentage of total DAH for 2015.

**Table 4. Flow of global DAH into selected programme areas, 2015**

<table>
<thead>
<tr>
<th>Selected areas</th>
<th>DAH in US$ and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>10.8 billion (29.7%)</td>
</tr>
<tr>
<td>Child and newborn health</td>
<td>6.5 billion (17.9%)</td>
</tr>
<tr>
<td>Maternal health</td>
<td>3.6 billion (9.8%)</td>
</tr>
<tr>
<td>Health system support</td>
<td>2.7 billion (7.3%)</td>
</tr>
<tr>
<td>NCDs</td>
<td>475 million (1.3%)</td>
</tr>
</tbody>
</table>


Despite contributing to over half of all deaths worldwide and becoming a major challenge in low- and middle-income countries in particular, NCDs received only 1.7% of total DAH in 2016 (1.7% of US$ 37.6 billion). Further, NCD funding as a percentage of total health funding remained almost constant between 2000 and 2014 (Table 5).

**Table 5. Development assistance for NCDs and all health 2000–2014**

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NCD funding</td>
<td>160</td>
<td>181</td>
<td>219</td>
<td>179</td>
<td>217</td>
<td>251</td>
<td>295</td>
<td>334</td>
<td>442</td>
<td>458</td>
<td>474</td>
<td>528</td>
<td>515</td>
<td>608</td>
<td>611</td>
</tr>
<tr>
<td>Total health</td>
<td>11601</td>
<td>12026</td>
<td>13821</td>
<td>15859</td>
<td>18057</td>
<td>19965</td>
<td>21886</td>
<td>25194</td>
<td>29236</td>
<td>30120</td>
<td>33935</td>
<td>54912</td>
<td>33129</td>
<td>36456</td>
<td>35890</td>
</tr>
<tr>
<td>funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCD funding</td>
<td>1.38</td>
<td>1.51</td>
<td>1.58</td>
<td>1.13</td>
<td>1.20</td>
<td>1.26</td>
<td>1.35</td>
<td>1.33</td>
<td>1.51</td>
<td>1.52</td>
<td>1.40</td>
<td>1.51</td>
<td>1.55</td>
<td>1.67</td>
<td>1.70</td>
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<td>as % of total</td>
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</tbody>
</table>

Source: IHME [21].

In addition to receiving disproportionately low levels of assistance overall, the NCD DAH situation is exacerbated by a significant imbalance in resource allocations to countries. The countries with the greatest burden of NCDs are generally not those receiving the highest proportion of NCD funding. This is depicted in Figure 3, which displays the countries with top disability-adjusted life-years (DALYs) side by side with the top recipients of NCD DAH.
With the exception of two countries – Turkey and South Africa – few countries are situated close to their DAH ranking [21]. These gaps between disease burden and funding represent substantial challenges for all countries seeking to address NCDs [21].

Within NCDs, in 2016, anti-tobacco programmes received US$ 103.5 million (16%) of NCD DAH, while mental health received US$ 129.6 million (20.1%). Only US$ 410 million were spent on other NCD areas in 2016 [21].

**Figure 3. Top 20 countries by 2015 NCD burden of disease versus average 2012–2014 DAH**

<table>
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<tr>
<td>China 1</td>
<td>1 Argentina</td>
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<tr>
<td>India 2</td>
<td>2 Brazil</td>
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<td>Indonesia 3</td>
<td>3 China</td>
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<td>Brazil 4</td>
<td>4 The Gambia</td>
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<tr>
<td>Pakistan 5</td>
<td>5 Democratic Republic of the Congo</td>
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<tr>
<td>Bangladesh 6</td>
<td>6 Afghanistan</td>
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<tr>
<td>Nigeria 7</td>
<td>7 India</td>
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<tr>
<td>Mexico 8</td>
<td>8 Dominican Republic</td>
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<tr>
<td>Egypt 9</td>
<td>9 Palestinian Territory*</td>
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<tr>
<td>Philippines 10</td>
<td>10 Sri Lanka</td>
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<tr>
<td>Vietnam 11</td>
<td>11 Kenya</td>
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<tr>
<td>Ukraine 12</td>
<td>12 Uganda</td>
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<tr>
<td>Thailand 13</td>
<td>13 Zambia</td>
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<tr>
<td>Ethiopia 14</td>
<td>14 Vietnam</td>
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<tr>
<td>Iran 15</td>
<td>15 Malawi</td>
</tr>
<tr>
<td>Turkey 16</td>
<td>16 Rwanda</td>
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<tr>
<td>Democratic Republic of the Congo 17</td>
<td>17 Turkey</td>
</tr>
<tr>
<td>Myanmar 18</td>
<td>18 South Africa</td>
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<tr>
<td>South Africa 19</td>
<td>19 Mexico</td>
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<tr>
<td>Argentina 20</td>
<td>20 Samoa</td>
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<tr>
<td>Afghanistan 22</td>
<td>21 Indonesia</td>
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<tr>
<td>Uganda 28</td>
<td>22 Ethiopia</td>
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<td>Kenya 30</td>
<td>23 Pakistan</td>
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<td>Sri Lanka 45</td>
<td>24 Bangladesh</td>
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<td>Zambia 48</td>
<td>25 Egypt</td>
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<tr>
<td>Malawi 54</td>
<td>26 Nigeria</td>
</tr>
<tr>
<td>Dominican Republic 75</td>
<td>27 Thailand</td>
</tr>
<tr>
<td>Rwanda 74</td>
<td>28 Philippines</td>
</tr>
<tr>
<td>Palestinian Territory* 97</td>
<td>29 Ukraine</td>
</tr>
<tr>
<td>The Gambia 111</td>
<td>30 Iran</td>
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<tr>
<td>Samoa 126</td>
<td>31 Myanmar</td>
</tr>
</tbody>
</table>

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* Occupied
In terms of actors, private philanthropy has been traditionally the biggest supporter of the NCD agenda, channelling resources through NGOs and foundations, as well as United Nations agencies, although to a lesser extent in the case of the United Nations. In 2016, the philanthropy contribution to NCDs amounted to US$ 245 million. Globally, NGOs and foundations disbursed a total of US$ 274.5 million coming from various sources. The United Nations agencies, mainly WHO and the Pan American Health Organization (PAHO), channelled about US$ 172.9 million, with the major contributions coming from the United States (US$ 23.3 million), the United Kingdom (US$ 24.8 million), the Bill & Melinda Gates Foundation (US$ 21.1 million), and private philanthropy (US$ 13.6 million). The Gates Foundation channelled an additional US$ 43 million through its foundation for a total contribution of US$ 64.2 million to NCD DAH in 2016.

In general, governments remain the main source of funding for official development assistance. The Governments of the United States and the United Kingdom are the biggest funders of global health. In 2016, the United States spent US$ 12.8 billion (or 34% of DAH) on global health, of which US$ 53.7 million were spent on NCDs through various channels. In comparison, the United Kingdom Government spent US$ 4.1 billion (or 10.9% of total DAH) on global health, while private philanthropy provided US$ 2.2 billion (5.8%) and the Bill & Melinda Gates Foundation contributed US$ 2.9 billion (7.8%) in 2016 [21].

Governments have favoured certain channels for DAH spending. In 2016 alone, United States NGOs received US$ 4.4 billion or 34.2% of total DAH from the United States Government, while international NGOs (headquartered in high-income countries other than the United States) received US$ 792 million in United States DAH. The Global Fund and the United Nations agencies received US$ 906 million and US$ 654.9 million respectively from the United States [21]. While governments have been major funders of official development assistance, some have demonstrated greater commitment. For example, in 2013, the United Kingdom Government marked an important milestone in its development assistance when it devoted 0.7% of the country’s gross national product (GNP) to official development assistance. The United Kingdom joined Denmark, Luxembourg, the Netherlands, Norway and Sweden in reaching this target [26].

United Nations agencies are receiving as well as channelling funds. Funding for the United Nations agencies collectively decreased from US$ 5.1 billion to US$ 4.7 billion in 2016. There were fewer funds available for WHO as well. In 2016, the Organization took a 16.8% cut in financing and received US$ 2.2 billion. Out of this US$ 2.2 billion, US$ 682.3 million went to infectious diseases and US$ 609.3 million was spent on health system strengthening and sectorwide approaches [21].
In 2016, WHO continued to lead global action to reduce the burden of noncommunicable conditions, focusing on the four primary NCDs and their shared major risk factors, as well as poor nutrition, foodborne diseases, mental health conditions, substance abuse, disability, violence and injuries. However, the Organization also documented the largest funding gap for NCDs.

The total approved biennium budget (2016–2017) for NCDs was US$ 376 million. Available resources at the end of 2016 were US$ 219 million or 58% of the approved programme budget. Expenditure was US$ 121 million or 32% of the approved programme budget and 55% of the funds available. The NCD programmes had the lowest available funding after the first year of implementation when compared to the other categories (Figure 4). Available funds for the regions varied from 37% in the African Region to 64% in the South-East Asia Region [27].

Figure 4. Base technical programme areas, funding and gap (US$ millions)

The MDG era was marked by significant increases in development assistance for the MDG-related health focus areas, particularly HIV/AIDS, tuberculosis and malaria. However, the NCDs were excluded from the MDGs, mainly because of the perception that they were diseases of affluence. The first United Nations High-level Meeting on NCDs in 2011 elevated NCDs on the development agenda. However, the second United Nations High-level Meeting on NCDs in 2014, in its review of the progress made in overcoming the burden of NCDs in countries, concluded that it was “insufficient and highly uneven”. The slow progress on NCDs at national level, particularly in low-income countries, can be partially explained by the lack of local capacities (technical, financial, human) to implement the global-level commitments. This is especially problematic in countries that are heavily dependent on DAH. However, to date, DAH continues to be poorly aligned with the global disease burden, particularly for NCDs.

Although an accurate figure for NGO spending on health is difficult to estimate, since NGO budgets are supported by multiple sources and the programme areas are diverse, NGOs and private foundations are disbursing the largest share of DAH among all the actors. According to the most recent report of the Institute for Health Metrics and Evaluation (IHME), financing of DAH from NGOs amounted to US$ 11.3 billion or 30.1% of total DAH in 2016, followed by the United States bilateral agencies (15.4%) and the Global Fund (9.9%) [21].

Resource flows into NCDs, and into health generally, are not limited to DAH. On the whole, government health expenditure as a source is considerably larger than DAH, with US$ 19.80 in government health expenditure spent for each DAH dollar [21]. However, governments in low- and middle-income countries are allocating very little to NCD prevention and care, which increases the vulnerability of households to high health care costs when emergencies strike. For example, more than 50% of current spending on cardiovascular diseases in low-income countries comes out of the pockets of patients and their households, 33% is from national governments, and 13% is from donors [28].

3.4 FROM MDGS TO SDGS: CAPITALIZING ON A MOMENTUM FOR COLLABORATIVE ACTION ON UNIVERSAL HEALTH COVERAGE AND NCDs

The MDG era was marked by significant increases in development assistance for the MDG-related health focus areas, particularly HIV/AIDS, tuberculosis and malaria. However, the NCDs were excluded from the MDGs, mainly because of the perception that they were diseases of affluence. The first United Nations High-level Meeting on NCDs in 2011 elevated NCDs on the development agenda. However, the second United Nations High-level Meeting on NCDs in 2014, in its review of the progress made in overcoming the burden of NCDs in countries, concluded that it was “insufficient and highly uneven”. The slow progress on NCDs at national level, particularly in low-income countries, can be partially explained by the lack of local capacities (technical, financial, human) to implement the global-level commitments. This is especially problematic in countries that are heavily dependent on DAH. However, to date, DAH continues to be poorly aligned with the global disease burden, particularly for NCDs.
At the United Nations Sustainable Development Summit, 25–27 September 2015, Member States gathered at the United Nations in New York, United States, to adopt a new agenda for sustainable development, with a set of Sustainable Development Goals (SDGs) and associated targets. *Transforming our world: the 2030 Agenda for Sustainable Development* recognized NCDs as an important part of sustainable development, causing unnecessary mortality and human suffering with associated social and economic costs.

The new SDGs include a target on the reduction of premature mortality from NCDs (SDG target 3.4): “By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.” The 2030 Agenda for Sustainable Development also includes a target on universal health coverage (SDG target 3.8), which has major implications for NCDs: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.” Target 3.8 has two indicators – 3.8.1 on coverage of essential health services, defined as services that all countries, irrespective of their income level or epidemiological and demographic profile, have to provide; and 3.8.2 on the proportion of a country’s population with catastrophic spending on health.

Specifically, universal health coverage indicator 3.8.1 on essential health services includes coverage of (a) reproductive, maternal, newborn and child health; (b) infectious diseases; (c) NCDs; and (d) service capacity and access, among the general and most disadvantaged populations. In the recently introduced WHO and World Bank publication *Tracking universal health coverage: 2017 global monitoring report*, for each of the four categories specified in indicator 3.8.1, 16 tracer indicators were selected, including NCD indicators for prevention, as well as indicators for curative services [29].

While NCDs did not see much of a boost during the MDG era, the SDGs now present a prime opportunity for the NCD community to capitalize on increased awareness. In addition to improving epidemiology and surveillance for NCDs, country governments and development agencies can collaborate to generate fully costed NCD frameworks and take advantage of the spotlight provided by the SDGs.

However, moving from 8 MDGs to 17 SDGs implies that NCDs will have to compete with many other areas for the limited funding for development assistance. Even if global health experiences a boom in official development assistance, as witnessed in the MDG era, this boom will now have to be shared among an increased pool of priorities.
To add to the complexity of the challenge, measures to tackle NCDs and their shared risk factors (tobacco use, alcohol abuse, lack of physical activity and unhealthy diets) need to extend beyond health systems and require multisectoral and multistakeholder partnerships at both global and national levels. To address this issue, the World Bank identified 71 distinct intersectoral policies (fiscal, regulatory, infrastructural, and informational) for reducing behavioural and environmental risks to be included in essential universal health coverage packages, and 29 out of these 71 were defined as candidates for early implementation [29]. The World Bank estimated that for lower middle-income countries, the mortality reduction from implementing essential universal health coverage can only achieve about half of the mortality reduction in NCDs called for by the 2030 Agenda for Sustainable Development. Full achievement of premature mortality reduction from NCDs will require increased investments or sustained intersectoral action, and actions by finance ministries to tax smoking and polluting emissions and to reduce and eliminate subsidies on fossil fuels [19].

Therefore, making the case for NCDs is all the more important, and linking NCDs back to the overall goal of “Ensuring healthy lives and promoting well-being for all at all ages” will be crucial. On the other hand, if all other sectors fulfil their commitments towards the implementation of the 2030 Agenda for Sustainable Development, the co-benefits (positive externalities) will be enjoyed by all sectors, including health. At this time, there is limited, insufficient understanding of the interconnected nature of the SDGs, whereby action on NCDs and their risk factors can benefit other areas of sustainable development.

Annex 5 explores the synergies among the SDGs benefiting the health sector and NCDs.
4 DAH funding for NCDs and tracking resource flows: understanding the challenges

4.1 CATEGORIZATION AND DEFINITION OF NCDs

The case for NCD funding represents unique challenges distinct from those of more defined conditions, such as HIV/AIDS or maternal and child health. The risk factors and outcomes of NCDs are so disparate that it can be very difficult to weave a united narrative and control plan. The inconsistent categorization of NCD funding presents a major obstacle in tracking financial flows into NCDs. Closer examination reveals numerous gaps between agreement on a clear definition of NCDs and what exactly constitutes NCD funding. While this paper looks at NCDs using the “4X4 approach” (four major NCDs, namely cardiovascular diseases, cancers, chronic respiratory diseases and diabetes; and four common modifiable risk factors, namely unhealthy diet, physical inactivity, smoking and harmful use of alcohol) presented in the Global NCD Action Plan, the NCD definition is sometimes considered more broadly in national plans to reflect the reality of local disease burdens and may include other conditions, such as degenerative disorders, kidney and eye diseases and injuries.

4.2 METHODOLOGICAL CHALLENGES

Incomplete data sources. Existing studies of NCD donor funding have focused on official sources and pathways of information, such as the OECD/DAC creditor reporting system or direct budget information. This leaves out most private health funding, particularly from corporations and foundations, based outside the United States. In addition, health
Perception of NCDs. NCDs are still not widely considered part of the broader development agenda in a traditional sense. Even though the root causes of NCDs are dependent on the level of economic development and the social determinants of health, immediate risk factors for NCDs can be related to personal behaviours, such as tobacco use, poor diet, harmful use of alcohol and lack of physical exercise. In addition to these factors, metabolic risk factors, including high blood pressure, obesity, hyperglycaemia, and hyperlipidaemia, can all increase the risk.

Other Challenges to DAH for NCDs

Partial information. When the information is derived from known sources, it may still be incomplete. For example, most studies of DAH focus on measuring DAH in terms of disbursements made by donors. This has an advantage of tracking actual international transfer of resources rather than tracking commitments, which only constitute an obligation for donors. An important contribution has been through the WHO’s Global Health Expenditure Database, which enables insights into actual resource flows into country budgets but depicting revenue sources of health spending for the years 2000–2015 [31]. However, the tracking of disbursements also means that “the aid activities were planned and approved in earlier years, reflecting the push to meet the MDG targets rather than SDGs”. Therefore, to have a complete picture of donor priorities, it is critical to analyse commitments as well [32].

Inconsistent methodologies. As donor funding for NCDs is a relatively new phenomenon, there are no clear and uniform protocols and definitions for reporting. Aside from the lack of clear definition, the same stream of funding may be categorized differently over different years as general NCD funding or as disease specific, resulting in wide variations in data [33]. Different methodological approaches have also yielded different estimates for DAH. For example, according to the WHO Global Health Expenditure Database [33], which relies on country health expenditure data, the total DAH in 2016 was US$ 19.2 billion. The IHME estimated the total DAH as US$ 37.6 billion due to the inclusion of additional donors (for example, IHME includes philanthropic private donations to NGOs) [21].
of developing NCDs [34]. Therefore, action on NCDs often continues to be confined to the domain of health systems without giving adequate attention to the underlying determinants of NCDs that lie outside the health sector and are beyond the individual’s control [35].

Graduation of countries from health aid. Over the past two decades, many formerly low-income countries have moved to middle-income status, including such populous countries as China, India and Nigeria [24]. Although 31% of country-specific aid is presently directed towards middle-income countries, donors are increasingly introducing so-called “graduation rules”, when external support is discontinued after countries reach a particular GDP level [36]. After graduation, countries are encouraged to increase domestic financing for health services. However, many of those middle-income countries have significant inequalities in terms of health and income. Therefore, the poorest populations and the highest disease burden started to shift towards middle-income countries [17]. Ironically, these are the countries with a growing NCD burden, which is affecting the most vulnerable populations (for example, ethnic groups that suffer discrimination, refugees, older adults and poor populations) [37].

In addition, even if countries have achieved sufficient fiscal space for increased health spending, they may not have enough political will or institutional capacity to support these populations through the provision of needed health services [35]. The consensus is growing internationally that national income growth alone may not be a good criterion to use for the allocation of foreign aid, and donors should align their support with recipient-country government priorities in line with the principles of the Paris Declaration on Aid Effectiveness [17].

DAH for universal health coverage through health system strengthening. To achieve the health-related SDGs, including the NCD target (SDG 3.4) and the NCD-related targets of the 2030 Agenda for Sustainable Development, a higher proportion of DAH should be invested in countries’ efforts to achieve universal health coverage through health system strengthening. However, donor investments in health systems continue to be low. According to a recent WHO-commissioned study, in 2015, of the US$ 22.9 billion disbursements in DAH, only 10.9% (US$ 2.5 billion) was for systemwide health system strengthening [38]. Of the total DAH on health system strengthening, US$ 2.2 billion was for a specific country or region, and US$ 311.4 million was global DAH, contributing to systemwide health system strengthening across countries. Greater DAH investments were made in programmes rather than health system strengthening. In 2015, US$ 15.9 billion (69.6% of DAH) was devoted to infectious disease programmes, reproductive, maternal, newborn and child health, and NCDs (programme-specific funding), with the largest proportion allocated to infectious diseases (Figure 5) [24].
Vertical, disease-specific programmes have long been donors’ favourites due to their potential to deliver services to a large number of people quickly and with measurable results. However, vertical programmes may be approaching the point of diminishing returns. Successful donor strategies in global health need to take into account major demographic and epidemiological changes requiring broader systemwide approaches. Even from the favourable disease-specific vertical funding perspective, NCDs are still faring poorly. In 2015, NCDs received a disproportionately low share of DAH – only 1.8% (US$ 294 million, according to this source [24]).

The ambitious development agenda will require significant investments in health systems to make progress towards the targets of the health goal (SDG 3). However, current levels of investments in universal health coverage through systemwide health system strengthening, as well as disease-specific spending on NCDs, continue to fall short. Stenberg et al. [39] found that the health workforce and health facilities (including equipment and operating costs) will be the main cost drivers for the health system strengthening costs through 2030 to meet the health-related SDG targets. According to their projection, most resources will be needed to support first-level (primary) clinical services. The ambitious scenario projections, where 67 low- and middle-income countries attain the global SDG targets, estimated an additional US$ 371 billion for health targets, the equivalent of an additional US$ 58 per person per year for the final years of scale-up. Around 75% of costs will be for health systems, and 44% of programme-specific costs will be required for NCDs. This investment will result in 97 million lives saved and increase life expectancy by 3.1–8.4 years, depending on the country profile [35].
Health area-focused allocations. Resources for health aid are not infinite and decisions for prioritizing disease focus areas and programmes are inevitable. Epidemiological and demographic challenges with the growing burden of NCDs are creating difficulties for donors as they now need to carefully consider their responses to the problems of maternal and child health, as well as addressing the unfinished agenda of infectious diseases and antimicrobial resistance. To identify the investment priorities that provide the greatest benefits with available DAH resources, information is needed on the cost-effectiveness of potential interventions [19]. To address this issue, WHO has recently updated Appendix 3 of its Global NCD Action Plan based on the newly available evidence of cost-effectiveness of the proposed NCD interventions. The WHO “best buys” and other recommended interventions comprise a total of 88 interventions, including policy actions, “the most cost-effective interventions” and “other recommended interventions”. WHO recommends that when considering interventions for the prevention and control of NCDs, attention should be given to both economic and non-economic criteria, such as health impact, acceptability, sustainability, scalability, equity, ethics, multisectoral actions, and monitoring [40].

Funding health policy and systems research for NCDs. NCD policies and programmes should be based on sound scientific evidence generated through research. Despite robust scientific evidence on NCD prevention and control, a significant knowledge-to-action gap remains. Understanding how to implement interventions effectively is vital in developing ambitious national responses in order to meet the NCD-related targets included in the Global NCD Action Plan and the 2030 Agenda for Sustainable Development. It has proved to be particularly challenging to translate WHO best buys into practice, irrespective of their demonstrated value for money.

Some of the implementation challenges are clearly linked to the weak performance of health systems. Health system research and implementation research are needed to identify the barriers to the effective implementation of cost-effective best-buy interventions and develop effective strategies to scale up these interventions. It is concerning that limited research is conducted in low-income countries, especially in sub-Saharan Africa. Overcoming this problem will require increased investments and efficient use of available resources. One of the proposals for increased efficiency includes using existing research infrastructures for NCDs. For example, in Uganda the research infrastructure to conduct HIV surveys was used as a platform for a survey of hypertension and other chronic NCDs [41].

On a similar note, research is also essential to showcase how NCD interventions can be implemented in low-resource settings, considering many competing health priorities. Investments in implementation research can improve the effectiveness of health programmes and yield high returns on DAH. Hence, there is a paramount need for sufficient and reliable funding to support health policy and systems research as
countries strive to achieve the universal health coverage and NCD targets of the 2030 Agenda for Sustainable Development. Over the period 2010–2014 donors committed an average of US$ 434 million a year for health policy and systems research in low- and middle-income countries. However, this amount constituted only 2% of donor funding for health and population projects. Up to 94% came from just 10 donors, showing the vulnerability of funding due to such a narrow funding base. Almost half of all funding for health policy and systems research was provided by various public agencies of the United States and the Global Fund. Table 6 lists the main donors of health policy and systems research in low- and middle-income countries. On the bright side, the largest share of funding was committed to countries in sub-Saharan Africa, which corresponds well to the region’s growing disease burden and lack of capacity to resource health policy and systems research [42].

Table 6. Top donors of health policy and systems research funding, 2000–2014

<table>
<thead>
<tr>
<th>Donor</th>
<th>Total commitments to health (2014, US$ millions)</th>
<th>Total commitments to health policy and systems research (2014, US$ millions)</th>
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<tbody>
<tr>
<td>United States</td>
<td>72 438.7</td>
<td>1 262.6</td>
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<tr>
<td>Global Fund</td>
<td>29 317.9</td>
<td>574.9</td>
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<tr>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>10 357.7</td>
<td>491.7</td>
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<td>International Bank for Reconstruction and Development</td>
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<td>466.1</td>
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<td>International Development Association</td>
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<td>428.2</td>
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<tr>
<td>Canada</td>
<td>6 327.8</td>
<td>214.9</td>
</tr>
<tr>
<td>United Kingdom(^a)</td>
<td>15 180.9</td>
<td>123.2</td>
</tr>
<tr>
<td>Norway(^a)</td>
<td>3 577.4</td>
<td>110.2</td>
</tr>
<tr>
<td>Australia</td>
<td>3 956.5</td>
<td>39.4</td>
</tr>
<tr>
<td>France</td>
<td>4 038.2</td>
<td>37.3</td>
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<tr>
<td>Donor</td>
<td>Total commitments to health (2014, US$ millions)</td>
<td>Total commitments to health policy and systems research (2014, US$ millions)</td>
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<tr>
<td>Sweden</td>
<td>2 853.3</td>
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<tr>
<td>UNFPA</td>
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<td>28.5</td>
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<tr>
<td>Inter-American Development Bank</td>
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<td>25.2</td>
</tr>
<tr>
<td>EU institutions</td>
<td>8 192.3</td>
<td>22.8</td>
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<td>UNAIDS</td>
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<tr>
<td>Ireland</td>
<td>1 614.6</td>
<td>17.4</td>
</tr>
<tr>
<td>Gavi, the Vaccine Alliance</td>
<td>7 521.2</td>
<td>17.4</td>
</tr>
<tr>
<td>Islamic Development Bank</td>
<td>1 815.5</td>
<td>17.2</td>
</tr>
<tr>
<td>Germany</td>
<td>5 729.9</td>
<td>16.4</td>
</tr>
<tr>
<td>Belgium</td>
<td>2 138.8</td>
<td>16.1</td>
</tr>
<tr>
<td>Total, top 10 donors</td>
<td>174 026.4</td>
<td>3 748.5</td>
</tr>
<tr>
<td>Total, all donors</td>
<td>246 013.3</td>
<td>3 995.3</td>
</tr>
<tr>
<td>% top 10 donors/all donors</td>
<td>71%</td>
<td>94%</td>
</tr>
</tbody>
</table>

* Estimates for these three donors also include core contributions made to the Alliance in support of health policy and systems research activities. Source: Gripin et al. [42].
DAH is essential for averting preventable deaths and human suffering, especially in countries with limited domestic capacity to address health needs. The mounting evidence suggests that the growing health aid since 2000 has helped to reduce the mortality and morbidity from many infectious diseases and maternal and child health conditions in low- and middle-income countries. However, economic development of aid-recipient countries and the changing disease patterns, with NCDs taking a centre stage, require new approaches to reallocating resources in order to address new priorities. The burden of disease will continue to be a primary consideration in choosing new health investments, but aid efficiency will also be important. Efficient resource allocation will imply the cost-effectiveness analysis of interventions. Using health aid to fund cost-effective interventions (NCD best buys) in highly burdened countries could yield the highest returns on investment [19].

However, direct attribution for improved health to the efforts of one particular donor may be difficult to establish due to the proliferation of global health actors and other factors influencing health, including the social, economic and commercial determinants of health.

The principles of effective development cooperation were articulated in the Busan Partnership Agreement, endorsed by 160 countries and more than 50 organizations. These principles – ownership of development priorities by developing countries, focus on results, inclusive development partnerships, and transparency and accountability to each other – provide a foundation for development effectiveness.

The concept of development effectiveness may address many of the criticisms that foreign aid has been historically subjected to, such as "narrow focus on aid; rigid and often ineffective and irrelevant measurements of successes and failures; the need to address systemic inequality at the international level and improve partner-country ownership of development; and limited attention to and insufficient understanding of issues related to
power and the root causes of poverty”. If well operationalized, development effectiveness could provide a basis for effective public-private partnerships with implications for accountability and implementation mechanisms [43].

Box 9 presents a case study illustrating the important role civil society plays in bringing together multiple stakeholders for joint action.

**Box 9. Case study: NCD Alliance of Kenya: building networks, alliances and partnerships towards the achievement of national commitments and global targets**

The NCD Alliance of Kenya (NCDAK) emerged to comprehensively and sustainably address the rising prevalence of NCDs. The NCDAK is a registered NGO that has brought together over 30 multisectoral stakeholders, including patient support groups, CSOs and government agencies. The NCDAK members support the Ministry of Health of Kenya both directly and indirectly through technical assistance, data sharing and advocacy roles. For example, to help build awareness and support around breast cancer, the NCDAK organized a statement of unity gala dinner and fundraiser. This event also served as a platform to popularize and trigger the implementation of the National NCD Strategy and the NCD Community Health Strategy Module 13 at the national and county levels. Now that the NCD Strategy is being rolled out, the NCDAK remains an involved supporter of the effort, assisting with data collection to monitor the effects of the strategy. This CSO has brought together a variety of actors to support efforts along the NCD prevention and control spectrum.

Source: Working Group member.

5.2 NATIONAL NCD PLANS AS A TOOL FOR COOPERATION

In every health system, priorities need to be set to determine the allocation of scarce resources. The success of NCD prevention and control is highly influenced by the extent of government commitment to health in general, and how this translates into multisectoral planning and action to address NCDs and their shared risk factors [44]. The challenge for countries is to build upon their existing structures and activities, using the leverage from international partners and experiences shared by others.

In countries where external assistance plays a significant role, national health policies, strategies and plans are increasingly seen as the key to improve development effectiveness. Both countries and aid agencies
now consider strong national health policy and planning processes to be critical for the harmonization and alignment of external and internal financial and technical inputs to the health sector and for addressing unproductive fragmentation and duplication [44].

Most countries have been developing national health policies, strategies and plans for decades to give direction and coherence to their efforts to improve health. WHO has a long track record of supporting countries in this endeavour through technical cooperation and facilitation of national policy dialogue and intercountry exchange of best practices [45], as well as through normative work and high-level international policy frameworks. In many developing countries, diverse domestic and external agencies are stepping up support [30].

At a glance, the literature on national health policy planning reveals that there is often an interchangeable use of the terms national health “policy”, “plan”, “strategy” and “programme”. There is a lack of consistency and consensus over the way the terms are used [46]. At the same time, such differential usage reflects the diversity of approaches and levels at which national health policy is undertaken, as well as differing aims [30].

In sum, policies, strategies and plans cover a wide spectrum of dimensions and hierarchies. They range:

- from values and vision, policy direction, strategy, and strategic planning, to detailed operational planning;
- from “comprehensive” health planning to “disease-specific or programme” planning;
- from long-term, 10–20-year time horizons, to the five-year plan, the three-year rolling plan, and the yearly operational plan;
- from national to regional or district plans;
- from highest-level endorsement of the vision and the policy directions to approval of operational plans at national and local levels [47].

5.2.1 ASSESSING NATIONAL CAPACITIES FOR NCD
RESPONSE

Irrespective of a wide variation in strategies and plans, the process of national planning is a critical prerequisite for effective NCD responses. To assess the capacity of countries to respond to NCDs, WHO conducts periodic global country capacity surveys. In these surveys, information is collected on countries’ NCD infrastructure, NCD-relevant policies, surveillance and health system response. Comparisons of the survey results over the years provide a valuable picture of global progress on NCDs.

In 2015, 92% of countries reported including NCDs in their national health plans, with the WHO South-East Asia Region and the Western Pacific Region reporting 100% of countries. Of the reporting countries (177 countries or 91% response rate), 64% included NCDs in their national development agenda, 77% of countries had a set of NCD indicators in their plans, and 60% had a set of time-bound national targets for these indicators. However, only 62% of countries reported having an operational integrated plan addressing the major NCDs and their risk factors. Further, only 53% of countries observed multisectoral integrated NCD plans [48].

In addition to global country capacity surveys, WHO publishes a Progress Monitor to take stock of countries’ progress on selected NCD indicators. The Progress Monitor is a tool based on the data from all WHO Member States tracked against 10 progress indicators to chart progress in developing national responses encompassing NCD management, risk factors, mortality statistics, access to treatment and national targets [43]. The Progress Monitor describes achievements and challenges countries face in fulfilling their promises as articulated in high-level political declarations on NCDs. Specifically, Progress Monitor indicator 4 refers to the existence of multisectoral integrated NCD policies, strategies or action plans. Only 41% of countries have fully achieved this indicator, which implies that a country not only had an operational, multisectoral integrated NCD plan, but also had to indicate that this plan covered the four main NCDs, as well as the four main NCD risk factors [49].
5.2.2 NATIONAL NCD PLANS: POSITIVE TRENDS AND CHALLENGES

National NCD plans are useful tools for improving aid effectiveness and development impact. The Working Group identified some positive trends and potential concerns that countries should consider when developing their plans (Box 10).

The case study in Box 11 closely examines the common pitfalls of national NCD plans in five countries of the WHO Western Pacific Region. Avoiding these pitfalls will be important for ensuring the alignment of international cooperation with national NCD plans.

**Box 10. Factors in developing national NCD plans**

<table>
<thead>
<tr>
<th>Positive trends</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>- There is increasing institutional recognition of NCDs</td>
<td>- Plans are not always informed with local evidence of the disease burden and health needs</td>
</tr>
<tr>
<td>- Countries are moving from disease-based programmes to integrated NCD programmes</td>
<td>- Sectorwide and NCD-specific policies and plans are weakly aligned</td>
</tr>
<tr>
<td>- NCDs are increasingly included in sectorwide health plans</td>
<td>- Plans are not developed with participation and endorsement of all the stakeholders (health and non-health)</td>
</tr>
<tr>
<td>- The high burden of NCDs is recognized</td>
<td>- NCD plans are not costed and lack information on financial and implementation feasibility</td>
</tr>
<tr>
<td>- There is explicit acknowledgment of the need for multisectoral actions</td>
<td>- National NCD plans often do not include realistic quantifiable targets</td>
</tr>
</tbody>
</table>
Box 11. Case study: Alignment of NCDs in sectorwide health policies and plans: cases of five countries in the WHO Western Pacific Region

Following a qualitative analysis of the five national plan cases, encompassing the national plans of Cambodia, Fiji, Malaysia, Mongolia and the Philippines, one study identified three major areas of concern in the increasingly complex NCD policy landscape in low- and middle-income countries [34].

**NCD plans not reflective of local needs and priorities**

The sectorwide health plans did not fully take into consideration local disease burden and health needs. Often there was a conflict between local needs and global priorities, and global priorities usually prevailed despite the contradictory local evidence. The lack of engagement of the NCD-specific units in the sectorwide health policy and planning process to ensure inclusion of NCDs and related activities appropriate to the country-level epidemiology and disease burden in the sectorwide health plans was apparent.

**Weak alignment between sectorwide and NCD-specific policies and plans**

The analysis also uncovered a weak alignment between sectorwide and NCD-specific policies and plans in terms of goals and targets, financial resource allocation and unclear division of roles and responsibilities between the NCD-specific and sectorwide structures.

**Lack of financial analysis, costing and feasibility to implement NCD responses**

Of the five countries examined, only Fiji’s NCD plan included financial considerations for costing and financing the proposed interventions. However, the budget indicated was a major underestimation. None of the plans (either sectorwide or NCD-specific) provided any analysis of the public health expenditure for NCDs, despite the evidence that a substantial proportion of public health expenditure is being spent on treatment costs for NCDs [50].

The elements of successful approaches to multisectoral NCD plans, based on the country-specific contexts, may include:

- high-level commitment and champions (for example, mayors, royalty, health ministers, prime ministers);
- availability of dedicated resources;
- relevant institutional structures;
- joint multisectoral and multistakeholder planning;
- legislative tools (for example, to reduce specific NCD risks or to set up structures for multisectoral coordination mechanisms);
- mutual accountability mechanisms (health sector and other relevant sectors);
- monitoring and reporting (for example, targets will focus action and results are important for advocacy) [50].
5.2.3 STATUS OF FINANCING OF NATIONAL NCD RESPONSES

The WHO global country capacity survey (2015) uncovered financing gaps for certain interventions and actions that target the prevention and control of NCDs. For example, the survey revealed that funding for health care and treatment was the most prevalent (94% of countries), with funding also prevalent for primary prevention of NCDs (88%), health promotion activities (87%), and early detection and screening (85%) [48]. The prevalence of funding for surveillance, monitoring and evaluation, and capacity-building reported by the countries was slightly lower overall, with only 81% of countries reporting funding for each of these. Palliative care funding was considerably less prevalent, with less than two thirds of countries (64%) reporting having funding. The African Region (40%), the Region of the Americas (44%) and the Eastern Mediterranean Region (50%) reported particularly low levels of funding for palliative care. These findings reveal opportunities for improved country capacity across the board, which can best be achieved through a focus on primary care delivery and efforts to achieve universal health coverage. Figure 6 details the levels of funding for NCDs by activities and functions.

Figure 6. Percentage of countries with funding for NCD activities by function and WHO region

Source: WHO Global Country Capacity Survey 2015
5.2.4 MAJOR FUNDING SOURCES FOR NCDs

In terms of funding sources for NCDs, the WHO country capacity surveys identified the following major sources of NCD financing: government revenues (94% of countries); international donors (64%); health insurance (62%); and earmarked taxes (34%) (Table 7) [48].

Table 7. Major funding sources for NCDs: percentage of countries with funding source

<table>
<thead>
<tr>
<th>Category</th>
<th>Region/income group</th>
<th>General government revenues</th>
<th>Health insurance</th>
<th>International donors</th>
<th>Earmarked taxes</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO region</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td></td>
<td>86</td>
<td>31</td>
<td>86</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Americas</td>
<td></td>
<td>97</td>
<td>85</td>
<td>76</td>
<td>50</td>
<td>32</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td></td>
<td>90</td>
<td>60</td>
<td>55</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Europe</td>
<td></td>
<td>98</td>
<td>75</td>
<td>35</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>South-East Asia</td>
<td></td>
<td>100</td>
<td>45</td>
<td>91</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>Western Pacific</td>
<td></td>
<td>96</td>
<td>52</td>
<td>76</td>
<td>52</td>
<td>24</td>
</tr>
<tr>
<td>World Bank</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-income</td>
<td></td>
<td>77</td>
<td>15</td>
<td>77</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Lower middle-income</td>
<td></td>
<td>93</td>
<td>53</td>
<td>87</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Upper middle-income</td>
<td></td>
<td>100</td>
<td>82</td>
<td>78</td>
<td>50</td>
<td>16</td>
</tr>
<tr>
<td>Income group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-income</td>
<td></td>
<td>98</td>
<td>71</td>
<td>29</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>94</td>
<td>62</td>
<td>64</td>
<td>34</td>
<td>21</td>
</tr>
</tbody>
</table>

As Table 7 indicates, low-income countries received less funding from all sources: 77% of low-income countries received government funding for NCDs versus 97% of countries in other income groups; 15% received funds from health insurance versus 69% in other income groups; and 8% received earmarked taxes compared with 39% in other income groups. While 87% of lower middle-income countries received international donations, only 77% of low-income countries obtained this source of funding, indicating a major discrepancy between the need for resources and the available funding through development assistance [48].
Most alarming is the fact that in addition to formal funding sources, there is growing evidence that NCDs are increasingly contributing to catastrophic out-of-pocket health expenditures in low- and middle-income countries, pushing households deeper into poverty. Catastrophic health expenditure is measured as households’ capacity to pay, defined as total expenditure (out-of-pocket) net of food expenses. Overall, across the low- and middle-income countries, the largest population experiencing catastrophic health expenditure comprised persons with renal diseases (187.7 million), followed by cardiovascular diseases (138.4 million), chronic infectious diseases (101.9 million), endocrine diseases (46.9 million), cancers (14.3 million), respiratory diseases (9.6 million), and injuries (0.9 million). An obvious result of unaffordable health care is poor treatment adherence and subsequent discontinuation of treatment. For example, in a study of cardiovascular disease patients in Argentina, China, India, and the United Republic of Tanzania, up to 99% of households reported not taking the needed medications because of the high cost of treatment. Poor adherence to treatment in patients living with NCDs often leads to further deterioration of health and higher health care costs when emergencies strike. On the path to universal health coverage, low- and middle-income countries may need to focus on targeting financial risk protection to include services and treatments for conditions that have high prevalence and risk of impoverishment, such as NCDs [51].

5.3 MAKING AN INVESTMENT CASE FOR NCDs

MDGs were vertically set up, drawing attention, resources and accountability to the selected health concerns of low- and middle-income countries. For example, spending by bilateral agencies on tackling NCDs was lower in the late 2000s than it was in the 1990s, despite the fact that the contribution of NCDs to the global disease burden was significant [52].

The shift towards a more holistic approach to health and development required for the implementation of the 2030 Agenda for Sustainable Development calls for distinguishing between actions in the health sector and actions in other sectors to realize health outcomes. Advancing the policy coherence agenda requires a Health in All Policies approach and effective collaboration across ministries and different sectors. Significant reductions in premature mortality due to NCDs can only be achieved through action on the NCD risk factors, including prevention of alcohol abuse, reduction of tobacco consumption, and reducing death, disease and illness from environmental pollution and road traffic accidents. This implies action to tackle “profit-driven diseases” and their commercial
determinants, including through the use of regulatory measures and sanctions against marketing health-harming products, such as unhealthy foods, sugary drinks and alcohol. The new development agenda calls for more focus on disease prevention and health promotion through policy coherence and intersectoral collaboration [40].

As mentioned earlier, the implementation of effective national NCD responses will require new investments. Ironically, the lower-income countries that face the most rapid shift in the NCD burden are also the least prepared. An analysis of the health systems of 172 countries and the relative preparedness of their national health systems to administer effective NCD responses indicated that the countries that will experience the greatest increases in death and disability over the next 25 years are also projected to see the smallest increases in their spending for health [53].

However, to overcome the health system weaknesses to address NCDs in low- and middle-income countries will require more than addressing just a budget constraint. Aligning health system performance with the 2030 Agenda for Sustainable Development will require significant changes requiring irreversible investments, such as system design, institutional arrangements, financing mechanisms, human resource policies, information systems, legal reforms to strengthen regulatory capacities, and the re-evaluation of the role of external agencies, such as donors. Therefore, priority-setting exercises for universal health coverage to include NCDs need to go beyond the cost-effective analysis of recommended interventions and include several other considerations associated with changes in the design of health systems; possible synergies and system interactions between interventions; uncertainty in estimates of costs and benefits; and weak governance and political constraints [54].

Mobilizing investment and ensuring that it contributes to broader development objectives should be an important priority in all countries. “New generation” investment policies are expected to address challenges at both the national and global levels. It is important to bear in mind that external assistance constitutes a relatively small part of global health expenditure. In 2015, the world spent US$ 7.3 trillion on health, approximately 10% of the global GDP. Domestic finances for health were the main source of health funding in all but a small number of lower-income countries. DAH was less than 0.3% of global health expenditure, though it still constituted an important funding source for low-income countries. For example, in 2015, the average share of external resources to health spending in the 31 low-income countries was 30%, while in the 50 lower middle-income and 57 upper middle-income countries it was 3% and less than 1%, respectively [55].

At present, many commodity-dependent African economies are experiencing a marked slowdown compounded by natural disasters, localized armed conflicts and political instability, which negatively impact the health systems with declining public budgets, changing donor priorities and unpredictable flows of much needed aid (Box 12).
In post-conflict Sierra Leone in 2001, the national government and international donors launched an ambitious Free Health Care Initiative to remove user fees from the provision of health care services to pregnant women and children aged under 5 years. The Ebola epidemic in 2014 and the global economic slowdown have ended the initiative. As a result, there are not enough domestic resources available to continue the Free Health Care Initiative or undertake efforts towards universal health coverage. Increased donor support will be critical for the next decade to avoid a complete collapse of the health system.

In Mozambique, a combination of falling commodity prices, armed conflict, a severe drought and the discovery of hidden government debts has eroded trust in the government and resulted in international donors suspending aid and loans to the country. Although the aid-dependent health sector was granted an additional 10% in public funds to compensate for the withdrawal of foreign assistance, the plans to strengthen the country’s health care financing system to achieve universal health coverage have been put on hold.

In Guinea-Bissau, most donors suspended direct contributions to the State budget in 2014 following the internal conflict resulting in the coup d’état. The withdrawal of foreign assistance has left the health system chronically underfunded and susceptible to a myriad of problems, such as illegal charges and health care workers routinely misappropriating revenues from the sale of medicines. Initially, the World Bank stepped in to support public health salaries to avoid health workers' strikes, but with the end of this support, international development partners started a negotiation process with NGOs to allow the provision of basic health services in the country.


Hence, DAH will continue to play an important role in lower-income countries to ensure that health programmes remain resilient to economic downturns, and that social protection is provided for low-income and vulnerable groups. For reference, Annex 6 provides a list of low-income countries that are recipients of official development assistance.

For countries dependent on foreign aid it will be particularly important to demonstrate increased country ownership of their health policies, plans and programmes. The core notion of development effectiveness is precisely the country ownership of a national development strategy and donor alignment with this strategy. If a country has a strong vision for national development, then it should be capable of coordinating donors, as countries such as Botswana and India have demonstrated [56]. In addition, in line with the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the focus on development results, mutual accountability, and more transparency and predictability of development cooperation is key for development effectiveness.
To achieve sustainable progress, countries that are heavily burdened by NCDs, but lack the domestic capacity for effective responses, will need to demonstrate how additional investments to tackle NCDs and their risk factors will secure high health, social and economic returns to simultaneously address the health and development challenges. Sustained global efforts are being made to help countries accelerate progress, including the Global NCD Action Plan and its Appendix 3 outlining the cost-effective “best-buy” interventions for addressing the NCDs and their risk factors.

However, much work needs to be done to calculate where additional investments are needed to improve health systems and intersectoral action in low-income countries. Strategic investment frameworks already exist for HIV/AIDS and women’s and children’s health that demonstrate that investing in health is not only about financial resources (Annex 7). All key enablers – policy, health systems, community engagement and innovation - should be addressed for sustained change [57]. Similarly, the NCD investment frameworks should support the strengthening of social, legal, regulatory and health system capacities and align to country development objectives in order to enable sound and effective responses and efficient use of development resources.

While leveraging such a comprehensive investment framework might be a daunting task, countries can rely on tools from WHO to facilitate the process. As stated by the GCM/NCD Working Group on financing, “Countries can use tools developed by WHO to assess their own expenditure data, adding or substituting interventions according to national needs or priorities, and to inform an investment case for NCDs” [58]. One such example is the investment case for Barbados, prepared using the WHO OneHealth Tool [59]. In the case of Barbados, creating an investment case allowed the country to focus on diabetes and cardiovascular diseases, which affect between 49 000 and 75 000 Barbadians, and estimate the direct and indirect costs of NCDs in Barbados. This is a clear example of favouring local evidence while aligning with global commitments, and collaborating with partners.

Overarching investment frameworks and more detailed country-specific costed and prioritized national NCD plans are critical tools for countries to express their demand for development assistance and international cooperation in order to accelerate the implementation of the global commitments made at the United Nations high-level meetings on NCDs in 2011 and 2014 [60].
Each country will determine its own financing path towards universal health coverage. However, the investment analysis can help countries to identify context-specific interventions of the highest value within national benefit packages supported by public financing. Synergies with existing delivery platforms and funding streams, including those of HIV, tuberculosis, malaria, and women’s and children’s health, should also be closely examined. However, economic arguments are not sufficient for requesting additional support. Donors are increasingly making allocation decisions based on the quality of governance in recipient countries. Robust accountability frameworks and multisectoral coordination mechanisms are critical to ensure proper coordination and alignment, and need to be set up with the contribution of relevant stakeholder groups.

5.4 MOBILIZING DOMESTIC RESOURCES FOR NCDs

Domestic sources of funding, coupled with local priority setting and efficient use of resources, are the most important domestic financing options to replace donor funding in specific country contexts. There are important lessons to be learned on resource mobilization activities for HIV/AIDS as an alternative to donor funding.

HIV and NCDs share many similarities due to the chronic nature of HIV/AIDS, with long-term implications for treatment costs and medical care throughout the lifetime of the patient. Based on data from 17 low- and middle-income countries, four major strategies were identified to decrease dependency on donor funding that have relevance to NCDs:

• **Earmarking of taxes.** This offers potential to increase government funds available for specific diseases (which could include NCDs). Many countries have earmarked taxes exclusively for health interventions, for example, on air traffic and tobacco products [61].

• **Concessionary loans.** Low-interest loans and deferred payment schedules are available to eligible countries from the International Monetary Fund, World Bank and other development banks. In addition, governments can pursue official development assistance loans for health, which have a grant element of at least 25% due to their low interest and long-term payment schedules.

• **Debt conversion.** This strategy began with the launch of the Heavily Indebted Poor Countries Initiative in 1996, which linked debt relief to poverty reduction. Debt conversion entails channelling resources from debt repayments towards investments in health.
• **Risk-pooling schemes and special social assistance programmes.** Such initiatives are particularly important as countries move towards universal health coverage. If well designed and implemented, pre-paid health schemes can prevent catastrophic out-of-pocket health expenditures and encourage prevention, early diagnosis and treatment by removing financial barriers to health care [62]. Table 8 provides a summary of strategies that were effectively used for HIV and could also be applicable to NCDs.

### Table 8. Summary of potential strategies for additional financing of HIV programmes

<table>
<thead>
<tr>
<th>Options</th>
<th>Financing sources</th>
<th>Financing agents</th>
<th>Recurring funding source</th>
<th>Examples of magnitude/feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concessionary loans for HIV programmes</strong></td>
<td>Domestic (when loan is repaid)</td>
<td>Ministry of finance</td>
<td>No</td>
<td>India: US$ 255 million concessionary loan to this middle-income country provides 7.8% of the five-year HIV budget and is to be repaid over 25 years. Low-income countries may find concessionary loans hard to repay, as their HIV programmes cost 0.5–4% of GDP.</td>
</tr>
<tr>
<td><strong>Debt conversion</strong></td>
<td>External</td>
<td>Ministry of finance</td>
<td>No</td>
<td>Indonesia: Debt conversion mobilized US$ 35.5 million for health programmes, the equivalent of 15% of the funding needed for the national response of US$ 241 million. Pakistan: Debt conversion was the equivalent of 45% of the annual cost of the HIV programme. However, HIV prevalence in Pakistan is very low (less than 0.1%). Hence, the resource requirements were lower.</td>
</tr>
<tr>
<td><strong>Risk-pooling schemes and special social assistance programme covering HIV services</strong></td>
<td>Domestic, public and private</td>
<td>Health insurance entities</td>
<td>Yes</td>
<td>Social health insurance schemes provide 60% of the HIV funding of Chile, 69% in Colombia, 10% in El Salvador, 11% in Paraguay, 9% in Peru and 8% in Uruguay. In Kenya, Malawi, Namibia, United Republic of Tanzania and Zambia, private insurance is less than 6.1% of national HIV expenditure.</td>
</tr>
</tbody>
</table>

Source: Katz et al. [62]
In addition, two case studies (Boxes 13 and 14) illustrate country programmes that have combined a variety of approaches in novel ways to effectively fund the fight against NCDs. Multisectoral involvement across parts of the government, civil society, academia and industry was critical to the success of these programmes.

**Box 13. Case Study: Public health product tax in Hungary**

NCDs are the leading cause of morbidity and mortality in Hungary. Over two thirds of Hungary’s adult population is overweight or obese, and Hungary’s per capita salt consumption is the highest in the European Region. In response to this growing public health crisis, the Government of Hungary has passed a variety of initiatives, including legislation to ensure nutritional standards in public catering, eliminate the use of trans fats in food products, and improve the nutritional quality of cafeteria food in schools. In 2011, the government introduced a public health product tax, designed and refined through multisectoral collaboration among the Ministry of Health, National Institute for Health Development, National Institute for Food and Nutrition Science, Ministry of Finance, and WHO. This tax targets foods that contain high amounts of sugar or salt, such as alcoholic beverages, energy drinks, salty snacks, and prepackaged confections. Once the law was passed, authorities worked to continuously respond to and close loopholes as they became evident, ultimately resulting in an effective law.

The public health product tax has resulted in a variety of health-promoting impacts over a period of four years:

- Approximately 40% of manufacturers have reformulated products so that they are healthier in order to avoid the tax.
- Population awareness and practice of healthy eating habits has increased.
- Approximately US$ 219 million has been raised and earmarked for health spending, equating to roughly 1.2% of government health expenditure in Hungary.

An impact assessment conducted by the National Institute for Food and Nutrition Science in 2015 showed that consumers of unhealthy food products responded to the tax by choosing a cheaper, often healthier product (7–16% of those surveyed), consuming less of the unhealthy product (5–16%), changing to another brand of the product (5–11%) or substituting some other food (often a healthier alternative). Overall, this successful implementation of a fiscal instrument demonstrates that introducing a tax on a well defined set of food items can contribute to healthier food choices. The implementers concluded that as a result of focusing on a relatively narrow set of food items with an unequivocally negative impact on health, this law was well justified and well accepted by citizens.

Source: Good practice brief: public health product tax in Hungary. WHO Regional Office for Europe.
The Thai Ministry of Public Health has placed a substantial focus on reducing NCDs by addressing their risk factors. The Thai health leadership identified smoking, alcohol use, overweight, inadequate exercise, sodium intake, and breastfeeding rates as target areas, and worked to address these risk factors from three angles:

- the policy angle, using legislation to put in place national multisectoral mechanisms, such as tobacco and alcohol control acts, and establishment of a National Food Committee, a Health Promotion Foundation, and a National Health Commission, all chaired by the Prime Minister;
- the social angle, by promoting social mobilization on all risk factors, led by committed champions of civil society and community networks;
- the intellectual angle, which facilitated evidence generation and management through risk factor research centres and collaborative programmes.

This three-pronged approach has helped build a focus on prevention and has already contributed to a number of success stories. The Thai Health Promotion Foundation Act of 2001 implemented a 2% additional levy on excise tax for tobacco and alcohol, raising US$ 150 million per year. The funds raised by this tax support finance and implementation of various bodies on health promotion, including NGOs, civic groups, and governmental operations both within and outside the Thai Ministry of Public Health. The Thai Government has also endorsed multisectoral plans, including the Thailand Healthy Lifestyle Strategic Plan, intended to combat NCDs through broader population interventions, which has been partially implemented. The Ministry of Public Health has identified integration of vertical programmes, improved cross-cutting accountability mechanisms, and enhanced coverage for mobile populations as key areas for future growth of the NCD risk factor programme.


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5.5 BEYOND NATIONAL NCD PLANS: ADDRESSING ALIGNMENT WITH GOVERNMENT POLICY

5.5.1 ALIGNMENT OF DEVELOPMENT COOPERATION AND NATIONAL PLANS: NEW PERSPECTIVES

Traditionally, donors saw weak government policies or plans as a main obstacle to achieving effective alignment of development assistance. In the more modern development perspective, national plans are seen as a means to an end, so the main focus remains on development cooperation and partner–government relationships, rather than on the presence of the “quality” plan. Experience from many countries suggests that donors have frequently put pressure on governments to produce unrealistic plans, jeopardizing the effective alignment and implementation of policies [63].
National plans and strategies should be prepared with the local context in mind to be able to produce realistic, feasible and effective results over time, with the involvement of government and other relevant stakeholders from the outset. Put in the development perspective, multisectoral and multistakeholder NCD plans are as important as other contextual variables, such as the political nature of the development process, critical actor and stakeholder perspectives to be incorporated in plans, and the division of roles and responsibilities, along with accountability for the results.

A key lesson on the alignment of development cooperation and national plans is the importance of establishing coordination mechanisms around national government plans, building on the priorities and including a corresponding framework for monitoring and evaluation, and aligning both aid and government resources to an overall agreed plan. The framework presented in Figure 7 details the working framework for development assistance coordination in Tajikistan following the collapse of the Soviet Union and the disruption that followed due to serious civil conflict. The recent history of civil conflict has meant that the country shared many common features with fragile States, such as weak governance, vertical planning and central decision-making. Increasing foreign assistance brought additional challenges within the context of an increasingly complex aid architecture. Greater focus on synchronizing action around a common planning and accountability framework, supported by alignment of resources, has been widely viewed as a step forward towards improved development effectiveness.

**Figure 7. Working framework for analysing coordination**

![Diagram](image-url)

5.5.2 REVIEWS AND MECHANISMS TO COMPLEMENT NATIONAL PLANS

National health plans are a basis for setting priorities, monitoring results and mobilizing resources. However, plans have their limitations. There are a number of additional mechanisms that countries use to facilitate alignment around government policies. Box 15 provides examples of additional strategies that Mozambique, Uganda, the United Republic of Tanzania and Zambia have implemented to handle development coordination.

Box 15. Development cooperation alignment strategies

Alignment above the sector level. In Mozambique, the United Republic of Tanzania and Zambia, the group of donors supporting poverty reduction strategies harmonized and aligned their support at strategy level but not at the sector level. As support for poverty reduction strategies involves significant support for specific sector policies, such as education and health, the positive synergies only reinforce the alignment.

Joint assistance strategy. Uganda, the United Republic of Tanzania and Zambia started developing joint assistance strategies well before the Paris Declaration was endorsed. Development of a joint assistance strategy involves a negotiation process that provides an opportunity for all participating stakeholders to understand other stakeholders’ positions, thus increasing the sense of ownership. In the United Republic of Tanzania, the close involvement of the Ministry of Finance, the development of a national strategic framework, and the willingness of partners to overcome challenges were the determining factors for success. Regular joint reviews of progress increase the effectiveness of this mechanism.

Codes of conduct. Mozambique introduced a code of conduct to define the principles and mechanisms to guide, coordinate and facilitate productive relations between the Ministry of Health and cooperating partners in the pursuit of the policy goals of the health sector.

Annual sector reviews. Customary annual sector reviews provide an opportunity for reviewing progress and making corrections as needed. However, caution is needed to make sure that focus is not only on the performance of government, and that enough attention is paid to the performance of donors as well, particularly in terms of predictability of aid and timely disbursement of committed funds.

Special policy review events. Mozambique has a mechanism known as the Sector Coordination Council, which meets twice a year to discuss important policy decisions and policy developments. The council meetings provide an opportunity to highlight some major issues, including the budget support that need an urgent follow-up.
The Fourth High-Level Forum on Aid Effectiveness, Busan, Republic of Korea, 2011, effectively changed the frame of discussion from aid effectiveness to development effectiveness. The Busan Partnership Agreement offered a framework to recognize the multistakeholder nature of the new international development cooperation architecture to go beyond official development assistance and incorporate other international collaboration flows. The participants of the conference included a wide array of stakeholders, comprising local governments, CSOs, the private sector, parliamentarians, international development banks, and other international organizations, as well as the Southern providers of official development assistance [64].

Four years later, with the introduction of the 2030 Agenda for Sustainable Development, the need for development cooperation at the global, regional, national and local levels became more evident. By providing an interconnected framework that reflects the coherence and interlinkages of all development goals, the idea of international cooperation has gained even more prominence. SDGs explicitly include a partnership goal (SDG 17), which the international development community has recognized as a means for implementing the SDGs in a holistic manner. There is increased recognition that the traditional North–South official development assistance era is long gone, and the landscape of international cooperation is giving way to South–South and triangular cooperation (see definitions in Box 16) [64]. This is partly due to the growing economic power of the South. For example, between 1990 and 2008, world trade increased almost 4 times, while South–South trade grew more than tenfold. By 2010, countries in the southern hemisphere accounted for 37% of global trade, with South–South flows making up about half of this total. As Southern countries are taking ownership of their development, they are increasingly playing a prominent role in identifying their own problems and finding or adapting Southern solutions. Examples of South–South and triangular cooperation are included in Boxes 17 and 18, respectively.
South–South cooperation refers to a partnership in which two or more Southern countries pursue their individual or shared national or institutional capacity development objectives. The common factor is that all arrangements should be country led and based on exchanges of knowledge, skills and technical know-how through collective actions and inclusive partnerships, involving governments, civil society, academia or the private sector, for the individual or mutual benefit of the countries involved.

Triangular cooperation refers to a South–South cooperation partnership assisted by a development partner of one of the OECD/DAC member countries, an emerging economy, a multilateral agency, an international foundation, or an international NGO. The assistance may be in the form of financial, technical or administrative support.

Source: IHP+/UHC2030 [64].

The Association of South-East Asian Nations (ASEAN) concept for promoting healthy lifestyles links priority areas for health promotion interventions; key target groups based on stages through the lifespan; and key levels, sectors, settings and strategies for implementation.

The Regional Action Plan on Healthy Lifestyles was introduced to strengthen ASEAN cooperation among member countries to promote healthy lifestyles in the region, focusing specifically on the following priority areas: accident and injury prevention; alcohol consumption; communicable disease control; healthy ageing; mental health; NCD prevention and control; nutrition; physical activity; substance abuse; tobacco control; and women’s and children’s health.

Source: IHP+/UHC2030 [64].
Mexico, once a low spender on health like the Philippines, has increased funding for its Seguro Popular programme more than tenfold in the last decade. The programme now covers over 40 million previously uninsured people. The World Bank connected health officials from the Philippines with their Mexican peers to learn from their experiences in achieving sustainable universal health care. “The reforms in the health insurance system (in Mexico) started in 2003, while we are starting or about to start. Mexico provides a good example for the Philippines because in both countries universal health care is being implemented in a decentralized way,” noted the Secretary of Health of the Philippines.

The knowledge exchange helped the Philippine participants understand best practices and challenges in organizational reform to achieve universal health care.

Senegal had extensive and successful experience with nutrition intervention, especially in decentralization and community involvement. Senegal had also implemented several World Bank-funded projects in the area. World Bank staff therefore connected Malawi with Senegal to learn about strategies for making nutrition more effective.

Source: Bollyky et al. [53].

It is worth noting that South–South cooperation and triangular cooperation are not limited to aid, since they include many other types of cooperation and financial flows. A much broader understanding of international cooperation can help “nurture a more imaginative approach to NCD responses, spanning multiple sectors of government and encompassing various stakeholders” [64]. Table 9 details the modalities of South–South cooperation and triangular cooperation.

Table 9. Overview of South–South cooperation and triangular cooperation modalities

<table>
<thead>
<tr>
<th>Types of cooperation</th>
<th>South–South cooperation</th>
<th>Triangular cooperation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical cooperation and networking</td>
<td>Technical cooperation and training</td>
<td>Knowledge exchange programmes</td>
</tr>
<tr>
<td>Technical assistance, technology transfer, capacity-building</td>
<td>Technical assistance, technology transfer, capacity-building, exchange visits, study tours, Internet sites</td>
<td>Exchange visits, study tours, trainings, peer reviews</td>
</tr>
<tr>
<td>Exchange visits, study tours, Internet sites</td>
<td>Internet sites, discussion groups, online forums, databases</td>
<td></td>
</tr>
</tbody>
</table>

Source: Bollyky et al. [53].
<table>
<thead>
<tr>
<th></th>
<th><strong>South–South cooperation</strong></th>
<th><strong>Triangular cooperation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cooperation partners</strong></td>
<td>Governments and public institutions</td>
<td>Ministries and public institutions, international agencies, NGOs, academic institutions</td>
</tr>
<tr>
<td></td>
<td><strong>Main funding sources</strong></td>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td><strong>Participating partners</strong></td>
<td>Bilateral and multilateral development agencies</td>
<td>Long-term vision but often translated into short-term projects</td>
</tr>
<tr>
<td></td>
<td><strong>Duration</strong></td>
<td>Short-term projects</td>
</tr>
<tr>
<td></td>
<td>Short-term projects; sometimes programmes with long-term vision</td>
<td><strong>Performance monitoring</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Results are rarely monitored</strong></td>
<td><strong>Results monitored, documented and shared</strong></td>
</tr>
</tbody>
</table>

To ensure that development cooperation commitments are translated into concrete actions, UHC2030 introduced the framework of the “seven behaviours” or critical areas where international development partners need to focus to accelerate progress towards universal health coverage [65]. The seven behaviours of development partners for effective collaboration support the idea of a cohesive, costed national NCD strategy and plan that can be an entry point for development partners, allowing them to intervene where they can best add value. Similarly, these seven behaviours inform countries of their development partners’ priorities, and allow them to streamline country needs and priorities with development partners’ interests in the most efficient way. This alignment comes from simplifying processes and keeping a single focus. When procurement and supply systems are harmonized and aligned, parallel systems phase out. This strengthens country systems and creates more value from the partnership. Further, partners improve process clarity and foster transparency and mutual accountability (Box 19, Figure 8).
Box 19. Effective development cooperation practices in the health sector

1. A strong, single national health strategy is supported by both government and development partners; they agree on priorities reflected in the national health strategy, and underpinning subsector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.

2. Resource inputs are recorded on the national health budget and in line with national priorities, with predictability of government and development partner funding.

3. Financial management systems are harmonized and aligned; requisite capacity-building is done or under way, and country systems are strengthened and used.

4. Procurement and supply systems are harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money. National ownership can include benefiting from global procurement.

5. Joint monitoring of process and results is based on one information and accountability platform; joint processes for mutual accountability on EDC are in place, such as joint annual reviews or compact reviews.

6. Technical support is strategically planned and provided in a well coordinated manner; opportunities for systematic learning between countries are developed and supported by agencies through South–South and triangular cooperation.

7. Civil society operates within an environment that maximizes its engagement in and contribution to health sector development.

Note: An eighth dimension was added: the private sector is engaged within an environment that maximizes its engagement in and contribution to health sector development. Source: UHC2030.

Figure 8. The seven behaviours of development partners for effective collaboration

- Provide well-coordinated technical assistance
- Support a single national health strategy
- Support south-to-south and triangular cooperation
- Record all funds for health in the national budget
- Use one information and accountability platform
- Harmonize and align with national procurement and supply systems
- Harmonize and align with national financial management systems

Source: UHC2030.
Similarly, to ensure successful implementation of the 2030 Agenda for Sustainable Development and development effectiveness, OECD proposes a 10-step policy framework “to make partnerships effective coalitions for action” [66] (Box 20).

**Box 20. Policy framework for post-2015 partnerships**

1. Secure high-level leadership
2. Ensure partnerships are country led and context specific
3. Avoid duplication of efforts and fragmentation
4. Make governance inclusive and transparent
5. Apply the right type of partnership for the challenge
6. Agree on principles, targets, implementation plans and enforcement mechanisms
7. Clarify roles and responsibilities
8. Maintain a clear focus on results
9. Measure and monitor progress towards goals and targets
10. Mobilize the required financial resources and use them effectively.

*Source: OECD [66]*
Despite the increased attention being given to the development challenges of low- and middle-income countries, the gap between needed and committed resources for health remains. A major increase in donor spending for NCDs may take time, but continued monitoring of and research on disease trends and advocacy for resource mobilization should continue. As domestic resources increase in low- and middle-income countries, a declining portion of health activities should be financed through health aid. However, international cooperation and external resource flows into health will remain essential for many of those countries, particularly in terms of supporting the high cost of transition and avoiding the abrupt discontinuation of important health programmes and services.

The Lancet Commission on Investing in Health argued that as the economies of low- and middle-income countries grow, donor funding should increasingly go to “core functions” of global health, or what Schäferhoff et al. refer to as “global functions” [67]. The authors distinguish between three global functions (supplying global public goods, management of externalities, and leadership) and one country-specific function (providing support to low- and middle-income countries for country priorities). They define global functions as issues that address transnational challenges. However, investments in these global functions will bring universal benefits, particularly to the poor and otherwise vulnerable populations. Country-specific functions are referred to as “time-limited problems” that justify international action due to the limited capacity of specific countries to initiate an effective response [67]. Box 21 provides a classification of donor aid according to this framework.
Box 21. Classification of donor aid for health as global and country-specific functions and subfunctions

Global

Supplying global public goods
• Research and development for health tools
• Development and harmonization of international health regulations
• Knowledge generation and sharing
• Intellectual property sharing
• Market-shaping activities.

Management of cross-border externalities
• Outbreak preparedness and response
• Responses to antimicrobial resistance
• Responses to marketing of unhealthy products
• Control of cross-border disease movement.

Exercising leadership and stewardship
• Health advocacy and priority setting (convening of policy-makers for negotiation and consensus building for strategy and policy)
• Promotion of development effectiveness and accountability.

Country-specific

Providing support to low-income, lower middle-income, and upper middle-income countries for country-specific purposes
• Achieving convergence – for example, for control of infectious diseases and to provide reproductive, maternal, newborn, and child health interventions and services
• Controlling NCDs and injuries
• Health system strengthening

Successes of narrowly targeted interventions and innovative global initiatives and partnerships have played their important role and they offer important lessons. These initially vertically set-up partnerships evolved significantly as they matured, and started to gradually align their work with national priorities, scaling up their spending on broader health system strengthening and emphasizing the delivery of results as well as efficiency. Similarly, a narrow vertical focus on NCDs is increasingly being replaced by calls for the integration of NCDs in other programme areas (for example, reproductive health, HIV/AIDS and tuberculosis), exploring synergies and technical efficiency for maximizing health outcomes. The WHO GCM/NCD Working Group on the inclusion of NCDs in other programmatic areas (2016–2017) provided recommendations on how to advance action in this regard. The Working Group recommendations are provided in Annex 8.
Newer donors that do not report to the OECD/DAC, so-called non-traditional donors (for example, China, India, Islamic Republic of Iran, Kazakhstan, Kuwait, Russian Federation, and South Africa), are contributing significant resources but are not well understood in the current data systems, jeopardizing a realistic understanding of resource flows. For example, it is estimated that the new sources of funding represent up to two thirds of total official development assistance to Tajikistan [68].

Annex 9 provides a list of the OECD/DAC and non-DAC countries that are the largest providers of financing for development.

External donor funding should be seen as complementary to government financing with a greater emphasis on technical cooperation. Donors and governments should be confident that external aid is the only best option to support programmes and ensure proper monitoring and evaluation of results. The results of impact evaluations should be public to ensure transparency and mutual accountability. Focus on results and predictability should become the guiding principles for development effectiveness. As the nature of DAH changes, the need for better data systems to capture the fuller breadth of external resource flows into health will become critical.

Finally, the increasingly important role of civil society, particularly the NGOs, should not be overlooked. NGOs and other CSOs often play a significant part in governance and are a driving force behind international cooperation and major global partnership agreements. Civil society participation is especially important in policy development consultations and implementation, information gathering and dissemination, monitoring the results and holding governments accountable, and advocacy and resource mobilization.
Governments should increase investments in health information and disease surveillance, monitoring and evaluation, and research systems to provide evidence for effective interventions and advocacy, and to support resource mobilization efforts for NCDs.

RATIONALE

Weak health information and surveillance systems to monitor the shared NCD risk factors and NCD mortality and morbidity are often blamed by development agencies for the lack of external resource allocation to countries. The issue of multimorbidity with NCDs needs special attention. Most low- and middle-income countries do not collect morbidity data on the prevalence of multimorbidity. In addition, there is no research taking place in low- and middle-income countries to document the cost, prevalence and outcomes of people with multiple chronic conditions, while studies of single diseases are more common. This fact has serious health policy implications for spending on health. For example, evidence indicates that in high-income countries, about two thirds of health spending and adverse health outcomes occur in patients with multiple chronic diseases [69].

An increase in the volume and quality of epidemiological data about the rapid rise of NCDs in low- and middle-income countries is essential for evidence-based policy and advocacy, thus contributing to better decision-making and mobilization of both external and domestic resources that are more in line with the actual burden of disease of countries and the expected impact and cost-effectiveness of interventions to address NCDs. In addition, investments in health systems and implementation research can help identify the bottlenecks to the implementation of cost-effective NCD interventions in low-resource settings and within the range of existing health systems.
POLICY ACTIONS

1. Conduct mapping of capacities and gaps in NCD surveillance and health information at the national level, reflecting the particular circumstances and challenges of the country in developing its national NCD plan.

2. Conduct a baseline assessment and develop a prioritized research agenda for NCDs and their shared risk factors.

3. Adopt national-level targets and indicators considering inequalities among different areas in the country. Poorer areas may require more external assistance to meet national goals and targets.

4. Engage academic and research institutions in monitoring the burden of NCDs and their risk factors, assessing the expected impact of the national NCD plan and disseminating findings to all relevant stakeholders.

5. Mobilize resources (domestic and external) to develop or strengthen surveillance systems for the monitoring and evaluation of NCD targets and goals.

6. Invest in implementation research and health system research to support the implementation and scale-up of cost-effective priority NCD interventions.

Box 22. Improved NCD surveillance, monitoring and evaluation in Rwanda

Rwanda has embraced a goal of 80% reduction in deaths from NCDs and injuries among those aged 40 years and younger by 2020. To track progress towards these goals, Rwanda aimed to build a reliable monitoring and evaluation (M&E) system to track morbidity and mortality. The Rwanda Ministry of Health has published a detailed framework in the Monitoring and Evaluation Plan for the Health Sector Strategic Plan (HSSP III) report. In addition to tracking NCDs, this M&E system seeks to monitor the country’s universal health coverage. Rwanda’s M&E system tracks outputs such as service delivery, outcomes such as intervention coverage and risk factor reduction, and impacts such as improved household health and wealth as measured through vital registration and economic indicators. To identify strengths and areas for improvement in the planned M&E system, a working group of technical experts, government officials, CSOs, and development partners facilitated by the International Health Partnership assessed the HSSP III in June 2012. The joint assessment team concluded that the HSSP III report is a comprehensive document that has benefited from a collaborative development process, and that further fiscal space analysis will be key to ensure realistic continued viability.

Governments should urgently develop and implement high-quality, multisectoral, integrated NCD plans that are prioritized and costed, in close collaboration with relevant stakeholders, including development partners and non-State actors.

RATIONALE

National multisectoral NCD action plans that are prioritized according to the disease burden and costed appropriately are an important tool to express countries’ demand for international cooperation, as well as to work towards implementation of a broad range of interventions tailored to a country’s specific needs. When resources are limited, governments should use these action plans to prioritize high-impact, cost-effective interventions to achieve universal health coverage and increase access to a wider package of services as more resources become available.

Development of a comprehensive national multisectoral NCD action plan requires high-level leadership and multisectoral coordination to facilitate the development of appropriate context-specific strategies for the prevention and control of NCDs [70]. The involvement of development agencies early on in the process is a prerequisite to ensure the mobilization of external resources in support of national NCD goals and targets. At present, only 53% of Member States report having an operational, multisectoral national policy, strategy or action plan that integrates several NCDs and their risk factors [48].

POLICY ACTIONS

1. Adopt participatory approaches to involve all relevant stakeholders, including communities, the private sector, academia, development agencies and civil society, to develop, implement and evaluate a high-quality national multisectoral NCD plan.


3. Define the costs and develop a budget for the national multisectoral NCD plan, setting priorities within available resources and clearly defining the key roles of health and other sectors to be involved in the implementation of the NCD plan.

4. Develop mechanisms for responsible engagement of the private sector to address national NCD prevention and control.

5. Formalize an intersectoral approach by creating appropriate coordination mechanisms, including national councils at the highest level, to bring together heads of national agencies and ministries to set out strategies and contribute meaningfully to agreed national targets for the prevention and control of NCDs.
Facing a growing burden of NCDs, Brazil launched its NCD Action Plan 2011–2022 at a United Nations high-level meeting in 2011. The plan incorporates about 20 sectors, including sports, finance, agriculture and communication, with partners from NGOs, universities, civil society and the private sector. The plan aims to address tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol. The three main strategic action areas for addressing these NCD components are (a) surveillance, monitoring, and evaluation; (b) integral care; and (c) prevention and health promotion. Each of the strategic action areas is further broken down, for a total of over 320 actions to combat NCDs.

So far, the detailed multisectoral plan has led to numerous achievements in each of the strategic action areas. The 2013 National Health Survey produced national data on health status, risk behaviours, health care access and financing. To improve integral care, Brazil’s Unified Health System (SUS) partnered with more than 45,000 commercial pharmacies to offer free medicine to treat hypertension, diabetes and asthma. To reduce the prevalence of NCDs and promote health, the Ministry of Health signed a salt reduction agreement with the Association of Food Industries to reduce salt in food and eliminate trans fats. In 2013, 95% of instant pasta products met these new goals for reduced salt. Harsher penalties for drinking and driving, passed in 2012, have led to decreased rates of drunk driving. Advances in surveillance allow the Government of Brazil to monitor the successes of the plan, which have included significant increases in daily fruit intake, increased levels of physical activity, and greater rates of mammograms among women. Brazil plans to maintain multisectoral commitment to the NCD agenda in order to continue reaching its goals.

Governments should develop NCD investment frameworks to communicate the urgent need for accelerated and targeted investments in NCDs as part of the 2030 Agenda for Sustainable Development.

RATIONALE

Inclusion of NCDs in the 2030 Agenda for Sustainable Development is an essential step to reframe the debate and mobilize resources to scale up available cost-effective interventions for the prevention and control of NCDs [10]. Annex 10 contains detailed recommendations from the WHO GCM/NCD Working Group on financing for NCDs (Working Group 5.1, 2015).

Governments should take advantage of this “powerful political opportunity to institutionalize NCD prevention and control into policies and programmes within the broader development agenda”. Strong government commitment to the implementation of the SDG agenda is a necessary precondition to encourage development agencies to entrust governments with more aid. Developing country-led investment frameworks for NCDs will help governments to make the case for accelerated and targeted investments. Building on their multisectoral NCD action plans (recommendation 2 above), governments can rapidly adopt and develop investment frameworks or “investment cases” that demonstrate powerfully how spending on priority NCD interventions can achieve high impact in a cost-effective manner and can be financed in an affordable and sustainable way, while distributing health benefits equitably across the population.

POLICY ACTIONS

1. Use the authorizing environment and multisectoral structures created for the national NCD plan to design an NCD investment case.

2. Harness the technical capacity behind the national NCD plan to develop the investment case, modelling several agreed scenarios that define the scope of a national NCD programme over the medium term (for example, five years) while also estimating the longer-term (for example, to 2030 and beyond) impact and financing of efforts to address NCDs.

3. Select the scenarios that convey the most powerful and compelling narrative for how priority investments in NCDs can drive gains in health outcomes, support economic progress, and ensure equitable social advances for the country.

4. Conduct a well-articulated advocacy campaign to present the investment case to national and international stakeholders, including ministries of health and finance and other relevant branches of government; local CSOs, NGOs, and private sector organizations; and external partner funding agencies, including multilateral, bilateral, and philanthropic institutions.
An NCD investment case for Barbados published in 2016 revealed that the country is losing 2.6% of its GDP per year to health care costs and productivity losses from diabetes and cardiovascular diseases alone. To address this challenge, partners in Barbados used an NCD institutional and context assessment framework developed by UNDP to assess where the most cost-effective NCD interventions intersect with political opportunity in the country. The United Nations Interagency Task Force on the Prevention and Control of NCDs endorsed the recommendations made in the Barbados NCD Strategic Plan. This plan places particular focus on fighting childhood obesity, through strengthening breastfeeding practices, physical activity, and dietary, regulatory and fiscal policies. The Minister of Health in Barbados used this investment case at the Sixty-ninth World Health Assembly to appeal to more developed countries to urgently fulfil their obligations of financial and technical support in the fight against NCDs in less developed countries. In his remarks, the Minister of Health noted that such regional and international capacity-building efforts would be critical to reaching the Sustainable Development Goals.

Governments should develop or expand existing and emerging forms of development cooperation beyond the traditional donor-recipient model to address NCDs through North–South, South–South and triangular cooperation.

RATIONALE

In accordance with the principles of the Paris Declaration, the Busan Partnership for Effective Development Co-operation and the Accra Agenda for Action, global and regional actors can support government actions at national level by promoting knowledge sharing, facilitating networks, evaluating interventions, and developing global and regional standards. They can also build on existing mechanisms, such as international agreements supporting national actions (for example, the WHO Framework Convention on Tobacco Control), and apply them to other priority areas, such as reducing salt intake and promoting healthy nutrition. International partnerships can also support countries in designing and using innovative mechanisms to promote behaviour change (for example, results-based financing) and address the link between health and poverty, including developing strategies to support the most vulnerable population groups [71]. The NCD agenda is broad and multifaceted and various support mechanism can be made available through North–South, South–South and triangular cooperation.

POLICY ACTIONS

1. Look beyond financial aid: international cooperation may include trade, technology transfer, and capacity-building via North–South, South–South, and triangular cooperation.

2. Build, develop and strengthen national, regional and global networks of policy-makers and development agencies to advocate action, create awareness, and provide conducive environments for combating NCDs (for example, healthy cities, healthy schools).

3. Facilitate and provide for multisectoral development cooperation to integrate NCD prevention and control into policies across all government sectors in order to advance the 2030 Sustainable Development Agenda, including the NCD-related targets.

4. Enhance coordination and partnership among different global health communities to promote the integration of NCDs into other programmatic areas.2

5. Promote sharing of experiences and best practices on NCD prevention and control at national, regional and global levels.

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2 Refer to Working Group 3.1 on the inclusion of NCDs in other programmatic areas.
The WHO STEPwise approach to chronic disease risk factor surveillance (STEPS) is a simple, standardized method for collecting, analysing and disseminating data in WHO member countries. STEPS simplifies surveillance for countries by providing predesigned questionnaires, user manuals and support resources. STEPS survey instruments are available for NCD risk factors and for strokes. Countries can better prepare for, implement and respond to their own STEPS surveys through the knowledge sharing facilitated by regional and global STEPS reports. This standardized questionnaire reduces the front-end workload for individual countries, smooths implementation through the sharing of best practices, and allows straightforward comparison of results within and across countries yearly. As of October 2017, 105 countries across all six WHO regions had published the results of their STEPS survey.

Governments should promote and enhance cooperation with non-State actors, including civil society organizations, to strengthen advocacy and mutual accountability, and ensure the implementation of national NCD plans.

RATIONALE

The primary responsibility for the implementation of commitments made at the highest-level rests with governments. However, the role of partnerships between governments and non-State actors should be explicitly acknowledged to institutionalize the whole-of-government and whole-of-society approach to address NCDs. Non-State actors play a major role in international development. They provide development services and humanitarian relief, promote innovations in service delivery and advocate support for the disadvantaged and vulnerable groups of society.

The advantages of greater cooperation and a multisectoral partnership approach to overcome the NCD challenge include greater access to expert input and advocacy from partners, more publicity for policy goals, and increased opportunities for engaging at national, regional and global levels with key stakeholders in both health and relevant non-health sectors.

POLICY ACTIONS

1. Foster a conducive policy environment to create an inclusive participatory mechanism for all stakeholders, including academia, CSOs, development agencies, NGOs, professional associations and the private sector.

2. Develop and implement advocacy campaigns to promote multistakeholder participation and multisectoral partnerships consistent with the priorities of the national NCD plan.

3. Define the role for relevant non-State actors in the implementation of the national NCD plan.

4. Coordinate with development agencies to encourage support for CSOs in a manner that promotes cooperation and networking among CSOs and avoids duplication of efforts.

5. Support and empower communities to engage in regulatory measures on NCD risk factors.
Facing rising obesity and diabetes prevalence, on 2 April 2013, the President of Mexico instructed the Ministry of Health to devise a National Strategy for the Prevention and Control of Overweight, Obesity, and Diabetes. This strategy seeks to reverse the epidemic of NCDs through a combination of public health interventions, medical care and intersectoral public policies. One pillar of the strategy concerns regulatory standards and fiscal policy, including policies designed to reduce intake of foods and beverages with limited nutritional value. To reduce the consumption of sugar-sweetened beverages in the population, an intersectoral group including the federal government, Congress, academia, CSOs, and international organizations jointly proposed a special tax to be levied on soft drinks and sugar-sweetened beverages. Each partner in the initiative contributed strategically to the ultimate success of the initiative. Members of CSOs and research institutions carried out a mass media campaign, including radio, television and print media. The soft drink industry responded with a media campaign against the tax coupled with intense lobbying of Congress and other regulatory agencies. Despite these challenges, the strong multisectoral coalition was able to reach a treasury reform calling for a tax of 10% on sugar-sweetened beverages. This new tax led to collection of over US$ 9 million in 2014. Studies showed a 6% reduction in purchases of the dutiable sugar-sweetened beverages in 2014 compared to 2013, as well as an approximately 7% increase in purchases of non-taxed beverages. Preliminary data suggest that this cooperative effort has gained public acceptability and protected public health.

Governments should build their institutional capacity to engage effectively with development agencies to ensure aid coordination and efficiency, mutual accountability, and development impact of external resources to support national NCD priorities.

RATIONALE

Increased international attention to aid effectiveness has elevated donors’ interest in supporting the capacity of partner countries as a means of improving local leadership and ownership to ensure aid effectiveness and development impact of external resources [72]. Bilateral and multilateral development agencies bring much-needed resources to low-income countries, but failure of coordination increases the burden on already pressured national institutions. Strong country leadership and political commitment are essential to ensure that governments can effectively set priorities and coordinate the actions of donors on NCDs, and simultaneously implement the legal and governance reforms needed to strengthen human resources, public financial management and procurement systems, and regulatory capacity to ensure the efficient use of resources.

POLICY ACTIONS

1. Invest in the analysis of systemic constraints, including the assessment of the national political economy, legal and regulatory mechanisms, and the institutional, organizational and human resource needs to address the systemic barriers to local capacity development.

2. Integrate capacity development priorities into national NCD plans, health sector strategies and the broader national development agenda.

3. Define a role for non-State actors in national capacity-building for a comprehensive approach to NCDs and holding governments accountable for results.

4. Engage and coordinate with development agencies for concerted capacity-building support over a defined period of time to ensure sustainability and development impact of external aid.

5. Encourage and monitor individual donor policy coherence and alignment with national NCD plans and strategies for developing a joint approach and mutual accountability.

6. Create and sustain national forums and other mechanisms for coordinating donor support to NCD plans, and develop and use monitoring systems to ensure that donor aid is aligned with national priorities and to improve transparency and accountability for the use of donor and domestic funding for NCD interventions.

7. Invest in strengthening the capacity of national ministries of health to play a leadership role in facilitating multisectoral and multistakeholder action for comprehensive NCD care and control.
Box 27. Expanded NCD capacity through donor assistance in Argentina

Box 27. NCDs and injuries generate a heavy health and economic burden in Argentina. NCDs are responsible for 81% of all deaths and about 62% of the years of potential life lost in the country. About half of NCD deaths were in adults younger than 65 years.

In June 2015, Argentina received a US$ 350 million World Bank loan for its Protecting Vulnerable People against Noncommunicable Diseases project. The project has three main components:

• improving the readiness of public health care facilities to provide higher-quality services for NCDs for vulnerable population groups and expanding the scope of selected services through financed payments under the eligible expenditure programmes;

• protecting vulnerable population groups against prevalent NCD risk factors through population-based multisectoral interventions focused on healthy diets, physical activity, and tobacco control;

• supporting national and provincial NCD surveillance through capacity-building and project implementation.

The project is making a key contribution to achieving the results articulated in the Country Partnership Strategy for Argentina and has a strong poverty focus. The loan was facilitated through the United Nations system and multilateral development banks, and can ultimately contribute to inequity reduction and whole-of-society responses. Programme leaders in Argentina anticipate that 3.2 million at-risk adults aged between 40 and 64 years will benefit from improved primary health care supported through this loan.

References


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70. Review of coordination mechanisms for development cooperation in Takijistan. WHO Regional Office for Europe, 2009


74. Inventory of donor approaches to capacity development: what we are learning. OECD DAC Capacity Development Team; 2010.
## WHO GCM/NCD WORKING GROUP 3.2 MEMBERS

<table>
<thead>
<tr>
<th>Member</th>
<th>Country</th>
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<tbody>
<tr>
<td>Dr Hussain Abdul Rahman AL RAND</td>
<td>United Arab Emirates</td>
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<tr>
<td>Dr Mary AMUYUNZU-NYAMONGO</td>
<td>Kenya</td>
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<tr>
<td>Dr Nino BERDZULI</td>
<td>Georgia</td>
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<td>Dr Omar BIN MIHAT</td>
<td>Malaysia</td>
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<td>Professor Randah Ribhi HAMADEH</td>
<td>Bahrain</td>
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<tr>
<td>Dr Eduardo JARAMILLO NAVARRETE</td>
<td>Mexico</td>
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<td>Dr Guna Raj LOHANI</td>
<td>Nepal</td>
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<td>Professor Deborah MALTA</td>
<td>Brazil</td>
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<td>Professor Eva MARTOS</td>
<td>Hungary</td>
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<tr>
<td>Professor Mohammad Reza MASJEDI</td>
<td>Islamic Republic of Iran</td>
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<tr>
<td>Dr Supattra SRIVANICHAKORN</td>
<td>Thailand</td>
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<tr>
<td>Mr Lesley-Charles USURUA</td>
<td>Namibia</td>
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<tr>
<td>Professor Wen-Qiang WEI</td>
<td>China</td>
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Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, 2011

Noncommunicable diseases are a challenge of epidemic proportions and its socioeconomic and developmental impacts are vast. At the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, 2011, it was acknowledged that the global burden and threat of NCDs constitutes one of the major challenges for development in the 21st century. NCDs undermine social and economic progress throughout the world and threaten the achievement of internationally agreed development goals.

Relevant key acknowledgments within the 2011 Political Declaration that are fundamental to the development of this working group:

Paragraph 3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases.

Paragraph 4. Recognize also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to non-communicable diseases.

Paragraph 47. Acknowledge the contribution of aid targeted at the health sector, while recognizing that much more needs to be done. We call for the fulfilment of all official development assistance-related commitments, including the commitments by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance by 2015, as well as the commitments contained in the Programme of Action for the Least Developed Countries for the
Decade 2011–2020, and strongly urge those developed countries that have not yet done so to make additional concrete efforts to fulfil their commitments.

Paragraph 48. Stress the importance of North-South, South-South and triangular cooperation, in the prevention and control of non-communicable diseases, to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation.

Paragraph 49. Promote all possible means to identify and mobilize adequate, predictable and sustained financial resources and the necessary human and technical resources, and to consider support for voluntary, cost-effective, innovative approaches for a long-term financing of non-communicable disease prevention and control, taking into account the Millennium Development Goals.

Paragraph 50. Acknowledge the contribution of international cooperation and assistance in the prevention and control of non-communicable diseases, and in this regard encourage the continued inclusion of non-communicable diseases in development cooperation agendas and initiatives.

Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, May 2013

ANNEX 4: GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020

Paragraph 12. The total cost of implementing a combination of very cost-effective population-wide and individual interventions, in terms of current health spending, amounts to 4% in low-income countries, 2% in lower middle-income countries and less than 1% in upper middle-income and high-income countries. The cost of implementing the action plan by the Secretariat is estimated at US$ 940.26 million for the eight-year period 2013–2020. The above estimates for implementation of the action plan should be viewed against the cost of inaction. Continuing “business as usual” will result in loss of productivity and an escalation of health care costs in all countries.

Objective 2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of non-communicable diseases.
Objective 2: Policy options for Member States

Paragraph 30 (e). Develop national plan and allocate budget: As appropriate to national context, develop and implement a national multisectoral noncommunicable disease policy and plan; and taking into account national priorities and domestic circumstances, in coordination with the relevant organizations and ministries, including the Ministry of Finance, increase and prioritize budgetary allocations for addressing surveillance, prevention, early detection and treatment of noncommunicable diseases and related care and support, including palliative care.

Paragraph 30 (f). Strengthen multisectoral action: As appropriate to the national context, set up a national multisectoral mechanism – high-level commission, agency or task force – for engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on noncommunicable diseases, in order to implement health-in-all-policies and whole-of-government and whole-of-society approaches, to convene multistakeholder working groups, to secure budgetary allocations for implementing and evaluating multisectoral action and to monitor and act on the social and environmental determinants of noncommunicable diseases.

Objective 2: Proposed actions for international partners

Paragraph 32 (d). Enhance the quality of aid for prevention and control of noncommunicable diseases by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results orientation.

Objective 5: Actions for the Secretariat

Paragraph 54 (c). Policy advice and dialogue: Promote sharing of intercountry research expertise and experience and publish/disseminate guidance (“toolkits”) on how to strengthen links among policy, practice and products of research on prevention and control of noncommunicable diseases.

Objective 6: Proposed actions for international partners

Paragraph 61. Strengthen North–South, South–South and triangular cooperation and forge collaborative partnerships, as appropriate, to:

- Mobilize resources, promote investment and strengthen national capacity for surveillance, monitoring and evaluation, on all aspects of prevention and control of noncommunicable diseases.
• Facilitate surveillance and monitoring and the translation of results to provide the basis for advocacy, policy development and coordinated action and to reinforce political commitment.

• Promote the use of information and communications technology to improve capacity for surveillance and monitoring and to disseminate, as appropriate, data on trends in risk factors, determinants and noncommunicable diseases.

• Provide support for the other actions set out for Member States and the Secretariat under objective 6 for monitoring and evaluating progress in prevention and control of noncommunicable diseases at the national, regional and global levels.

Appendix 3

• Raise public and political awareness, understanding and practice about prevention and control of NCDs.

• Integrate NCDs into the social and development agenda and poverty alleviation strategies.

• Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learnt and best practices.

• Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels.

• Implement other policy options in objective 1 (To raise the priority accorded to the prevention and control of noncommunicable diseases).

Resolution adopted by the General Assembly on 10 July 2014

Paragraph 14. Acknowledge that, despite some improvements, commitments to promote, establish or support and strengthen, by 2013, multisectoral national policies and plans for the prevention and control of non-communicable diseases, and to increase and prioritize budgetary allocations for addressing non-communicable diseases, were often not translated into action, owing to a number of factors, including the lack of national capacity.

Paragraph 30 (ii). By 2015, consider developing or strengthening national multisectoral policies and plans to achieve the national targets by 2025, taking into account the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020.
Paragraph 30 (viii). Strengthen the capacity of ministries of health to exercise a strategic leadership and coordination role in policy development that engages all stakeholders across government, non-governmental organizations, civil society and the private sector, ensuring that issues relating to non-communicable diseases receive an appropriate, coordinated, comprehensive and integrated response.

Paragraph 30 (ix). Align international cooperation on non-communicable diseases with national plans concerning non-communicable diseases in order to strengthen aid effectiveness and the development impact of external resources in support of non-communicable diseases.

Paragraph 30 (x). Develop and implement national policies and plans, as relevant, with financial and human resources allocated particularly to addressing non-communicable diseases, in which social determinants are included.

Paragraph 30 (h). Continue to strengthen international cooperation in support of national, regional and global plans for the prevention and control of non-communicable diseases, inter alia, through the exchange of best practices in the areas of health promotion, legislation, regulation, strengthening of health systems, training of health-care personnel and the development of appropriate health-care infrastructure and diagnostics and by promoting the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms for the production of affordable, safe, effective and quality medicines and vaccines, while recognizing the leading role of the World Health Organization as the primary specialized agency for health in that regard.

Paragraph 31. Continue to strengthen international cooperation through North-South, South-South and triangular cooperation in the prevention and control of non-communicable diseases to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation.

Paragraph 32. Continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms.
Terms of reference for the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

The scope and purpose of the global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD) are to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.

Terms of reference for Working Group 3.2

The WHO GCM/NCD Working Group on alignment of international cooperation with national plans on NCDs (Working Group 3.2, 2016–2017) was formed under objective 3 in the GCM/NCD work plan. Action 3.2 emphasizes the mandate of the Working Group.

Objective 3. Provide a forum to identify barriers and share innovative solutions and actions for the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and to promote sustained actions across sectors.

Action 3.2. Establish a Working Group in 2016 to recommend ways and means of encouraging Member States and non-State actors to align international cooperation on non-communicable diseases with national plans concerning non-communicable diseases in order to strengthen aid effectiveness and the development impact of external resources in support of noncommunicable diseases. The Working Group will produce a report with recommendations.
# OECD HIGH-LEVEL FORUMS ON AID EFFECTIVENESS

<table>
<thead>
<tr>
<th>Forum/venue</th>
<th>Participants</th>
<th>Major themes</th>
<th>Key outcomes</th>
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<tr>
<td><strong>Rome, Italy</strong>&lt;br&gt;February 2003&lt;br&gt;First High-Level Forum on Aid Effectiveness: Harmonizing donor practices for effective aid delivery</td>
<td>Developed countries: 22&lt;br&gt;Developing countries: 28&lt;br&gt;Multilateral regional organizations: 22&lt;br&gt;Civil society: 0</td>
<td>• Identified that practices do not always fit well with national development priorities&lt;br&gt;• Partner countries assuming a stronger leadership role in the coordination of development, assisting in building their capacity to do so&lt;br&gt;• Need to harmonize efforts at an international and regional level (nine activities to harmonize coordination)</td>
<td>Agreed document: Rome Declaration&lt;br&gt;OECD/DAC established the Working Party on Aid Effectiveness (successor to Task Force on Donor Practices)</td>
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<td><strong>Paris, France</strong>&lt;br&gt;March 2005&lt;br&gt;Second High-Level Forum on Aid Effectiveness: Harmonization, alignment, results</td>
<td>Developed countries: 32&lt;br&gt;Developing countries: 53&lt;br&gt;Multilateral regional organizations: 33&lt;br&gt;Civil society: 13</td>
<td>Paris declaration:&lt;br&gt;• Ownership&lt;br&gt;• Harmonization&lt;br&gt;• Alignment&lt;br&gt;• Results-based management&lt;br&gt;• Mutual accountability&lt;br&gt;• Established indicators (targets) to track progress&lt;br&gt;• Donors encouraged to use strengthened country systems</td>
<td>Agreed document: Paris Declaration was signed (137 countries and 30 international institutions)&lt;br&gt;Implementation of monitoring framework with two progress surveys, 2008 and 2010</td>
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<td><strong>Accra, Ghana</strong>&lt;br&gt;September 2008&lt;br&gt;Third High-Level Forum on Aid Effectiveness</td>
<td>Developed countries: 42&lt;br&gt;Developing countries: 39&lt;br&gt;Multilateral organizations: 30&lt;br&gt;Civil society: 50</td>
<td>• First time negotiations included development partners, partner countries and civil society&lt;br&gt;• Countries determine their own development strategies by playing a more active role in designing development policies and take a stronger leadership role in coordinating aid. Donors use existing fiduciary and procurement systems to deliver aid&lt;br&gt;• Inclusive partnerships in which all partners – not only DAC donors and developing countries but also new donors, foundations and civil society – participate fully&lt;br&gt;• Delivering results that will have real and measurable impact on development</td>
<td>Agreed document: Accra Agenda for Action signed, highlighting the value of cooperation that reaches beyond traditional aid agreements</td>
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<tr>
<td>Forum/venue</td>
<td>Participants</td>
<td>Major themes</td>
<td>Key outcomes</td>
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<tr>
<td><strong>Busan, Republic of Korea</strong></td>
<td>Developed countries: 45</td>
<td>• Key themes: transparency, results management, accountability, fragile States and sustainability</td>
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<tr>
<td><strong>December 2011</strong></td>
<td>Developing countries: 100</td>
<td>• End of “aid effectiveness” and a new push for “development effectiveness”</td>
<td>Agreed document: Global Partnership (Busan Partnership) for Effective Development Co-operation founded</td>
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<tr>
<td><strong>Fourth High-Level Forum on Aid Effectiveness</strong></td>
<td>Multilateral organizations: 53</td>
<td>• Reinforced country ownership</td>
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<td></td>
<td>Civil society: over 700</td>
<td>• Considered the role of the private sector</td>
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<td>• Considered the role of the re-emerging partners (China, India, Brazil)</td>
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<td></td>
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<td>• Recognition of contribution of South–South and triangular cooperation to development</td>
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## Annex 4

### UNITED NATIONS INTERNATIONAL CONFERENCES ON FINANCING FOR DEVELOPMENT

<table>
<thead>
<tr>
<th>Venue/date</th>
<th>Participants</th>
<th>Major themes</th>
<th>Key outcomes</th>
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| **Monterrey, Mexico**       | 182 States represented at the conference along with associate members, United Nations agencies, international organizations and regional commissions, among others | • Mobilization of domestic financial resources  
• Mobilizing international resources: foreign direct investment and other private flows  
• International trade as an engine for development  
• Increasing international financial and technical cooperation for development  
• External debt  
• Addressing systemic issues: enhancing the coherence and consistency of the international monetary, financial and trading systems in support of development | Agreed document: Monterrey Consensus on Financing for Development  
Also: United States Millennium Challenge Corporation  
European Union announced increased aid budgets                                                                                                                                                                                                                           |
| **Doha, Qatar**             | 162 States represented at the conference along with associate members, United Nations agencies, international organizations and regional commissions, among others | Addressed same key themes as Monterrey, 2002  
Additional areas:  
• Acknowledgment of global financial crisis and its impact on aid  
• Acknowledgment of climate change  
• Acknowledged that countries emerging from conflict need extra assistance | Agreed document: Doha Declaration on Financing for Development                                                                                                                                                                                                                  |
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<tr>
<th>Venue/date</th>
<th>Participants</th>
<th>Major themes</th>
<th>Key outcomes</th>
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| Addis Ababa, Ethiopia July 2015 Third International Conference on Financing for Development | 174 States and the European Union represented at the conference along with associate members, United Nations agencies, international organizations and regional commissions, among others | • Encouraged better alignment between multistakeholder partnerships in health and improved contributions to strengthening health systems  
• Committed to enhanced international coordination and enabling environments to strengthen national health systems  
• Committed to substantially increased financing and the recruitment, development, training and retention of the health workforce  
• Committed to strengthening the implementation of the WHO Framework Convention on Tobacco Control | Agreed document: Addis Ababa Action Agenda  
United Nations Interagency Task Force on Financing for Development founded |

**Paragraph 32 of Addis Ababa Action Agenda:** We note the enormous burden that non-communicable diseases place on developed and developing countries. These costs are particularly challenging for small island developing States. We recognize, in particular, that, as part of a comprehensive strategy of prevention and control, price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and health-care costs, and represent a revenue stream for financing for development in many countries.

References:
## Annex 5

### SYNERGIES AMONG THE SDGs WITH A BEARING ON NCDs

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<th>Action across sectors and the SDGs</th>
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<tr>
<th>1</th>
<th>NO POVERTY</th>
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<tr>
<td>Poverty and poor health are interlinked and mutually reinforcing. People living in poverty are disproportionately exposed to various risk factors for poor health in their homes, at work, and in their communities. In the absence of universal health coverage, the poor have reduced access to critical treatment and prevention services. Catastrophic health conditions, in turn, drive people into poverty, especially in the absence of adequate and affordable social protection, since they often are forced to leave the labour market. Any policy framework that is serious about poverty eradication must actively seek synergies between health promotion and social welfare sectors. Cash transfer schemes that are health sensitive and inclusive are an exemplary win–win measure. Cash transfers have been shown to achieve a range of impacts in health, spanning nutrition, maternal and child health, health service demand and uptake, and, increasingly, prevention of HIV and sexually transmitted infections.</td>
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<th>4</th>
<th>QUALITY EDUCATION</th>
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<td>Coordination between the health and education sectors can advance the goals of both simultaneously. Schools offer an ideal setting for health promotion. Messages related to diet or exercise, for example, can be promoted and reinforced to help improve students’ health and nutritional status while also contributing to improved cognitive function, attentiveness and test scores. Similarly, primary school deworming efforts within a sanitation response have been shown to have both health and nutritional benefits, while also reducing school absenteeism. In Kenya, deworming efforts have been shown to be more cost-effective than alternative methods for encouraging school participation.</td>
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<th>5</th>
<th>GENDER EQUALITY</th>
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<td>Action on health and health equity must address the gender inequities that hold back women, their families and societies. Coordination between the health and gender sectors can ensure that women have equal access to essential health and medical services; have decent jobs with equal pay; are empowered to make decisions over their lives, bodies, and finances; and are not inequitably exposed to health risks because of their gender (whether from household chores, second-hand smoke, or gender-based violence). The intergenerational health benefits of investing in women’s empowerment have also been well documented. For example, putting cash in the hands of women is a remarkably strong cross-cutting investment that can lift the health of women and their families while tackling a range of other economic and non-economic gender inequities.</td>
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There are numerous mutually beneficial innovations in health and sustainable energy that have emerged in recent years through cross-sectoral collaboration. For example, the Global Alliance for Clean Cookstoves introduces fuel-efficient stoves to increase energy efficiency and reduce deforestation while also reducing indoor air pollution, a major NCD risk factor. Since women and young children are often disproportionately and inequitably exposed to smoke from stoves, there are significant gender and health equity benefits. Meanwhile, equipping solar panels at health centres can ensure access to affordable, reliable and modern energy services, while also allowing health clinics to maintain cold chains and remain operational and connected.

Better health leads to more productive societies, and, where economic growth is inclusive, this in turn leads to better health outcomes. Taxation of health-harming products is a powerful win–win synergy between the health and economic sectors. Such taxes enable people to be healthier and economies more productive, while raising government revenue and reducing health care costs down the road. Conversely, where health is sacrificed for perceived economic gain – whether in working conditions, tobacco production or deregulated food environments – inequities and disparities widen, making inclusive economic growth harder – not easier – to achieve.

Action across sectors for health and health equity aims to enhance opportunities amongst individuals within countries. It is a key approach of health promotion that seeks to mainstream health in all policies tackling differences in socioeconomic status, gender, ethnicity, disability status and sexuality, which may deepen health inequities if not addressed. Action across sectors for health should emphasize that the right to health is a basic human right. For example, the school health programmes and services provided through the education sector are an extension of primary health care to school settings, which provides children with essential health care services and has broader implications in advancing fair and equal societies for all.

Urbanization offers significant opportunities for improving health but, where it is inadequately managed, urbanization can also pose unique health risks, such as increased exposure to NCD risk factors. Multiple synergies are possible across health, housing, sanitation, air quality, transport and urban planning. Realizing these synergies requires municipal governments to understand health threats and map epidemics, and then develop effective and equitable multisectoral policies and plans that address these while supporting broader efforts to make cities inclusive, safe, resilient and sustainable.

Whether through national AIDS bodies, national coordinating mechanisms for tobacco control, multisectoral NCD committees, or intersectoral coordination platforms for global health crises, action across sectors is, at its core, about better governance. This includes increased policy coherence, better conflict of interest management, and improved co-benefit analysis, planning and financing. In this way action across sectors promotes effective, accountable, and transparent institutions at all levels.
### DAC List of Recipients of Official Development Assistance

#### Least Developed Countries
- Afghanistan
- Angola
- Bangladesh
- Benin
- Bhutan
- Burkina Faso
- Burundi
- Cambodia
- Central African Republic
- Chad
- Comoros
- Democratic Republic of the Congo
- Djibouti
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Guinea-Bissau
- Haiti
- Kiribati
- Lao People’s Democratic Republic
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali

#### Other Low-Income Countries (per capita GNI US$ 1045 in 2013)
- Democratic People’s Republic of Korea
- Kenya
- Tajikistan
- Zimbabwe

#### Lower Middle-Income Countries and Territories
- Armenia
- Bolivia
- Cabo Verde
- Cameroon
- Congo
- Côte d’Ivoire
- Egypt
- El Salvador
- Georgia
- Ghana
- Guatemala
- Guyana
- Honduras
- India
- Indonesia
- Kosovo
- Kyrgyzstan
- Micronesia (Federated States of)
- Mongolia
- Morocco
- Nicaragua
- Nigeria
- Pakistan
- Papua New Guinea
- Paraguay
- Philippines
- Republic of Moldova

#### Upper Middle-Income Countries and Territories
- Albania
- Algeria
- Antigua and Barbuda
- Argentina
- Azerbaijan
- Belarus
- Belize
- Bosnia and Herzegovina
- Botswana
- Brazil
- Chile
- China
- Colombia
- Cook Islands
- Costa Rica
- Cuba
- Dominica
- Dominican Republic
- Ecuador
- Fiji
- Gabon
- Grenada
- Iraq
- Islamic Republic of Iran
- Jamaica
- Jordan
- Kazakhstan
- Lebanon
<table>
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<tr>
<th>Least developed countries</th>
<th>Other low-income countries (per capita GNI US$ 1045 in 2013)</th>
<th>Lower middle-income countries and territories (per capita GNI US$ 1046–4125 in 2013)</th>
<th>Upper middle-income countries and territories (per capita GNI US$ 4126–12745 in 2013)</th>
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<tr>
<td>Mauritania</td>
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<td>West Bank and Gaza Strip</td>
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<td>Solomon Islands</td>
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<td>Nauru</td>
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<tr>
<td>Uganda</td>
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<td></td>
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<tr>
<td>United Republic of Tanzania</td>
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<td>Serbia</td>
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<td>Thailand</td>
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<td></td>
<td></td>
<td></td>
<td>The former Yugoslav Republic of Macedonia</td>
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<td>Tonga</td>
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<td>Uruguay</td>
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<td></td>
<td></td>
<td></td>
<td>Venezuela (Bolivarian Republic of)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wallis and Futuna</td>
</tr>
</tbody>
</table>

Note: United Nations General Assembly resolution 68/L adopted on 4 December 2013 decided that Equatorial Guinea will graduate from the least developed country category three and a half years after the adoption of the resolution and that Vanuatu will graduate four years after the adoption of the resolution. Antigua and Barbuda, Chile and Uruguay exceeded the high-income country threshold in 2012 and 2013. In accordance with the DAC rules for revision of this list, all three will graduate from the list in 2017 if they remain high-income countries until 2016.
## HIV/AIDS INVESTMENT FRAMEWORK

### Table: Critical enablers and Basic programme activities

<table>
<thead>
<tr>
<th>Critical enablers</th>
<th>Basic programme activities</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social enablers</strong></td>
<td>PMTCT</td>
<td>Reduce risk</td>
</tr>
<tr>
<td>Political commitment and advocacy</td>
<td>Condom promotion and distribution</td>
<td>Reduce likelihood of transmission</td>
</tr>
<tr>
<td>Laws, legal policies, and practices</td>
<td>Key population (sex work, MSM, IDU programmes)</td>
<td></td>
</tr>
<tr>
<td>Community mobilisation</td>
<td>Treatment, care, and support to people living with HIV/AIDS (including facility-based testing)</td>
<td></td>
</tr>
<tr>
<td>Stigma reduction</td>
<td>Male circumcision*</td>
<td>Reduce mortality and morbidity</td>
</tr>
<tr>
<td>Mass media</td>
<td>Behaviour change programmes</td>
<td></td>
</tr>
<tr>
<td>Local responses to change risk environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Programme enablers</strong></td>
<td></td>
<td></td>
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<tr>
<td>Community centred design and delivery</td>
<td></td>
<td></td>
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<tr>
<td>Programme communication</td>
<td></td>
<td></td>
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<tr>
<td>Management and incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement and distribution</td>
<td></td>
<td></td>
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<tr>
<td>Research and innovation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Annex 7

GLOBAL INVESTMENT FRAMEWORK FOR WOMEN’S AND CHILDREN’S HEALTH

CONTEXT
Existing health systems and service delivery, current levels of health expenditure, epidemiological and demographic transitions, changes in the level and distribution of wealth, food security, climate change, migration and conflict

STRATEGIC AND EQUITABLE INVESTMENTS IN KEY ENABLERS AND INTERVENTIONS

Policy enablers
- Laws, policies and political commitment for equitable access

Health system enablers
- Improving management of health workers, commodities, financing and data for decision-making

Community engagement
- Knowledge transfer and demand generation

Innovation
- Research and development, implementation science

KEY ENABLERS

Strategic and equitable investments in key enablers and interventions

Cross-cutting issues
Social determinants of health including education, living environment, roads, transport, and sex as well as equity and human rights

Health and nutrition gains
Diseases averted
- CVD, diabetes, cancers, chronic respiratory diseases

Life years saved
- 388,000,000 people will die in the next 10 years of a chronic diseases

Health life
- Impacts illness, disability, and quality of life

Wider societal gains
Socio-economic development
- Increased human capital and education
- Increased employment, productivity and income per capita
- Social value of improved health
- Reduced health care costs

Enhanced political and social capital
- Healthy populations build stronger communities and societies

Environmental gains
- Through reduced population pressure on resources

Recommendation 1: Governments should assess existing national health policies with a view to developing or strengthening strategies to ensure integration of the prevention and control of NCDs with other health programmes, with a particular emphasis on HIV, tuberculosis, maternal and child health, and sexual and reproductive health.

Recommendation 2: Governments should develop, disseminate and use context-specific evidence, best practices and investment cases supporting integration in order to ensure prioritization, implementation and scale-up of the integration of NCDs and other programme areas.

Recommendation 3: Heads of State and Government need to realize their commitment to establish a high-level multisectoral mechanism or commission on NCDs, with clear guidance from the health sector, which should prioritize and lead an integrated approach between NCDs and all programmatic areas and sectors.

Recommendation 4: Governments should consider the engaged, focused and coordinated support of international development partners, intergovernmental organizations and non-State actors in order to effectively implement the integration of the prevention and control of NCDs with other programme areas.

Recommendation 5: Governments must build an adequate and sustainable health workforce that has the resources and capacities to manage and integrate NCDs.

Recommendation 6: Governments should incorporate and integrate NCD services at all levels of health care, with a particular focus on primary and community care services, applying an integrated, people-centred approach.

Recommendation 7: Invest in research and implementation of innovative technologies to support integration, scale-up and outreach of NCD strategies and programmes.
## OECD/DAC and Non-DAC Countries Providing Financing for Development

### Top 30 Net Official Development Assistance As a Share of GNI

<table>
<thead>
<tr>
<th>Country</th>
<th>Net official development assistance</th>
<th>As a share of GNI</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>30,986</td>
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<tr>
<td>United Kingdom</td>
<td>18,545</td>
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</tr>
<tr>
<td>Germany</td>
<td>17,940</td>
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<tr>
<td>Japan</td>
<td>9,203</td>
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<tr>
<td>France</td>
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<td>Sweden</td>
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<td>Saudi Arabia</td>
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<tr>
<td>United Arab Emirates</td>
<td>4,381</td>
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<tr>
<td>Norway</td>
<td>4,278</td>
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<tr>
<td>Canada</td>
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<td>Italy</td>
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<tr>
<td>Turkey</td>
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<tr>
<td>Switzerland</td>
<td>3,529</td>
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<tr>
<td>Australia</td>
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<tr>
<td>China</td>
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<tr>
<td>Denmark</td>
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<td>Belgium</td>
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<td>Qatar</td>
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<td>Finland</td>
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<td>Russian Federation</td>
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<td>Ireland</td>
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<td>Poland</td>
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<tr>
<td>Luxembourg</td>
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<tr>
<td>Brazil</td>
<td>316</td>
<td>0.02</td>
</tr>
</tbody>
</table>

OVERARCHING RECOMMENDATIONS FROM THE GCM/NCD WORKING GROUP ON FINANCING FOR NCDs

Recommendation 1: Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 by 2025.

Recommendation 2: Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives.

Recommendation 3: Complement domestic resources for NCDs with official development assistance (ODA) and catalyse additional resources from other sources to increase health expenditure on the prevention and control of NCDs, consistent with country priorities.

Recommendation 4: Promote and incentivize financing and engagement from the private sector to address NCDs consistent with country priorities on NCDs.

Recommendation 5: Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.
Recommendation 1: Governments need to establish sound national statutory and regulatory frameworks to enable more concrete contributions from the diverse range of private sector entities to NCD prevention and control goals and targets.

Recommendation 2: Governments should establish a multistakeholder platform for engagement on and implementation, monitoring and evaluation of NCD prevention and control that involves all relevant stakeholders, including relevant private sector entities.

Recommendation 3: Governments should develop a robust accountability mechanism to review and ensure effective delivery of the commitments and contributions from the diverse range of private sector entities to national NCD responses and achievement of NCD targets.

Recommendation 4: Governments should better align private sector incentives with national public health goals to encourage and facilitate a stronger contribution to NCD prevention and control from the diverse range of private sector entities.

Recommendation 5: Heads of State and Government must protect their national policies for the prevention and control of NCDs from undue influence by any form of vested interest in order to harness contributions from the full range of private sector entities; real, perceived or potential conflicts of interest must be acknowledged and managed.

Recommendation 6: Countries need to share knowledge and data to support collective action on NCD prevention; this includes pledges and commitments made by transnational corporations to ensure that these are applied consistently across the world, not just in high-income countries, and are tailored for local relevance.
Recommendation 7: Governments should set a strong regulatory framework to underpin engagement with the wide range of relevant private sector entities to protect children from marketing of unhealthy foods and non-alcoholic beverages, so as to support the full implementation of the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children.

Recommendation 8: Governments should elicit clear time-bound commitments from the diverse range of private sector entities involved in the food supply chain to reduce salt, sugar, fat and trans fat in processed foods, aligned with relevant WHO guidelines and agreements.

Recommendation 9: Governments should work with relevant stakeholders, including private sector entities, to provide consistent, coherent, simple and clear messages, to the public, private sector and politicians, to improve understanding of the harms of products high in salt, sugar and fats, including through accurate, standardized, comprehensible and readable front-of-pack labelling.

Recommendation 10: Governments should engage with the diverse range of private sector entities and other relevant stakeholders in promoting and creating an enabling environment in order to develop comprehensive workplace health programmes combining occupational health and safety, health promotion, and health coverage, in both the public and private sectors.

Recommendation 11: Governments should implement a strong regulatory framework to achieve greater coherence for national workplace health initiatives in both the public and private sectors, taking into account existing international obligations to protect workers’ health in workplaces.

Recommendation 12: Governments should recognize that a wide range of private sector entities are important stakeholders for the supply of essential medicines and technologies in public and private sectors, and should engage with them to ensure that safe, effective, affordable and quality-assured products are available on a sustainable basis, and that data on market share to support planning and service delivery are also available.

Recommendation 13: Governments should actively explore opportunities through public–private partnerships to increase access to safe, effective, affordable and quality-assured essential NCD medicines and health technologies to support achievement of the targets of the Global Action Plan on NCDs and contribute to universal health coverage.