Report of the first meeting of the
Strategic and Technical Advisory Group for Noncommunicable Diseases:
virtual meeting, 27–28 October 2021
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### Acronyms and abbreviations

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CARICOM</td>
<td>Caribbean Community</td>
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<tr>
<td>HLM</td>
<td>high-level meeting</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>FENSA</td>
<td>Framework for Engagement with Non-State Actors</td>
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<td>LMICs</td>
<td>low- and middle-income countries</td>
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<td>MPTF</td>
<td>Multi-Partner Trust Fund</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NCD-GAP</td>
<td>Global action plan for the prevention and control of noncommunicable diseases</td>
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<tr>
<td>ODA</td>
<td>overseas development assistance</td>
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<td>OECD</td>
<td>Organisation of Economic Co-operation and Development</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>STAG-NCD</td>
<td>Strategic and Technical Advisory Group on the Prevention and Control of Noncommunicable Diseases</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction

The World Health Organization (WHO), through its global programme on noncommunicable diseases (NCDs), leads and guides the global effort on surveillance, prevention and control of NCDs to reduce the avoidable burden of morbidity, mortality and disability due to noncommunicable diseases (NCDs).

Its major functions include:

- providing global leadership to reduce the avoidable burden of morbidity, mortality and disability through strategy development, political and multisectoral engagement, strengthening accountability, advocacy and partnerships, including with civil society;
- developing policy options, norms and standards of NCD prevention and care;
- facilitating universal access to people-centred prevention and care;
- shaping the NCD research and innovation agenda and stimulating the generation, translation and dissemination of knowledge;
- working with WHO regional and country offices, providing technical support for Member States and partners, to catalyse change and build sustainable capacity; and
- monitoring, evaluating and reporting on the status of the NCD epidemic and progress in attaining the voluntary global NCD targets and the Sustainable Development Goal (SDG) target 3.4 on NCDs.

Mission and functions of STAG-NCD

The Strategic and Technical Advisory Group on the Prevention and Control of Noncommunicable Diseases (STAG-NCD) acts as an advisory body to WHO to further its efforts and work in addressing the prevention and control of NCDs.

The aim is to strengthen international and national action to: reduce premature mortality from NCDs through prevention and treatment; progressively cover additional people with health services, medicines, vaccines, diagnostic and health technologies; and strengthen efforts to address NCDs as part of Universal Health Coverage (UHC).

In its capacity as an advisory body to WHO, the STAG-NCD has the following functions:

1. To identify and describe current and future challenges;
2. To advise WHO on strategic directions to be prioritized;
3. To advise WHO on the development of global strategic documents; and
4. To propose other strategic interventions and activities for implementation by WHO.

The Terms of Reference for STAG-NCD are provided here.

The first meeting of the STAG-NCD took place virtually from 27–28 October 2021 (see agenda in Annex 1). The meeting was organized by the WHO NCD...
Programme, which provides the Secretariat for the advisory body. For 2021–2022, there are 24 members of STAG-NCD. Twenty-two members were in attendance for the first meeting. The STAG-NCD members were joined by staff from WHO headquarters and representatives from its six Regional Offices (see list of participants in Annex 2).

A background paper summarizing the key milestones in the development of the global public health agenda for addressing NCDs over the last two decades was circulated among all STAG-NCD members (Annex 3). The purpose of the document was to provide the necessary background information and key questions to guide the discussions of the first meeting of STAG-NCD. The agenda for the meeting and the list of participants are in Annex 2 and Annex 3, respectively.

This report provides a summary of the first meeting of STAG-NCD, with a focus on the strategic discussions and recommendations of STAG-NCD to WHO for the topics addressed.

The consolidated report was reviewed by the STAG-NCD Chair and by STAG-NCD members. An outcome document containing the recommendations of this report is submitted by the Chair of the STAG-NCD and the Director of the WHO NCD Programme to the Director-General of WHO.

**Objectives of the first meeting of STAG-NCD**

At this first meeting, WHO requested STAG-NCD to review and advise on a number of areas of WHO NCD work. The WHO STAG-NCD Secretariat and the Chair of STAG developed the agenda for the first meeting based on the priorities of WHO’s NCD work in 2021–2022, notably on the recommendations outlined in the *Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of NCDs 2013–2030* (1).

The agenda items are summarized below:

**Day 1**

- Introduction and welcome remarks;
- Setting the scene, scope and purpose;
- Introduction, vision and contribution of STAG-NCD members;
- Focusing the limited financial resources available for NCDs and raising resources for scale-up of the most cost-effective options, considering the impact of COVID-19; and
- Exploring why progress in addressing tobacco use has not yet been seen in relation to other risk factors: physical inactivity, unhealthy diet and harmful use of alcohol.

**Day 2**

- What is the “ask” of NCD directors in WHO headquarters and the regions from STAG-NCD?
- Ensuring that those affected by NCDs are diagnosed and treated to improve health outcomes, using very cost effective and sustainable approaches;
- Strengthening monitoring and surveillance of NCD responses;
- Exercising the leadership and coordination role of WHO in the preparatory process towards the fourth High-level Meeting (HLM) of the United Nations General Assembly (UNGA) on the Prevention and Control of NCDs in 2025.
Summary recommendations

Scaling up cost-effective interventions to address risk factors

STAG-NCD recommends that WHO should:

Technical support

1. Provide technical support and mentorship to help countries build political commitment and accelerate their response to NCDs.

2. Provide countries with technical guidance on undertaking costing exercises, on incorporating NCD funding needs into budget plans, and to ensuring sustainability of NCD programmes.

3. Provide further technical guidance to countries to strengthen health information systems.

Monitoring

4. Guide and support countries to strengthen accountability and transparency.

5. Encourage countries and donors to introduce shadow reporting from civil society to verify the implementation of NCD policies and interventions.

Policy development

6. Support countries to document their best practices and pathways to policy success, and to analyse their political, economic, social landscape, so that they can better tailor their policies and interventions.

7. Further support countries to develop sustainable health financing mechanisms and to integrate NCDs into universal health care (UHC) packages, thereby safeguarding equity and sustainability.

8. Support countries to produce fact sheets and other communication tools, devise tax policies for sugar, salt and trans fats, and develop national investment cases for addressing NCDs.

Access to health care

9. Provide further technical support to improve access to quality medicines, diagnostics and devices, including support to strengthen national regulatory authorities, treatment optimization, and technologies to increase purchasing power and improve affordability.

10. Continue to provide technical support for sustainable, cost-effective and integrated primary and secondary health care programmes, using treatment of diabetes, hypertension, tobacco use and other risk factors as entry points.
Improving diagnosis and treatment, monitoring and surveillance

STAG-NCD recommends that WHO should:

**Diagnosis and treatment**

11. Continue to provide technical guidance for early detection and treatment of diabetes, hypertension and other comorbidities through an integrated primary health care approach.

12. Further support countries to empower people to take an enlightened interest in self-care by actively promoting health literacy.

**Health care provision**

13. Provide further technical support to countries to prioritize cost-effective, high-impact NCD interventions as core essential components of a UHC basic benefits package.

14. Continue to enhance countries’ capacity to address NCDs through strengthening of workforce capabilities in ministries of health, and through the institutionalization of protocol-based training of grassroots health care workers in NCD management and COVID-19 recovery.

**“Best buy” options**

15. Continue to develop and support the uptake of simple operational guidance for implementing best buys for countries and other partners.

16. Provide technical support to government ministries and civil society organizations to work as one to finance and scale-up NCD best buys, protecting these initiatives from interference from commercial entities with conflicting interests.

**Monitoring and surveillance**

17. Continue to support countries to effectively engage people living with NCDs, embracing their involvement across governance, policy development, service design and delivery, and monitoring and evaluation, taking into account conflicts of interest.

18. Continue to support countries to develop responsive and robust information systems for surveillance and monitoring of progress of NCD prevention and control.
Opening session

At the commencement of the opening session, Dr Bente Mikkelsen, Director, WHO Global NCD Programme, presented the Declaration of Interests of the STAG-NCD members. Eight members had declared interests which were considered potentially significant but unlikely to affect the expert judgment on the issues under consideration in the First Meeting of STAG-NCD.

Professor Veronika Skvortsova, Former Minister of Health, Russian Federation, was nominated and confirmed as Chair of STAG-NCD. She presented the provisional agenda of the meeting which was adopted.

Dr Jennifer Cohn was nominated as co-Chair and confirmed. Dr Andre Pascal and Dr Khaleda Islam were nominated as Rapporteurs and confirmed.

Professor Skvortsova welcomed all participants and highlighted the need to focus discussions and recommendations of STAG-NCD on the key NCD issues outlined in the agenda and on building back better in the context of the COVID-19 pandemic. In her opening remarks, she recalled that the first Global Ministerial Conference on Healthy Lifestyles and NCDs was organized jointly in Moscow in April 2011 by the World Health Organization and the Government of the Russian Federation. The “Moscow Declaration”(2), the outcome of the conference, acknowledges the impact of NCDs on health and socio-economic development and the existence of significant inequities in the burden of NCDs and in access to prevention and control. These are ongoing challenges of NCDs which can only be tackled through whole-of-society and whole-of-government approaches and by UHC. She stressed that WHO should be at the centre of civil society action for NCD prevention and control. She also emphasized the need for sustainable financial mechanisms to support NCD prevention and control, particularly in low- and middle-income countries (LMICs). In this regard, the United Nations (UN) Multi-Partner Trust Fund (MPTF) is a significant new partnership initiative convened by the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs, to catalyse stronger responses to NCDs and mental health at country level.

On behalf of the WHO Director-General, Dr Ren Minghui, Assistant Director-General, Universal Health Coverage/Communicable and Noncommunicable Diseases and Dr Naoko Yamamoto, Assistant Director-General for Healthier Populations, delivered the opening addresses.

Dr Ren Minghui thanked the STAG-NCD members for agreeing to serve on the STAG-NCD and welcomed all participants to the first meeting. He stated that the establishment of STAG-NCD by WHO was a reflection of the need to discuss and debate pathways for all countries to better address NCDs during the COVID-19 pandemic and during the recovery phase. He requested that STAG-NCD assist WHO to seize this moment of crisis to transform the NCD agenda and move NCDs from the periphery of public health discussions to centre stage, where they belong. He said that the UN General Assembly Resolution 75/130 (3) was a strong signal of intent to bolster resilience to future shocks. The resolution noted with concern that people living with NCDs are more susceptible to the risk of developing severe COVID-19 symptoms and are among those most affected by the pandemic; it recognized that necessary efforts for the prevention and control of NCDs are hampered by a lack of universal access to essential health services, medicines, diagnostics and health technologies for NCDs. He informed STAG-NCD that the World Health Assembly (WHA) has asked the WHO Secretariat for support through development of an “Implementation roadmap 2023–2030 for the global action
plan for the prevention and control of NCDs 2013–2030” (4) and that the roadmap will provide a basis for countries to decide on pathways to accelerate progress towards achievement of SDG target 3.4 in the next 10 years. The roadmap will go hand-in-hand with an updated set of best buys and other recommended interventions for the prevention of NCDs, and a new web-based simulation tool to support countries in selecting a prioritized set of NCD interventions. The implementation roadmap, the best buys and the simulation tool will be completed in 2022 and will be presented to the WHA in 2023. He invited STAG-NCD to seize this opportunity to help WHO to turn the clock forward on the rights of 1.7 billion people living with NCDs around the world, and give them the opportunity to attaining health-for-all we all seek.

Dr Naoko Yamamoto, in her opening remarks, stressed the critical importance of implementing health promotion and population-wide prevention strategies to address the root causes of the NCD epidemic, including through whole-of-society and whole-of-government approaches. A life-course approach to NCD prevention that addresses behavioural and environmental risk factors as well as social determinants of health has the undeniable potential to halve the global NCD burden. The challenges of rising costs of medical care, widening inequalities and the impact of ageing populations on the NCD burden call for acceleration of UHC and more effective transformation of scientific evidence to concrete action to tackle NCDs at global, regional and national levels. She asked the STAG-NCD for their strategic advice and guidance in making this transformation a reality.

Dr Bente Mikkelsen set the scene for the meeting by providing the background, scope and objectives. She pointed out that in 2019, NCDs accounted for 74% of global deaths and that seven out of the 10 leading causes of death were NCDs. While mortality trends for communicable diseases and perinatal conditions are declining, NCD mortality continues to rise. Over the last ten years, an average of 15.2 million people a year between the ages of 30 and 70 years have died from NCDs; 12.9 million of them were from LMICs. The rate of progress in reducing premature mortality has slowed since 2010, but inequities in relation to NCDs have widened. For example, the combined population of 30 LMICs (1 billion people) have a three-fold greater risk of dying from an NCD compared to the population of 45 high-income countries (HICs) (range 8%–14% vs 25%–31%).

She stated that despite high-level commitments, the progress in NCD prevention and control has not been adequate. For example:

- only 6% of WHO Member States (n=14) were on track to achieve SDG target 3.4 (a 30% reduction in premature mortality from NCDs by 2030 against a 2015 baseline);
- only 34 countries have implemented 10 or more of the commitments made on NCDs at the UN General Assembly, while 66 have implemented fewer than five, including four that have implemented none;
- No countries are on track to achieve all nine voluntary global targets for 2025, set by the WHA in 2013 against a baseline in 2010; and
- the WHO Global Monitoring Report for UHC in 2019 shows rapid improvements in coverage of communicable disease, but shows relatively little change in NCD services and capacities since 2000, particularly in low-income countries.

Although 136 countries have reported that NCD services have been disrupted during the COVID-19 pandemic, only 107 have included NCDs in national COVID-19 recovery plans.
The implementation roadmap 2023–2030 for the NCD-GAP is to ensure the following:

- alignment with the 2030 Agenda and other internationally agreed NCD targets;
- that the health-care needs of the rapidly growing 30–70 years population group are addressed;
- identification of options for achieving NCD targets;
- resilience of health systems to treat people with NCDs during complex emergencies;
- that recommendations from the mid-point evaluation lead to corrective actions; and
- the use of COVID-19 as a new lens through which to view NCDs when building back better.

She drew the attention of the STAG-NCD to the 12 recommendations of the Mid-point evaluation of the NCD-GAP 2013–2020 (5) (see Table A3, Annex 3), and explained the three strategic directions of the implementation roadmap that will be submitted to the Executive Board and the WHA in 2022.

1. Accelerate national response based on the understanding of the epidemiology and risk factors of NCDs and the identified barriers and enablers in countries.

2. Prioritize and scale-up the implementation of most impactful and feasible interventions in the national context.

3. Ensure timely, reliable and sustained national data on NCD risk factors, diseases and mortality for data-driven actions and to strengthen accountability.

In order to accelerate NCD prevention and control at country level, WHO is in the process of further updating Appendix 3 of the NCD-GAP, which contains best buys and other recommended interventions for NCDs. Finally, Dr Mikkelsen highlighted the escalating demand from countries for technical support for NCD prevention and control and the dire need to strengthen the capacity of WHO at all levels to respond to these demands.

Dr Ruediger Krech, Director Health Promotion, spoke about the fundamental need to complement NCD management efforts with multilevel and multifaceted interventions to tackle the underlying root causes of NCDs. These multilevel interventions address the main NCD risk factors: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. To facilitate their implementation, WHO has developed technical packages and tools (“signature solutions”) such as MPOWER, which addresses all aspects of tobacco control. He reiterated the need to increase levels of physical activity by changing social norms and attitudes to create active societies and active people, providing opportunities to create active environments through green spaces and creating active systems through governance and policy. He informed STAG-NCD that WHO has established separate strategic advisory groups to strengthen the work related to behavioural risk factors of NCDs, health promotion, well-being and social determinants of health, and mental health and substance abuse.
Session 1: Members’ areas of expertise

Session 1 was chaired by Professor Veronika Skvortsova and supported by Dr Cherian Varghese, Cross-cutting Lead NCD and Special Initiatives. STAG-NCD members briefly presented their vision of WHO’s NCD prevention and control programme and their planned contribution to the STAG-NCD. They expressed interest in contributing to the NCD agenda based on a wide range of expertise and experience including:

- surveillance and monitoring
- improving accuracy of data
- population prevention
- health promotion
- primary health care (PHC) approaches
- public health approaches
- health governance
- multisectoral action
- promoting health equity
- patient perspectives
- health system research
- implementation research
- policy development and implementation
- policy analysis
- stroke prevention, care and rehabilitation
- models of stroke care for low-resource settings
- NCD care in hospital
- cancer registries
- communicable diseases
- working with civil society networks
- promoting accountability
- combatting industry interference
- addressing commercial determinants of health
- convening public–private partnerships to advance the NCD agenda
- forging south–south collaboration.
Session 2: Scaling up cost-effective interventions to address risk factors

Session 2 was chaired by Dr Jennifer Cohn and supported by Dr Ruediger Krech.

Key questions

WHO needs to better adapt its NCD programme to the range of country contexts in which it works, in the COVID-19 pandemic and post-COVID-19 period.

Taking NCD-GAP mid-point evaluation recommendations 2 and 3 (see Table A3, Annex 3) as the starting point, and framing them through the settings of low-, lower-middle, upper-middle and high-income countries, the meeting considered the following questions:

• How can Member States focus the limited financial resources available for NCDs on the most cost-effective NCD interventions, and how can they raise resources for scale-up, considering the impact of COVID-19?

• Mindful of the impacts seen in tobacco control, what measures can Member States adopt to address other NCD risk factors: harmful use of alcohol, unhealthy diet, and physical inactivity?

STAG-NCD:

WELCOMES and applauds WHO’s leadership since the beginning of the COVID-19 pandemic to control the pandemic while continuing to accelerate global efforts to tackle NCDs despite the impact of the pandemic.

NOTES the interplay between COVID-19 and NCDs that is directly and indirectly causing morbidity and mortality in four ways:

• due to people living with NCDs being more susceptible to the risk of developing severe COVID-19 and suffering worse outcomes;

• due to the inability of health systems to provide ongoing essential health services, for the prevention, early diagnosis and treatment of NCDs during the COVID-19 pandemic;

• due to the socioeconomic impact of the interplay between the COVID-19 pandemic and NCD epidemic which is affecting people in their most productive years;

• due to increased digital marketing of unhealthy products during lockdown/stay at home orders.

NOTES that COVID-19 services and public health campaigns could be used for opportunistic screening of NCDs and for imparting health education to people on tobacco cessation, physical activity, healthy diet and avoiding harmful use of alcohol, all of which can also help to build up immunity against infections, while also preventing NCDs. Learning from the lessons of COVID-19 that the role of patient and community participation in NCD prevention and control could be further strengthened and that help-lines, and mobile and telemedicine technologies can be further developed to strengthen NCD management.
ACKNOWLEDGES:

- That transnational corporations and commercial determinants of NCDs are closely linked, making it unrealistic to expect that high-income countries, where transnational corporations are headquartered, would act against their national interests to finance NCD prevention in LMIC;

- The need to provide intellectual capital to strengthen the policy backbone of Ministries of Health in LMIC, enabling them to develop and implement policies for taxation of tobacco, alcohol and unhealthy food and other cost-effective policies;

- The need to tap into reasons beyond health to convince decision-makers of the importance of policies that support healthy behaviour, for example the need to implement alcohol control policies to safeguard the efficiency of the workforce and the resulting impact on the economy; and

- That Small Island Developing states (SIDs) are in a special category in the NCD policy dialogue, based on their distinct vulnerabilities to climate change, food insecurity and other impacts.

RECOGNIZES the need to:

- Engage and resource the civil society and communities more widely to harness their potential contribution to support NCD prevention and control efforts;

- Focus not only on policy development but also on tracking policy implementation and policy outcomes at country level;

- Better understand how to motivate behaviour change including through anthropological and behavioural science research; and

- Shift resources and provide on-line training resources to empower grassroots-level health workers and communities to harness their contribution to address NCDs.

EMPHASIZES that WHO needs to provide technical support to countries to:

- Enable patient groups to contribute to health education, self-care, screening and social mobilization as appropriate;

- Improve and monitor quality of in-patient NCD care;

- Strengthen multisectoral collaboration through mapping of the stakeholder landscape and identification of barriers and enablers; and

- Help build a political enabling regulatory and legislative environment, and good governance and transparency as a way of combatting industry interference.

RECOGNIZES the need to build evidence on implementation of best buys and build policy relevant research prioritizations to help guide donors and researchers.

RECOGNIZES WHO's convening power to enable and influence relevant stakeholders, excluding those with conflicting interests to enhance their impact on accelerating NCD prevention and control, at national, regional and global levels.

STAG-NCD also notes that the difference between what has happened in the control of tobacco and other risk factors is in large part because of the courage of the intergovernmental agencies to promote the Framework Convention on Tobacco Control (FCTC), particularly Article 5.3, which deals with the issue of how governments protect policies from industry interference. The FCTC facilitated injection of resources, generation of evidence on tobacco control
interventions and policies, and the development of process and outcome indicators for monitoring tobacco control. FCTC and evidence of the harmful effects of secondhand smoke have also helped the denormalization of the tobacco industry.

The alcohol industry relies on very heavy use of alcohol for a significant part of its sales and profits. Thus, it interferes with effective policies that would have the effect of reducing its profits. There are real issues that WHO needs to address in terms of the relationship with the industry now, and the extent to which WHO can play a role in normative influence across the UN system. Within its own processes, it should look very carefully at interactions such as the current dialogues with the alcohol industry; for example, it should be asking questions about how closely aligned the dialogues are with the Framework for Engagement with Non-State Actors (FENSA).

Cross-border marketing of unhealthy products is a contributor to NCDs. Big influential producers of unhealthy commodities now utilise digital platforms for cross-border marketing. Their profits are based on marketing and the collection of digital data, which allows targeting to an unprecedented extent; this include targeting the most vulnerable in order to ensure they buy the products.

WHO’s advocacy efforts to prevent harmful use of alcohol should also target political leadership because, in many countries, the alcohol industry, including the informal industry, has close and powerful links to politicians, making it difficult to effectively implement prevention policies.

With regard to behavioural risk factors other than tobacco, the evidence base on cost-effective policies and interventions (best buys) needs broader dissemination, and process and outcome indicators for tracking progress of implementation need further development. There should also be better clarity about the conflict of interest that exists in the branding of sports and cultural events by producers of unhealthy commodities.

**STAG-NCD recommends that:**

In order for the WHO NCD programme to be better adapted to the range of country contexts, WHO adopts the following measures:

**Technical support**

1. WHO should provide technical support and mentorship to countries, targeted according to their financial and human resource capacity for implementation, to help them to build political commitment and accelerate the national response to NCDs.

2. WHO should provide technical guidance to countries to undertake costing exercises, to incorporate NCD funding needs into the budget plans for the COVID-19 recovery programmes, and to mobilize domestic finances to ensure sustainability of NCD programmes, including through taxation of tobacco, alcohol and unhealthy food and beverages.

3. WHO should provide further technical guidance to countries to strengthen health information systems, including through the development of user-friendly integrated NCD databases that are open source and capable of accommodating individual data as well as facility-based data (at all levels of care). These should be interoperable with other data systems, and with telemedicine and mobile technologies. This includes a database of resource personnel for capacity development of the PHC workforce and disease-based registries, where appropriate.
4. WHO should provide guidance and support to countries to strengthen accountability and transparency by creating dashboards and reports that use clear indicators to track country performance in implementing policies, guidelines and national NCD indicators and in achieving process and clinical outcomes, including in-patient outcomes.

5. WHO should encourage countries and donors to introduce and resource shadow reporting from civil society to verify the implementation of NCD policies and interventions, thereby providing an additional perspective on the level of implementation.

Policy development

6. WHO should support countries to document their best practices and pathways to policy success, and to analyse their political, economic, social landscape, so that they can better tailor their policies and interventions, particularly during the recovery phase of the COVID-19 pandemic.

7. WHO should further support countries to develop sustainable health financing mechanisms and to integrate NCDs into UHC packages, thereby safeguarding equity and sustainability.

8. WHO should support countries to develop fact sheets and other communication tools, develop tax policies for sugar, salt and trans fats, and national investment cases for addressing NCDs based on their own epidemiological context, cost-effective solutions and return on investment.

Access to health care

9. WHO should provide further technical support to countries to improve access to quality medicines, diagnostics and devices, including through WHO support to strengthen national regulatory authorities, treatment optimization to help focus markets on a core set of essential medicines, and technologies to increase purchasing power and improve affordability.

10. WHO should continue to provide technical support to countries to increase access to NCD care by bringing it closer to people’s homes, including through team-based care, task shifting and sharing, and integration into primary health care. This includes preventing heart attacks and strokes through sustainable, cost-effective and integrated primary and secondary health care programmes, using treatment of diabetes, hypertension, tobacco use and other risk factors as entry points.

Session 3: What is required of STAG-NCD

Session 3 was chaired by Professor Veronika Skvortsova, supported by Dr Cherian Varghese. The session brought together the global and regional NCD offices and WHO departments covering different areas of NCDs. They made brief presentations on what they require from STAG-NCD, summarized below.

WHO Regional Office for Africa – Dr Jean-Marie Dangou, coordinator, NCDs

- A mechanism to ensure that the three levels of WHO work as a single coordinated entity to maximize the capacity of WHO;
- Advocacy and communication to accelerate implementation of existing
initiatives, including NCD technical packages across all regions; and

• The addressing of human resource and funding gaps in the African regional office to enable better support for the 47 country offices and ministries of health.

**WHO Regional Office for the Eastern Mediterranean** – Dr Asmus Hammerich, Director, NCDs

• Mobilization of resources to strengthen governance for NCD prevention and control;

• Mechanisms to counteract industry influence on prevention;

• Strategies to improve access to quality services, including in countries in conflict; and

• Better data on mortality, risk factors and service delivery.

**WHO Regional Office for Europe** – Dr Kremlin Wickramasinghe, a.i. Head, WHO European Office for Prevention and Control of Noncommunicable Diseases (NCD Office) and Adviser (Nutrition)

• Innovative mechanisms to motivate countries to move from policies to action;

• Documentation of country case studies that demonstrate the impact of NCD policies;

• Policy review tools to assess the level of policy implementation;

• Benchmarking tools such as data dashboards to compare country performance; and

• Tools to harness the power of digital technologies to scale-up NCD action.

**WHO Regional Office for Europe** – Dr Carina Ferreira-Borges, Regional Adviser, Alcohol, Illicit Drugs and Prison Health

• How do we move forward on a broad NCD agenda with many diseases when resources are limited?

• What is the best way of demonstrating the impact of NCD policies and the interventions of this broad agenda?

**WHO Regional Office for South East Asia** – Dr Manju Rani, Regional Adviser NCDs

• Guidance on public–private partnerships to scale up NCDs service delivery;

• Guidance on operationalizing multisectoral action and its accountability;

• Effective use of digital innovations to drive the NCDs agenda; and

• Easy-to-measure simplified indicators to demonstrate impact of policies and interventions on NCDs.

**WHO Headquarters** – Dr Bente Mikkelsen, Director, NCDs

• Maximization of impact of WHO global initiatives, tools and technical packages;

• Increased coverage of NCD services through UHC; and

• Keeping NCDs high on the list of priorities in global and national health agendas.

**WHO Headquarters** – Dr Svetlana Axelrod, Director, Global NCD Platform

• Highlighting of the role of the United Nations Interagency Task Force (UNIATF)
on NCDs in influencing the UN system and for collective advocacy;

- Advocacy for mobilization of resources for the Multi-Partner Trust Fund;
- Dissemination of tools to facilitate multisectoral action and multi-stakeholder engagement; and
- Dissemination of decision-making tool to guide collaboration with private-sector entities.

**Session 4: Improving diagnosis and treatment, monitoring and surveillance**

Session 4 was chaired by Dr Jennifer Cohn and supported Dr Slim Slama, Unit Head (NCD).

**Key question**

WHO needs to better adapt its NCD programme to the range of country contexts in which it works, in the COVID-19 and post-COVID-19 period.

Taking NCD-GAP mid-point evaluation recommendations 4 and 6 (see Table A3, Annex 3) as the starting point, and framing them through the settings of low-, lower-middle, upper-middle and high-income countries, the meeting considered the following questions:

- How can Member States be supported to ensure that those affected by NCDs are diagnosed and treated, using cost-effective and sustainable approaches to improve health outcomes?
- How can Member States be supported to further strengthen monitoring and surveillance of NCD responses?

**STAG-NCD:**

EMPHASIZES the importance of integrating NCD services with communicable diseases, including COVID-19 services, taking cognizance of the limited financial resources, health workforce shortfall, technology gaps and other country realities. The interplay between NCDs and the pandemic has amplified the need for health systems to be strengthened to deliver all core NCD services and for to recognize the detection and treatment of NCDs as essential public health functions. Efforts also need to be made to better diagnose and treat hypertension and pre-eclampsia in pregnancy, including through integration of NCD programmes with maternal and child health programmes, as appropriate, recognizing that addressing hypertension in pregnancy will improve maternal and foetal health outcomes and prevent low birth weight, which is a marker of increased NCD risk in later life. A major push is needed to scale-up the WHO best buy that focuses on early detection and treatment of hypertension and diabetes through an integrated total-risk approach.

EMPHASIZES the need to promote procurement and use of safe, quality, efficacious and affordable medicines, including generics, for treatment of NCDs, given that medicines are one of the most expensive items for health systems, particularly in LMICs that lack manufacturing capabilities. Tackling NCDs also requires removing policy barriers to access of essential medicines, addressing the disconnect between the availability of core NCD medicines and insurance
coverage, facilitating access and quality assurance of basic diagnostics and technologies, including point-of-care devices.

RECOGNIZES that health financing and insurance schemes need to first expand coverage for high-impact, high-return NCD interventions (best buys) to everyone, while eliminating out-of-pocket payments.

RECOGNIZES the need for meaningful engagement of civil society and people living with NCDs, including, where appropriate, by strengthening civil society alliances to raise awareness, strengthen advocacy, deliver services, contribute in kind, and monitor progress and accountability.

RECOGNIZES the need to promote and facilitate international, interregional and intercountry collaboration for exchange of best practices in the implementation of best buys, multisectoral action, taxation of unhealthy products, legislation, regulation of marketing of unhealthy commodities and pharmaceutical promotion, health system strengthening, use of digital technologies and training of health personnel, so as to disseminate learning from the experiences of countries in meeting the challenges of NCD prevention and control.

RECOGNIZES the importance of promoting operational research to strengthen the scientific basis for decision-making, in particular research designed to better understand implementation capacity, feasibility and impact on health equity of interventions and policy options contained in Appendix 3 to the NCD-GAP (6).

RECOGNIZES the convening power of WHO to mobilize bilateral and multilateral donors, private sector, including the health insurance industry, ministries of health, finance and other ministries and civil society organizations to work as one within the scope of their respective mandates, to finance and scale-up NCD best buys using integrated approaches and avoiding fragmentation.

NOTES that actions to tackle NCDs can be accelerated by constructively engaging with some elements of the private sector – with the exception of producers and marketers of unhealthy products, including tobacco and alcohol products, and with due attention to the management of commercial and other vested interests. Where it is possible to protect against any influence that would reduce the likelihood of effective policies being developed and implemented, to explore ways to accelerate NCD prevention and control, including through public–private partnerships and strategic purchase of services.

NOTES that ministries of health need to take into account commercial and other vested interests when working in partnership with the private sector, which include: food and non-alcoholic beverage companies in areas such as labelling and market regulation; the technology industry for improving access to quality diagnostics, basic technologies for detection of NCDs and for harnessing mobile and telemedicine technologies; the pharmaceutical industry for improving access to affordable, quality-assured essential medicines, and the private health care sector to regulate quality of care and to streamline and monitor patient flows between public and private health sectors to make progress towards UHC.
STAG-NCD recommends that:

In order for the WHO NCD programme to be better adapted to the range of country contexts, WHO adopts the following measures:

**Diagnosis and treatment**

11. WHO should continue to provide technical guidance for early detection and treatment of diabetes, hypertension and other comorbidities through a primary health care approach, avoiding fragmentation and promoting integration of NCD services, engaging and empowering health care professionals, community health workers, lay people, communities and providers of traditional medicine, as appropriate.

12. WHO should further support countries to empower people to take an enlightened interest in self-care by actively promoting health literacy, including through effective public health and communication campaigns grounded in behavioural science and responsive to local needs and contexts.

**Health care provision**

13. WHO should provide further technical support to countries to prioritize very cost-effective, high-impact NCD interventions as core essential components of a UHC basic benefits package. Several useful tools, including the updated Appendix 3 “best buys” (7), the WHO Package of essential noncommunicable (PEN) disease interventions (8), cardiovascular risk assessment charts and other guidelines exist to support priority setting and development of the basic benefits package. PHC services for slum and shanty dwellers and floating, migrant populations in urban settings require special focus.

14. WHO should continue its work on enhancing the capacity of countries to address NCDs, including through strengthening of the capabilities of the ministry of health workforce in areas such as taxation, legislation, regulation, multisectoral action, surveillance and monitoring, and by promoting the use of protocol-based training of grassroots health care workers to accelerate delivery of quality care for NCD management and COVID-19 recovery. Initiatives to strengthen the capacity of the health workforce for NCD prevention and control should be institutionalized and go beyond one-off training sessions provided by NGOs and the pharmaceutical industry.

15. Given the resource limitations in LMICs, made worse by the COVID-19 pandemic, special attention should be paid to sustainability and equity of NCD prevention and control programmes at all levels of health care. WHO should consider the development of online NCD training programmes for community health workers and continue to develop and support the uptake of simple, where possible algorithmic, operational guidance for implementing best buys for countries and other implementing partners.

16. WHO should provide technical support to ministries of health, finance, trade and industry and other ministries and civil society organizations to work as one within the scope of their respective mandates, to finance and scale-up NCD best buys using integrated approaches, avoiding fragmentation and protecting these initiatives from interference from commercial entities with conflicting interests.

**Monitoring and surveillance**

17. WHO continues to support countries to effectively engage people living with NCDs, embracing their involvement across governance, policy development,
18. WHO should continue to support countries to develop responsive and robust information systems for surveillance and monitoring of progress of NCD prevention and control. This includes conducting regular STEPs surveys, strengthening accuracy of death registration systems, reporting on national targets and indicators based on the global monitoring framework, monitoring implementation of best-buy policies and best-buy health system interventions at all levels of care, and making better use of health-facility-based information and introduction of electronic medical records, where feasible. A regularly updated country-specific dashboard of key policy adoption and process, and of clinical outcomes, would help increase transparency and accountability for all stakeholders.

Session 5: Health diplomacy

Session 5 was chaired by Professor Veronika Skvortsova and supported by Dr Bente Mikkelsen. Mr Menno Van Hilten, Cross-cutting Lead, NCD Strategy, presented the background and set the scene for the session by introducing the concept of health diplomacy. He explained the difference between Resolutions of the United Nations General Assembly (UNGA) and the World Health Assembly (WHA). The former are commitments from heads of state and governments, while the latter provides guidance for implementing them. He reminded the participants that there have been three high-level meetings (HLMs) – in September 2011, July 2014 and September 2018 – at which a total of 63 commitments have been made. The fourth HLM will be in 2025. During the preparatory phase a series of meetings will be held at which recommendations will be made. These will then analysed in the UN Secretary-General’s report that is submitted to the UNGA in 2024. A report is prepared by the WHO Director-General containing recommendations to be discussed in the UNGA. Two ambassadors act as co-facilitators. The recommendations are edited and a zero draft outcome document prepared that forms the starting point of negotiations. After negotiation, the document is adopted at the HLM. One of the most important outcomes of this health diplomacy process for NCDs is SDG 3.4.

Health diplomacy can result in duplication of efforts. It works through political consensus and over the last 10 years there has been no consensus on international financing for NCDs, or for the commercial determinants of health or medicines. These issues are difficult to solve through diplomatic approaches as economic, trade and health interests may conflict with each other. Menno van Hilten outlined the national commitments made at HLMs on governance, risk factors, health systems and surveillance. HLMs have given various assignments to WHO that have been delivered, including the global monitoring framework with targets and indicators, the NCD-GAP 2013–2020, currently being updated to 2030, partnerships for NCD prevention and control (the Global Coordination Mechanism, United Nations Interagency Task Force and the WHO/UNDP/UNICEF Multi-Partner Trust Fund). WHO was also asked to develop an approach for the private sector and NGOs to publish and register their contributions to national NCD responses, which is under development. For the HLM in 2018, a high-level commission was set up by the WHO Director-General. The commission issued six recommendations on: leadership; prioritization and scaling-up; embedding and expanding NCD within service design and delivery, and monitoring and evaluation, taking into account conflicts of interest.
PHC and UHC; collaboration and regulation; finance; and accountability for NCD prevention and control.

The challenges and obstacles to NCD prevention and control have been discussed in many meetings and in the reports of the UN Secretary-General. The key obstacles are weak policy backbone and lack of knowledge to address commercial determinants and implement tax-related measures; industry interference in attempts to reduce risk factors; the difficulties of scaling up measures due to weak capacity of health systems; and lack of interest in increasing international finance.

The following question was posed to STAG-NCD:

How could WHO better exercise its leadership and coordination role in the preparatory process towards the fourth HLM of the UNGA on Prevention and Control of NCDs in 2025, and the meeting itself, framed through:

- the status of the assignments given to WHO;
- the report of the UN Secretary-General and its recommendations (2024);
- the preparatory meetings, expected outcomes, and contributions; and
- the “asks” for the outcome document.

**STAG-NCD proposes:**

**Preparatory activities**

- Regional consultations in the lead up to the fourth HLM, to focus on regional priorities and regional calls to action to feed into the outcome document.
- Engagement of regional political blocks (OECD, CARICOM, etc.) to build capacity and technical understanding of the issues. Leveraging high-profile meetings (e.g. meeting of the Commonwealth Ministers, Road Safety etc.) and other summits (e.g. G7, G20) that take place before 2025, to draw attention to the NCD agenda.

**Reports**

- Preparation of a snapshot report showcasing where countries are in terms of implementation of commitments of previous HLMS and the achievement of SDG 3.4. This could also include projections of progress into the future, using modelling.
- Preparation of a civil society monitoring report, so that when governments are reporting on progress, shadow reporting from civil society can provide an additional perspective.

**“Asks” in the outcome document**

- To keep a strong focus on private-sector interference as a key obstacle to NCD prevention and ways of mitigating it.
- To emphasize equity issues and human rights: e.g. for the same consumption level of alcohol, greater harm is experienced by vulnerable groups than by non-vulnerable groups, and women and children’s human rights are violated because of increased severity of domestic violence and maltreatment of children triggered by harmful use of alcohol.
- To focus on specific, time-bound national commitments with accountability mechanisms rather than commitments at global level.
- To add granularity to asks of the outcome document: e.g. reduce premature
mortality by providing equitable outpatient and in-patient care of heart attacks and strokes and prevention of heart attacks and strokes using hypertension and diabetes as entry points through a sustainable PHC approach.

Closing session

The closing session was chaired by Professor Veronika Skvortsova and supported by Dr Bente Mikkelsen. Rapporteurs presented their reports summarizing the strategic conversation and identifying key issues in relation to WHO’s work on NCD prevention and control at global, regional and country level.

The devastating socio-economic and health impact of the COVID-19 pandemic, and the interplay between the pandemic and the NCD epidemic requires WHO to adopt innovative and results-oriented approaches to guide Member States towards 2025 and 2030 targets. STAG-NCD acknowledges and applauds WHO’s indispensable leadership on NCD prevention and control at global regional and national levels, including by supporting countries through surveillance and monitoring, providing technical guidance on evidence-based strategies, strengthening multisectoral action, promoting research and innovation and, through the meaningful engagement of civil society, affecting communities and other partners.

The STAG-NCD is concerned and alarmed about the lack of awareness on national agendas and acknowledgement on global agendas that:

- There is a causal relationship between underlying NCDs and COVID-19 fatality.
- COVID-19 has severely disrupted NCD services, leaving a backlog of patients who require care.
- Funding to tackle the COVID-19 response in countries is not sensitive to addressing co-morbidities from NCDs.
- Telehealth and mobile health programmes are not reaching community health workers and hard-to-reach populations with information on the prevention and management of NCDs.
- Underinvestment in health systems that meet the health-care needs of people living with NCDs hinders both NCD prevention and control and pandemic preparedness.

STAG-NCD welcomes:

- The WHO NCD implementation roadmap 2023–2030, including an NCD data portal; heatmaps for countries to identify specific NCDs and their contribution to the premature mortality; the web-based simulation tool; interventions for NCDs that are updated with the latest evidence and aligned to PHC and UHC frameworks;
- WHO guidance to promote policy coherence for NCDs and risk factors among all relevant government sectors and involving relevant stakeholders;
- WHO guidance to support countries in making informed decisions on pursuing meaningful multi-stakeholder collaboration, including with the private sector, without conflicting interests and civil societies;
- WHO guidance for meaningful engagement of people living with NCD and mental health conditions in the co-design of NCD policies, programmes, and services;
• An updated set of best buys and other recommendations for the prevention and control of NCDs; and
• The new “business model” that will set out how WHO will work with countries to provide country support (including strategic policy advice, technical assistance) through “signature solutions”, special initiatives, and projects.

Draft outcomes from the sessions:

WHO leadership and core capacity

• WHO should continue exercising its leadership and coordination role, and remain the credible leader in setting standards, promoting and monitoring action for the prevention and control of NCDs in relation to the work of the UN Development System and beyond, and providing global leadership at relevant fora.
• WHO should use the power of purpose, the strength of multi-stakeholder collaborations, new initiatives, global communications strategies and creative storytelling to mobilize action, shape policies and define priorities for the preparatory process leading to the fourth UN High-level Meeting.
• WHO should ensure that its actions to end COVID-19 (resources to tackle the COVID-19 response, COVID-19 vaccination programmes, the pandemic preparedness and response plans) and country efforts to build forward better are sensitive to prevention of NCDs and to the needs of people suffering from NCDs.
• WHO should support countries towards NCD targets, including SDG target 3.4, through adequate and predictable funding for NCD prevention and control programmes at all levels of WHO and for dedicated staffing in WHO country offices.

Country support

• WHO should meet the demands for technical assistance from countries to adapt and titrate WHO NCD packages and signature solutions to epidemiological, health system and resource contexts, enabling all Member States to prioritize and accelerate best buy interventions, with a focus on population-wide prevention, rehabilitation, PHC and UHC.
• WHO should deliver results at the speed and scale needed to reach SDG 3.4 by 2030 through strengthening partnerships and coalitions to promote the roll-out of the WHO NCD implementation roadmap 2023–2030. This includes strategic partnerships to improve access to medicines and technologies, for implementation research, and capacity-building initiatives to strengthen the health workforce, including community health workers in particular, for population-wide prevention of NCD and service delivery through a PHC approach.
• WHO should support countries to increase investment in NCD prevention and control through domestic financing, including through health taxes, and to mobilize external aid from international financial institutions and development cooperation agencies.

Health promotion

• WHO should address the social, political and commercial risk factors for NCDs through health promotion advocacy, technical assistance, and global governance mechanisms to increase accountability, evidence and research. Fast
technology developments need to be addressed with regard to their potential benefits and risks. WHO should make it a priority to address cross-border marketing of unhealthy products in digital media, and industry interference to weaken effective policy.

**Digital health and innovation**

- WHO should use lessons learned in the COVID-19 pandemic to support countries to scale up telehealth, mobile health and other digital technologies to strengthen health literacy, advocacy for NCD prevention and empowerment of communities, and to train and assist community health workers to provide equitable NCD care to remote populations.

**Data and impact**

- WHO should provide further support to strengthen national health information systems, surveillance and monitoring to generate reliable and timely data to prioritize and track implementation of NCD policies and interventions across the full spectrum of NCDs and to assess the impact.

**Partnerships**

- WHO should engage and energize civil society, including people living with NCDs, to scale up shadow reporting of physical activity, alcohol, tobacco and food-related corporate public relations and industry interference, and to mobilize political support to redress the underinvestment in NCD prevention and control.

The STAG-NCD Chair, Professor Veronika Skvortsova, presented the draft outcomes to WHO Director-General Dr Tedros Adhanom Ghebreyesus, who joined the first STAG-NCD meeting during the closing session. He thanked the members for serving in the group and for their advice to WHO to strengthen NCD prevention and control to accelerate action at global, regional and country levels to attain SDG target 3.4.

**Plans for the 2022 STAG-NCD meetings**

The WHO Secretariat announced that the second and third meetings of STAG-NCD will be held at WHO Headquarters in Geneva Switzerland in June and November 2022.

**Closing remarks**

The meeting was closed with final remarks and appreciation to all participants offered by Dr Bente Mikkelsen on behalf of WHO, and by Professor Veronika Skvortsova on behalf of the STAG-NCD.
References


(5) Mid-point evaluation of the implementation of the WHO global action plan, op cit.


(7) ibid.


Annex 1: Agenda for STAG-NCD first meeting

| First meeting of the Strategic and Technical Advisory Group (STAG) for NCDs | 27–28 October 2021  |
| | WHO Headquarters – Geneva, Switzerland (Virtual) |

**WEDNESDAY 27 October 2021**

| Session 1 | 13:00–13:40 | Welcome and opening remarks |
| | | Nomination of Chair, Co-chair and rapporteurs |
| | | Adoption of agenda |
| | | Welcome remarks – Chair |
| | | Setting the scene, scope, and purpose |
| | Dr Ren Minghui |
| | Dr Naoko Yamamoto |
| | Dr Bente Mikkelsen |
| | Dr Ruediger Krech |

| Session 2 | 13:40–15:00 | Introduction by STAG members (3 minutes each) on their vision and contribution to the STAG-NCD |
| STAG-NCD members in alphabetical order |

| 15:00–15:15 | BREAK |

| Session 3 | 15:15–16:45 | Question 1 How could the WHO NCD programme be better adapted to the range of country contexts in which it works in the COVID-19 pandemic and post-COVID-19 period, framed through the settings of low-, lower-middle, upper-middle and high-income countries, including through operationalization of the following mid-point evaluation recommendations of the NCD-GAP: |
| | | • Get Member States to focus the limited financial resources available for NCDs on the most cost effective NCD interventions and to raise resources for scale-up, considering the impact of COVID-19. |
| | | • Explore why progress seen in relation to addressing tobacco use has not yet been seen in relation to other risk factors-harmful use of alcohol, unhealthy diet and physical inactivity. |
| | STAG-NCD members |

| 16:45–17:00 | Summary of day 1 and plan for day 2 | Co-chair |

**THURSDAY 28 October 2021**

| Session 4 | 13:00–14:00 | NCD directors in HQ and the regions – what is their ask from STAG-NCD? |
| Directors covering NCD prevention and control in HQ and regions |
Question 1: How could the WHO NCD programme be better adapted to the range of country contexts in which it works in the COVID-19 pandemic and post-COVID-19 period, framed through the settings of low-, lower-middle, upper-middle and high-income countries, including through operationalization of the following mid-point evaluation recommendations of the NCD-GAP:

- Support Member States more to ensure that those affected by NCDs are diagnosed and treated to improve health outcomes, using very cost effective and sustainable approaches.
- Support Member States to further strengthen monitoring and surveillance of NCD responses.

Question 2: How could WHO better exercise its leadership and coordination role in the preparatory process towards the fourth High-level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs in 2025, and the meeting itself, framed through:

- The status of the assignments given to WHO
- The report of the UN Secretary-General and its recommendations (2024)
- The preparatory meetings, expected outcomes, and contributions
- The “asks” for the outcome document.
## Annex 2: List of participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Affiliation</th>
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Annex 3: Background paper to first meeting of the STAG-NCD group

The World Health Organization (WHO) established the Strategic and Technical Advisory Group on the Prevention and Control of Noncommunicable Diseases (STAG-NCD) in October 2021. The STAG-NCD has 24 members and acts as an advisory body to WHO’s Director-General to further WHO's efforts and work in addressing the prevention and control of NCDs. The aim is to strengthen international and national action in these important public health areas and, thereby, (a) reduce premature mortality from NCDs through prevention and treatment; (b) progressively cover additional people with health services, medicines, vaccines, diagnostics and health technologies; and (c) strengthen efforts to address NCDs as part of Universal Health Coverage (UHC).

In this capacity, the STAG-NCD has the following functions:

• To identify and describe current and future challenges;
• To advise WHO on strategic directions to be prioritized;
• To advise WHO on the development of global strategic documents; and
• To propose other strategic interventions and activities for implementation by WHO.

The STAG shall normally meet once each year. However, WHO may convene additional meetings. STAG meetings may be held in person (at WHO headquarters in Geneva or another location, as determined by WHO) or virtually, via video or teleconference.

Scope and purpose

This background paper summarizes the key milestones in the development of the global public health agenda for addressing NCDs over the last two decades. It outlines where the world is and where the world wants to be in NCD prevention and control in a decade. It presents the challenges in achieving the internationally agreed NCD goals and targets for 2025 and 2030, the interconnected commitments made by countries, technical guidance provided by WHO and the role of the civil society and the private sector in contributing to the implementation of national NCD responses.

The purpose of the document is to provide the necessary background information and key questions to guide the discussions of the first meeting of STAG-NCD. It covers the following.

• The commitments made by governments on prevention and control of NCD at the World Health Assembly (WHA) and the United Nations General Assembly (UNGA);
• The guidance provided by WHO as requested by WHA on how to realize those commitments, in particular the WHO Global Strategy for NCD prevention and control, WHO Global NCD Action Plan (NCD-GAP), best buys and other recommendations;
• The dynamics that have shaped the global NCD agenda and trajectory since 2011;
• Where the world stands today and where the world is aiming to go by 2030;
• Key challenges for the implementation of NCD-GAP 2013–2030;
• Main recommendations of the mid-point evaluation of NCD-GAP; and
• The NCD roadmap.

NCD prevention and control

Governments have made commitments on the prevention and control of NCDs which are included in the 2011, 2014 and 2018 Political Declarations of the UNGA on the Prevention and Control of NCD (5, 6, 7), the 2013 Global NCD Action Plan (8), the 2019 Political Declaration on UHC (9), and the 2030 Sustainable Development Goals (SDG) (10).

These include:

• Exercise strategic leadership of heads of state and government to address NCDs by promoting a whole-of-society response;
• Scale up implementation of the commitments to address NCD as part of the national response to the implementation of the 2030 Sustainable Development Agenda;
• Accelerate efforts towards the achievement of UHC by 2030 to ensure healthy lives and promote wellbeing for all throughout the life-course;
• Strengthen national multistakeholder dialogue mechanisms with accountability for the implementation of national multisectoral NCD action plans;
• Implement policy, legislative, regulatory and fiscal measures to minimize exposure to behavioural risk factors; and
• Prioritize and integrate the set of cost-effective, affordable and evidence-based NCD interventions (WHO best buys) to prevent and manage NCD.

One decade after the 2011 first High-level Meeting of the UNGA on the prevention and control of NCD, new data from WHO shows that the NCD targets are not just aspirational but achievable:

• In 2019, 42% of Member States had the ability to report on progress in attaining the nine voluntary global NCD targets using data from risk-factor surveys and cause-specific mortality systems (11);
• In 2019, 14 Member States were on track to achieve a 33% reduction in risk of premature mortality from NCD by 2030 against a 2015 baseline (SDG target 3.4.1) (12).

To provide guidance to Member States, international partners and WHO on how to realize these commitments, the WHA endorsed the global strategy for the prevention and control of NCDs in May 2013 (resolution WHA66.10) (13). In line with the 2011 Political Declaration on NCDs, the strategy presented a pragmatic public health approach for addressing NCDs by focusing on four major NCDs (cardiovascular disease, cancer, chronic respiratory disease, diabetes) that can be prevented by mitigating four modifiable risk behaviours (tobacco use, harmful use of alcohol, physical inactivity and unhealthy diet), shared by them. The strategy recognizes that the global NCD burden cannot be addressed in a sustainable manner through a single disease or a single risk factor focus. It also reiterates the critical need for a synergistic combination of population-based and health-system approaches to prevent and control NCD. Further, the strategy emphasizes the potential for prevention of NCDs through reduction of exposure of populations to lifestyle and environmental risk factors throughout the life-course.
It’s time to deliver on the promises made at the UNGA and develop ambitious national NCD responses for achieving SDGs 3.4 and 3.8.

Implementation roadmap 2023–2030

By 2030, reduce by one third premature mortality from NCDs (2015 baseline)

2030 milestone: 9 targets extended to 2030 (2010 baseline)

2025 milestone: 9 voluntary global NCD targets (2010 baseline)

Components of national NCD responses

Governance

Risk factors

Health systems

Surveillance

2011 UN Political Declaration, 2014 Outcome Document, and 2018 Political Declaration on NCDs
2019 Political Declaration on UHC


WHO GPW13

Best buys and other recommended interventions

WHO signature solutions

ECOSOC

In 2013, to accelerate national efforts to address NCDs, the WHA adopted a comprehensive global monitoring framework with 25 indicators and nine voluntary global targets for 2025 (Fig. A1). The WHA endorsed a set of actions organized around the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 (NCD-GAP) which, when implemented collectively by Member States, international partners and WHO, help to achieve the commitments made by world leaders in September 2011. The set of actions is organized around six objectives, aimed at strengthening national capacity, multisectoral action to reduce exposure to risk factors, health systems, international co-operation, and the monitoring of progress in attaining the nine voluntary global NCD targets (Table A1).

Table A1. Nine voluntary global NCD targets

<table>
<thead>
<tr>
<th>Nine voluntary global NCD targets</th>
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<tbody>
<tr>
<td>1. One third relative reduction in the overall mortality from CVD, cancer, diabetes or CRD</td>
</tr>
<tr>
<td>2. At least 10% relative reduction in the harmful use of alcohol.</td>
</tr>
<tr>
<td>3. A 15% relative reduction in prevalence of insufficient physical activity</td>
</tr>
<tr>
<td>4. A 30% relative reduction in mean population intake of salt/sodium</td>
</tr>
<tr>
<td>5. A 30% relative reduction in prevalence of current tobacco use</td>
</tr>
</tbody>
</table>
6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure,

7. Halt the rise in diabetes and obesity

8. At least 50% of eligible people (age 40 years and older with a 10-year cardiovascular risk ≥20%) including those with CVD to receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes

9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities

In September 2015, world leaders adopted a set of 17 Sustainable Development Goals (SDGs), with associated targets, including one for NCDs, SDG 3.4 (14). SDG target 3.4 is defined as: “By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.” This target of a 33.3% relative reduction in the probability of dying from the four main NCDs was aligned to the NCD mortality target within the Global Monitoring Framework and is measured against 2015 as the common baseline set for all SDGs (15).

In May 2018, the 71st World Health Assembly adopted the Global Action Plan on Physical Activity 2018–2030, which included a target of “a 15% relative reduction in the global prevalence of physical inactivity in adults and in adolescents by 2030” (16). This target was aligned to the physical activity target within the Global Monitoring Framework, and proposed an extension by five years to 2030.

The Global action plan for the prevention and control of NCDs 2013–2020 (NCD-GAP) comprises a menu of policy options and cost-effective and recommended interventions (“Appendix 3”) to assist Member States, as appropriate for their national context, in implementing measures towards achieving SDG Target 3.4. Appendix 3 has been updated to take into consideration the emergence of new evidence of cost-effectiveness and the issuance of new WHO recommendations that show evidence of effective interventions. An updated Appendix 3 was endorsed in May 2017 by the Seventieth WHA. It comprises a total of 88 interventions, including overarching/enabling policy actions, cost-effective interventions, and other recommended interventions. Sixteen of them are considered to be the most cost-effective and feasible for implementation, with an average cost-effectiveness ratio of ≤$100/DALY averted in low- and lower-middle-income countries (best buys) (18).

Heads of states and governments adopted the Political Declaration of the High-level Meeting of the UNGA on the Prevention and Control of NCDs on 20 September 2011 (19). It is widely recognized as a major milestone in the global fight against NCDs. The Political Declaration acknowledged that NCDs undermine social and economic development throughout the world and recognized the primary role and responsibility of governments in responding to the challenge, engaging all sectors of society. It was a significant beginning in the fight against NCDs and provided the impetus for placing NCDs high on the global political, health and development agendas. The Political Declaration reiterated the importance of implementing the WHO Framework Convention on Tobacco Control, the Global Strategy for the Prevention and Control of NCDs as well as the Global Strategy on Diet, Physical Activity and Health and the Global Strategy to Reduce the Harmful Use of Alcohol.
It also triggered a chain of dynamics that shaped the NCD trajectory in the last decade. The WHO NCD-GAP (20) followed from commitments made in the Political Declaration on NCDs. The NCD-GAP provides a roadmap and a menu of policy options for addressing NCDs for Member States and other stakeholders. The NCD-GAP, and the actions that flowed from it in the last decade, have helped countries to make progress in addressing NCDs (21). Some mechanisms and global events which have contributed to this include (a) the adoption of commitments at the UN General Assembly in 2014, 2015, 2018 and 2019 on the prevention and control of NCDs; (b) the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs (UNIATF) in 2014 for coordination of UN activities to support national NCD responses (22); (c) the establishment of a global coordination mechanism on the prevention and control of NCDs by the WHA in 2014 (23); (d) inclusion of NCDs in SDG target 3.4 of the Sustainable Development Agenda in 2015 (5); (f) the Addis Ababa Action Agenda on Financing for Development in 2015 (24); (g) the appointment of a Global Ambassador for NCDs and Injuries in 2016; (h) the establishment of an independent High-level Commission on NCDs by the WHO Director-General in 2017 (25); and (i) the Global Conferences on NCDs, in Montevideo, Uruguay in 2017 and Muscat Oman in 2019.

In addition, two global health movements have shaped the pathways to prevention and control of NCDs and steered the associated political agenda. One is the focus on primary health care and the other is the pursuit of UHC (26). They have steered countries towards seeking the right balance between progressively covering additional people with nationally determined sets of health services including for NCDs, while strengthening primary health care as the foundation of a sustainable health system for UHC.

The Seventy-second WHA extended the period of the NCD-GAP to 2030, ensuring alignment with the 2030 Agenda for sustainable development and the SDGs (27). WHO is tracking the implementation of NCD-GAP across its six objectives by monitoring and reporting on nine process indicators and 10 progress monitoring indicators (28).

In May 2018, WHO announced the Triple Billion targets of the Thirteenth General Programme of Work (GPW13): a shared vision among WHO and Member States, which helps countries to accelerate the delivery of the SDG (29). The targets are to ensure that by 2023: one billion more people enjoy better health and well-being, one billion more people benefit from universal health coverage and one billion more people are better protected from health emergencies.

In 2020, a comprehensive mid-point evaluation of the progress achieved in the implementation of the NCD-GAP was conducted, as mandated by resolution WHA66.10 (30). The evaluation has issued a set of recommendations to strengthen WHO’s global and national action for prevention and control of NCDs. The task now is to accelerate implementation of the NCD-GAP 2013–2030, taking these recommendations and GPW13 into consideration, recognizing that the COVID-19 pandemic has undone years of progress on NCD and SDG.

**Where the world stands today and where the world is aiming to go by 2030**

Deaths from NCDs are on the rise. The global share of NCD deaths among all deaths increased from 61% in 2000 to 74% in 2019 (31). At a global level, seven of the 10 leading causes of deaths in 2019 were NCDs (32). Trends in deaths from NCDs in all age-groups were driven by diverse changes across regions in 2000–2019. Globally, the greatest decline in mortality was seen for chronic respiratory
diseases, with a 37% decline for all ages, followed by cardiovascular diseases (27%) and cancer (16%) (33). However, the progress is not comparable to that made for curbing communicable diseases and is unequal across regions and income groups (34). Diabetes has shown an unfavourable trend, with a 3% increase (35).

Deaths from NCDs between the ages of 30 and 70 – the most economically productive age span – are classed as “premature” deaths, and are rapidly increasing (36) (Table A2). Cardiovascular diseases continue to be the main NCDs, claiming the largest number of lives among people in the 30–70 age group (37). The majority of premature deaths from NCDs (85%) in 2019 occurred in low- and middle-income countries (38).

Table A2. Deaths from NCDs between the ages of 30 and 70 (2000 to 2019)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2000 (millions)</th>
<th>2010 (millions)</th>
<th>2015 (millions)</th>
<th>2019 (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70 years of age</td>
<td>16.8</td>
<td>19.9</td>
<td>21.8</td>
<td>23.8</td>
</tr>
<tr>
<td>30–70 years of age</td>
<td>12.7</td>
<td>13.7</td>
<td>14.7</td>
<td>15.7</td>
</tr>
<tr>
<td>&lt;30 years of age</td>
<td>1.7</td>
<td>1.5</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Total deaths</td>
<td>31.2</td>
<td>35.1</td>
<td>37.9</td>
<td>40.9</td>
</tr>
</tbody>
</table>

The risk of dying between the ages of 30 and 70 years from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease has dropped over one fifth from 22.9% in 2000 to 17.8% in 2019 (39). Despite the reduction achieved at the start of this century, this progress has not been sustained. The global annualized rate of reduction in premature NCD mortality has declined by 30% since 2015, to just below 1% (from the 1.4% observed between 2000–2015) (40). WHO regions that had already achieved relatively low premature NCD mortality by 2019 show the highest rate of decline since 2015. The declines were up to 40% in the Region of the Americas and the Western Pacific Region, and up to 30% in the European Region. In contrast, regions with the highest premature NCD mortalities by 2019 showed rapid decreases in mortality during 2015–2019. For example, the annualized rate of reduction increased 14% in the South-East Asia Region and 86% in the Eastern Mediterranean Region. Premature mortality from NCDs parallels, and can partly be attributed to, a lack of success in addressing many NCD risk factors. Although tobacco use is steadily declining, the prevalence of obesity is on the rise, and reduction in harmful alcohol consumption has stagnated globally (41) and is increasing in the Americas, South-East Asia and the Western Pacific regions (42).

In February 2021, most countries reported disruptions in services related to NCDs (37%). These disruptions relate to screening, prevention, treatment and rehabilitation services (43). Preliminary estimates suggest the total number of global deaths attributable to COVID-19 in 2020 due to these disruptions to be at least 3 million, with similar estimates expected for 2021.
Key challenges for the implementation of NCD-GAP 2013–2030

The mid-point evaluation of the NCD-GAP identified many future challenges for NCD prevention and control across each of the six NCD-GAP objectives (44). Some of these challenges are summarized below.

Inadequate resources for implementation of NCD-GAP

Raising the profile of NCD has contributed to an increase in the number of countries that have adopted a national NCD action plan since 2013. Sustainable funding mechanisms are required for accelerated implementation of national NCD plans. The COVID-19 pandemic that emerged in early 2020 occurred against a backdrop of underinvestment in NCD prevention and control. The pandemic has caused major disruptions to NCD service delivery and will continue to exert a negative impact on NCD activities for many years. Member States have the challenging task of identifying and leveraging the domestic financial resources needed to respond effectively to NCDs. Priority resource allocation should be accorded to high impact/good return NCD interventions. External donor assistance could be usefully utilized to strengthen health systems rather than for initiating vertical/single disease programmes. In the long-term, as responsibility for funding health programmes shifts from external donors towards domestic resources, maintaining an array of vertical programmes, particularly at the primary care level is unlikely to be sustainable for LMIC governments. Another key challenge is to provide WHO with adequate financial and human resources to provide technical support to implementation of the NCD agenda, particularly at the country level.

Inadequate capacity for country response including multisectoral action

There is a statistically significant association between performance on WHO NCD progress indicators and country income group, with high-income countries performing better than LMICs. In LMICs there is a severe shortage of financial and human resources to implement national NCD action plans, even when condensed down to a smaller number of 16 high-impact best buys. Per capita spending on health is $40 (38–43) in low-income countries, $81 (74–89) in lower-middle-income countries, $491 (461–524) in upper-middle-income countries and US$5252 (5184–5319) in high-income countries (45).

Joint work among different ministries and departments at country level is essential to achieve the NCD agenda as well as the GPW13 and SDGs. Partnerships also need to be forged with other stakeholders, such as civil society and the private sector. As of 2019, fewer than half of all countries had a high-level mechanism to facilitate multisectoral action. Even in countries where such mechanisms are in place, they do not seem to be associated with the benefits expected, partly due to inappropriate composition and suboptimal functioning of multisectoral/multistakeholder groups.

Impediments to reducing exposure to modifiable risk factors

Lack of supportive legal frameworks, insufficient implementation of laws that exist, industry interference, influence of vested commercial interests obstructing effective regulatory legal frameworks on tobacco, alcohol and healthy eating, and poor organization of civil society are impediments to reducing population exposure to risk factors. Multisectoral engagement, for example beyond the health sector and with the private sector, requires people with appropriate political, diplomatic and networking skills and experience. In some countries, staff in the Ministry of Health lack the necessary skills, experience and specific
technical knowledge e.g. on taxation of sugar-sweetened beverages. Incremental progress has been made in addressing tobacco use, primarily due to the WHO Framework Convention on Tobacco Control (WHO FCTC) and the monitoring of its implementation. Similar progress is not yet evident with other risk factors, including harmful use of alcohol, healthy diet and physical activity.

**Complexities in embedding NCD in UHC**

Each year, about 100 million people are pushed into extreme poverty because of out-of-pocket spending on health. Current government spending on health, particularly in many LMICs, is not adequate for achieving UHC. While some progress has been made on early diagnosis of NCDs and access to essential NCD medicines, more work is needed to ensure that NCDs are managed effectively and equitably through primary care. One of the major challenges to the development of UHC is the rising prevalence of NCDs, partly driven by the ageing of populations. There is a need to define specific requirements for NCD management within the UHC and PHC agendas in terms of integration, multisectoral PHC policy, financing, workforce competencies, essential services packages, service delivery models, health information systems and access to diagnostics and medicines. Efforts have been made to include NCDs in the basic primary health care packages offered in different settings. Given that resources are limited and NCDs comprise a large number of diseases and risk factors, the process has to be incremental, starting with NCDs that can be treated through high-impact/high-return interventions, and gradually expanding to include other comorbidities and NCD interventions. The mid-point evaluation of NCD-GAP recognizes the crucial importance of using integrated approaches and not solely focusing on a single NCD or a risk factor.

**Lack of investment in implementation research**

Investment in and support for NCD research is suboptimal, despite the recognition that there are still many evidence gaps, for example in terms of how best to promote implementation of high-impact/high-return interventions (best buys), depending on the contexts. In 2015, just over one fifth of countries (22%) had an operational policy and plan on NCD research. By 2019, around two thirds of countries still lacked such a policy. In 2019, only four low-income countries had such a policy (46). Most of the improvement that occurred between 2015 and 2019 in NCD research was in high-income countries. The vacuum created by limited engagement of WHO in NCD research is currently being filled by the private sector e.g. pharmaceutical and food industry. This raises concerns about conflict of interest, particularly as some sectors, e.g. tobacco, has used research to seek to gain undue influence.

In addition to limited funding for research, another major reason for low research output is the disparity in scientific capacity between high-income and low-income countries. According to the United Nations Educational, Scientific and Cultural Organization (UNESCO) and Eurostat, high-income countries have approximately 50 times more health researchers per million inhabitants (349) than low-income countries (7), ranging (across the 81 countries) from 1,209 in Singapore to 0.2 in Zimbabwe (47).

**Weak surveillance and monitoring systems**

In addition to the nine voluntary global targets in the NCD-GAP, there are 25 health outcome indicators within a global monitoring framework, a further nine action plan implementation progress indicators and 10 commitment fulfilment
progress indicators. Member States regularly report on the progress they are making in implementing their national NCD responses (48, 49). STEPS surveys have been conducted in 120 countries, but few are able to repeat them every five years, as recommended by WHO (50). In 2019, only around a third of countries had a functioning system for generating reliable cause-specific mortality data. Whether they did have a functioning system is largely related to country-income group; no low-income country had such a system, as compared to more than three quarters of high-income countries (78%).

The indicators on risk-factor surveys and cause-specific mortality systems are combined to give an assessment of the extent to which a country will be able to report against the voluntary global NCD targets. In 2019, more than half of countries (58%) have not yet considered able to report against these targets, making any final evaluation of the NCD-GAP a challenge (51). Monitoring progress in NCD prevention and control with reliable and actionable data depends on strong country data and health information systems. There are large gaps in the availability of NCD data in many countries. Strengthening country capacity for data and information remains a major challenge.

Mid-point evaluation of NCD-GAP; recommendations for WHO

Main recommendations for WHO across the six objectives of NCD-GAP are summarized in Table A3.

Table A3. Recommendations of the mid-point evaluation of NCD-GAP

<table>
<thead>
<tr>
<th>NCD-GAP Objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1. WHO Secretariat and Member States to find sustainable funding mechanisms to allow for a dramatic acceleration of NCD implementation.</td>
</tr>
<tr>
<td>WHO Secretariat to:</td>
</tr>
<tr>
<td>• develop proposals as to how NCD funding can be incorporated into plans to build back better;</td>
</tr>
<tr>
<td>• continue to work with the OECD to introduce a purpose code to track spending on NCDs within overseas development assistance (ODA); and</td>
</tr>
<tr>
<td>• introduce, with UNIATF and international partners, a Catalytic/Multi-Partner Trust Fund for NCDs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCD-GAP objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2. WHO Secretariat and Member States to consider how best to use limited financial resources available for NCDs by focusing on the most cost-effective options based on available evidence.</td>
</tr>
<tr>
<td>WHO Secretariat to:</td>
</tr>
<tr>
<td>• provide technical support to Member States to help focus domestic financial resources on those actions which will be most cost-effective;</td>
</tr>
<tr>
<td>• update the best buys from a diverse range of regional and national settings and provide further guidance on total funding needed to implement them; and</td>
</tr>
<tr>
<td>• work with Member States to collect and report in-country expenditure on NCDs.</td>
</tr>
</tbody>
</table>
### NCD-GAP objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments

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

**WHO Secretariat to:**
- explore why the progress seen in tobacco control is not being seen for other risk factors;
- explore why policies on harmful use of alcohol are not associated with implementation of identified cost-effective actions on harmful use of alcohol;
- explore what the barriers are to implementation of actions that are not showing a positive association with income group in high-income country; and
- review whether the range of cost-effective interventions for physical activity can be expanded.

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

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

**WHO Secretariat:**
- together with Member States, to identify practical ways in which responses to NCDs can be better integrated into PHC and UHC;
- together with Member States, to improve monitoring of the number and proportion of people receiving essential medicines in PHC, particularly to reduce cardiovascular risk;
- together with Member States, international partners and non-state actors to recognize and emphasize that it is important not to focus solely on a single NCD; and
- to develop more concrete guidance on integrated NCD management in primary care.

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

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

**WHO Secretariat:**
- and Member States to determine if lack of sufficient funding or an efficient funding mechanism might be an underlying reason why little progress has been made on NCD research and if so how this can be resolved;
- to develop a clear plan as to how it will support this area of work, including identifying current research priorities and needs and how these will be addressed;
- to identify respective roles and responsibilities for this objective, particularly given the establishment of a Science Division; and
- to identify ways in which WHO collaborating centres can contribute to this objective.
NCD-GAP objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

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

WHO Secretariat:

- and Member States to identify how to conduct risk factor surveys in a more cost-effective and sustainable manner that builds local capacity and is coherent with other national data systems;
- to ensure that future reporting to Member States on the AP indicator set includes the indicator on research (AP5);
- to revise and update the AP indicator definitions and to clarify the baseline year for progress reporting to the WHA, and then report on these to Member States;
- to make data more readily available publicly and to use the available data more, for example through in-house analysis in collaboration with partners;
- to brief Member States on what monitoring and reporting implications there are of extending the NCD-GAP to 2030;
- Member States, international partners and non-State actors to develop metrics for actors other than Member States, that is WHO, international partners and non-state actors.
- and Member States to strengthen mechanisms for validation of country-reported data, for example through civil society and in-county verification.
- and Member States to ensure that the final evaluation of NCD-GAP is able to assess progress at the outcome level, as specified in the global monitoring framework.

The NCD roadmap

The overarching goal of the NCD-GAP and SDG 3.4 is to reduce premature mortality (33% by 2030) (52, 53, 54, 55). The rate of decline of the probability of dying from cardiovascular disease, cancer, diabetes and chronic lung disease between the ages of 30 and 70 years is “insufficient to meet Sustainable Development Goal target 3.4” and at the current rate of progress, SDG target 3.4 would only be achieved by fewer than one-tenth of countries by 2030, most from the high-income group (56, 57, 58). In many countries, the 2021/2022 COVID-19 pandemic is derailing the progress of NCD prevention and control (59).

An implementation roadmap 2023–2030 is being developed for the global action plan for the prevention and control of noncommunicable diseases 2013–2030, taking into consideration the recommendations of the mid-point evaluation of the NCD-GAP 2013–2020. The implementation roadmap will focus on three strategic directions: i) to understand the drivers and trajectories of the NCD burden across countries and epidemiological regions; ii) to scale up the implementation of the most impactful and feasible interventions in the national context; and iii) to ensure timely and reliable data on NCD risk factors, diseases and mortality for informed decision-making and accountability. The draft roadmap will be submitted through the Executive Board at its 150th session, and through subsequent consultations with Member States and relevant stakeholders, for consideration by the Seventy-fifth WHA.
The challenge of reaching SDG target 3.4 on NCDs was already significant, even before the COVID-19 pandemic emerged. Compounded by political polarization and challenged multilateralism, the number of people and inequalities from NCDs are growing. No country has yet been able to:

- achieve the domestic commitments made at the UNGA in 2011, 2014 and 2018;
- implement the recommended actions for Member States made by the WHA in 2013 (60) and 2017 (61);
- implement the guidance provided by WHO through signature solutions (62), special initiatives, investment cases and packages; and
- implement the recommendations arising from the mid-point evaluation of the WHO NCD-GAP (63) and the WHO High-level Commission on NCDs (64).

The STAG-NCD is invited to consider the following questions in its first meeting:

How could the WHO NCD programme be better adapted to the range of country contexts in which it works in the COVID-19 pandemic and post-COVID-19 period, framed through the settings of low-, lower-middle, upper-middle and high-income countries, including through operationalization of the following mid-point evaluation recommendations of the NCD-GAP:

- Get Member States to focus the limited financial resources available for NCDs on the most cost-effective NCD interventions and to raise resources for scale-up, considering the impact of COVID-19;
- Explore why progress seen in relation to addressing tobacco use has not yet been seen in relation to other risk factors: harmful use of alcohol, unhealthy diet and physical inactivity;
- Support Member States more to ensure that those affected by NCDs are diagnosed and treated to improve health outcomes, using very cost-effective and sustainable approaches; and support Member States to further strengthen monitoring and surveillance of NCD responses.

How could WHO better exercise its leadership and coordination role in the preparatory process towards the fourth High-level Meeting of the UNGA on the Prevention and Control of NCDs in 2025, and the meeting itself, framed through:

- the status of the assignments given to WHO;
- the report of the UN Secretary-General and its recommendations (2024);
- the preparatory meetings, expected outcomes, and contributions; and
- the “asks” for the outcome document.
Annex references


(2) In accordance with SDG targets 3.4 (NCDs and its risk factors), 3.5 (harmful use of alcohol), 3.8 (UHC) and 3.a (tobacco control) of the 2030 Agenda for Sustainable Development.


(19) UNGA. Resolution A/RES/66/2, op. cit.


(22) United Nations Inter-Agency Task Force on NCDS (UNIATF) [website] (https://www.who.int/groups/un-inter-agency-task-force-on-NCDs).


(30) Mid-point evaluation of the implementation of the WHO global action plan, op cit.


(38) The global health observatory. SDG Target 3.4, op cit.


(42) Ibid.


(44) Mid-point evaluation of the implementation of the WHO global action plan, op cit.


(50) STEPwise Approach to NCD Risk Factor Surveillance (STEPS) [website] (https://www.who.int/ncds/surveillance/steps/en/).

(51) Mid-point evaluation of the implementation of the WHO global action plan, op cit.


(59) Preparation for the third high-level meeting of the General Assembly; 2018, op cit.


(63) Mid-point evaluation of the implementation of the WHO global action plan, op cit.
