Report of the first dialogue convened by the World Health Organization Global Coordination Mechanism on Noncommunicable Diseases

Geneva, 20–21 April 2015
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Foreword

World leaders assembled in 2011 at the first United Nations High-level Meeting on NCDs and agreed on a roadmap of national commitments on how governments will address the NCD epidemic. In 2014, ministers assembled at the second United Nations High-level Meeting on NCDs and agreed to prioritize four time-bound commitments for implementation in 2015 and 2016: to set national targets for NCDs, to develop national multisectoral NCD policies and plans, to start reducing risk factors for NCDs, and to enable health systems to respond. Ministers also agreed that a third High-level Meeting on NCDs would take place in 2018 to review the progress made. Furthermore, in September 2015, world leaders are envisaged to adopt a target as part of the proposed sustainable development goals to, by 2030, reduce premature mortality from cancers and other NCDs by one third.

Following the landmark 2011 United Nations Political Declaration on NCDs, WHO, United Nations organizations, the World Bank and international development agencies have started to help countries build national NCD solutions, based on local insights and global perspectives, to transform their commitments on NCDs into domestic action.

It is becoming clear that significant additional investments are required to address NCDs in the post-2015 era. These investments will need to rely primarily on domestic public finance. The potential to increase taxation on tobacco and alcohol exists in many countries. Even if only a portion of the proceeds were allocated to health, access to services would be greatly enhanced.

Equally important, there is also a major role for the use of international public finance to leverage domestic finance for addressing NCDs, and improve the catalytic role of official development assistance to complement national NCD efforts.

Discussions during a dialogue convened on 20–21 April 2015 by the WHO Global Coordination Mechanism on NCDs emphasized the importance of domestic action and conveyed a sense of urgency in mobilizing international development agencies in playing a greater role to leverage and complement national NCD efforts in developing countries.

This report is written primarily for all partners concerned with action to encourage the continued inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

We hope that the international development agencies will step up their efforts to support national action against NCDs in preparation for the adoption of the sustainable development goals in September 2015 and the lead-up to the third High-level Meeting on NCDs in 2018.

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Abbreviations

DANIDA  Danish International Development Agency
GCM/NCD  Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases
NCD  noncommunicable disease
NGO  nongovernmental organization
OECD  Organisation for Economic Co-operation and Development
RCT  randomized controlled trial
SDG  sustainable development goal
TRIPS  Agreement on Trade-Related Aspects of Intellectual Property Rights
WHO  World Health Organization
Executive summary

Noncommunicable diseases (NCDs) such as cardiovascular diseases, diabetes, cancer and chronic respiratory diseases constitute one of the major challenges for development in the 21st century. These diseases undermine social and economic development throughout the world, threaten the achievement of internationally agreed development goals and may lead to increasing inequalities within and between countries and populations. On 20–21 April 2015, the World Health Organization (WHO) convened a dialogue on how to encourage the continued inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies. The dialogue was convened in response to objective 1, action 1.1, included in the WHO Global Coordination Mechanism on the Prevention and Control of NCDs (GCM/NCD) workplan 2014–2015. The dialogue provided a strategic discussion platform on how to improve the inclusion of NCDs in development agendas. A list of participants is included in Annex 1.

In preparation of the dialogue, an open call was made for submission of papers on its topic. In that context 10 different organizations and individuals submitted a total of 19 substantive papers responding to specific questions related to the topic of the dialogue. The submitted papers were posted on the GCM/NCD webpage together with a summary paper summarizing the inputs received and an information note, which together provided background information for the dialogue meeting.

A common theme across the discussions was that although NCDs were currently well positioned in the proposed sustainable development goals (SDGs) 2015–2030, participants called on Member States and non-State actors not to be complacent. Participants conveyed a sense of urgency when they called on the international community to step up efforts to ensure that proposed NCD targets in the SDGs were accompanied by robust means of implementation and relevant indicators. The third International Conference on Financing for Development (Addis Ababa, Ethiopia, July 2015) would also be an important step in setting the parameters for financing of NCD prevention and control in the post-2015 era as part of financing for development and health. Participants spoke of the need to strengthen national capacities for NCDs, to enable developing countries in the post-2015 era to (a) increase domestic budgetary allocations for NCDs (e.g. through additional tobacco and alcohol taxes); (b) continue to strengthen the monitoring of progress towards NCD-related targets; (c) reduce risk factors for NCDs by implementing the best buys from the WHO Global NCD Action Plan and through creation of health-promoting environments; (d) promote adequate provisions for NCDs within universal health coverage as a means to strengthen and orient health systems to include the prevention and control of NCDs and the underlying social determinants through people-centred primary health care; and (e) engage the private sector in government-led national NCD responses. Participants also highlighted the need to create synergies between the global NCD accountability framework (at the World Health Assembly, United Nations Economic and Social Council and United Nations General Assembly)
and the forthcoming accountability framework that would be established for the SDGs. Participants emphasized the importance of facilitating knowledge and information sharing between all stakeholders, and the need to develop effective mechanisms to facilitate that and to promote the important role of civil society as “thought leaders” and delivery partners.

On the generation of evidence, participants called on international development agencies and United Nations agencies to work with countries in building and disseminating information and research on how NCDs affect the poorest 20% of the population (the two lowest income quintiles) at national level – the so-called “bottom billion” – in order to mobilize decision-makers in the post-2015 era to scale up domestic and international action. An immediate opportunity included the establishment of a community of practice and research network to gather data and generate evidence on the links between the poorest people, poverty and NCDs. Participants felt that the dialogue could be the beginning of a wider process to mobilize stakeholders around a deeper understanding of the close linkages between NCDs, development and poverty globally, the inherent equity and human rights aspects, and the need to address the major gap that existed in understanding how NCDs affected the bottom billion. Participants highlighted the need to establish an initiative to address that gap.

In the high-level segment, the dialogue reacknowledged that NCDs constituted one of the major challenges for development in the 21st century. Speakers emphasized that health was the primary responsibility of governments, and that, therefore, Heads of State had committed themselves in 2011 to integrate NCDs into national development plans. A review of international experience was required to identify and disseminate lessons learned on how to adopt approaches to NCD policy development that involved all government departments, ensuring that NCDs received an appropriate multisectoral and multistakeholder response. Key opportunities included (a) fulfilling the commitments from world leaders in 2011 to integrate NCDs into existing HIV/AIDS, reproductive health and communicable disease programmes; and (b) strengthening policy coherence between the trade, health and development sectors, including the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), to further public health, in particular to provide access to affordable essential medicines and vaccines for all, while strengthening safeguards for investment treaties to ensure that the right to regulate was retained in areas critical for health.

A discussion on supply and demand of technical assistance for NCD prevention and control included views that, while there was demand for catalytic support for technical assistance, that demand was not systematically documented. One view held that the international community needed to develop an approach under the aegis of WHO to map the demand for technical assistance from developing countries in the area of NCDs. It was also recommended that the international development agencies started preparing themselves for the post-2015 era, now that NCDs were firmly embedded into the proposed SDGs. Put another way, catalytic support to foster the implementation of the proposed SDGs could not be carried out effectively without addressing prevention and control of NCDs. Participants called on international development agencies, organizations in the United Nations system, the World Bank and regional development banks to step up to their commitments to respond to the requests from developing countries to
support national NCD responses and raise the priority accorded to NCDs in their programmes. An opportunity existed in “building NCDs into the DNA” of development organizations.

Finally, during a session addressing NCD financing, there was agreement that domestic financing was the crux of the implementation of national NCD responses. The significant investments required to scale up national NCD responses would need to primarily rely on domestic public resources, but those needed to be much more strongly supported by international cooperation and partnerships. Catalytic support, through aid and expertise, needed to be provided by international development agencies, philanthropic foundations and nongovernmental organizations in those areas where technical capacity fell short (e.g. to help developing countries improve tobacco tax legislation and administration). International development agencies had yet to fully embrace NCDs in their development programmes. One view held that little progress had been made by international development agencies despite their commitments to do so in the 2011 United Nations Political Declaration on NCDs and the 2014 United Nations Outcome Document on NCDs.
WHO Director-General addresses the place of noncommunicable diseases in strategies and agendas

Dr Margaret Chan, Director-General of the World Health Organization

Opening remarks at the dialogue on how to encourage the continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

Geneva, Switzerland, 21 April 2015

Ambassadors, invited speakers, experts in public health, representatives of sister United Nations agencies, professional associations, civil society and philanthropies, ladies and gentlemen,

Welcome to this high-level dialogue, where you will be discussing the response to noncommunicable diseases as an issue for development cooperation and a route to poverty reduction.

The challenges facing public health have changed dramatically in character and complexity since the start of this century, when NCDs were not included among the Millennium Development Goals.

Since then, a number of events and reports, and a host of research studies and economic estimates, have increased the visibility of NCDs as a development issue and caused several long-standing assumptions to crumble.

Fifteen years into the 21st century, the health community is grappling with some game-changing statistics.

Worldwide, NCDs have overtaken infectious diseases as the leading cause of mortality. This shift challenges traditional development thinking, which has long focused primarily on infectious diseases and maternal and child mortality as priorities for international action. We continue to support this focus, but need to make space for additional challenges.

Around 70% of the world’s poor now live in middle-income countries, where economic growth and modernization have opened wide the entry point for the spread of unhealthy lifestyles. This is likely the first time in history that economic growth threatens to damage health rather than improve it.

NCDs can no longer be conceptualized as a rich country problem. WHO estimates that 80% of the burden from NCDs now falls on low- and middle-income countries, where people develop these diseases earlier, fall sicker, and unfortunately die sooner than their counterparts in wealthy nations.

Dr Chan, Director- General, WHO
Nor can we continue to think of NCDs as the killers of the old and frail. WHO estimates that NCDs are responsible for 14 million premature deaths in the developing world each year.

In some developing countries in Asia, the number of deaths from cardiovascular disease before the age of 55 is twice that in wealthy countries. The reference to type 2 diabetes as “adult onset diabetes” is no longer apt, as so many children are now being diagnosed with this disease. Just two decades ago, type 2 diabetes was almost never seen in children.

The responsibility for the rise in NCDs does not fall on individuals who choose to eat, smoke and drink too much or opt for a sedentary lifestyle. The responsibility falls on the environments in which these choices are made.

Can children be blamed for an addiction to nicotine when single cigarettes are sold at the gates of their schoolhouse? Can parents be blamed for their overweight children when cities have no green spaces or the crime rate is so high that children are not safe playing outdoors? For the millions of people living in so-called “urban food deserts”, healthy eating is simply not an option.

Ladies and gentlemen,

This is the first big challenge. The evidence, statistics and arguments you put forward for international cooperation must stress the need for policy solutions that shape social environments. These solutions must be supported at the highest level of government, and they need to be put in place through a whole-of-government approach.

A second big challenge is competition. With 17 goals and 169 targets currently proposed for the post-2015 development agenda, this is competition for a sliver or some crumbs from the pie, not a piece.

You are being asked to sharpen the evidence showing the two-way links between NCDs and poverty. You are being asked to make a stronger case for viewing the prevention and control of NCDs as an explicit poverty reduction strategy.

You are being asked to provide an inventory of international agencies that have integrated NCDs into their development policies and extract the lessons learned. We want to hear your proposals about how official development assistance can be used to strengthen prevention and control, yet without compromising funding for other health priorities.

We ask you to do all of these things because of your expertise, knowledge and experience.

A third big challenge is the opposition. This is opposition from powerful economic operators who strongly oppose any regulatory control or restrictions on their marketing of health-harming products.

The responsibility for the rise in NCDs does not fall on individuals who choose to eat, smoke and drink too much or opt for a sedentary lifestyle. The responsibility falls on the environments in which these choices are made.

Can children be blamed for an addiction to nicotine when single cigarettes are sold at the gates of their schoolhouse? Can parents be blamed for their overweight children when cities have no green spaces or the crime rate is so high that children are not safe playing outdoors? For the millions of people living in so-called “urban food deserts”, healthy eating is simply not an option.

Dr Chan, Director- General, WHO
This is a formidable obstacle to prevention. Economic power readily translates into political power. We rely on civil society for support in many areas, but most especially in this one.

The public health community has some tools in hand to respond to these challenges. The 2011 United Nations Political Declaration on NCDs sets out some compelling arguments.

It positions these diseases as one of the major challenges for development in the 21st century. It points out their threat to economies and their contribution to inequalities.

It gives the primary role and responsibility of responding to these challenges to governments. And it underscores how strongly prevention and control depend on the engagement of multiple non-health sectors.

To guide work, we have an action plan through 2020, a monitoring framework with nine global targets, and a set of effective and affordable interventions, known as “best buys”, that can make a difference in any resource setting.

As the root causes of NCDs lie beyond the direct purview and responsibility of the health sector, combating these diseases is a complex task involving multiple sectors. Here, too, we have support from the Global Coordination Mechanism and a United Nations Interagency Task Force.

Ladies and gentlemen,

Let me conclude by repeating two points made in the discussion paper prepared for this meeting.

First, the United Nations General Assembly’s 2014 progress review found no lack of high-level government commitment to NCDs. But it witnessed, in far too many countries, a lack of capacity to act, largely because of insufficient national expertise in low- and middle-income countries. International cooperation can provide this expertise.

Second, efforts to prevent and control NCDs depend on a well-functioning health system, ideally one that aims to reach universal health coverage. Any look at the interactions between NCDs and poverty must also look at ways to increase access to care and reduce the catastrophic medical bills that push so many millions of families below the poverty line each year.

Thank you.
1. Introduction

On 20–21 April 2015, the World Health Organization (WHO) convened a dialogue on how to encourage the continued inclusion of noncommunicable diseases (NCDs) in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies. The dialogue, called in response to objective 1, action 1.1, of the WHO Global Coordination Mechanism on the Prevention and Control of NCDs (GCM/NCD) workplan 2014–2015, provided a strategic discussion platform on ways forward between the different stakeholders. Participants included Member States, United Nations agencies and other intergovernmental organizations, nongovernmental organizations (NGOs) in official relations with WHO, as well as eligible participants to the WHO GCM/NCD, including relevant NGOs, philanthropies, WHO collaborating centres, academic institutions and business associations.

The meeting was co-chaired by H.E. Ambassador Mr Jean-Marc Hoscheit, Permanent Representative of Luxembourg to the United Nations in Geneva, and H.E. Mr Taonga Mushayavanhu, Permanent Representative of Zimbabwe to the United Nations in Geneva.

A complete list of participants is included in Annex 1.

The meeting aimed to raise awareness that a world free of the avoidable burden of NCDs was achievable, but only if rich and poor countries alike followed a shared commitment to put in place the necessary policies and resources for the prevention and control of NCDs, and placed action to address NCDs higher on the national and global political agendas, in collaboration with all stakeholders.

In preparation of the dialogue, a call was made for submission of papers on its topic. In this context 10 different organizations and individuals submitted a total of 19 substantive papers. These were posted on the GCM/NCD webpage together with a paper summarizing the inputs received and an information note, which together provided background information for the dialogue meeting.

The objectives of the dialogue were to:

- highlight the current scientific knowledge, available evidence and information on the relationship between NCDs, poverty and development, identify evidence gaps, and articulate a roadmap of how these gaps could be addressed;

- review international experience in incorporating the prevention and control of NCDs explicitly in poverty reduction strategies and in relevant social and economic policies;

- take stock of which international development agencies have integrated NCDs into their bilateral and multilateral international development policies, to which extent, and identify lessons learned;
• promote discussions on the role of philanthropic foundations, NGOs and private sector entities in addressing NCDs in development cooperation agendas;

• assess to which extent NCDs are included in the ongoing discussions in New York on the post-2015 development agenda; and

• explore options in the post-2015 development era for the continued inclusion of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies.

The dialogue took note of and upheld the commitments made by governments on addressing NCDs at the United Nations General Assembly and the World Health Assembly, including the 2011 United Nations Political Declaration on NCDs, 1 2014 United Nations Outcome Document on NCDs, 2 WHO Global NCD Action Plan 2013–2020, 3 WHO Global Monitoring Framework for NCDs (including its nine global targets), WHO GCM/NCD, 4 and United Nations Interagency Task Force on NCDs. 5 Furthermore, discussion took into account the overarching principles and approaches indicated in the WHO Global NCD Action Plan 2013–2020 (paragraph 18), i.e. a life-course approach; empowerment of people and communities; evidence-based strategies; universal health coverage; management of real, perceived or potential conflicts of interest; a human rights approach; an equity-based approach; national action, international cooperation and solidarity; and multisectoral action. Finally, discussions aligned with those on the broader post-2015 development agenda at the United Nations General Assembly.

Expected outcomes of the dialogue included increased awareness of the role of NCDs in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies. Another output of the dialogue was the present report reflecting its results.

The next dialogue of the WHO GCM/NCD will take place in Geneva on 30 November and 1 December 2015 and will focus on how to strengthen international cooperation on the prevention and control of NCDs within the framework of North–South, South–South and triangular cooperation.

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1 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

2 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases.


4 WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases.

prevention and control of NCDs within the framework of North–South, South–South and triangular cooperation.

2. Context and initial reflections

As the global burden of NCDs grows, their impact on development becomes increasingly severe. The total number of premature deaths from NCDs before the age of 70 in the world in 2012 was 16 million, including 13 million (82%) in developing countries. The percentage of people who die from NCDs before the age of 70 is 47% in developing countries versus 28% in developed countries. NCDs are responsible for premature deaths and disability, which in turn lower economic productivity and growth and increase the health and poverty risks of populations. Lack of access to affordable medicines and health care services often compound these mortality rates.

Participants at the dialogue observed that NCDs acted as barriers to poverty alleviation and to sustainable development, which underlined the need to move swiftly from political commitment to action. Government commitments around this topic are already substantial. They include the four national time-bound commitments for all countries included in the 2014 United Nations Outcome Document on NCDs, i.e. by 2015, consider setting national targets, taking into account the nine global targets for NCDs to be attained by 2025; by 2015, consider developing national multisectoral policies and plans, taking into account the WHO Global NCD Action Plan 2013–2020; by 2016, reduce risk factors for NCDs through the implementation of interventions building on the guidance set out in Appendix 3 of the WHO Global NCD Action Plan 2013–2020; and by 2016, strengthen health systems through people-centred primary health care and universal health coverage, building on the guidance set out in Appendix 3 of the WHO Global NCD Action Plan 2013–2020.

There is also considerable stakeholder commitment to accelerate progress during the next three years in preparation for the third High-level Meeting on NCDs in 2018. However, as noted by the United Nations Secretary-General as he transmitted the report of the Director-General of the World Health Organization on the prevention and control of noncommunicable diseases to the General Assembly in 2014, progress has been insufficient and highly uneven, and continued efforts are essential for achieving a world free of the avoidable burden of noncommunicable diseases.

3. Scope of discussions

3.1 Encouraging the continued inclusion of NCDs in internationally agreed development goals

The first session of the dialogue focused on the continued inclusion of NCDs in internationally agreed development goals, and how that could be encouraged.

Participants agreed that although NCDs were currently well positioned in the draft sustainable development goals (SDGs), advocacy efforts were still needed to ensure their inclusion in the final post-2015 development agenda. The third International Conference on Financing for Development would be held in Addis Ababa, Ethiopia, from 13 to 16 July 2015, and was
expected to result in an intergovernmentally negotiated and agreed outcome. It was widely acknowledged that that constituted a key contribution to support the implementation of the post-2015 development agenda.

It is widely agreed that NCDs constitute one of the major challenges for development in the 21st century, and that there are significant synergies between universal health coverage and achieving the SDG agenda. NCDs particularly have links with the majority of the SDGs through NCD risk factors and their demonstrable impacts on development. In all countries, and by any metric, NCDs now require a national response. However, only 50% of countries currently have an operational national multisectoral NCD action plan. The barriers that prevent the development of national responses seem mainly related to limited national capacities, lack of expertise and lack of financing for NCDs.

The dialogue’s first session made a number of observations in that regard. Those noted that some developing countries had limited technical capacity to address NCDs alone, and required catalytic support from the international community to support their national efforts. That catalytic support needed to be provided by WHO, United Nations agencies, the World Bank, NGOs and international development agencies, as well as relevant private sector entities, as appropriate. Some support existed through WHO technical assistance, the establishment of the United Nations Interagency Task Force on NCDs, as well as NGOs, which provided advocacy, supported implementation, promoted accountability and might play a “watchdog” role in the post-2015 era with regard to the fulfilment of commitments. However, the vast majority of international development agencies had not yet included NCDs in their portfolio of programmes. Also, it was noted that the Organisation for Economic Co-operation and Development (OECD), which was instrumental in both setting development policy and tracking resources for development and aid, was yet to embrace NCDs in OECD development policy and adequately reflect NCDs in the monitoring of aid flows. The focus of the catalytic support to be provided by the international community was not to finance national action. Instead, it was to use international cooperation to share available expertise to strengthen national capacities where needed on how to develop legislation to reduce risk factors, address unfair trade to reduce risk factors, raise the priority given to gender, implement pro-poor interventions for NCDs, promote health-in-all-policies, and develop cross-sectoral policies that engaged sectors beyond health and integrates their combined efforts.

There are ways to effect transformational change in moving forward, and participants highlighted a number of areas of opportunity. One method would be to ensure that domestic budgetary allocations for NCDs (e.g. through additional alcohol and tobacco taxes) were the crux of implementing national NCD responses in the post-2015 era. Domestic public finance for NCDs was central to a broader global investment framework for NCDs. Many developing countries did not have sufficient domestic resources for NCDs and less than 1.23% of development assistance for health was channelled towards those conditions. In order to meet the resource needs, the NCD community and national governments needed to be able to show the returns on investment in order to promote the involvement of new investors and to encourage ministries of finance to prioritize NCDs. Another method would be to engage relevant industries
in the private sector, locally and globally, in government-led national NCD responses that took into account the SDG-related target on NCDs for 2030, the nine global NCD targets for 2025, the roadmap of national commitments included in the 2011 United Nations Political Declaration on NCDs and 2014 United Nations Outcome Document on NCDs, and the WHO Global NCD Action Plan 2013–2020. Other opportunities noted included promoting universal health coverage as a means 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; continuing to strengthen the monitoring of progress towards NCD-related targets and build linkages between the global NCD accountability framework (at the World Health Assembly, United Nations Economic and Social Council and United Nations General Assembly) and the accountability framework that would be established for the SDGs (this could be accomplished by strengthening the NCD component of national health information systems); and using available opportunities to integrate NCDs into existing programmes to leverage synergies with other global issues such as air pollution and climate change, human rights, gender, reproductive health and trade. Another approach suggested was to strengthen the capacities of domestic NGOs to support implementation of national programmes for NCDs beyond the health sector.

Operationalizing these recommendations would require a number of innovative approaches for success. Rebalancing the “outdated” donor–recipient relationship and continuing to highlight the importance of domestic action on NCDs were crucial. Furthermore, the inclusion of NCDs in donors’ bilateral and multilateral policies – which could provide catalytic assistance to support national NCD efforts – was key, as many developing countries did not have the domestic resources available to address NCDs adequately. At the same time, a new framework of governance and metrics would enable performance evaluations of all international partners – not just Member States – against a global accountability framework. Policy coherence might be promoted through published reviews on the impact of international institution and national government operations on the achievement of the nine global NCD targets, with a view to building bridges between development, finance and trade, as part of efforts to address systemic issues.

Key messages from this session included:

- Global conversations are veering from the “scale of the problem” to the “nature of needed responses”; this is an encouraging sign that it is now accepted in global circles that NCDs are a major problem to be tackled.

- Implementation of the SDGs presents overarching challenges for countries because of the complex nature of public policy responses demanded in the 17 goals.

- There are complex interdependencies between health, agriculture and environmental sustainability agendas, which call for new frameworks for intersectoral collaboration, and these are particularly relevant for prevention and control of NCDs. New metrics
for whole-of-government performance, and instruments for allocation of labour and collaborative division of work, would be needed.

- NCD prevention and control has a huge interplay with personal demand; in ways it would reflect a societal change towards healthier behaviours. The health sector reorientation is therefore only part of what is needed towards mainstreaming this new agenda.

- New constituencies, including the private sector, should be engaged and capacities to manage this should be built up.

- Some governments and ministries of health are constrained in their ability to drive this new agenda, which requires significant reorientation of capacity and a whole new set of different competencies.

### 3.2 How to continue the inclusion of NCDs in poverty reduction strategies?

The second session highlighted the current scientific approaches to generate evidence and international experience about the relationship between NCDs, poverty and development, and the lessons learned on incorporating the prevention and control of NCDs explicitly in poverty reduction strategies and in relevant social and economic policies.

A key question discussed in that regard was: To what extent was the set of very cost-effective and affordable NCD interventions for all Member States (“best buys”) included in the WHO Global NCD Action Plan 2013–2020 pro-poor? One presentation in that area highlighted several principles of prevention: (a) small reductions in risk factor levels, when achieved across the whole population, resulted in a large reduction in NCD events; (b) drug therapy to reduce cardiovascular disease risk was most cost-effective in persons who were at high risk of developing the disease in the next 10 years; and (c) best results were achieved through a combination of population-based prevention and inexpensive management approaches for high-risk individuals delivered at scale. Through implementation of WHO “best buys” on tobacco, alcohol and diet and physical activity, the adverse economic effects associated with NCDs could be effectively diminished. For instance, China, India and Indonesia had very high tobacco usage rates among young men – and yet innovations have demonstrated how urgent, focused action could save huge numbers of people from premature deaths.

Presentations also highlighted the importance of, and current gaps in, generating evidence about the links between NCDs, poverty and development. Population-level research projects that aimed to look at the impact of poverty reduction strategies on NCDs usually could not take a randomized controlled trial (RCT) approach. Major funding agencies tended to discourage non-RCT proposals and lack of funding was a barrier to generating evidence in that important area. The international community needed a global platform with quality control methods to share case studies with rich context-specific information and facilitate dialogue between researchers and funding agencies in order to make better use of the evidence available.
In that regard, a possible role was suggested for international funders to look at the metrics used to identify links between NCDs and poverty and to fund research that looked at those risk factors. Encouraging submissions to such a platform required recognition by funding agencies, universities and other institutions. One lesson learned from the World Bank South Asia Food and Nutrition Security Initiative was that community-driven development organizations could serve as a mechanism to include NCD prevention in poverty reduction strategies. It also showed that non-health stakeholders thought that “nutrition/NCDs” were not their expertise or responsibility and sometimes they were reluctant to initiate programmes, with the result that opportunities were missed. In moving forward, it would be important to reorient the scientific approach and the “nature of evidence” required to link poverty reduction and NCD prevention; to create more opportunities to promote action-oriented research; and to provide training for village-level stakeholders to identify opportunities to include NCD prevention in development programmes and to recognize and support non-health-sector individuals and organizations who took the initiative to link poverty and NCD prevention.

Another presentation explored ways to address the social determinants of NCDs through multisectoral action. Because social determinants were so pivotal in causing NCDs, action on social determinants was both possible and necessary, and that had implications for development cooperation and the SDGs. One solution presented was cross-sectoral co-financing, or having benefitting sectors pool their resources. The logic was that if each sector contributed its willingness to pay for the benefits it received from a programme, development synergies were achieved, resources were optimized, and welfare loss was avoided. In terms of ideas for cross-sectoral policy options that went beyond the health sector, it was suggested to explore the options presented in Appendix 3 of the WHO Global NCD Action Plan.

Participants at the dialogue listened to different perspectives from NGOs, collaborating centres, United Nations agencies and the private sector. Presentations highlighted new interesting areas of research but also made clear that, while evidence was strong for tobacco, gaps persisted in understanding the links between NCDs and poverty. At present, there were not enough examples of how NCDs had been successfully integrated into poverty reduction strategies. While the prevention and control of NCDs should be seen as an investment, stakeholders should ask about the return on that investment.

However, as discussions in the session indicated, there were opportunities to improve that situation over the coming few years, and thereby respond to objective 5 of the WHO Global NCD Action Plan 2013–2020, namely “to promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases”. These opportunities included prioritizing operational and economic research that was required for NCD programme implementation and evaluation in poverty reduction contexts; defining a coordinated agenda to close the gaps in NCD research in that area, with the aim of enhancing international collaboration to promote and support the multidimensional and multisectoral research that was needed to generate the evidence base on the return on investment of including NCDs into poverty reduction strategies; encouraging academic institutions to incorporate that

Because social determinants are so pivotal in causing NCDs, action on social determinants is both possible and necessary, and this has implications for development cooperation and the SDGs.
kind of research into their plans and facilitate collaborative research through multicentre projects; and taking the social determinants of health into account, including gender and human rights perspectives, when integrating NCDs into poverty reduction strategies.

Key recommendations that emanated from the session comprised:

- Include NCDs in the poverty research agenda, and poverty in the NCD research agenda. Such an agenda could then include research on subjects such as the impact of NCDs on the poor; monitoring of the impact of poverty on the distribution of NCD risk factors; and evaluation of the impact of community-based interventions on NCD risk factor levels, and on morbidity and mortality associated with NCDs among the poor.

- Encourage the development of pilot projects that work with community-based poverty reduction strategies to complement classic regulatory measures (such as tobacco taxes).

- Reorient the research agenda.

These recommendations could be operationalized by creating a learning platform and, possibly, a research community and communities of practice for data exchange that would generate knowledge and help to translate knowledge into action.

### 3.3 Feasibility of developing sustainable development frameworks to reduce NCD risk factors and respond to the NCD health care needs of the “bottom billion”

In a third session the dialogue considered preliminary data on the disease burden and risk factors among the poorest 1 billion people, along with lessons learned in Malawi and Rwanda, as well as India, and explored ways to work with countries in building and disseminating information on the relationship between NCDs and the two lowest income quintiles.

In Malawi, where about a third of the disease burden was due to NCDs and injuries, most of the current NCD burden was unexplained by any modelled risk factor – suggesting that addressing behavioural risk factors would not significantly impact those numbers. Remaining challenges included (a) large gaps in financial resources, due to inadequate national budgets and no health development partners for nationwide NCD programme implementation; and (b) the fact that there were no routine monitoring and evaluation systems for NCDs, nor any data baseline against which to measure progress. That made it difficult to determine the effectiveness of NCD programmes due to lack of data over time, and also impeded building a case for the investment potential in the NCD area.

The presentation on Rwanda indicated that the country had made remarkable progress in public health but it was still affected by extreme poverty. According to the 2010 Demographic and Health Survey, 73% of rural Rwandans lived in multidimensional poverty. Estimates from the Global Burden of Disease Study 2013 suggested that 26% of Rwanda’s life expectancy gain between 1990 and 2013 was due to efforts to combat and injuries. Rwanda had a multisectoral
approach to prevention of risk factors and was also a leader on policies in tobacco control, reduction of road traffic accidents and promotion of physical activity.

Current strategies in Rwanda for fighting NCDs and injuries were based mainly on service delivery and addressing household air pollution. Decisions on the funding allocation had also been influenced by the 2010 Global Burden of Disease models, which indicated that in Rwanda only 23% of the total NCD burden was explained by behavioural risk factors. Specifically, a comparative risk assessment of the burden of disease and injury published in *Lancet* in 2013 showed that while the prevention of risk factors had high impact on cardiovascular disease and cirrhosis, it was more marginal for other NCDs and injuries. Cardiac registries from district hospitals in Rwanda showed that atherosclerotic heart disease accounted for very little of the heart failure burden and suggested that Global Burden of Disease models might be overestimating the impact of ischaemic cardiovascular disease. Disease-specific registries from Rwanda and review of STEPS\(^6\) data and Global Burden of Disease models suggested that the funding strategy for NCDs and injuries should place a significant emphasis on service delivery and monitoring and evaluation.

A presentation on the distribution of NCDs in India highlighted the problem that the exact burden of the illnesses and their patterns or determinants of the very poor were not known well. That information was essential for effective policies, and therefore there was a need to generate data while providing comprehensive quality care among the poor. Addressing NCDs would require looking at health inequity and targeting underlying determinants; using technology such as mobile phones in order to reach wider audiences; and looking at potential barriers around societal and governmental will.

This presentation indicated significant levels of adult undernutrition among the bottom quintile in the country, associated with the triple burden of communicable diseases, noncommunicable diseases (quantity and patterns need detailed study) and injuries, besides the high morbidity in the maternal and child groups. The presentation noted the importance of addressing the social determinants through multisectoral, pro-poor interventions, and provision of quality health care (primary and secondary) close to where people live. This would improve quality of life, unleashing economic productivity and generating data in the process. A word of caution was sounded that even within individual countries, because of widespread economic, social and lifestyle disparities, attempts to paint the canvas with the same brush would be counterproductive.

The dialogue noted that addressing NCDs was indeed relevant to addressing the needs of the “bottom billion”, the poorest 20% of people in the world. Available evidence – while limited – suggested that the social, economic and physical environments in developing countries afforded the poorest people in their countries much lower levels of protection from the risks and

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\(^6\) STEPwise approach to chronic disease risk factor surveillance (STEPS).
consequences of NCDs than did those in developed countries. Furthermore, the nature of both the NCDs and the risk factors might be different among those living in extreme poverty from those in other populations. In developed countries the poorest people often benefited from multisectoral national policies and plans to reduce the exposure to risk factors and to enable health systems to respond. In order to enhance impact, the NCD agenda thus needed to be expanded, refined and adapted to equitably address the needs of the poorest billion people.

The discussion indicated the potential immediate opportunities to address the needs of the bottom billion as an important, complementary dimension to overall NCD response. The three case studies presented – Malawi, Rwanda and Chhattisgarh state in India – illustrated the challenges and opportunities of addressing NCDs among the poorest populations. One such opportunity was the implementation of “best buys” as a pro-poor intervention to reduce the exposure to risk factors. Other opportunities included addressing a broader set of risk factors (e.g. household air pollution) and endemic NCDs such as rheumatic heart disease, enabling health systems to respond to the health care needs of the poorest with regard to NCDs through people-centred primary health care and universal health coverage.

Speakers emphasized that for the NCD community, an equity focus posed myriad new challenges. In the most vulnerable populations, action on the main risk factors would not necessarily translate into adequate help for the bottom billion. Other distinct, innovative approaches were required. The most striking example of that in the area of cardiovascular disease was found in rheumatic heart disease, an NCD that disproportionately affected the bottom billion in developing countries. A noncommunicable disease with a communicable aetiology, it had different risk factors from other cardiovascular health issues. For that reason, it was argued that rheumatic heart disease did not sit comfortably within established disease control frameworks. Furthermore, it was suggested that for the SDG framework to effectively address poverty in all its forms, it must make sustained commitments to the NCDs of the bottom billion, such as rheumatic heart disease. While current global efforts to link NCDs to poverty and development cooperation were gaining momentum, and increasingly engaged actors from outside the health sector, in order to be sustainable and effective those efforts would need to consider the bottom billion.

The main recommendations that emanated from this session were to:

- Track the NCD epidemic among the poorest 20% of the population (or build national capacities to do so).
- Work with countries in building and disseminating information about the necessary evidence base to inform policy-makers about the relationship between NCDs and the bottom billion, and provide donors with evidence of how prevention and control of NCDs can explicitly reduce poverty and where this has successfully been integrated into poverty reduction strategies. It was noted that the NCD community needs to work on the framing of the argument and evidence in a meaningful way to development actors.
• Build this evidence base by providing comprehensive and universal health care without causing financial burden on individuals, while documenting these experiences well.

The above suggestions could be operationalized by making the “data revolution” a reality. In that regard participants emphasized the need for disaggregation of data in order to fully understand the burden of NCDs and how gender and other social determinants of health shaped the distribution of risk factors. Overall, discussions in the session resulted in a deeper understanding of the close linkages between NCDs, development and poverty, the inherent equity and human rights aspects, and emphasized the gap that persisted in the understanding of how NCDs affected the poorest 20% of people in the world, and the need to promote initiatives to address that gap and rethink how assistance was allocated, shifting focus from “poor countries” to “poor people”.

3.4 Raising the priority accorded to NCDs in development cooperation, and enhancing cooperation

A high-level segment explored how to continue to raise the priority accorded to NCDs in development cooperation at global and national levels, and how to enhance such cooperation.

Opening remarks were delivered by Dr Margaret Chan, Director-General of WHO, and by Dr Oleg Chestnov, Assistant Director-General of WHO, followed by speeches by H.E. Mr Ambassador Stephen Ndun’gu Karau, Permanent Representative of Kenya to the United Nations in Geneva, and H.E. Mr Ambassador Jan Knutsson, Permanent Representative of Sweden to the United Nations in Geneva.

The segment provided an opportunity to engage in a high-level exchange on how to raise the priority accorded to NCDs in development cooperation at global and national levels, and how to continue to strengthen international cooperation through North–South, South–South and triangular cooperation in the prevention and control of NCDs.

During this segment, the dialogue reacknowledged that NCDs constituted one of the major challenges for development in the 21st century. The discussion served as a reminder that the health of people was the primary responsibility of governments, and that, therefore, Heads of State and Government committed themselves in 2011 to integrate NCDs into national development plans. It also emphasized that health gains could be achieved much more readily by influencing public policies in sectors such as trade, taxation, education, agriculture, urban development, food and pharmaceutical production, rather than by making changes in health policy alone. Accordingly, case studies and guidance about this “how to” experience should be made available, as that would enable countries to adopt approaches to policy development that involved all government departments and relevant non-State actors.

Key recommendations discussed in this segment included:

- Health gains can be achieved much more readily by influencing public policies in sectors such as trade, taxation, education, agriculture, urban development, food and pharmaceutical production, rather than by making changes in health policy alone.
• fulfilling the commitments from world leaders in 2011 to integrate NCDs into existing HIV/AIDS, reproductive health and communicable diseases programmes; and

• strengthening policy coherence between the trade, health and development sectors, including WTO/TRIPS, to further public health, in particular to provide access to affordable essential medicines and vaccines for all, while strengthening safeguards for investment treaties to ensure that the right to regulate is retained in areas critical for health.

3.5 The extent to which NCDs are currently included in development cooperation agendas and initiatives

The fourth session of the dialogue explored the extent to which international development agencies had incorporated NCDs into their bilateral and multilateral policies to respond to the demand from developing countries for technical assistance, and also reviewed the extent of the demand from developing countries for such assistance.

The first presentation of the session addressed the extent to which international development agencies had embraced NCDs, and to what extent developing countries were requesting technical assistance to support national NCD efforts. It was noted that while NCDs resulted in 50% of the global disease burden, they received the smallest amount of donor funding of all major global health areas, accounting for only 1.23%, or US$ 377 million, of all development assistance for health in 2011. The presentation listed several disconnects: bilateral donors were the dominant funding source in global health, providing 52% of overall development assistance for health but only 11% of the NCD assistance. The World Bank and WHO provided the majority of resources from the multilaterals, with Bloomberg Philanthropies and the Bill & Melinda Gates Foundation providing considerably more funds than direct bilateral funding. Bilateral donors, as direct contributors, have to date been largely absent in NCD policy and funding; international development NGOs largely lack explicit policy or funding on NCDs. However, NCDs were at the top of requests from developing countries for upstream policy advice, sophisticated technical assistance and capacity-building, and 136 of 144 WHO country cooperation strategies currently included requests for support in addressing NCDs.

As indicated in the presentation, that raised questions about why, with those levels of demand, such important players were missing, and how they could be better engaged. Potential questions that were raised involved whether the current understanding of the IDA agenda, enablers and barriers was sufficiently sophisticated and nuanced; whether governments of low- and middle-income countries were assertively and consistently requesting assistance and resources according to the local disease burden; whether there were currently sufficient levels of civil society activism; whether the evidence (of the scope of the emerging epidemic(s), solvability, cost-effectiveness, links to poverty and poverty reduction, pro-poor nature of interventions) was consistently vigilant; whether messages and communications were constant, clear, simple, compelling and at scale; and whether appropriate strategies and people were being used to influence key decision-makers.
A presentation from the Danish NCD Alliance considered the role of NGOs in building national capacity for addressing NCDs. Means of influencing governments included popular support; evidence and documentation; and strategic advocacy. That could include South–South and North–South collaboration through twinning engagements, in the present case between the Danish NCD Alliance and the national alliances of Burundi, Kenya, Rwanda, Uganda, United Republic of Tanzania (mainland) and Zanzibar. Notably, the financing for such initiatives was obtained from the Danish International Development Agency (DANIDA) Civil Society Fund (thus non-health related). The twinning arrangements focused on organizational capacity development, advocacy for national documentation, enhanced data surveys, engaging with members of Parliament, annual stakeholder meetings with the NCD desk of the ministry of health, and press campaigns. Inclusion of NCDs in national development plans and national health plans and strategies was deemed to have been successful but implementation had been challenging. For instance, all East Africa countries except one had included NCDs in their national development plans but only Zanzibar had included operational targets to meet its goals. All countries had included NCDs in their national health plans. NCDs were not prioritized in budgets or in staff allocation, and implementation of the plans was lacking in all countries. The presentation suggested that NGOs from both North and South must work together in convincing national governments to document their NCD challenges; to include them in national development plans; and to prioritize them in negotiations with donors.

Key recommendations from the discussion on supply and demand of technical assistance for NCD prevention and control were as follows:

- There is demand for catalytic support for technical assistance but the demand is systematically not documented – the international community needs to develop an approach to map the demand for technical assistance from developing countries in the area of NCDs. This implies developing a more compelling framing of the NCD needs, and learning from advocacy efforts in other health areas with a view to framing NCDs as a driver of poverty and major impediment to development.

- International development agencies have to “walk the talk” and start preparing themselves for the post-2015 era, now that NCDs are firmly embedded into the SDGs.

- The World Bank and regional development banks needs to step up to their commitments to respond to the requests from developing countries to support national NCD responses. Accordingly, international financial institutions need to raise the priority accorded to NCDs in their programmes.

- NGOs should enhance communication across areas of expertise, and in particular between health and development specialists, to ensure that NCD prevention is incorporated into policies and plans.
• Since bilateral development agencies have committed to align their agendas and aid around the priorities of developing countries (in the Paris Declaration on Aid Effectiveness and the Busan Declaration of the Busan Partnership for Effective Development Co-operation), it is essential that governments in developing countries include NCDs in their own national development plans, and call for technical cooperation on NCDs. As a way to promote this it was suggested to involve NCD NGOs in developing countries in the development planning cycle.

• There is an opportunity to “build NCDs into the DNA” of the major governmental and nongovernmental international development organizations through explicitly including NCDs in bilateral and multilateral development cooperation policies.

• Finally, it was suggested to enhance investments in building the capacity of civil society to support the implementation of national efforts on NCDs.

### 3.6 Adequate, predictable and sustainable resources for NCD prevention and control

A final session focused on the continued exploration of the provision of adequate, predictable and sustainable resources for NCD prevention and control through bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms. That provided an opportunity to discuss bottlenecks and constraints facing donors in allocating resources for NCDs and ways to overcome them.

During the session the dialogue participants learned about the business case for incorporation of NCDs into development cooperation agendas based on the recently published report of the United Nations Interagency Task Force on NCDs – *The emerging global health crisis: noncommunicable diseases in low- and middle-income countries*, by the United States-based think tank the Council on Foreign Relations. The presentation highlighted that the burden of NCDs in developing countries was increasing faster, in younger populations, and with worse outcomes than in wealthier settings. That trend was not merely a by-product of economic success and unhealthy lifestyles and was expected to accelerate in coming years. The presentation made the case for greater donor engagement on NCDs. In the United States of America, for instance, there were no dedicated programmes or budget for NCDs in global health programmes, with only small scale and ad hoc efforts to integrate objectives into existing United States global health programmes. International aid for NCDs was similarly low. More investments were needed to address NCDs to ensure the continued effectiveness of global health investments and to support economic development and trade. In low- and middle-income countries, NCDs caused more premature (under age 60) death and disability than HIV, tuberculosis and malaria combined. Those results spurred greater health and welfare expenditures and lowered the productivity of the labour force. Given the scale of those trends, the effects would reverberate. Low- and middle-income countries represented roughly half of global growth since the 2008 financial crisis and demonstrated the highest rates of return on private sector investment in frontier markets.

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In low- and middle-income countries, NCDs cause more premature (under age 60) death and disability than HIV, tuberculosis and malaria combined.
This session highlighted that NCDs required a sustainable model for allocating resources, which should be multisectoral, involve innovating finance mechanisms, and have more active involvement of the private sector. NCDs prematurely took 16 million lives annually; however, they were only covered by a small fraction of donor funding. Many countries (both donor and recipient) were guided by the Millennium Development Goals, but with the start of the post-2015 development agenda, NCD prevention and control needed to be greatly enhanced.

However, in terms of improving the state of affairs, the presentation noted that because a vast majority of NCD funding would need to come from domestic government budgets, a way forward would be to demonstrate, at country level, the link between NCDs, economic growth and poverty alleviation, and also to align calls for governments to meet their United Nations General Assembly commitments with advocacy for increased government revenue for NCDs and other health interventions. Increases in resources for NCDs required formulating a compelling case to the ministries of finance, developmental agencies and donors that clearly defined how chronic diseases negatively affected the socioeconomic environment and increased levels of poverty. This would allow more effective mobilization of resources for the prevention and control of NCDs domestically, bilaterally, multilaterally and through innovative financing mechanisms. It was noted that enhanced leadership on the part of ministries of health, possibly in a twinning arrangement with ministries of finance and trade, would be important in order to ensure coordinated policy action. Speakers also emphasized the importance of a multisectoral response to NCDs, and the need for public and private contributions (in kind or financial) to the prevention and control of NCDs. With regard to engaging with the private sector, the need to develop a new typology reflecting a diverse body of organizations was emphasized, e.g. to differentiate between pro-health organizations and those that ministries should not engage with.

Speakers emphasized that the health of people was the primary responsibility of governments, and that domestic financing was absolutely critical to action against NCDs. While the solutions and responses to NCDs should be national and community based, some governments might need assistance to develop evidence and formulate the arguments to prioritize NCD prevention and control. With regard to engaging communities, the lessons to learn from the HIV movement were highlighted, as was the importance of facilitating a strong “patient voice” at the national and international level. Furthermore, it was noted that though the global price tag of inaction was well known, information about national costs and the size of the official development assistance funding gap was still missing. Some developing countries had limited technical capacity to address NCDs. Accordingly, it was argued, access to catalytic support and expertise was required, and that was where the international community, including WHO, the World Bank, United Nations agencies and NGOs, had a significant role to play. However, to date, many bilateral donors had failed to engage as direct contributors to NCDs. In that regard, it was suggested not to wait for NCD-specific funding opportunities to come through but to build on health synergies through existing platforms, e.g. campaigns to broaden human papillomavirus (HPV) vaccination. The discussions noted that only anecdotal evidence on such support was available and that there was a need to scale up efforts to systematically document the evidence.
on the support provided. Finally, it was noted that action on NCDs should be considered an integral part of the general strengthening of national health systems.

Participants also called on governments to accelerate their commitment to integrate the set of very cost-effective and affordable NCD interventions within existing national communicable diseases, reproductive health, maternal and child health, and nutrition programmes, especially at the primary care level, and to strengthen the health systems to enable that enhanced integration.

Participants noted that the third International Conference on Financing for Development to be held in Addis Ababa, Ethiopia, in July 2015 would provide an unprecedented opportunity to argue for revenue from “sin taxes” on tobacco and alcohol and probably on unhealthy food products, to be reinvested for prevention and control of NCDs.Traditionally, any earmarking of tax revenue had not been taken up by ministries of finance, as it reduced their discretion in allocating government resources between the health and other sectors. However, there was a general sense that ministries of finance appeared to respond positively to the public health arguments associated with these taxes, as there was extensive evidence that tobacco tax, and hence price, increases led to a reduction in tobacco use.

Finally, in the field of innovative financing (i.e., voluntary contributions, levies or taxes, and financial mechanisms), participants suggested that new structures could be created similar to those already existing in other health sectors to channel additional public funds and increase additional private capital (philanthropic and investment) for scaling up interventions. Innovative financing mechanisms were expected to account for an increasingly large portion of financing for development activities, so there was an opportunity to tap into those mechanisms in support of NCDs. Participants conveyed that there were many models to explore in order to test what would best fit the demand from donors and investors (public, charitable and investment), the needs of the NCD sector and how Member States could be involved in that space, and called for rigorous exploration of that area.

In summary, key recommendations that were heard during the session included:

- Domestic financing is the crux of the implementation of national NCD responses.
- International investments for strengthening national NCD responses will need to primarily rely on domestic public resources, supported by international cooperation and partnerships.
- Catalytic support, through aid and expertise, to domestic action and leveraging domestic finance should be provided by the international development agencies, philanthropic foundations and NGOs where technical capacity falls short (e.g. to help developing countries improve tobacco tax legislation and administration).
- International development agencies should fully embrace NCDs in their development programmes, since little progress has been made since 2011, despite their commitments to do so in the 2011 United Nations Political Declaration on NCDs and 2014 United Nations Outcome Document on NCDs.
• Governments, international organizations, civil society and the private sector should review where links can be built and existing platforms leveraged to increase resources for NCDs in all their forms.

• In operationalizing these recommendations, a business and investment case for NCDs could be developed, with sufficient research to bridge the gap of data on current levels of domestic financing for NCDs.

4. Conclusions

World leaders agreed in 2011 that NCDs constituted one of the major challenges to development in the 21st century. The discussion at the dialogue on NCDs and development cooperation provided participants with first-hand accounts of how poverty and NCDs were intrinsically linked, why more research was needed concerning the links between NCDs and poverty, and how health gains could be achieved much more readily by including NCDs into poverty reduction strategies than by taking action in the health sector alone. The dialogue embarked from the widely recognized notion that NCDs constituted one of the major challenges to development in the 21st century. It also acknowledged that in all countries, and by any metric, NCDs now required a national response; however, only 50% of countries had currently formulated such a response. Participants noted that the barriers that prevented the other 50% of countries from developing national responses seemed mainly related to limited technical capacities and expertise, and lack of domestic financing for NCDs.

However, there were a number of opportunities for transformational change of that situation in the coming years. Those included the time-bound commitments made in the 2014 United Nations Outcome Document on NCDs to set national targets and develop national plans in 2015 and start implementing these plans in 2016; the proposed SDGs, in which NCDs were well reflected; the potential roles of Member States, United Nations agencies, the World Bank, NGOs and international development agencies, as well as relevant private sector entities; and links with broader issues, such as air pollution and climate change, trade, human rights and gender.

The discussions among participants during the two-day dialogue clearly established that, while addressing NCDs must be country driven and financed to a significant degree through domestic resources, not all developing countries were in a position to address NCDs alone, and that consequently more catalytic support was needed from elsewhere, including from international development agencies, United Nations organizations, international financial institutions and NGOs. Participants conveyed a sense of urgency in calling on governments and the international community to scale up action for the prevention and control of NCDs at local, national and global levels.
Annex 1. List of participants

Dialogue on how to encourage the continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies

20-21 April 2015, WHO headquarters, Geneva, Switzerland
Executive Board Room

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<th>Email</th>
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## Annex 2. Agenda

**Agenda**

Dialogue on how to encourage the continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies

(Geneva, 20–21 April 2015)

### DAY 1 AGENDA – 20 APRIL 2015

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
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<tbody>
<tr>
<td>Registration and coffee</td>
<td>08:00–09:30</td>
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<tr>
<td><strong>OPENING SESSION</strong></td>
<td>09:30–10:00</td>
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<tr>
<td>• Opening of the dialogue</td>
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<tr>
<td>Dr Oleg Chestnov, Assistant Director-General, WHO</td>
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<tr>
<td>• Welcome remarks by the Co-Chairs</td>
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<td>• H.E. Ambassador Mr Jean-Marc Hoscheit, Permanent Representative</td>
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<td>of Luxembourg to the United Nations in Geneva</td>
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<td>• H.E. Ambassador Mr Taonga Mushayavanhu, Permanent Representative</td>
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<td>of the Republic of Zimbabwe to the United Nations in Geneva</td>
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<tr>
<td>**SESSION ONE: How to encourage the continued inclusion of NCDs in</td>
<td>10:00–11:45</td>
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<td>internationally agreed development goals?</td>
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<tr>
<td>This session will focus on the global context, take stock on how NCDs</td>
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<td>are featured in the process to define the sustainable development</td>
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<td>goals by September 2015, and where we stand in realizing the</td>
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<td>commitments included in the 2011 United Nations Political Declaration</td>
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<td>on NCDs and 2014 United Nations Outcome Document on NCDs.</td>
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<tr>
<td>• What are the latest updates on the global burden of NCDs and where do</td>
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<td>we stand in realizing the commitments made in the 2011 United Nations</td>
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<tr>
<td>Political Declaration on NCDs and 2014 United Nations Outcome</td>
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<td>Document on NCDs to include NCDs in development cooperation agendas and</td>
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<td>initiatives?</td>
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<td>Keynote speaker: Dr Sania Nishtar, President, Heartfile</td>
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<td>• How are NCDs featured in ongoing discussions on the post-2015</td>
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<td>development agenda?</td>
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<td>Keynote speaker: Christian Friis Bach, Executive Secretary, Under</td>
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<td>Secretary-</td>
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</table>
General, United Nations Economic Commission for Europe (UNECE)
- NCDs, universal health coverage and the post-2015 SDGs
Keynote speaker: Dr Ties Jan Boerma, Director, Health Statistics and Information Systems, World Health Organization
- Panel:
  - Katie Dain, Executive Director, NCD Alliance
  - James Hospedales, Executive Director, Caribbean Public Health Agency
  - Arnaud Bernaert, Senior Director, Head of Global Health and Healthcare Industries, World Economic Forum (by WebEx)
  - Dr Kibachio Joseph Mwangi, Head of NCD Control Unit, Ministry of Health, Kenya
- Plenary debate

Coffee 11:45–12:00

**SESSION TWO: How to continue the inclusion of NCDs in poverty reduction strategies?**  12:00–13:30

This session will highlight the current scientific approaches to generate evidence and international experience about the relationship between NCDs, poverty and development, and the lessons learned of incorporating the prevention and control of NCDs explicitly in poverty reduction strategies and in relevant social and economic policies.

- To what extent is the set of very cost-effective and affordable NCD interventions for all Member States (“best buys”) included in the WHO Global NCD Action Plan 2013–2020 pro-poor?
Keynote speaker: Professor K. Srinath Reddy, President, Public Health Foundation of India (PHFI)
- Generating evidence about the links between NCDs, poverty and development
Keynote speaker: Kremlin Wickramasinghe, Researcher, British Heart Foundation Centre on Population Approaches for NCD Prevention, Nuffield Department of Population Health, University of Oxford
- Addressing the social determinants of noncommunicable diseases through multisectoral action
Keynote speaker: Mandeep Dhaliwal, Director, HIV, Health and Development, United Nations Development Programme
- Panel:
  - Celina Gorre, Executive Director of the Global Alliance for Chronic Diseases
  - Gerald Yonga, Director of the NCD Research Policy Unit at Aga
<table>
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<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>13:30–14:45</td>
<td>Lunch break</td>
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<tr>
<td>14:45–16:45</td>
<td>SESSION THREE: Is it feasible to develop sustainable development frameworks to reduce NCD risk factors and respond to the NCD health care needs of the “bottom billion”?</td>
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<td>This session will present preliminary data on the disease burden and risk factors amongst the poorest 1 billion people, along with lessons learned in two countries, and explore ways to work with countries in building and disseminating information on the relationship between NCDs and the two lowest income quintiles.</td>
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<td>• How much do we know about NCDs and the “bottom billion”?</td>
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<td>Keynote speaker: Gene Bukhman, Director, Program in Global NCDs and Social Change, Harvard Medical School</td>
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<td>• Hidden, misunderstood and underreported: what do we know about NCDs among the poorest in Malawi?</td>
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<td>Keynote speaker: Beatrice Mwagomba, NCD and Mental Health Program Manager, Ministry of Health, Malawi</td>
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<td></td>
<td>• Hidden, misunderstood and underreported: what do we know about NCDs among the poorest in Rwanda?</td>
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<td>Keynote speaker: Marie Aimee Muhimpundu, NCD Program Coordinator, Rwanda Biomedical Center, Ministry of Health, Rwanda</td>
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<td>• Panel:</td>
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<td>• Johanna Ralston, Chief Executive Officer, World Heart Federation</td>
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<td>• Raman Kataria, paediatric surgeon at Jan Swasthya Sahyog</td>
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<td>• Silvia Stringhini, PhD, expert in health inequalities, Lausanne University Centre</td>
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<td></td>
<td>• Plenary debate</td>
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<tr>
<td>16:45–17:00</td>
<td>Summary of Day One – Co-Chairs</td>
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<td>17:15</td>
<td>Reception at WHO (the main cafeteria)</td>
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## DAY 2 AGENDA – 21 APRIL 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08:00–09:30</td>
<td>Registration and coffee</td>
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<tr>
<td>09:30–10:30</td>
<td><strong>HIGH-LEVEL SEGMENT</strong>: How to continue to raise the priority accorded to NCDs in development cooperation at global and national levels, and how to enhance such cooperation?</td>
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<tr>
<td>10:30–10:45</td>
<td>Coffee</td>
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<tr>
<td>10:45–13:00</td>
<td><strong>SESSION FOUR</strong>: To which extent are NCDs included in development cooperation agendas and initiatives?</td>
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This segment provides an opportunity to engage in a high-level exchange on how to raise the priority accorded to NCDs in development cooperation at global and national levels, and how to continue to strengthen international cooperation through North–South, South–South and triangular cooperation in the prevention and control of NCDs.

- Welcoming remarks by the Co-Chairs
  - H.E. Ambassador Mr Jean-Marc Hoscheid, Permanent Representative of Luxembourg to the United Nations in Geneva
  - H.E. Ambassador Mr Taonga Mushayavanhu, Permanent Representative of the Republic of Zimbabwe to the United Nations in Geneva
- Opening remarks
  Dr Margaret Chan, Director-General, WHO
- Statements by
  H.E. Ambassador Dr Stephen Nduń’gu Karau, Permanent Representative of Kenya to the United Nations in Geneva
  H.E. Ambassador Mr Jan Knutsson, Permanent Representative of Sweden to the United Nations in Geneva
- Plenary debate

This session will explore to which extent international development agencies have incorporated NCDs into their bilateral and multilateral policies to respond to the demand from developing countries for technical assistance, and will also review the extent of the demand from developing countries for such assistance.

- To which extent have international development agencies embraced NCDs, and to which extent are developing countries requesting for technical assistance to support national NCD efforts?
- What is the role of NGOs in building national capacity for addressing

Keynote speaker: Rob Moodie, Professor of Public Health, Melbourne School of Population and Global Health, University of Melbourne
NCDs?
Keynote speaker: Susanne Volqvartz, Director of Development, Danish NCD Alliance

- Panel:
  - Simon Gillespie, Chief Executive, British Heart Foundation, and President, European Heart Network
  - William Kafura, Head of Physical NCD, Ministry of Health and Social Welfare, Tanzania
  - Matthias Reinicke, Advisor, Health Systems, European Commission
  - Jean Pierre Cayol, Programme Coordinator, International Atomic Energy Agency (IAEA)
  - Hani Eskandar, ICT Applications Coordinator, International Telecommunication Union (ITU)
  - Dr Xenia Scheil-Adlung, Health Policy Coordinator at the International Labour Organization (ILO)

- Plenary debate

<table>
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<tr>
<th>Lunch break</th>
<th>13:00–14:30</th>
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**SESSION FIVE: How to continue to explore the provision of adequate, predictable and sustainable resources for NCD prevention and control through bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms?**

This session provides an opportunity to discuss bottlenecks and constraints facing donors in allocating resources for NCDs and ways to overcome them.

- The business case for incorporating NCDs in development cooperation agendas

Keynote speaker: Thomas J. Bollyky, Senior Fellow for Global Health, Economics, and Development, Council on Foreign Relations

- Panel:
  - Christoph Benn, Director of External Relations, the Global Fund to Fight AIDS, Tuberculosis and Malaria
  - Mario Ottiglio, Director, Public Affairs, Communications & Global Health Policy, International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)
  - Stephen Jan, Senior Health Economist, Professor in the Sydney Medical School and Associate at the Menzies Centre for Health Policy
  - Karen Sealey, International Health Consultant, Ministry of Health, Trinidad & Tobago
- Dudley Tarlton, Programme Specialist, Health and Development, United Nations Development Programme

- Plenary debate

**CLOSING SESSION: Conclusions and the way forward**

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<th>16:15–16:30</th>
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<tr>
<td>Concluding remarks by the Co-Chairs</td>
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<tr>
<td>H.E. Ambassador Mr Jean-Marc Hoscheit, Permanent Representative of Luxembourg to the United Nations in Geneva</td>
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<td>H.E. Ambassador Mr Taonga Mushayavanhu, Permanent Representative of the Republic of Zimbabwe to the United Nations in Geneva</td>
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