WHO Global Coordination Mechanism on the Prevention and Control of NCDs

(WHO GCM/NCD)

Side Event: NCDs and Sustainable Development – The Way Forward

30 January 2017

Prince Mahidol Award Conference (PMAC)

Bangkok, Thailand

KEY MESSAGES:

- Tracking development assistance resource flows into NCDs is imprecise due to the lack of common agreement on the definition of NCDs and their risk factors.
- NCDs still are not perceived as a development issue in the classic sense of the development agenda.
- There is not sufficient understanding of the interconnected nature of the SDGs, where action on NCDs and their risk factors can benefit other areas of sustainable development.
- UHC is a good mobilizing framework, but it is not broad enough to incorporate action on NCD risk factors, which involve sectors beyond health.
- Domestic resource mobilization is key. However, external support will be necessary for the most impoverished countries with high NCD burden.
- National strategies and plans with clear priorities and budgets are critical to mobilize resources for NCDs.
- Involvement of civil society, populations and the private sector to help governments fulfill their commitments is essential.
Background

Noncommunicable diseases (NCDs), which are mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and their shared risk factors – tobacco, harmful use of alcohol, unhealthy diets and physical inactivity – remain the leading causes of death globally, taking more than 38 million lives every year. Nearly three-quarters of these NCD deaths (28 million) occur in low- and middle-income countries (LMIC). About 42% of the NCD mortality is premature, taking lives of people between the ages of 30 and 70, and the burden is higher in low-income countries, where nearly 48% of NCD deaths are premature as opposed to 28% premature NCD deaths in high-income countries.1

At the UN Summit in 25-27 September 2015, Member States gathered at the United Nations in New York, USA to adopt a new agenda for Sustainable Development, with a set of Sustainable Development Goals (SDGs) and associated targets. Transforming Our World: The 2030 Agenda for Sustainable Development (the 2030 Agenda) recognized NCDs as an important part of sustainable development, causing premature mortality and unnecessary human suffering with associated social and economic costs. The 2030 Agenda included SDG target 3.4 on the reduction of premature mortality from noncommunicable diseases by one-third by 2030.2

The NCD (3.4) and the NCD-related targets (3.5, 3.8, 3a, 3b and Goal 17) included in the 2030 Agenda for Sustainable Development derive from commitments made by governments at the UN High-level Meetings on NCDs, first in September 2011 and then during the second meeting in July 2014. The second meeting reviewed the progress in overcoming the burden of NCDs in countries and concluded that it was “insufficient and highly uneven”.3

Globally, premature deaths from the four main NCDs fell by 15% from 2000 to 2012.1 This decline in mortality is insufficient to meet various NCD targets, including SDG 3.4. However, it demonstrates that change is possible, and it is feasible to curb the global NCD epidemic and meet the SDG targets, as well as the nine NCD targets of the WHO Global Action Plan on the Prevention and Control of NCDs (2013 – 2020).

The slow progress in addressing NCDs at the national level, particularly in low-income countries, can be explained by:

(i) the lack of national capacities (technical, financial, human) as well as of policy expertise to integrate measures to address NCDs in national responses to the Sustainable Development Goals and implement the four national commitments made at the second High-level meeting in 2014

(ii) the unmet need for technical assistance through bilateral and multilateral channels to strengthen national capacities, including the legal and regulatory frameworks and national multisectoral and multistakeholder responses for the prevention and control of NCDs

(iii) interference by powerful economic operators in an effort to hamper the implementation of the new targets for alcohol, tobacco and diet-related NCDs. This is especially problematic in countries that are heavily dependent on Development Assistance for Health (DAH).

In the MDG era, the DAH for health was poorly aligned with the global disease burden, particularly for NCDs. Despite the high burden of disease, international assistance to address NCDs was extremely low. For example, in 2015, US$10.8 billion (9.7% of DAH) was spent on HIV/AIDS, US$6.5 billion (17.9%) was spent on child and newborn health, and US$3.6 billion (9.8%) was devoted to maternal health. By contrast, health system support in the same year represented US$2.7 billion (7.3%), and only US$475 million (1.3%) was estimated to have been spent on NCDs.4

Despite the evidence that NCDs impede social and economic development, increase inequalities and perpetuate poverty, they remain largely absent from the agendas of major development assistance initiatives. As country economies grow, the proportion of development support diminishes as part of the overall health funding. To tackle NCDs, countries are expected to raise revenues by making their tax systems more efficient and introducing measures to combat tax evasion and illicit tax flows. This marks a fundamental change in patterns of DAH, where more of the burden is placed on domestic budgets. However, to implement these changes, initial catalytic support from development agencies will be required to assist low-income countries build national capacities and generate enough resources to respond to NCDs.5

Measures to tackle NCDs and their shared risk factors (tobacco use, harmful use of alcohol, lack of exercise and unhealthy diets) need to extend beyond health systems and require multi-sectoral and multi-stakeholder partnerships for “the whole-of-government and whole-of-society approach” at both global and national levels, involving relevant NGOs, selected private sector entities, academic institutions and community groups.

The 2030 Agenda presents an opportunity to adopt a more coherent and comprehensive approach to health as countries move towards Universal Health Coverage (UHC), focusing their efforts on integrated, people-centered health services and financial risk protection.

**Purpose**

The purpose of the meeting was to gather global and national health leaders to discuss a paradigm shift in DAH and the importance of catalytic development funding to help countries build national capacities in order to achieve the SDG target 3.4 on NCDs. The outcomes of the meeting were intended to support the recommendations of the WHO GCM/NCD Working Group on the alignment of international cooperation with national NCD plans in order “to strengthen aid effectiveness and the development impact of external resources in support of noncommunicable diseases.”6

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5 WHO GCM/NCD Working Group Report on Financing NCDs, 2016. Available at http://www.who.int/global-coordination-mechanism/working-groups/final_5_1with_annexes6may16.pdf?ua=1

6 World Health Organization, Prevention and Control of Noncommunicable Diseases. A67/14 Add1: Terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases, 8 May 2014.
Objectives:

1. Discuss the complex global health landscape and the place of NCDs within the UHC and SDG frameworks

2. Articulate the impact of NCDs on the most vulnerable populations and sustainable development

3. Highlight the challenges to ensuring “whole-of-government” and “whole-of-society” response to meet the NCD targets of the 2030 Agenda and the WHO Global Action Plan on NCDs (2013-2020)

4. Highlight the importance of tracking resources and aligning international development assistance to national health strategies and plans

5. Propose solutions for increased international cooperation and policy coherence at global, regional and national levels

Participants

Participants at the WHO GCM/NCD side event included policy makers, academicians, NGOs and civil society representatives and other stakeholders who were attending the Prince Mahidol Award Conference.

The Panel included:

Dr Téa Collins (Moderator), Advisor, WHO Global Coordination Mechanism on NCDs

SPEAKERS:

Dr Bente Mikkelsen, Head of the Secretariat, WHO Global Coordination Mechanism on NCDs

Dr Tim Evans, Senior Director, Health, Nutrition and Population, The World Bank Group

Dr Ariel Pablos-Mendez, Immediate Past Assistant Administrator, Bureau of Global Health, USAID

Dr Rachel Nugent, Vice President, Chronic Noncommunicable Diseases Global Initiative, RTI International

Dr Supattra Srivanichakorn, Medical Expert, Department of Disease Control, Ministry of Public Health, Thailand

Dr Jennifer Adams – Acting Assistant Administrator, Bureau of Global Health, USAID

Dr Douglas Webb, Team Leader, Health and Innovative Financing, HIV, Health and Development Group, UNDP

Meeting notes and photos: Evie Robertson
Presentations

The meeting was opened by Dr Téa Collins, who welcomed the participants, explained the session objectives and expected outcomes (e.g. to inform the work of the WHO GCM/NCD Working Group), and introduced the speakers (speaker bios and the event program were provided to all participants and are included in Annexes I and II). She stressed that the focus of the session would be on development assistance/cooperation on NCDs, since the domestic and innovative financing mechanisms were covered by the WHO GCM/NCD’s Working Group on NCD financing. Dr Collins alerted the participants that the outcomes of the side event would be used to inform the work of the GCM/NCD’s working group on the alignment of international development cooperation with national plans on NCDs.

The floor was given to Dr Bente Mikkelsen, who also welcomed the participants to the WHO GCM/NCD side event and delivered an opening presentation. Dr Mikkelsen’s presentation explained the challenges the NCD epidemic is posing to sustainable development. She particularly stressed the devastating impact of the growing burden of NCDs and their risk factors in low- and middle-income countries and the effects of NCDs on vulnerable populations, such as women, children and displaced populations, as well as the poor and marginalized communities.

Dr Mikkelsen also talked about the interlinked nature of the SDGs, which now include NCDs as an important part of sustainable development, causing premature mortality and unnecessary human suffering with associated social and economic costs. More specifically, the NCD target (3.4) of Goal 3 on health aims at one-third reduction of premature mortality from non-communicable diseases by 2030. Dr Mikkelsen also highlighted the crucial role of Goal 17 on the Global Partnerships for Sustainable Development in effectively addressing NCDs at the global, regional and national levels.
Dr Mikkelsen referred to the major events and milestones supporting the NCD agenda and the need for technical cooperation to ensure the commitments made at the highest level are met:

**April 2011 Moscow, Russia** – WHO First Ministerial Conference on Healthy Lifestyles and NCD Control resulted in the Moscow Declaration.

**September 2011 New York, USA** – First High-level Meeting on the Prevention and Control of Non-communicable Diseases resulted in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.


**July 2015 Addis Ababa, Ethiopia** – Third International Conference on Financing for Development resulted in the Addis Ababa Action Agenda (AAAA) and noted “the enormous burden that non-communicable diseases place on developed and developing countries.” (Paragraph 32).


**2018 (Date TBC) New York, USA** – Third HLM on NCDs, where the four time-bound commitments of the 2014 Outcome Document will be reviewed


**2030 Milestone** – Review of the NCD-related targets in the SDGs.

Dr Mikkelsen went on to describe the role of the Global Coordination Mechanism (WHO GCM/NCD) in the complicated global health landscape as an “incubator” of development cooperation on NCDs.
She stressed the importance of the WHO GCM/NCD’s mandate “to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, and global levels”, since curbing the NCD epidemic will require a multistakeholder and multisectoral action, not only a health system response. However, this was the area in most need for improvement. Dr Mikkelsen said that “bolder measures were needed by governments, international partners and WHO to ensure that all commitments were fully implemented.”

Dr Mikkelsen then highlighted the work of the WHO GCM/NCD’s Working Groups, whose work was highly relevant to the side event:

1. Working Group on how to realize governments’ commitments to provide financing for NCDs (2015)

2. Working Group on how to realize governments’ commitments to engage with the private sector for the prevention and control of NCDs (2015)

3. Working Group on how to align international development cooperation on NCDs with national NCD plans to strengthen aid effectiveness and the development impact of external resources (2016-2017)

The Working Group members (two per each of the six WHO regions) are experts who are nominated by the Member States and then appointed by the WHO Director-General in consultation with them. The Members meet throughout the year and produce a report with “actionable recommendations” to accelerate the implementation of the WHO Global Action Plan on NCDs (2013-2020). Each Working Group is co-chaired by prominent government officials (from developed and developing countries), who are also appointed by the WHO Director-General in consultation with Member States.

The NCD Financing Group completed its work in 2015. However, the Working Group on international cooperation is still active, and the GCM side event provided an excellent opportunity to inform the recommendations of the Working Group. Dr Mikkelsen closed by encouraging all stakeholders to engage in the global movement to tackle NCDs and become a GCM participant, engage in GCM activities and highlight their work in the area.

Dr Mikkelsen’s presentation was followed by a presentation by Dr Rachel Nugent, who presented the findings of the WHO GCM/NCD commissioned research on development assistance resource flows into NCDs globally. Dr Nugent stressed that the research was still preliminary (work in progress) and the data presented were for discussion, not for referencing and dissemination until the findings were final. Dr Nugent also introduced her co-investigator Dr Andrea Feigl, who was in the audience to assist with handling questions from the meeting participants.

Dr Nugent set the stage for her presentation by explaining that tracking NCD expenditures “remains a relatively new interest for LMICs and donors.” The vast majority of payments are “out of pocket”, hitting the vulnerable populations hardest. Only a few services are offered by the public sector, national health sub-accounts that separate NCD expenditures are still not well developed, and there is no OECD DAC tracking code for NCDs.

The highlights of Dr Nugent’s preliminary findings included:
NCD tracking is imprecise
- 24% of NCD funding goes to low-income countries, 66% to middle-income countries
- Two-thirds of NCD funding is aimed at multiple conditions, or integrated funding
- Philanthropy is focused on prevention, public funders on PHC and integration, and the private sector (industry) is mainly concerned with treatment
- Non-health sector provides significant funding for prevention and rehabilitation.

Other highlights included the fact that only about 1% of DAH is spent on NCDs, which is a very low amount to meaningfully help countries heavily dependent on external resources to meet the NCD commitments articulated in the WHO Global NCD Action Plan (2013-2020) and the 2030 Agenda for Sustainable Development.

Apart from the fact that development assistance for NCDs is extremely low, the research showed that the funding that is available is very poorly aligned to the disease burden. In other words, countries with the highest burden of NCDs are not necessarily the top recipients of NCD DAH. This is especially true for NCDs and, to some extent, for HIV/AIDS.

Dr Nugent’s research was complemented by a qualitative part, where 15 key knowledge brokers were contacted for in-depth interviews.

The interviews covered the following three major areas of interest:

1. Financing flows and their positioning within their respective organizations
2. Information on how NCDs, and specifically NCDs affecting the poorest are prioritized within each organization’s funding portfolio
3. The future of financing of NCDs, and the relevance and potential impact of framing NCDs

The highlights of the qualitative interviews included:
- Need for more evidence on the economic burden of NCDs and the cost-effectiveness of available interventions
- Need for more evidence for NCD burden among the poorest to justify and leverage more funding
- But even additional evidence is expected to create only modest increases in NCD funding.
- The interviews provided a clear message of no new vertical programs
- Particular interest in the potential of NCD integration into broader health programming

After Dr Nugent’s presentation, Dr Collins asked the speakers to address the place of NCDs in their respective agencies’ work and then provide some personal/expert insights into the future of NCD financing frameworks as part of the sustainable development agenda.

**Dr Tim Evans** spoke about the World Bank’s work in the area of Health, Nutrition and Population. He particularly stressed the importance of paying attention to nutrition as the key area to prevent NCDs. Dr Evans said that the World Bank is focusing on adolescent health as a means to reduce incidence of NCDs along with other health problems later on in life.

Some other areas of the Bank’s work that Dr Evans highlighted included:

- **Multisectorality** – focus on other areas that influence health, not just the health sector. For example, cash transfer programs to women, education, or early childhood development.

- **Universal health coverage (UHC)** as a good mobilizing framework that can aid NCDs as well. He added that universalism meant “getting to the last mile, including all disadvantaged and displaced people, those who have no country or slip through the cracks.” By definition, UHC means ensuring effective coverage for all essential services according to the need. It is about managing health systems and progressively recognizing individuals’ right to health, and NCDs should be part of this agenda. In terms of financing, Dr Evans talked about sin taxes to finance NCDs and referred to the
Thailand success story about taxing tobacco and alcohol. Ultimately, it is the governments’ responsibility to focus on all population groups, especially the most vulnerable. However, Dr Evans stressed that it was critical to engage populations in healthcare, not just policy-makers.

**Workplace wellness** – the whole definition of occupational health has been expanded.

**Mental health** – “massive problem” that requires due attention to reduce stigma. This is especially important in crisis situations, where there are epidemic levels of pre-, current and post-traumatic stress disorders related to mass population movements.

Dr Evans referred to the joint World Bank/WHO meeting during the World Bank-International Monetary Fund Spring Meetings in April 2016, which aimed to move mental health from the margins to the mainstream of the global development agenda. The event engaged finance ministers, multilateral and bilateral organizations, the business community, technology innovators and civil society and to emphasize urgent investments needed in mental health services, and the expected returns in terms of health, social and economic benefits.

Dr Evans mentioned that if the global health community was concerned about eliminating extreme poverty, then it needed to be concerned about the financing of health systems as well. He also said that NCDs were not seen as a development issue “in the classic sense of the development agenda,” and 4X4 (four NCDs and their shared four risk factors) did not have much traction in the reality of health systems, particularly at the country level. He underscored that the answer to the challenge was not necessarily more donor resources but how to influence domestic resource mobilization and its allocation across the complex opportunities to increase health for all. Dr Evans said that UHC was the mobilizing framework that could be useful for the NCDs as well.

**Dr Ariel Pablos-Mendez** outlined some of the challenges in addressing NCDs, particularly from the standpoint of development assistance for health. He commended the Global Coordination Mechanism on NCDs for “doing everything right,” but explained that the lack of globally mobilized resources for NCDs was determined by a complex interaction of multiple factors, one of them being “bad timing” coinciding with recession when the NCD agenda was introduced as part of sustainable development. He also stressed the problem with the perception of NCDs as not posing an immediate
emergency, unlike Ebola or Zika, which forced governments to spend more on their immediate needs. Dr Pablos-Mendez said that 4X4 was an attempt to keep responses focused, but it did not embrace the whole health system fully. However, while the development assistance is winding down, most vulnerable populations are bearing the disease burden. This needs to be addressed and the funding made available.

Dr Pablos-Mendez gave some examples of successful intersectoral action from his work at USAID. He mentioned that USAID invested heavily in the social communication network, which could be used for NCDs as well. Dr Pablos-Mendez referred to some success stories that USAID had achieved in terms of addressing tobacco legislation and taxation to pay for health care. He mentioned that implementing a tax on sugar was more challenging, since the evidence on this was more complicated. At present only 33 countries are taxing sugar, but this should be the next step in the fight against NCDs.

Dr Pablos-Mendez acknowledged that sometimes vertical plans drive agendas more and the cross-cuts are difficult. The NCD agenda is large, and it is important to focus on a few specific things while trying to find win-win solutions and positive dividends on what countries have done successfully to address NCDs. He advocated using these “star” countries to learn from and adopt and adapt the strategies that work. At the global level, development assistance may be diluted by competing priorities, but this means that its significance becomes even greater. When there is a clear value proposition, then it becomes easier to raise funds.

**Dr Jennifer Adams** emphasized that effective assistance to countries has to be linked to broader development trends and agendas. She said that health is an integral part of the sustainable development agenda and should be addressed as a cross section of the 2030 Agenda.

She mentioned that USAID did not have an office devoted to NCDs, but the agency is addressing NCDs from a broader health system and multisectoral perspective. USAID is definitely concerned by
the growing burden of NCDs in low-income countries, but considers infectious diseases a pressing need.

The goal of the agency’s work in global health is to close gaps in addressing the high burden of diseases is low-income countries.

Some of the highlights of Dr Adams’s presentation included:

- USAID’s strategic priorities are centered around ending preventable maternal and child deaths, creating an AIDS-free generation and protecting communities from infectious diseases, while strengthening health systems.
- USAID recognizes the unfinished agenda of maternal and child health and infectious diseases and stresses the importance of leadership and governance as one of the main aspects of health system strengthening.
- There are some areas where USAID has raised and advanced the NCD cause, such as supply chain and access to medicines.
- Working with the global partners, particularly with the private sector, is important to address NCDs.
- USAID works with GAVI in order to address one of the NCDs (cervical cancer) by providing the HPV vaccine.
- UHC and the SDG frameworks are helpful to leverage the existing platforms and advance the NCD agenda.
- USAID is well poised to take advantage of advances and investments in social and behavioral change. USAID can integrate NCD prevention messages as well.
- Tobacco - USAID is partnering in Indonesia regarding child / maternal health and smoke free homes.
- Nutritional interventions to prevent NCDs – adolescents are a critical group.
- USAID has programs for vulnerable populations, such as disability and mental health (some work with Ebola survivors), and women and disabilities.
Dr Suppatra Srivanichakorn presented a country perspective by highlighting the achievements of Thailand in addressing NCDs.

Dr Srivanichakorn spoke about the disease burden caused by NCDs and their shared risk factors in Thailand. She stressed that 2/3 of deaths in the country were attributable to NCDs. Dr Srivanichakorn then provided the context in which the Thai Strategic Plan (2017-2036) for Health was developed. The contextual factors included: urbanization, ageing society, increasingly interconnected world, advancements in technology and climate change.

Dr Srivanichakorn introduced the four pillars of “excellence” of the Thai Health Strategy: (i) P&P excellence; (ii) Service excellence; (iii) People excellence and (iv) Governance excellence. To specifically address NCDs and their risk factors, Dr Srivanichakorn referred to the “triangle that moves the mountain”:

**Linkages between policy and politics** – Legalized national multisectoral mechanisms, chaired by the Prime Minister to tackle the NCD risk factors – Tobacco and Alcohol Control Acts, National Food Committee Act, Sin Tax Health Promotion Foundation, and National Health Commission

**Social mobilization** – Strong civil society and community networks to address NCD risk factors with committed champions with high social and intellectual capital

**Evidence Generation and Management** – Tobacco Research Center, Alcohol Research Center, HP/HS research networks, Food and Nutrition Policy Research Program

Dr Srivanichakorn also spoke about the successful domestic resource mobilization through so-called “sin” taxes on tobacco and alcohol. She also referred to the UHC scheme, which Thailand established
in 2002. Dr Srivanichakorn said that 20% of the UHC budget in Thailand is devoted to health promotion and disease prevention. In addition, there are special funds for the secondary prevention of metabolic diseases.

Dr Srivanichakorn concluded that despite the significant successes in tackling NCDs, some challenges still remain, particularly with respect to the primary prevention and quality of care.

**Dr Douglas Webb** spoke about his involvement (through UNDP) with the UN Interagency Task Force on the Prevention and Control of NCDs (UNIATF), which coordinates the activities of relevant UN agencies and other inter-governmental organizations to support governments to meet high-level commitments and respond to NCD epidemics worldwide. The UNIATF derives its mandate from ECOSOC and allows the UN agencies to bring their relevant competencies to the table.

Dr Webb described the UNDP’s work in NCDs as well. He specifically referred to the work done on the social determinants for health, since “health is both a prerequisite and an outcome of sustainable development.” He also spoke about the importance of action across the sectors and the need to develop investment cases for NCDs to attract funding. Dr Webb mentioned that in six countries – Barbados, Belarus, Vietnam, Kyrgyzstan, Mongolia, and Fiji – UNIATF has conducted a rapid assessment of the costs of inaction on NCDs. There are attempts to work with the countries to develop recommendations that will be most relevant to their planning and fiscal situation.

Dr Webb also highlighted some of the challenges of work at both country and global levels:
Layers of conflicts of incentives – Ministries of Health vs Ministries of Finance. Even within the same ministries there are myriads of challenges.

Return on investment analysis is generally a long-term process that may overrun the period of incumbency of the health ministry. It’s important to understand political vs economic capital.

The UN has its own internal conflicts of interest. Different agencies have different codes of engagement with the private sector.

The UN is also reliant on and guided by the Member States, so it cannot act independently.

The 2030 Agenda provides an excellent opportunity to domesticate SDGs at the country level.

The MDGs were in force for 15 years. It will take time before the thinking is restructured towards SDGs.

The Global Fund to Fight AIDS, TB and Malaria provides a major opportunity to look at co-morbidities and integrated services – for example, alcohol and diabetes, TB and diabetes, TB and tobacco control, HIV and NCDs treated in an integrated manner.

The UN does not have all the answers. Answers will have to come from the countries themselves.

There is a need to broaden South-South and triangular cooperation. Much of the future development support will be in the facilitation and learning of these exchange processes.

Overview of the Emerging Themes

Challenges:

Definition of NCDs and their place on the sustainable development agenda

4x4 does not have much traction in the reality of health systems, and its utility at the country level is often questioned.

It is difficult to track resources due to the lack of common agreement as to what should be included in NCDs and their risk factors.

This is not a development issue in “the classic sense of the development agenda”.

Myths about NCDs as a developmental challenge (e.g. that they only affect the rich countries, are caused by poor life-styles/behaviors or are the diseases of the ageing populations) still remain.

There is not sufficient understanding of the interconnected nature of the SDGs, where action on NCDs and their risk factors (multisectoral approach) for effective prevention and control of NCDs can benefit other areas of sustainable development.

There is need for more evidence on the burden (economic and health) on the poorest populations.

There is only limited published research on the impact of NCDs on economies, labor supply, and GDP growth.
Health Systems’ Response

- UHC is a good mobilizing framework, but it is not broad enough to incorporate action on NCD risk factors, which involve sectors beyond health.
- There is a need to prioritize health promotion, risk protection and disease prevention.
- Ministries of Health are often ill prepared to take the lead on action on NCDs across the sectors.
- Health systems need to engage with the populations they serve. People need to be the co-creators of their health systems.
- The eradication of poverty is linked to the NCD expenditure. Sustainable health system financing is important.
- Individuals’ right to health should be recognized.
- National strategies and plans with clear priorities and budgets are critical. Thailand is a success story.
- The balance should be shifted away from overemphasis on treatment at hospitals toward health promotion, strengthening prevention and primary care.
- Innovation and legal reform are needed to address NCDs and their risk factors.

Development funding for NCDs

- NCD expenditure is still a new agenda for development agencies.
- NCD tracking is imprecise.
- The recent trend in NCD financing as part of the development assistance for health is downward.
- Around 24% of NCD funding goes to low-income countries, and 66% to middle-income countries.
- Philanthropy is focused mainly on prevention, public funders support PHC and integration, and the private sector (industry) invests in treatment.
- Non-health sector provides significant funding for NCD prevention and rehabilitation.
- Development assistance for NCDs is poorly aligned with the disease burden.
- There is a certain ambiguity on how NCDs can attract bilateral donor funding.
- Infectious diseases and maternal and child health agendas remain a priority for donors.
- Domestic resource mobilization is key. However, there are countries dependent on external resources, and catalytic donor funding will be crucial to assist these countries.
- Countries also need technical assistance to put the legal mechanisms in place to address the risk factors (e.g. to administer “sin” taxes).
- The clear value proposition/investment cases are important to receive funds. Countries need to drive the agenda.
Preliminary findings indicate that only 20% or less of development assistance for NCDs reaches countries with the poorest billion, where the need for external assistance is higher.

Effective assistance to countries needs to be linked to broader development trends and agendas.

SDGs need to be “domesticated” at the country level, and the prioritization should be based on evidence.

Challenges of multisectoral action and engaging the private sector

Development agencies have multisectoral projects with NCD components, but it is hard to estimate how much is spent on NCDs specifically.

The health sector (Ministries of Health) is ill prepared to take the lead on intersectoral action for NCDs.

There are layers of conflicts among different ministries (e.g. MoH and Ministries of Finance).

UN agencies pose their own challenges, with different rules of working with the private sector.

Potential Solutions:

Traditional donors should be challenged to explicitly include NCDs in their funding portfolios.

An OECD tracking code would help to understand the resource flows into NCDs.

It is important to consider non-health sector funding for NCDs.

Development assistance should be better aligned with the disease burden.

Evidence should be provided about the NCD burden on the poorest and most vulnerable populations.

Improving the efficiency and effectiveness of available health budgets by making a better use of financial, human and other resources should be a strategic priority.

Strengthening the evidence base is key for improved investments to ensure value for money spent.

Country investment cases and sharing of best practices are important.

Strengthening the capacity of Ministries of Health, particularly the governance function, to facilitate action across the sectors is paramount. Initial catalytic funding will be required to achieve this.

National planning and integration of NCDs is paramount.

Action on NCDs goes beyond the health sector, including the social determinants of health that will benefit the whole 2030 Agenda for Sustainable Development.

Involvement of civil society, populations and private sector to help governments fulfill their commitments is essential.
Conclusions

At the end of the meeting, Dr Collins asked all panellists to make concluding remarks and provide one take-away message they considered the most important.

Dr Webb – Investment cases are a useful starting point to work on NCD financing. Do not expect major bilateral investments. There is a need to work with multilateral development banks.

Dr Pablos-Mendez – Local resources will be crucial, but we need to look at the bigger picture, identify who the major players are, those who care about the issue, and make the case why investing in NCDs is important.

Dr Evans – Using existing platforms, “piggybacks” will be important. For example, USAID has added NCDs to Demographic and Health Surveys (DHS). The private sector is very active in this area, and looking at their business will be a value-added that reaches all customers.

Dr Nugent – Collective action is needed where global public goods are concerned. Surveillance, research and development, fiscal policy design, global regulation are the areas where collective action is required.

Dr Mikkelsen – Domestic financing is important, but the big donors also have to take into account the global burden of disease and development impact that investing in NCDs can make. Some of the most impoverished countries will not be able to provide sustainable financing without external help.

The participants alone are responsible for the views and information expressed in their presentations, and they do not necessarily represent the decisions, policy or views of the World Health Organization or of the institutions with which they are affiliated.
ANNEX I

PMAC Side Session: NCDs and Sustainable Development
Panel Biographies

Date: 30 January 2017
Time: 14:00 - 17:30
Location: Room Lotus 10, Centara Grand & Bangkok Convention Centre at CentaraWorld,

Dr Bente Mikkelsen
Head of Secretariat for the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (WHO GCM/NCD)

Bente Mikkelsen is Head of the Secretariat of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (WHO GCM/NCD) at the World Health Organization in Geneva, Switzerland. The WHO GCM/NCD is tasked by WHO Member States to enhance the coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.

Dr Mikkelsen is a former CEO of the Southern and Eastern Norway Regional Health Authority (70,000 employees, 8 billion USD budget). She trained as a Gynaecologist and Obstetrician and holds a Master in Health Administration and Management degree from the University of Oslo. Her current focus is on the implementation of the Global Action Plan on NCDs in the context of the Sustainable Development Goals (SDGs). Dr Mikkelsen has particular interest in gender, equity and human rights, working across sectors, integration, innovation and new technologies.
Dr Téa E. Collins
Advisor, WHO Global Coordination Mechanism on the Prevention and Control of Non-Communicable Diseases (GCM/NCD)

Dr Téa Collins is an Advisor at the World Health Organization (WHO) Global Coordination Mechanism on the Prevention and Control of Non-Communicable Diseases (WHO GCM/NCD), where she oversees work on the alignment of development assistance for health and international cooperation with national NCD plans. Dr Collins came to WHO from the International Atomic Energy Agency (IAEA), where she provided technical advice and expertise on matters related to comprehensive cancer control and health systems strengthening to the Programme of Action for Cancer Therapy (PACT).

Prior to IAEA, Dr Collins advised the World Medical Association (WMA) on global health issues of concern to the medical profession in collaboration with the WHO Global Health Workforce Alliance. She also served as the first Executive Director of the NCD Alliance, a partnership of over 2,000 member organizations in 170 countries with a mission to combat the NCD epidemic by putting health at the center of all policies.

Dr Collins’ background includes work at the Ministry of Health in Georgia, managing World Bank and USAID-supported projects in the Caucasus region, and teaching graduate students at the George Washington University in Washington, DC. Dr Collins is a pediatrician with a Doctorate in Global Health from The George Washington University, as well as a Master’s in Public Health from Boston University and a Master’s in Public Administration from the Harvard University Kennedy School of Government. Dr Collins was a Presidential Scholar and Public Service Fellow at Harvard.

Dr Tim Evans
Senior Director of Health, Nutrition and Population at the World Bank Group

Between 2010-2013, Dr Evans was Dean of the James P. Grant School of Public Health at BRAC University, in Dhaka, Bangladesh, and Senior Advisor to the BRAC Health Program. From 2003-2010, he was Assistant Director General at the World Health Organization (WHO). Prior to this, he served as Director of the Health Equity Theme at the Rockefeller Foundation. Earlier in his career he was an attending physical of internal medicine at Brigham and Women’s Hospital in Boston, and was Assistant Professor in International Health Economics at the Harvard School of Public Health. He is a Board Member of a number of international health alliances.
Dr Evans has been at the forefront of advancing global health equity and strengthening health systems delivery for more than 20 years. At WHO he led the Commission on Social Determinants of Health and oversaw the production of the annual World Health report. He has been a co-founder of many partnerships including the Global Alliance on Vaccines and Immunization (GAVI).

Tim received his Medical Degree from McMaster University in Canada, and was a Research and Internal Medicine Resident at Brigham and Women’s Hospital. He earned a D.Phil. in Agricultural Economics from the University of Oxford, where he was a Rhodes Scholar.

**Dr Ariel Pablos-Mendez**

**Immediate Past Assistant Administrator, Bureau of Global Health, USAID**

Dr Ariel Pablos-Mendez was appointed in 2011 by the U.S. government to lead the Global Health Bureau of USAID. During his tenure, he catalysed the vision to end preventable child and maternal deaths and contributed to shaping an AIDS-Free Generation while supporting health systems strengthening, family planning and country ownership during the economic transition of health.

Dr Pablos-Mendez began his public health career at Columbia University, working on the emergence of multi-drug resistant tuberculosis in New York City in 1991. In 2007 he led the Global Surveillance Project on Anti-Tuberculosis Drug Resistance at the World Health Organization (WHO). He also served as Director of Knowledge Management at WHO in Geneva between 2004-2007, creating WHO Press, working to bridge the know-do gap in public health and promoting e-Health in the developing world. In 2007 he returned to the Rockefeller Foundation as Managing Director, where he had been a program officer from 1998-2004, spearheading public-private partnerships in R&D for diseases of poverty (e.g. the Global Alliance for TB Drug Development), the Foundation’s strategy on AIDS treatment in Africa (2001) and the Joint Learning Initiative on Human Resources for Health. From 2007-2011 he developed and led the Foundation’s initiative on the transformation of global health systems towards universal health coverage.

Dr Pablos-Mendez received his M.D. from the University of Guadalajara (Mexico), and his M.P.H. from Columbia University (New York), where he was Professor of Clinical Medicine and Public Health. He has over 100 publications and has been a member of various boards and international commissions.
Dr Rachel Nugent  
**Vice President, Chronic Noncommunicable Diseases Global Initiative, RTI International**

Dr Rachel Nugent is the current Vice President of the Chronic Noncommunicable Diseases Global Initiative within RTI International. Within this she leads a team charged with providing policy analysis, implementation, and evaluation of cost-effective strategies to prevent and control global Noncommunicable Diseases (NCDs). RTI’s global NCD experts generate and translate new evidence to help guide global and national decision making aimed at NCD detection, prevention and control.

Dr Nugent has over 30 years of experience in global development as a researcher, practitioner and policy advisor to governments. Dr Nugent is a member of the Lancet Commission on Noncommunicable Diseases and Injuries of the Poorest Billion, the U.S. Institute of Medicine Committee on Economic Evaluation, and the International Expert Group for the Global Nutrition Report. She also works with the World Health Organization, assisting the Global Coordination Mechanism Secretariat with the Working Group on Financing Noncommunicable Diseases, and is on the External Advisory Committee of the NCD Alliance and Children’s Heartlink. Dr Nugent’s interests include the economic benefits of controlling antimicrobial resistance, and she was the lead author and chair of ‘The Race Against Drug Resistance,’ a 2010 report from the Center for Global Development’s expert working group on global drug resistance.

Previously Dr Nugent was an Associate Professor of Global Health at the University of Washington, and Director and Principal Investigator of the Disease Control Priorities Network. She has previously worked at the Center for Global Development, the Population Reference Bureau, the Fogarty International Center of NIH and the Food and Agriculture Organization of the United Nations.

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Dr Supattra Srivanichakorn  
**Medical Expert, Department of Disease Control, Ministry of Public Health, Thailand**

Dr Suppatra Srivanichakorn has had a successful and distinguished career as a medical practitioner and health administrator in Thailand. She has occupied a number of key senior administrative positions within different departments of the Thai Ministry of Public Health. Between 2009-2013, Dr Srivanichakorn took up appointment as Director of the ASEAN Institute for Health Development,
Dr Srivanichakorn received her medical degree from Mahidol University in 1982 and subsequently worked as a medical practitioner and hospital director in North-Eastern Thailand for several years before completing a Masters Degree in Tropical Medicine from the Institute of Tropical Medicine in Antwerp, Belgium. She is also certified by the Board of Preventive Medicine and Epidemiology.

Dr Jennifer Adams
Acting Assistant Administrator, Bureau of Global Health, USAID

Dr Jennifer Adams is USAID’s Acting Assistant Administrator in the Bureau for Global Health. She manages Population and Reproductive Health, the Office for HIV/ AIDS, the Office of Health Systems, and other special assignments.

Dr Adams has worked for USAID for over 20 years, in the Central Asian Republics, Senegal, Brazil and Washington D.C. Previous roles have included head of USAID’s Office of Donor Engagement. Her duties involved analysis, communication and collaborative efforts to generate joint understanding and action on key development priorities with both bilateral and multilateral donor partners around the world. In 2008 she was appointed the first USAID Development Counselor to China, and prior to this she was the Mission Director for USAID in Brazil, where she initiated a successful public-private partnership, Mais Unidos, that engaged the 50 largest American Companies to support social entrepreneurship.

Dr Adams graduated from John Hopkins University, and has a Master of Philosophy degree from the Institute of Development Studies at the University of Sussex, and a PhD in Economics from Cambridge University.

Dr Douglas Webb
Team Leader, Health and Innovative Financing, HIV, Health and Development Group, UNDP

Dr Douglas Webb is a team leader in the HIV, Health and Development Group of UNDP’s Bureau for Policy and Programme Support. Dr Webb’s experience covers a range of social aspects of health and well-being and public sector responses. This includes the development of social protection systems; child focused social welfare systems, child protection, alternative child care structures, inter-country adoption policy, HIV-sensitive social programmes, structural HIV interventions, health emergency responses, non-communicable disease responses and tobacco prevention and control.

Dr Webb holds a PhD from the University of London, which examined social responses to HIV and AIDS in Namibia and South Africa in contexts of political transition. The research assessed how the dismantling of apartheid structures and associated socio-political changes impacted on the perceptions and responses to HIV. He has published over 30 articles and book chapters covering issues such as children affected by AIDS, adolescent sexual and reproductive health, HIV and AIDS and development. He was a member of the Joint Learning Initiative on Children and AIDS (2006-2008) and was on the Programme Committee for the International AIDS Conference in Vienna 2010.
AGENDA

NCDs and Sustainable Development – The Way Forward
January 30, 2017
14:00 – 17:30
Organizer: WHO Global Coordination Mechanism for the Prevention and Control of NCDs (WHO GCM/NCD)

Location: Centara Grand Convention Center, Bangkok, Thailand

Meeting Room: Lotus 10

Objectives:

1. Discuss the complex global health landscape and the place of NCDs within the UHC and SDG frameworks
2. Articulate the impact of NCDs on the most vulnerable populations and sustainable development
3. Highlight the challenges to ensuring “whole-of-government” and “whole-of-society” response to meet the NCD targets of the 2030 Agenda and the WHO Global Action Plan on NCDs (2013-2020)
4. Highlight the importance of tracking resources and aligning international development assistance to national health strategies and plans
5. Propose solutions for increased international cooperation and policy coherence at global, regional and national levels

14:00 – 14:10 Opening - Objectives of the meeting and program overview
Speaker introduction
Dr Téa Collins (Moderator)
WHO GCM/NCD

14:10 – 14:25 NCDs as a Global Development Challenge – Shaping a Collaborative Agenda
Dr Bente Mikkelsen
WHO GCM/NCD

14:25 – 14:45 From Development Assistance to Development Cooperation – Resource Tracking for NCDs
Dr Rachel Nugent
RTI International

14:45 – 15:00 Questions from the audience and panel discussion

15:00 – 15:30 BREAK
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
<th>Organization</th>
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<tbody>
<tr>
<td>15:30 – 15:45</td>
<td>World Bank Perspective: UHC as a Platform for Converging Agendas in Global Health</td>
<td>Dr Tim Evans</td>
<td>The World Bank Group</td>
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<td>15:45 – 16:00</td>
<td>Sustainable Development and NCDs: Challenges of Intersectoral action</td>
<td>Dr Ariel Pablos-Mendez</td>
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<td>16:00 – 16:15</td>
<td>Panel discussion, questions</td>
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<td>16:15 – 16:30</td>
<td>NCDs and USAID Global Health Programs</td>
<td>Dr Jennifer Adams</td>
<td>USAID</td>
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<tr>
<td>16:30 – 16:45</td>
<td>Addressing NCDs in Thailand</td>
<td>Dr Supattra Srivanichakorn</td>
<td>Ministry of Public Health of Thailand</td>
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<td>16:45 – 17:00</td>
<td>NCDs and the UN Interagency Taskforce: UNDP</td>
<td>Dr Douglas Webb</td>
<td>UNDP</td>
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<td>17:00 – 17:30</td>
<td>Panel discussion, questions and closing</td>
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