WHO DISCUSSION PAPER

WHO global coordination mechanism on the prevention and control of noncommunicable diseases

WHO GCM/NCD Working Group on alignment of international cooperation with national plans on NCDs

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This discussion paper supports the WHO GCM/NCD Working Group on alignment of international cooperation with national plans on NCDs (Working Group 3.2, 2016-2017). This group was formed under Action 3.2, Objective 3 of the GCM/NCD 2016-17 work plan to provide a forum to identify barriers and share innovative solutions and actions for the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and to promote sustained actions across sectors.

This discussion paper, and the feedback received on it will be considered by the working group, as an input into its work and to the development of recommendations for Member States to realise their commitments to align international cooperation with national plans. The report and the recommendations will be provided to the WHO Director-General by the end of 2016.

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Disclaimer

The authors alone, Dr Luke Allen, Dr Nick Townsend, and Dr Kremlin Wickramasinghe are responsible for the views expressed in this article, which do not necessarily represent the views, decisions or policies of any of the institutions mentioned. The authors report no competing interests and, in particular, no relationship with industry. This document does not represent an official position of the World Health Organization. It is a tool to explore the views of interested parties on the subject matter.

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1. Background

Non-communicable diseases mainly comprise of cardiovascular diseases, cancers, chronic respiratory diseases and diabetes but also include mental illness and other conditions. In line with previous work, the four major conditions are the focus of this document, however the broad principles of international alignment apply to all NCDs.

In 2011 the United Nations General Assembly adopted the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs. In 2013, the 66th World Health Assembly (WHA) approved the resolution WHA66.10 “follow up to the Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs” and agreed to establish the GCM/NCD. In May 2014, the 67th WHA endorsed the terms of reference of the GCM/NCD and its first work plan for the period of 2014-2015.

High-level commitments on the need for alignment of international cooperation on NCDs with national NCD plans and integrating measures to address NCDs into national health planning and development plans and policies, including the design process and implementation of the United Nations Development Assistance Framework, were clearly defined in the 2014 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 NCDs.

In line with these commitments, Objective 3 of the 2016-2017 GCM/NCD work plan, through Action 3.2, establishes a Working Group to recommend ways and means of encouraging Member States and non-State actors to align international cooperation on NCDs with national plans concerning NCDs in order to strengthen aid effectiveness and the impact of external resources in support of NCDs. The Working Group will produce a report with recommendations to be presented to the WHO director general.

This WHO discussion paper provides an overview of international cooperation to date, identifies possible barriers, and highlights potential means of promoting sustained action across sectors. International actors include countries, regional alliances, NGOs, private foundations, the private sector, civil society groups, and international organisations among others.

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1 http://www.who.int/healthinfo/global_burden_disease/en/
3 See WHA67/2014/REC/3, summary record of seventh meeting of Committee A of Sixty-seventh World Health Assembly, session 2.
4 Resolution A/RES/68/300, paragraphs 30 (v) and (ix)
Box 1: Definition and examples of international cooperation

International cooperation includes the exchange of money, in-kind resources and best practices in the areas of health promotion, legislation, regulation, strengthening of health systems, training of health-care personnel and the development of appropriate health-care infrastructure and diagnostics. It also extends to promoting the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms. WHO has the leading role as the primary specialized agency for health within the UN system.5

Case study:

In 2002 the Afghan Ministry of Health set about rebuilding the national health system and called on a number of international partners to collaborate in developing the ‘Basic Package of Health Services’ (BPHS). Experts from WHO, USAID, UNFPA, UNICEF and the NGO ‘Management Sciences for Health’ supported Ministry staff throughout the process. Many elements of the BPHS concerned with NCDs are delivered by international organisations. As an example; within mental health services, Medica Mondiale provides psycho-social support to women and girls who have been traumatised by the conflict.6,7

5 http://www.who.int/global-coordination-mechanism/ncd-themes/international-cooperation/en/
2. Rationale

NCDs caused 38 million deaths in low and middle income countries in 2012, and premature mortality from NCDs is disproportionately concentrated in lower-income settings. NCDs impose a large burden of human suffering and significant social and economic costs. Weak health systems, poverty, and harmful social, economic and physical environments can contribute to premature NCD mortality in developing countries. Trade, taxation, education, agriculture, urban development, and food and pharmaceutical production all influence the NCD burden in these countries. These areas are often targeted by international development partners, along with underlying drivers of disease such as gender equity, socioeconomic inequalities, urbanisation, population ageing and globalisation.

The last 25 years have seen a significant increase in international cooperation to bolster development. Development assistance for health (DAH) tripled from 2000 to 2011 before levelling off in recent years: funding for NCDs mirrored this trend but remains a very small proportion (1.2%) of overall DAH. The last few decades have also seen the creation of important new global health players such as the Global Fund, Bill and Melinda Gates Foundation, GAVI Alliance, and UNITAID. The donor landscape has also shifted as non-OECD states such as Brazil, China, India and Russia have become increasingly influential. These countries have emphasised South-South cooperation, cost-effective domestic solutions, and transferral of low-cost approaches. The proliferation of actors, mechanisms and monetary commitments contributed to large health gains in areas such as infant and maternal mortality, HIV/AIDS, and malaria, however the needs of donors have sometimes been prioritised over genuine needs of recipient countries, and governance mechanisms have not always been transparent. Despite a marked stagnation in post-financial crash DAH contributions, international actors continue to commit resources to addressing health needs in developing countries: approximately $610 million was spent on combatting NCDs in 2014 with development banks, NGOs and private foundations providing the largest contributions. Blended funding streams (financing from a mix of different sources) and

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8 http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1
novel sources of NCD financing are increasingly important: World Bank loans, bilateral aid, private, public and global institutional funding combined with newer finance streams like the Global Financing Facility\textsuperscript{15} offer greater fiscal space to combat NCDs in the context of universal health coverage.\textsuperscript{16} While the international community is important, domestically sourced government health spending continues to dwarf DAH, constituting 95% of spending in developing countries.\textsuperscript{17} DAH is more significant in low-income countries, where it constitutes a quarter of health expenditure compared with lower-middle income countries where it accounts for less than 3%.\textsuperscript{18} Within low-income countries domestic NCD financing is low (approximately US $1.90 per capita) compared with out-of-pocket payment which accounts for over half of all spending in these settings.\textsuperscript{19}

The alignment of donor priorities with national NCD plans is likely to have the biggest impact - positive or negative - in countries that are more dependent on external financial assistance (although this in not always the case).\textsuperscript{20} These countries may also be the most politically volatile. Nevertheless, development assistance has previously been successfully leveraged in the context of poor governance, political turmoil and underperforming economies to achieve remarkable achievements across a wide range of health outcomes.\textsuperscript{21}

There is a divergence in opinion over the extent to which international actors \textit{should} contribute to agenda setting, financing, and service delivery in developing countries. Whilst there is a general recognition that the international community can helpfully support developing countries, some feel that external support is indispensable whereas other would like to see countries operating independently and (they argue) sustainably. This trend is manifest in the shift from Millennium Development Goals to the 2015 Sustainable Development Goals.

Irrespective of normative considerations around the degree of support the international community offers, there is a strong argument that all assistance should align with national action plans (Box 2). Governments are the most legitimate and appropriate agents for coordinating various strategies and projects, and can provide holistic oversight of health and

\textsuperscript{15} Usher AD. Global Financing Facility: where will the funds come from?. The Lancet. 2015 Nov 13;386(10006):1809-10.
\textsuperscript{16} WHO GCM working group 5.1. Final report and recommendations from the Working Group on how to realize governments’ commitments to provide financing for NCDs. 2016.
\textsuperscript{17} Moon S, Omole O. Development assistance for health: critiques and proposals for change. 2003 Chatham House.
\textsuperscript{19} WHO. Health Accounts. Available at: http://www.who.int/health-accounts/subaccounts/en/ [Accessed 23/03/2016].
other programmes. Misalignment can result in wasteful duplication of efforts, unpredictable funding flows and weakening of health systems. Alignment of priorities, coherent financing, and coordinated service delivery can lead to powerful synergies, maximise comparative advantage, and strengthen the domestic health system. Alignment also benefits donors by strengthening aid effectiveness and development impact.

Alignment is a ubiquitous development issue, and formed the focus of the Rome and Paris aid effectiveness declarations. At the third high-level forum on aid effectiveness, hosted in Accra, 2008 the Global Partnership for Effective Development Cooperation was instituted to continue the cooperative international development agenda.

NCDs are most effectively addressed in the context of horizontal/integrated health systems. National NCD plans therefore need to have a broad system-level focus. Donor support can be particularly helpful with agenda setting, capacity building, financial support, implementation and help with monitoring and evaluation. Whilst there are many examples of effective alignment, barriers still remain.

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Box 2: Commitments from the Paris Declaration

We reaffirm the commitments made at Rome to harmonise and align aid delivery. We are encouraged that many donors and partner countries are making aid effectiveness a high priority, and we reaffirm our commitment to accelerate progress in implementation, especially in the following areas:

- Increasing alignment of aid with partner countries’ priorities, systems and procedures, and helping them strengthen their capacities.
- Strengthening partner countries’ national development strategies and associated operational frameworks (e.g., planning, budget, and performance assessment frameworks).
- Enhancing donors’ and partner countries’ respective accountability to their citizens and parliaments for their development policies, strategies and performance.
- Eliminating duplication of efforts and rationalising donor activities to make them as cost-effective as possible.
- Reforming and simplifying donor policies and procedures to encourage collaborative behaviour and progressive alignment with partner countries’ priorities, systems and procedures.
- Defining measures and standards of performance and accountability of partner country systems in public financial management, procurement, fiduciary safeguards and environmental assessments, in line with broadly accepted good practices and their quick and widespread application.

We commit ourselves to taking concrete and effective action to address the remaining challenges, including:

- Weaknesses in partner countries’ institutional capacities to develop and implement results-driven national development strategies.
- Failure to provide more predictable and multi-year commitments on aid flows to committed partner countries.
- Insufficient delegation of authority to donors’ field staff, and inadequate attention to incentives for effective development partnerships between donors and partner countries.
- Insufficient integration of global programmes and initiatives into partner countries’ broader development agendas, including in critical areas such as HIV/AIDS.
- Corruption and lack of transparency, which erode public support, impede effective resource mobilisation and allocation and divert resources away from activities that are vital for poverty reduction and sustainable economic development. Where corruption exists, it inhibits donors from relying on partner country systems.
3. Barriers to alignment

The very existence of the Paris declaration points to historic misalignment and broader mismanagement of international development assistance. The catalogue of failures on the part of donors and partner countries is well documented, including multiple examples of unfinished hospitals, duplicate and triplicate projects, well-run programmes abruptly ending when funding was re-allocated, and parallel health systems that undermine government efforts and poach key health workers from state services. Donor agencies have also struggled with government corruption, embezzlement, incompetence and a lack of accountability. Corruption may also be more entrenched in states with the most pressing health needs. Painful memories and a lack of trust between partners is a barrier to further alignment and cooperation.

The competencies and priorities of issue-focused donors do not always align with the national priorities of partner countries. Donors have a fiduciary-like responsibility to their funders and need to demonstrate that they are meeting pre-specified objectives in order to continue operating. This focus on delivering one specific result can cause friction when working with governments trying to deliver much broader outcomes. Seeking outcomes at the expense of processes can undermine health system sustainability and vertically oriented organisations are often not well positioned to address the multi-sectorial drivers of NCDs.

Managing implementation can be very difficult without formal national coordination mechanisms. Many countries benefit from UN country teams (UNCT) but these coordinating groups have yet to fully engage with the NCD agenda. Commenting on the GCM virtual dialogue on international cooperation, Malebogo Kebabonye-Pusoentsi, a public health worker from Botswana, shared success in aligning multiple international stakeholders with a national NCD strategy based on the 2008-2011 Global Action Plan. Coordinating the implementation proved to be more difficult with a lack of harmonised action resulting in duplication, a lack of ongoing accountability, and difficulties in monitoring and evaluation. Coordination on the ground is an ongoing challenge in developing countries. There have been many calls for coordination mechanisms, however these platforms are often resisted or fail to work effectively.

Developing and implementing NCD plans is particularly challenging in circumstances of political instability and social unrest. The world’s most fragile states are home to some of the world’s most vulnerable populations but coordinating sustained NCD action in this

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24 Reports of these failings are very well-established. See Cassels A, Janovsky K. Better health in developing countries: are sector-wide approaches the way of the future?. The Lancet. 1998 Nov 28;352(9142):1777-9.
26 http://gcmportal.org/global_discussion/discussions
context is incredibly challenging. In stable polities policy coherence is vital as combatting NCDs requires multisectoral support and cross-cutting initiatives.

Despite repeated calls to align donor accountability requirements, different agencies still use their own versions, tying up staff and resources, and representing significant transaction and opportunity costs.

International donors do not always acknowledge or measure the health impact of their work in other sectors, such as agriculture and education. Myopia in this area can limit meaningful engagement with multisectoral NCD action plans. There is scope to develop strategies, practices and accountability mechanisms for NCD activities, and broader programmes of work.

On the demand side countries need to be able to express demand for assistance. Developing business cases, including return on investment, is an important way of attracting funding from private businesses, development banks and philanthropists.27

4. Identifying Solutions

This section provides a number of statements for the Working Group to discuss based on the issues discussed above. Many of these options have been tried or mooted in other settings. There is value in discussing failures as well as successes in order to identify the characteristics of successful ways and means of fostering the alignment of international cooperation with the national NCD plans. These national, multisectoral plans constitute one of the key time bound commitments from the 2011 political declaration, and the UN General Assembly Outcome document from 2014\(^\text{28}\) forms the foundation for solutions in this area.

**International cooperation**

1. The current level and range of international cooperation on NCDs is sufficient.

2. The right global actors are engaged in supporting national NCD action plans.

3. ‘Cooperation’ occurs in many domains including surveillance, agenda setting, policy development, financing, service delivery, and monitoring and evaluation: solutions designed to foster greater cooperation may benefit from defining the domain of engagement.\(^\text{28}\) (See cross-sector framework\(^\text{29}\) for more domains).

**Alignment with national NCD plans**

1. Enhanced alignment will increase aid efficiency.

2. Where disjointed priorities are an issue, processes for engaging in mutual situational analysis may be beneficial.

3. Country-based donor representatives can facilitate accountability and communication between the partner country and other donors.

4. There is a strong case for an autonomous, funded coordination body based in office of premier to plan and oversee collaboration.

\(^{28}\) 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. A/RES/68/300

\(^{29}\) http://www.who.int/nmh/events/WHO-discussion-paper2.pdf
5. International partners should perform NCD impact assessments for all projects undertaken in recipient countries, even if they are not in the health domain.

6. International partners can help to develop assessment frameworks and engage non-health departments (education, agriculture, planning, education etc) in national NCD coordination.

Financial support

1. Transparency and cooperation in financial planning can help to protect partnering countries from abrupt discontinuations of financial support, and focus assistance appropriately.

2. Uniform accountability requirements from larger donors will reduce transaction costs. The development of this protocol should be a priority.

3. The use of OECD/DAC CRS codes for NCD work would foster accountability but may systematically disregard work in other sectors that also impact health.

4. An investment framework for developing business cases for investment would help to attract, align and maintain international financing. Integrating business cases and return on investment figures into national NCD plans is straightforward and will leverage external resources.