WHO Independent High-level Commission on NCDs
Report of Working Group 1
(October 2019)

Table of Contents

Chapter                                      Page
1.   Introduction                            2
2.   Multi-sectoral and multi-stakeholder national mechanisms to promote policy coherence through whole-of-government and whole-of-society engagement to achieve NCDs goals and targets 4
   a. Recommendations                         11
   c. Annex B: Examples of didactic guidance tools and approaches 21
   d. Annex C: Case Studies                   28
3.   Health literacy and education to empower the individual to make informed choices and promote healthy lifestyles 41
   a. Recommendations                         54
   b. Annex D: Case Studies                   61
   c. Annex E: Situational Analysis           78

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Introduction

Since 2011, noncommunicable diseases (NCDs) have been raised high in the international agenda, by means of commitments adopted at the three high level meetings of the UN General Assembly on NCDs, the 2030 Agenda for Sustainable Development and through WHO governing body resolutions and decisions, as well as through other UN commitments such as the Rome Declaration on Nutrition. This led to the integration of NCDs within the Sustainable Development Goals, in particular SDG 3.4, which targets reducing by one-third premature mortality from NCDs through prevention and treatment, and promoting mental health and wellbeing, by 2030, along with SDG 2.2 that aims to eliminate all forms of malnutrition, including overweight and obesity, stunting and wasting.

However, current evidence suggests that countries are not on target to achieve these goals with national NCD responses proving to be uneven. In particular, while in many instances policies are drafted and in place, they are not being implemented. ‘Time to deliver’ the report of the WHO Independent High-Level Commission on Noncommunicable Diseases found that progress towards fulfilling the four time-bound commitments of the 2014 Outcome document has been disappointing. The second of these commitments, to develop national multi-sectoral policies and plans to achieve the national NCD targets, recognizes that many of the drivers of NCDs and their risk factors lie outside the control of national health sectors. The 2014 Outcome document, in particular, called for due attention to a wide range of enabling factors that should underpin effective multi-sectoral public policies and action plans, including to promote health education and health literacy, with a particular focus on populations with low health awareness and/or literacy, and to consider establishing a national multi-sectoral mechanism, such as a high-level commission, agency or task force for engagement, policy coherence and mutual accountability of different spheres of policymaking that have a bearing on NCDs, in order to implement health-all-policies and whole-of-government and whole-of-society approaches, and to monitor and act on the determinants of NCDs, including social and environmental determinants.

Given the implementation challenges in these areas, the 2018 Political Declaration for the High-Level Meeting on NCDs re-prioritized the commitment from Heads of State and governments to providing strategic leadership, coordinated action and response for the prevention and control of NCDs. The 2018 Political Declaration called, in particular, for the establishment or strengthening of national multistakeholder dialogue mechanisms for the implementation of the national multi-sectoral action plans for NCDs, and for the empowerment of the individual to make informed choices by providing an enabling environment, strengthening health literacy through education, and implementing population-wide and targeted mass and social media campaigns that educate the public about NCD risk factors.

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5 WHO. Health in 2015: from MDGs, millennium development goals to SDGs, sustainable development goals. Geneva: World Health Organization; 2015. [link]
8 Paragraph 30 a (iii) and (vi), https://www.who.int/nmh/events/2014/a-res-68-300.pdf
According to the scope of work for the second phase of the WHO Independent High Level Commission on NCDs, Working Group 1 was tasked to:

- “develop innovative ideas for how WHO and partners can rapidly scale-up support to Member States to empower individuals by promoting health literacy among different populations for the prevention and mitigation of NCDs and mental health conditions and their risk factors, including by creating environments that support such education. It will explore experiences with education programmes and population-wide, targeted mass media and social media campaigns that educate the public about NCDs risk factors, in particular, the harms of smoking, tobacco use, and exposure to second hand smoke; the harmful use of alcohol and excessive intake of fats, sugars and salt; and ways to promote healthy and balanced diets, increase physical activity and mental health and well-being”.

- “elaborate a framework aimed at promoting multi-sectoral coordination and multi-stakeholder dialogues at national level to address NCD risk factors and determinants and advance the implementation of NCD and mental health national priorities, including through the establishment of multi-sectoral mechanisms or platforms, such as national NCDs commissions and equivalents of the GCM/NCDs” Information based on WHO experience and Member State best practices, will be gathered do prepare a report with recommendations and guidance on how to implement such mechanisms at the national level”.

Multisectoral and multi-stakeholder national coordination mechanisms to promote policy coherence through whole-of-government and whole-of-society engagement to achieve NCDs goals and targets

The first section of the report considers the development and implementation of multisectoral and multistakeholder NCD National Coordination Mechanisms (NCMs).

Many current mechanisms are temporary, often created to address specific policy needs such as the elaboration of legislation or regulation and are then dismantled, or built around a limited scope, dealing with NCDs risk factors separately. However, NCMs must be sustained in the long term if they are to be effective drivers in the prevention and control of NCDs and enable countries to reach the time bound NCD commitments.

Within this report, the importance of multisectoral/multistakeholder NCMs is discussed considering conflicts of interest that may arise when working with other sectors and stakeholders, in particular the private sector. The challenges of engaging with multiple partners in NCD NCMs are reviewed. Finally, recommendations are made that can be further developed into WHO guidance and policies, building on existing tools, by investigating when guidance has been useful and understanding why current tools are not being used. These recommendations should assist countries in setting up permanent, sustainable, mechanisms that will assist in their progress towards achieving SDG 3.4 and other NCD targets.

Many of the drivers of NCDs and their risk factors lie outside the control of the health sector. Good population health has positive impacts on productivity, sustainability and the economy. It benefits all sectors and society as a whole. Other stakeholders therefore bear a responsibility for and benefit from improving population health. They can contribute, within their own role, in achieving national NCD targets.

Addressing NCDs risk factors and determinants - including social, economic and environmental determinants - in an effective way requires a multisectoral and multistakeholder approach and for this to happen, coordination needs to take place between governmental sectors and non-State actors, which include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. Governments need to develop ways and means to allow such collaboration to take place in the most constructive way.

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13 WHO. Framework of engagement with non-State actors. World Health Organization; 2016. link
To date, the establishment of permanent multisectoral or multistakeholder mechanisms has been very challenging despite strong political calls for their implementation. Through the 2018 Political Declaration of the High-Level Meeting on NCDs Heads of State and governments called to strengthen commitment in this area, by providing strategic leadership, coordinated action and response for the prevention and control of NCDs. This was timely as the 2030 Sustainable Development Agenda challenges the global community to move towards whole-of-government and whole-of-society approaches that leave no one behind.

The UN Sustainable Development Goals (SDGs) provide a renewed impetus for joined-up action to address complex, contemporary problems and for the achievement of health and good governance. These SDG goals are ‘integrated and indivisible’ and both the private and public sector are needed to achieve them. It was hoped that this framing of the SDGs as collaborative would encourage the development and implementation of NCD national coordination mechanisms (NCMs) as they offered an interlinked / intersectoral approach, with related indicators: in particular SDG 17, which calls for cooperation, collaboration and partnership between government, civil society and businesses and encourages “the use of multistakeholder partnerships” but also SDG 3 which aims to “ensure healthy lives and promote wellbeing for all at all ages”.

It appears, however, that Head of States are often assigning responsibility for different SDGs goals to what are seen to be the relevant stakeholders rather than using the SDGs to encourage multisectoral work. This means that goals such as SDG 3.4 are still seen as the responsibility of individual government sectors, in this case health, rather than becoming truly multisectoral, as was hoped. It is imperative, therefore that countries are encouraged and supported in the development of such multisectoral approaches if the SDG goals are to be achieved.

**Multisectoral and multistakeholder approaches**

Multisectoral approaches are often termed ‘health-in-all-policies’, ‘whole-of-government’, ‘intersectoral’ or ‘cross-sectoral’, and include all government sectors. Multistakeholder approaches are also referred to as ‘whole-of-society’ and differ slightly in their reach, to include non-State actors as well as government sectors.

Although for many years the emphasis has been on whole of government approaches to health, the Political Declaration mandates that civil society and the private sector can contribute to achieving the implementation of national responses. It must be recognized that strong and clear governance is important when dealing with different stakeholders, in particular those that sit outside of government, with one of the main obstacles to success being the prevention and management of conflicts of interest and undue influence. Such concerns can lead governments to refuse any collaboration with non-State actors, although it must be recognised that such conflicts can also be found between government sectors.

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15 WHO. Key learning on Health in All Policies implementation from around the world – Information Brochure. Geneva, Switzerland: World Health Organization; 2018. [link]


17 HLPE. Multistakeholder partnerships to finance and improve food security and nutrition in the framework of the 2030 Agenda. 2018. [link]


Conflicts of interest within National Coordination Mechanisms

Despite the recognition that population health influences all aspects of society, health issues are a lesser concern for some government sectors\(^{21}\). Achieving buy-in from all sectors can be difficult, as sectors outside of health have their own responsibilities and do not commonly receive funding for health issues. Increasing budgets for NCDs, within other sectors, can also be important in encouraging buy-in for a coordinated NCM approach. On occasions, other sectors may directly oppose NCD health approaches, as they actually counter the goals of that sector. Despite these conflicts, it is thought that these government sectors are more responsive than non-State actors to agreed approaches as a part of an NCD NCM and that by engaging with relevant sectors, policy coherence and better implementation can be achieved.

It is clear that non-State actors will bring their own interests to any multistakeholder mechanism\(^{20}\) and working with the private sector is of particular concern within the NCD prevention and control field. Some refer to NCDs as “industrial epidemics”, and “diseases of consumers, workers, and community residents caused by industrial promotion of consumable products, job conditions and environmental pollution.”\(^{22}\). Others lead to define the strategies used by corporate actors to “promote products and choices that are detrimental to health” as “commercial determinants of health”\(^{22}\).

It is a concern for many, therefore, that once the private sector becomes a member of an NCM, it will have a say in its mandate, which could include developing policies and approaches, or advising the ministry of health. Indeed, some feel that the private sector will try to manipulate the NCM agenda. Effective public health policymaking often runs counter to the interests of industry\(^{23}\), who have a directive to maximize profits, and are therefore required to oppose policies which could limit profitability\(^{24}\). Such organizations use an array of strategies, collectively known as corporate political activity, in attempts to reduce, minimize or weaken policymaking\(^{25,26,27}\). Corporate influence on science goes beyond simply skewing evidence bases, with corporations also working to influence the interpretation of science and the use of science in policymaking\(^{28}\).

Recognizing the tactics industry uses to gain influence, some are concerned over the vulnerability of other stakeholders to industry interference. For example, some small NGOs or civil societies have difficulties in raising funds and may therefore take money from industry to support them. This, it is thought, could leave them open to industrial influence and make them not fit for purpose. This is a concern as civil society is recommended for inclusion and can play a positive role in NCD NCMs through advocacy and implementation\(^{29}\). Such stakeholders can be important in improving health literacy of the population or advocating for NCM agreed approaches. In many cases, NCD interventions, such as increased taxes, do not commonly have the support of the population, in particular when tax collection or allocation of funds are

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\(^{26}\) Aveyard P, Yach D, Gilmore AB, Capewell S. Should we welcome food industry funding of public health research? BMJ. 2016;353:i2161. [link]


not transparent; civil society can play a role in working to educate the population and to gain their support. They can also act in holding countries accountable through evaluating and tracking NCM approaches at the same time as acting as a watchdog for citizens’ rights.

It is clear that caution must be taken when engaging with non-health government sectors and in particular non-State actors, most crucially the private sector. However, it is also clear that context is important. It must be recognized that not all industries are equal and that approaches and influence vary considerably by country. Context, therefore, is an important consideration in developing and implementing NCD NCMs.

**Context is crucial for NCM development and stakeholder engagement**

There is no one stakeholder engagement model that can fit all the countries, as NCM entry points are context specific. Understanding the political and policy environment will help shape where resources need to be targeted and which sectors and stakeholders are recruited for NCD NCMs. In low and middle-income countries (LMICs), the situation is particularly problematic. Governments in LMICs face major challenges from non-State actors and the private sector in particular, as their existing governance and regulatory arrangements are not designed to effectively manage them. Considering the rapid development of the private sector within these countries and their greater vulnerability to the resources and tactics of major industry, it is imperative that LMICs are given the required support needed to develop NCMS and the required regulatory and legislative approaches to avoid industry pressure.

Similar to contextual differences between countries, not all industries are considered equal. Much of the private sector is not seen to have clear conflicts of interest to NCD NCMS but those who do, in particular tobacco, alcohol and the food and beverage industry are reportedly very powerful. Although some describe the possibility of positive outcomes from dialogue with certain industry within NCMS, all consider the tobacco industry as a “no-go”. This position has come about through years of advocacy, a strong evidence base on both the harm of smoking and the tactics engaged by tobacco companies to undermine public health approaches, along with the WHO Framework Convention on Tobacco Control.

Despite less perceived risk in other parts of the private sector, it should be noted that many of these industries are thought to be learning from the tobacco industry’s experience and that a number of industries have been seen to adopt similar approaches to influence science and the use of science in policymaking. This includes pharmaceutical companies, which are commonly engaged with health system actors, including in the targeted delivery of universal health coverage.

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30 WHO. Key learning on Health in All Policies implementation from around the world – Information Brochure. Geneva, Switzerland: World Health Organization; 2018. [link](https://www.who.int/health_policies/HIAP/key-learning-kit/en/)
32 Scott-Villiers P, Chisholm N, Wanjiku Kelbert A, Hossain N. Precarious lives: food, work and care after the global food crisis. 2016. [link](https://www.bmj.com/content/359/bmj.j4885)
33 Gilmore AB, Fooks G, Drope J, Bialous SA, Jackson RR. Exposing and addressing tobacco industry conduct in low-income and middle-income countries. Lancet Lond Engl. 2015 Mar 14;385(9972):1029–33. [link](https://www.bmj.com/content/359/bmj.j4885)
Overview of current country level NCMs

The WHO Country Capacity Survey tool collects data approximately every two years. Data are collected via a web-based questionnaire hosted on the WHO website, from NCD focal points within the ministry of health, or national institute/agency responsible for NCDs, in all WHO Member States. WHO Secretariat reviews responses for completeness and validates against existing data sources and supporting documentation submitted.

- **Operational NCMs**

At the time of writing, the 2019 Country Capacity Survey had responses from 192 Member States with less than half of these (n = 89) reporting that they had an operational national multisectoral commission, agency or mechanism, to oversee NCD engagement, policy coherence and accountability of sectors beyond health. There are difficulties to sustain multisectoral and multistakeholder national coordination mechanisms reported in previous surveys. There was great variation by region, with all countries reporting having an operational NCM in South-East Asia, compared to the African region in which only 19% of Member States (n = 9) reported to have operational NCMs, although a further eight, reported that such mechanisms were under development or currently not in effect. In total 13 Member States reported NCMs to be under development and a further 10 that they were currently ‘not in effect’. This left a remaining 76 countries reporting that there was no NCD NCM and that none were in development, plus an additional 3 countries who were unable to respond to the question and one that was unable to indicate the status of the NCM.

- **Leadership models**

Analysis of TORs from 2017 found that the average number of members in NCM NCDs was 24 with a range from nine to 44 members. Nominations for inclusions to the NCM came from Prime Ministers, Chief Medical Officers, Ministers of Health or interministerial order, or were ratified by the cabinet memorandum to support implementation of the NCD plan, approved by Prime Minister and Cabinet. The NCM NCDs tended to be presided over by high level individuals such as the Prime (or Deputy) Prime Minister (or equivalent), Minister of Health (or equivalent), or Cabinet Secretary. Meeting frequency varied from twice per year, to every 3 months (most common), to monthly. Some countries also set up small technical groups which met more frequently.

- **NCM membership**

Of those 89 Member States reporting to have fully operational NCMs, 83 (93%) included other non-health government ministries in them. This was lowest in Europe, with five countries in this region (17%) reporting no other government ministries in addition to health, being included. All countries with operational NCMs in Africa, the Americas, Eastern Mediterranean region and South-East Asia region reported other government sectors being involved in operational NCMs, only one country in the Western Pacific region did not. Sixty-three countries (equivalent to 71% of those with operational NCMs) reported that NGOs, community-based organizations or civil society were included, ranging from 100% in Africa to 53% of

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39 Regarding nutrition specifically, 148 Member States reported that they have nutrition coordination mechanisms, of which 37 Member States have their coordination mechanisms at the highest level of the government, such as in the Offices of the Presidents or Prime Ministers. Source: https://extranet.who.int/nutrition/gina/ and https://www.who.int/nutrition/publications/policies/global_nut_policyreview_2016-2017/en/
countries with operational NCMs in Europe. Fifty-four countries with operational NCMs (62%) reported that academia (including research centres) were a part of their NCD NCM, with this ranging from 91% (10 countries) in the Eastern Mediterranean to 17% (two countries) in the Western Pacific. ‘United Nations Agencies’ (29 countries, 33%) and ‘Other international institutions’ (19 countries, 21%) were the most poorly represented categories in operational NCD NCMs, although 78% and 56% of countries in Africa with operational NCMs reported to include UN agencies and other international institutes, respectively. Additionally, 50% of countries in South-East Asia with operational NCMs reporting to have both as members.

Fourty-seven countries with operational NCD NCMs included the private sector, with this ranging from 67% in Africa to 40% in Europe, which was the only region in which less than half of countries did so. Over two-thirds of countries (70%, n=33) with private sector involvement in their operational NCMs reported that they excluded the tobacco industry from participation in the NCM’s consultations and decision-making process, with 11 (23%) saying that they did not and three (6%) who did not know if the tobacco industry was excluded or not. For those 15 countries with NCD NCMs under development, all of them involved other government ministries and 11 (73%) the private sector.

**Experiences and challenges of engaging with non-health sectors and non-State actors in national coordination mechanisms**

It is agreed that NCD NCMs cannot be successful without the involvement of sectors beyond health and non-State actors. This should be seen as a way to empower and collaborate side by side with other stakeholders for the objectives of a healthy society, rather than as a loss of power and responsibility by the health sector. It is recognized, however, that this does take careful management to ensure that the NCM does not reproduce existing power asymmetries and strengthens the position of more powerful actors. 40

Such collaboration will bring challenges not only in encouraging and enabling non-health actors to engage with health issues, but also through the participation of health professionals in areas outside the health sector; namely leadership, advocacy, legislation and policy, where there may be little experience. This can be a challenge, as ministries of health are not always recognized to be the strongest part of government and with a traditional focus on health services, they may not have much experience of working with non-health actors. They can, therefore, be unsure of how to bring them in and engage with them.

On occasions, where it is considered that everything must be led by the health sector, it has taken time for it to open up to collaboration. This reportedly stems from a focus on health treatment and infectious disease, which can lead to NCMs adopting health-based indicators that are measured within the health ministry, leaving little incentive for other ministries to get involved. Such approaches can leave non-health sectors viewing NCMs as health forums.

Opening up both health and non-health sectors to acknowledge that the determinants of NCDs sit throughout society and are therefore the responsibility of government as a whole, requires a paradigm shift from the traditional health treatment model, particularly that focused on infectious disease. A need to create long-term consensus with multiple sectors and stakeholders, whilst simultaneously dealing with policy cycles within the country, is therefore recognized. Conversely, in an effort to be inclusive, it is

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40 HLPE. Multistakeholder partnerships to finance and improve food security and nutrition in the framework of the 2030 Agenda. 2018. [link]
believed that some countries start too large, by incorporating every government sector in the NCM and developing a large number of targets, or goals, to justify for their inclusion. This is thought to be unmanageable and leads to little tangible progress, with sectors still focusing on their own goals and little collaboration encouraged.

Similar to the challenges of collaborating between government sectors, many countries do not have a policy position on the role of non-State actors within NCMs and there is little agreement between stakeholders on the role the private sector should play. Although other health programmes, such as Tuberculosis (TB) and malaria, have engaged well with the private sector, NCDs are broad in comparison, as they arise due to a number of different risk factors. In addition, there is currently a lack of evidence base from which to develop guidance about the types of services and activities in which the private sector might have a comparative advantage over the public sector in the prevention of NCDs. At a time in which there is a focus on evidence-informed policy and evidence-based interventions, this is concerning as recommendations on working with the private sector, for Member States, cannot come from a solid evidence base.

To date, NCMs have adopted a national focus. However, multisectoral and multistakeholder engagement can be very effective at a local level. Municipalities have the advantage of being closer to the population, enabling a better knowledge of local needs and intersectoral interventions. Local authorities can therefore be key actors in implementing coordination mechanisms, especially in countries in which a growing level of political decentralization has occurred. National Coordination Mechanisms do not necessarily translate to the local level and different mechanisms for implementation at the local level are needed. Local authorities may, however, be less familiar with avoiding conflicts of interest when working with non-State actors and may therefore require strong support and guidance.

**Transparency and accountability in NCM engagement**

Countries must understand different modes of engagement and their ability to implement them in their own context which may encourage non-State actor participation in NCD NCMs. Within some countries, NCMs are thought to provide advice and a national focal point, but not have the authority to act. This can arise if they are convened at the level of the responsible ministries, rather than higher. Strong leadership is crucial in setting up an NCD NCM and agreeing goals, with the ministry of health often able to provide leadership - with the support of higher political support and systems - without being seen to dominate.

Engagement of non-State actors can be informed by the agreed goals, with aims and purposes of the NCM and the roles for stakeholders clearly and transparently defined. Requiring non-State actors to define their individual objectives when they join the mechanism and during the coordination process is crucial in enabling consistency in the stakeholders involved in NCMs from planning to implementation and to monitoring and evaluation. This requires transparency and the adoption of accountability mechanisms to ensure that any stakeholder serves the health of the population and the goals of the NCM. This will enable NCMs to hold stakeholders to account for their engagement and for the delivery of agreed NCM goals and actions.

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Tools for NCM development

Poor preparation and weak implementation of NCD NCMs suggest that utilization of and benefit from existing WHO guidance have been low. Many countries reported being unaware of tools, although most did make reference to guidance, targets and recommended interventions. It was suggested that heterogeneity between countries in a number of factors, including governance structure and differences between non-State actors, within those countries, means that it is difficult to come up with recommendations that cover all countries and regions, for all stakeholders. Although it was reported that NCMs would welcome guidance, Member States also recognized that there is no “one size fits all” approach to the development and implementation of national mechanisms.

As with NCM development tools, countries reported scarce use of official guidance on dealing with conflicts of interest in NCMs, or in how to deal with non-State actors, in particular the private sector, in NCD prevention and control. Many recognized that such guidance would be beneficial and saw it as an issue in NCM management. They felt that not all sectors understood the motivation for the private sector in linking with them, citing industry grants to ministries that sat on the NCM. Some countries made reference to the Framework of Engagement with Non-State actors (FENSA44), that governs the WHO’s engagements with non-State actors, at global, regional and country levels. They felt that similar guidance for Ministries and governments within Member States would be useful.

Recommendations for the WHO Independent High-level Commission on NCDs

It is well known that to address NCDs risk factors and determinants (including social, economic and environmental determinants) in an effective way, a coherent multisectoral approach needs to be complemented by multistakeholder approaches. Putting these ideas into practice is one of the greatest challenges at the national level. That is why the 2018 Political Declaration has called Heads of State and Government to strengthen their commitment by providing strategic leadership and coordinated action and response for the prevention and control of NCDs. The implementation of a national mechanism can help countries to fulfil this mandate although there is no “one-size fits all” approach.

When implementing public policies and interventions to address NCDs, governments face important challenges such as private sector interference as well as competing views and interests from other sectors beyond health, that prevent the much-needed policy coherence to tackle NCDs. It is also essential to ensure adequate action and transparency with respect to lobbying and interest-representation, including preventing and managing conflicts of interest.

Therefore the establishment of a permanent institutional mechanism at the national level, involving all relevant government sectors in line with the Health in All Policies approach, committing them to the development and implementation of a plan of action with clear goals and targets for each sector involved, including monitoring and accountability mechanisms, could pave the way to overcome problems of policy coherence and contribute to meeting health and development outcomes.

Bearing in mind the main responsibility of States to guarantee the right to health, it has been recognized that other stakeholders also bear a responsibility and can contribute, from their own role, to achieving health national targets. Therefore, coordination needs also to take place between Governmental sectors and other stakeholders, including the private sector, non-governmental organizations, academia, philanthropic foundations as well as the UN system. To this end, Governments need to develop ways and means to allow this interaction to take place in the most constructive way, being it through dialogue, collaboration, partnership or any other form that implies participation, while transparently managing and avoiding conflict of interest or any other undue influence.

The Commission makes the following recommendations that will enable Member States to establish or strengthen national NCD multisectoral and multistakeholder mechanisms:

**Recommendations for Member States**

1. Member States are encouraged to establish or strengthen sustainable national NCD multisectoral and multistakeholder mechanisms, taking into account the following elements:

- Establish a coherent institutional framework for National Coordination Mechanisms (NCMs) with clear distinction between two levels: multisectoral and multistakeholder engagement
It is recognized that strong and clear governance is critical when implementing effective whole-of-government and whole-of-society approaches for addressing NCDs and their shared risk factors and determinants. The institutional framework for NCM should be established by decree, law or act indicating overall purpose, resourcing, composition, including relevant ministries and stakeholders that can participate, as well as the principles of conflict of interest management.

A clear distinction between multisectoral and multistakeholder approaches is recommended when establishing NCMs. Multisectoral action refers to all governmental sectors, while multistakeholder refers to the engagement with other stakeholders, including non-State actors, such as non-governmental organizations, academia institutions, philanthropic foundations and the private sector.

NCMs can be implemented as a two-stage process:

- **Stage 1 - Multisectoral** - to work with relevant public sectors beyond health, in order to achieve synergies on the science and relevance to their agenda, to implement a health in all policies approach, and address the determinants of health;
- **Stage 2 - Multistakeholder** – Engagement of non-State actors under clearly defined opportunities and modes of engagement, and shared goals and objectives, and with conflict of interest management, as well as with UN agencies and other international organizations.

Establishing this clear delineation will allow for strong government collaboration, solidification and agreement before non-state actors are included in a multistakeholder mechanism.

- **NCMs require strong leadership and convening authority above the ministerial level**

NCMs require strong leadership, convening power and coordination. The lack of it constitutes one of the main obstacles to the success of NCMs. In order for this to happen it is recommended that they be convened or endorsed by an authority at least one level above that of the responsible ministries, thereby allowing the NCM the jurisdiction to coordinate and direct the activities of all sectors involved, as well as to convene and engage other stakeholders, including non-State-actors and UN agencies.

NCMs should be convened by a high-level authority such as the President, Prime Minister or Cabinet Secretary, where possible. This will be important in order to define priorities that have the capability to combine the interests of several ministries and identify social and economic gains that can be obtained with investments on the prevention and control of NCDs.

- **NCMs require a multisectoral plan/strategy with a common vision across relevant governmental sectors and which includes adequate financing for its implementation**

Setting up NCMs requires formulating domestic goals and priorities through a national multisectoral governmental NCD plan/strategy. NCMs should provide a core/common vision to achieve public health and development goals, taking into account the social, economic and environmental determinants of health. Further accountability can be sought through engagement with parliamentary committees or working-groups to provide more long-term sustainability.
The NCM framework should also include clear roles and responsibilities across the relevant government sectors involved, such as industry, agriculture, economy, finance and trade, sports, environment, labour and employment, information and communication, education and legislative representation as appropriate. This may require demonstrating the economic and social case for investment by other sectors in NCD prevention and control, in particular in relation to their responsibilities.

NCMs can consider identifying a set of short/medium term actions within the overall national multisectoral NCD plan/strategy, implementation of which can be prioritized as an initial stage. Where opportunities allow, Member States should learn from and leverage existing health governance platforms and mechanisms, within and beyond NCDs, in order to build on national experiences and lessons learned.

Dedicated resources and investment are required to support and sustain a coordinated implementation of the national multisectoral NCD plan/strategy. A costed work plan and funding sources for NCMs should be identified.

- **A multistakeholder approach within NCMs requires clear rules for engagement with non-State actors, in particular private sector.**

Governments have the primary role and responsibility of responding to the challenge of NCDs, but there is an urgent need to scale up the multiple contributions from the diverse range of non-State actors for the prevention and control of NCDs at national level.

The entry points and modes of engagement of stakeholders in NCMs are specific to country, condition and context. However, engagement of non-State actors should always contribute to agreed national goals and strategies, with a clear definition of roles and responsibilities for all stakeholders involved, in particular the private sector.

A framework of engagement for NCMs should define the different modes of engagement with relevant non-State actors and identify the country’s abilities to implement them. The framework should also provide non-State actors with a better understanding of the political and policy environment and provide governments with an understanding of the interests and motives of non-State actors. This will build a solid foundation for possible engagement, collaboration and partnerships.

There is a need for governments to be much more discerning when considering the varied roles of the diverse range of private sector entities, in order to identify and differentiate the contributions that different entities can make, and therefore the nature of engagement with those different entities. Clear terms of reference for engagement of non-State actors in NCM should be established, in particular when engagement with the private sector is considered. This should include the modalities for engagement in processes such as consultations on development of public policies, contribution to policy implementation, and participation in accountability mechanisms.

Considering that public health objectives and private sector interests do not always align, any framework of engagement for NCMs should always include a clearly defined procedure that safeguards from undue
influence by any form of real, perceived or potential conflict of interest to effectively prevent and control NCDs\textsuperscript{45}. This should involve explicit exclusion criteria of particular industries, such as the tobacco industry.

- **Support the operationalization of coordination mechanisms for NCDs at the local level, where relevant and appropriate**

Local authorities can be key actors in implementing coordination mechanisms in order to translate national action to the local level, especially in countries in which a growing level of political decentralization has occurred.

In some countries, action at a local level can complement nationally coordinated efforts, particularly in terms of collaborating with local non-State actors. Municipalities have the advantage of being closer to the population, enabling a better knowledge of local needs and intersectoral interventions. However, they may be less familiar with identifying and avoiding conflicts of interest when working with non-State actors and may therefore require strong support and guidance in this area in particular.

- **Promote and strengthen transparency, recording and monitoring of commitments from all stakeholders involved in NCMs and the implementation of accountability mechanisms**

The terms of reference, action plans with goals, targets and indicators, stakeholder commitments for NCMs should focus on the core business, be clearly defined and made publicly available.

All agreed commitments of non-State actors, including the private sector, towards the achievement of the national multisectoral NCD plan/strategy should be clearly documented and tracked to enable all stakeholders to be held accountable for their engagement.

Monitoring is key to the success of NCD NCMs. A transparent and formalized evaluation process of stakeholder engagement and commitments is required. It is encouraged that this evaluation be carried out by independent parties.

**Recommendations for WHO**

2. WHO should place an emphasis in supporting the operationalization of NCDs national coordination mechanisms (NCMs) at country level by:

- **Promoting the exchange of best practices, experiences, models of NCMs, as well as implementation research**

A focus on implementation would be useful, as countries are struggling to set up and operationalize NCMs despite guidance and recommendations. An implementation focus should consider the adaptation and contextualization of NCMs, and the monitoring and evaluation of stakeholder engagement and of scale up and sustainability across regions and within countries.

\textsuperscript{45} Such as WHO’s ‘Draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level’, at [https://www.who.int/nutrition/consultation-doi/nutrition-tool.pdf?ua=1](https://www.who.int/nutrition/consultation-doi/nutrition-tool.pdf?ua=1)
A broader analysis of existing mechanisms is required. This will include identifying facilitating factors from countries that have implemented NCMs. WHO should support current NCM monitoring through the development of NCM progress indicators and conduct qualitative reviews that include a focus on leadership and collaborative processes. WHO should support Member States in reviewing and sharing their experiences in developing and implementing NCMs. WHO can promote networks at a regional and global level, in order to enable countries to support each other in NCM implementation. Findings should be fed back to countries to enable best practice and common challenges to be identified.

WHO should provide support for Member States to develop capacity within implementation research and functional and leadership skills, with a specific focus on NCMs. Implementation measures and approaches should be included in NCM monitoring, technical guidance and capacity development provided for countries.

- **Elaborating, updating and/or contextualizing current tools and guidance that address capacity gaps towards engaging with the private sector in NCMs**

To encourage effective implementation of NCMs, WHO should elaborate, update and/or contextualize current tools and guidance, recognizing that there is no ‘one size fits all’ approach. Solutions are very context dependent, with countries varying in their socioeconomic, health system and political context. Tools and guidance should be seen as dynamic, in that they can be continually contextualized and adapted through reflection on the lessons learned from countries in developing and implementing NCMs. This should be done through ongoing monitoring, particularly qualitative reviews, and should take advantage of regional networks in developing context-relevant guidance.

WHO should support Member States in conducting stakeholder mappings, assessment of readiness for working with the private sector and ultimately developing frameworks of engagement with the private sector. Considering that there is no one private sector engagement model that can fit all Member States, any framework will need to allow countries to map and understand local private sector stakeholders, along with the different modes of engagement, and the country’s abilities to implement them.

- **Enhancing tailored made technical assistance to Member States in implementing NCMs**

Although a growing number of countries receive technical support to implement NCMs through WHO regional and country offices and other organizations, many challenges still remain due to capacity gaps. WHO should continue and enhance the provision of specialized technical support, led by regional and country offices, focused on technical assistance for the design, implementation and sustainability of NCMs, including through advice on issues such as engagement with non-State actors, and on conducting health impact assessments of cross-sectoral policies.

- **Strengthening its engagement and advocacy with the UN system in support of NCMs**

WHO should strengthen its coordination, collaboration and alignment with other relevant UN agencies and programmes to support Member States in addressing the social, environmental and economic determinants of health, in order to effectively realize the NCD and NCD-related SDGs.
UN agencies have already made commitments to support national multisectoral action through NCMs. WHO should further engage in enhanced advocacy and dialogue, including through existing platforms such as the UN interagency taskforce on prevention and control of NCDs. This should enhance the UN system’s participation as active stakeholders in NCMs, where and as appropriate, including through accountable commitments.

WHO is encouraged to call upon UN agencies and programmes to scale up and broaden intersectoral work, in a systematic way, integrating expertise relevant to public health-related legal issues into NCD country support, including by providing evidence, technical advice, and case studies relevant to legal challenges.
Table 1: Number and percentage of NCD NCMs by stage, for responding Member States (n=192), by region, Country Capacity Survey 2019

<table>
<thead>
<tr>
<th>Region</th>
<th>Operational</th>
<th>Under development</th>
<th>Not in effect</th>
<th>Other&lt;sup&gt;46&lt;/sup&gt;</th>
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</tr>
<tr>
<td>%</td>
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<tr>
<td>%</td>
<td>49</td>
<td>9</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>EMRO</td>
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<td>1</td>
<td>6</td>
</tr>
<tr>
<td>%</td>
<td>55</td>
<td>10</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>EURO</td>
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<td>20</td>
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<td>%</td>
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</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>%</td>
<td>91</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>12</td>
</tr>
<tr>
<td>%</td>
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<td>TOTAL</td>
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<td>15</td>
<td>11</td>
<td>78</td>
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<tr>
<td>%</td>
<td>46</td>
<td>8</td>
<td>6</td>
<td>40</td>
</tr>
</tbody>
</table>

<sup>46</sup> This mostly includes countries who either responded that they do not have a NCM or that they do not know or left a blank
Table 2: Number and percentage of NCD NCMs members for responding Member States with operational NCMs (n=89), by member type, by region, Country Capacity Survey 2019

<table>
<thead>
<tr>
<th>Region</th>
<th>Member Type</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Figure 1: percentage of NCD NCMs by stage for all responding Member States (n=192), Country Capacity Survey 2019

Figure 2: Percentage of NCD NCMs, by stage, by region, for all responding Member States (n=192), Country Capacity Survey 2019
<table>
<thead>
<tr>
<th></th>
<th>Other non-health Government Ministries</th>
<th>UN Agencies</th>
<th>Other International Institutions</th>
<th>Academia (including research centres)</th>
<th>NGOs / Community based orgs/ civil society</th>
<th>Private Sector</th>
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<td>20</td>
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<td>53</td>
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<td>40</td>
</tr>
<tr>
<td><strong>SEARO</strong></td>
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<td>2</td>
<td>7</td>
<td>6</td>
</tr>
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<td>18</td>
<td>0</td>
<td>18</td>
<td>64</td>
<td>55</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>83</td>
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<td>93</td>
<td>33</td>
<td>21</td>
<td>61</td>
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<td>53</td>
</tr>
</tbody>
</table>
Figure 3: Percentage of NCD NCMs members, by type, for responding Member States with operational NCMs (n=89), Country Capacity Survey 2019

- Private Sector
- NGOs /Community based orgs/civil society
- Academia (including research centres)
- Other International Institutions
- UN Agencies
- Other non-health Government Ministries

Figure 4: Percentage of NCD NCMs members, by type, by region, for responding Member States with operational NCMs (n=89), Country Capacity Survey 2019

AFRO
AMRO
EMRO
EURO
SEARO
WPRO

Legend:
- Other non-health Government Ministries
- UN Agencies
- Other International Institutions
- Academia (including research centres)
- NGOs /Community based orgs/civil society
- Private Sector
Annex B: Examples of didactic guidance tools and approaches

1. National Coordination Mechanism for Tobacco Control. A Model for the African Region
3. Health 2020 A European policy framework for strategy for the 21st century
4. Health in All Policies (HiAP) Framework for Country Action
6. Approaches to establishing country-level multisectoral coordination mechanisms for the prevention and control of noncommunicable diseases
1. **Tool name:** National Coordination Mechanism for Tobacco Control. A Model for the African Region  
   **Organization:** World Health Organization Regional Office for Africa  
   **Year:** 2015  
   **Link:** [https://www.afro.who.int/sites/default/files/2017-06/9789290232933.pdf](https://www.afro.who.int/sites/default/files/2017-06/9789290232933.pdf)  
   **Overview:** This document, on national coordination for tobacco control, provides guidance to enable Member States to establish and strengthen coordination of tobacco-control efforts in their respective countries. It promotes the need to strengthen capacity for coordination at national level and to ensure that a functional and effective coordination mechanism is in place at country level.  
   **Outline:**  
   - Guiding Principles  
   - Key Elements  
   - Key Players And Principal Roles  
   - Model Of National Coordination Mechanism:  
     - National Coordination Mechanism (NCM) Structure  
     - The Technical Working Group (TWG) Structure  
   - Model Of timeline to Establish national coordination mechanism (NCM)  
   - Key Deliverables And Outputs  
   - Monitoring And evaluation Of Coordination mechanism  
   **Recommendations on working with non-State actors:**  
   The document supports engagement with civil society and academic institutions within NCMs. It does not directly provide guidance on dealing with conflicts of interest within NCMs, but it does include mapping of relevant stakeholders in tobacco control that are not affiliated to the tobacco industry. It also recommends that in the process of establishing and monitoring coordination, countries should ensure that members of the NCM, including experts in the TWGs, are not affiliated to the tobacco industry.

2. **Tool name:** A Conceptual Framework for Action on the Social Determinants of Health  
   **Organization:** WHO, Geneva  
   **Year:** 2010  
   **Link:** [https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf](https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf)  
   **Overview:** This a discussion paper series on social determinants of health that provides a forum for sharing knowledge on how to tackle the social determinants of health to improve health equity. Papers in the document explore themes related to questions of strategy, governance, tools, and capacity building. The series aims to review country experiences with an eye to understanding practice, innovations, and encouraging frank debate on the connections between health and the broader policy environment.  
   **Outline:**
1. Introduction

2. Historical Trajectory

3. Defining Core Values: Health Equity, Human Rights, and Distribution of Power

4. Previous Theories and Models

5. Commission on Social Determinants of Health Conceptual Framework
   - Context-specific strategies to tackle both structural and intermediary determinants
   - Intersectoral action
   - Social participation and empowerment

6. Policies and Interventions

**Recommendations on working with non-State actors:**

The document recommends that participation of civil society and affected communities in the design and implementation of policies to address social determinants of health is essential to success. It discusses that conflicts of interest may arise in intersectoral action but does not provide guidance on how to deal with these, or how to engage with the private sector.

3. **Tool name:** Health 2020 A European policy framework for strategy for the 21st century

**Organization:** WHO

**Year:** 2013


**Overview:**

This framework discusses promoting new mechanisms for action, calling for innovative approaches, about developing a common understanding regarding objectives, individual tasks and responsibilities, and developing collaboration through learning and sharing platforms.

The policy framework identifies ways in which new collaborative leadership can use innovative approaches. It also details how to motivate and assist people, organizations, communities and countries to manage and adapt effectively to changing environments; facilitate the development of local capacities; and effectively challenge groups whose activities are detrimental to the public’s health.

The document also specifically champions citizens’ empowerment. Arguing that effective partnerships with citizens and communities, as well as with public and private stakeholders, are essential to gain insights into what affects health at the local level, winning support for action at the grassroots and contributing to community development.

**Outline:**

- Health is a major societal resource and asset
- A strong value base: reaching the highest attainable standard of health
Recommendations on working with non-State actors:

The document recommends that it is important to look for ways to cooperate appropriately and ethically with the private sector, including the pharmaceutical industry, especially since its involvement is increasing across the European Region. It suggests that attitudes towards the private sector vary between and within countries but that industry from the very local to the global is increasingly involved in every aspect of people’s lives. It suggests that businesses are in all communities, and at all levels, and that their knowledge and understanding of local communities represents an often-untapped resource and an asset that, if appropriately harnessed, can contribute significantly to health and well-being. Many small and large businesses are key sponsors of community-level activities, and there is real potential to build further on this. It is clear, however, that their influence can either help to enhance health or undermine it. Although the document mentions conflicts of interest at many times, it does not provide guidance on how to deal with or avoid them.

4. **Tool name:** Health in All Policies (HiAP) Framework for Country Action

**Organization:** WHO

**Year:** 2014

**Link:** [https://www.who.int/cardiovascular_diseases/140120HPRHiAPFramework.pdf](https://www.who.int/cardiovascular_diseases/140120HPRHiAPFramework.pdf)

**Overview:**

This document serves as a “starter’s kit” for applying Health in All Policies (HiAP) in decision-making and implementation at national and subnational levels. It is written to be easily adapted for use in different country contexts and at the regional and global levels.

**Outline:**

What is HiAP?
   - Background
   - Concept and principles
Why it matters

How to implement the Framework
   1 Establish the need and priorities for HiAP
   2 Frame planned action
   3 Identify supportive structures and processes
   4 Facilitate assessment and engagement
   5 Ensure monitoring, evaluation and reporting
   6 Build capacity

Roles and responsibilities
   A key role for the health sector
   Global action
   The role of WHO

Recommendations on working with non-State actors:

The document recommends that it is crucial that the health sector can communicate effectively across and within sectors with politicians, civil servants, key civil society organizations, and the private sector. It recommends that in developing a HiAP approach countries should: 1) Explore where there are common interests, conflicts, or unrealised potential. 2) Analyse and map who will support or oppose health priorities. 3) Identify also whether there is media or public scrutiny.

It also suggests that HiAP can provide a framework for regulation and practical tools that combine health, social and equity goals with economic development, and manage conflicts of interest transparently. These can support relationships with all sectors, including the private sector, to contribute positively to public health outcomes.


Organization: WHO

Year: 2016

Link: http://apps.who.int/ncd-multisectoral-plantool/

Overview:

This online tool provides guidance on assessing the situation, engaging relevant stakeholders, setting national NCD goals, targets, objectives and priorities for action, identifying roles and responsibilities of relevant stakeholders, defining milestones, timeframe, outputs and outcomes, developing implementation plan and monitoring the progress in implementing the NCD MAP. NCD policies, strategies and plans from selected countries are also provided.

The main purpose of this toolkit is to assist policy-makers and programme managers in developing, implementing and monitoring national multisectoral plans. It covers the main steps from situation
assessment, stakeholder engagement, and setting national NCD targets to implementation and monitoring and evaluation, including practical templates and examples. Countries are encouraged to adapt the tool in accordance with their national context.

Outline:

- Assessment
- Engagement
- Formulation
- Implementation
- Monitoring and Evaluation

Recommendations on working with non-State actors:

The document defines stakeholders including public sector, private sector and civil society. Within the private sector, it describes corporations and businesses, business associations, professional bodies, individual business leader and financial institutions. The tool advises on how to engage with stakeholders, discusses working with the private sector when there is no conflict of interest and advises to exclude the tobacco industry.

6. **Tool name:** Approaches to establishing country-level multisectoral coordination mechanisms for the prevention and control of noncommunicable diseases

**Organization:** WHO Regional Office for South-East Asia

**Year:** 2015


**Overview:**

Based on analyses of experiences of countries in addressing various health and similar challenges, this document details five key elements that are integral to an effective multisectoral coordination mechanism for NCDs, and five strategies to improve the involvement of relevant sectors in such a mechanism. The 5x5 approach in this document is presented to guide governments in their efforts to set up effective coordination mechanisms for NCDs at the national and subnational levels.

**Outline:**

- Introduction
- Background
- Rationale
- Methodology
- Scope of the document
• Challenges in establishing and sustaining effective multisectoral coordination mechanisms

NCD COORDINATION MECHANISMS

• Part 1: Five key elements of effective NCD coordination mechanisms
  Highest political leadership
  Clear scope and mandate of the mechanism
  Strong secretariat and sectoral focal points
  A costed, joint action plan and earmarked funds
  Robust accountability indicators

• Part 2: Five strategies to enhance engagement with relevant sectors in NCD coordination mechanisms
  Set the political agenda
  Generate evidence to make the business case
  Showcase benefits and share responsibilities
  Ensure joint accountability through process indicators
  Require periodic reporting to supraministerial authority

• Part 3: Role of intergovernmental, civil society and private sectors vis-a-vis NCD coordination mechanisms
  Role of intergovernmental and international development agencies
  Role of civil society
  Interactions with the private sector

Recommendations on working with non-State actors:

The document recommends that parties to the FCTC need to keep the tobacco industry out of NCD coordination mechanisms. Government interactions with the private sector entities with potential conflicts of interest need to be limited to those required to effectively regulate them and receive updates on their initiatives to comply with government requirements. It suggests that inputs from entities such as private health-care providers could often enhance implementation of the national multisectoral coordination plan. Mechanisms to channel their strengths need to be created. However, these mechanisms need to be operated in the most transparent manner and to the extent required for public welfare. The private sector, while informing government decisions, should not be allowed to influence policy-making.
Annex C: Case studies

Country case studies

1. Transparency – Health, a public database and a prerequisite for maintaining trust, France
2. Decreasing household air pollution, PMUY, India
3. National framework for NCD prevention, Iran
4. The Partnership for a Healthier Diet, Norway
5. Multisectoral and multistakeholder national committee, Oman
6. Integrated Strategy for the Promotion of Healthy Eating, Portugal
7. National NCD steering committee, Sri Lanka
8. War on Diabetes, Singapore

NGO case studies

1. NCD Alliance
2. Scaling up Nutrition Movement
3. Healthy Caribbean Coalition and Small island states, National NCD Commission, Barbados

WHO regions overview

1. WHO Regional Office for Africa
2. WHO Regional Office for the Americas
3. WHO Regional Office for the Eastern Mediterranean
4. WHO Regional Office for Europe
5. WHO South-East Asia Regional Office
6. WHO Western Pacific Region Office
Country case study 1: Transparency – Health, a public database and a prerequisite for maintaining trust, France

France passed a law on the 29th of December 2011 on strengthening the safety of medicines and health products guaranteeing the independence and impartiality of decisions made in the field of health. The law mandates the transparency of links between the health industries and other actors in the field of health, health professionals, students, learned societies, associations, media, etc.

It recognizes that not all interest relationships are conflicts of interest. In order to develop their products, companies might have to establish relations with certain experts, journalists or public actors. It is beneficial to preserve and develop this complementarity, which can advance science and allow therapeutic progress. But these links must be known to all and be publicly available.

This is done in France through the creation of a public database "Transparency - Health", which reports the existence of these links. The database is derived from statements made by companies these statements are updated twice a year and remain accessible for five years, with companies responsible for the accuracy of the published content. Every citizen with internet access can access this information, with three types of relationships recognized: 1) Agreement, 2) Benefits and 3) Remuneration:

1) Agreements arise between companies and health actors and involve obligations on both sides. For example, participation in a congress as a speaker (obligation fulfilled by the professional), with responsibility for transportation and accommodation (obligation fulfilled by the company). They may also include a research activity or clinical trial on a health product, participation in a scientific congress, training action, etc. The database includes the identity of the parties concerned in such agreements, the date of the agreement, its precise purpose, the amount and the organizer, the name, the date and the venue of the event, if applicable.

2) Benefits include everything that is allocated or provided without consideration by a company to a health player (donation of equipment, meals, transportation, accommodation, etc.). The database reports the identity of the parties concerned, the amount, the nature and the date of each benefit when the amount of each benefit is greater than or equal to 10 euros including tax.

3) Remunerations are the payments made by companies to healthcare actors in exchange for work. The database records the identity of the parties, the date of payment and the amount, as long as it is greater than or equal to 10 euros.

Country case study 2: Decreasing household air pollution, PMUY, India

In 2016, the Government of India launched Pradhan Mantri Ujjwala Yojana (PMUY) with the intention of providing 80 million households “below the poverty level” with liquefied petroleum gas (LPG) by 2019 with the aim of reducing exposure to household air pollution. LPG cylinders are issued in the name of the women of the household, with priority to homes in marginalized communities.

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47 Dr Michel Chauliac (2019) Risk assessment and management for safeguarding against potential conflict of interest in nutrition. Geneva. [link](link)
48 Base Transparence Sante [link](link)
Some 70 million of the 80 million households targeted for coverage by 2020 have already been reached. The initiative has led to significant reductions in exposure to household air pollution in the homes connected to LPG, reducing health risks in particular for women, children and older people, who tend to spend more time at home close to cooking stoves.

The Indian Council of Medical Research, is engaged in further evaluating the health benefits obtained, as well as examining sustainability of the LPG connection for cooking. Recent studies have shown that if India was to completely address the issue of household air pollution it could enable India’s household air pollution to be brought within the reach of national standards.

This initiative has been widely advertised on billboards around the country, in particular emphasizing the co-benefits of saving time from the collection of fire-wood, thereby enabling women and girls to be better educated and/or get paid work outside the home. Such interventions are timely as household air pollution, including household, has been added to the Global 5x5 NCD framework.

**Country case study 3: National framework for NCD prevention, Iran**

Iran recognised a need for intersectoral collaboration in the prevention of NCD, leading to the creation of the Supreme Council for Health and Food Security, which provided an action plan to obtain support from other sectors. This was approved by the President, who chairs the Supreme Council, the Speaker of the House and the Vice President. Once the action plan was approved by the Supreme Council, every sector was obliged to follow it as this approval was akin to endorsement of the cabinet and therefore lawful.

Agreement was reached with each ministry involved in the intersectoral collaboration, with agreements signed by the Ministry of Health and that ministry, such that each ministry became responsible for the action related to their sector. This included securing the resources, endorsed by parliament, in their annual budget.

This national plan then led to the development of a sub national plan recognising that the main part of NCD prevention did not occur at the national level and that this national plan had to be carried out by the provincial and district levels. After training and dissemination, provincial governors then become responsible and accountable for implementation in their province of a provincial action plan.

The evaluation of the national and provincial action plans is supported by extensive data collection, which is seen as important for engagement. These data on the burden of NCDs and risk factors within the country were initially important in discussions with the President on the importance of developing coordinated approaches to prevent NCDs. The sub-national level of data collection is also being used to evaluate and encourage implementation at the sub-national level. Through the use of data access and visualisation tools it is possible to compare between provinces and districts by risk factors and NCD outcomes. This motivates governors at the district level to mobilise resources for implementation of the action plan.

**Country case study 4: The Partnership for a Healthier Diet, Norway**

In December 2016, the food industry and the Ministry of Health and Care Services in Norway, signed a Letter of Intent for facilitating a healthier diet. The ‘Partnership for a healthier diet’ agreement is valid until

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49 [https://www.helsedirektoratet.no/english/partnership-for-a-healthier-diet](https://www.helsedirektoratet.no/english/partnership-for-a-healthier-diet)
31 December 2021 and has the goal to achieve a more comprehensive collaboration between the health authorities and the food industry, with the aim of making it easier for consumers to make healthier choices. In order to reduce risk and conflicts of interest, the partnership is Government led, with the Directorate of Health holding the secretariat. Transparency is ensured in all aspects of the partnership, including through the publication of: the agreement and all involved partners, the agenda and notes from all meetings, a list of members and the mandate of coordination group, the common goals of the agreement, the monitoring and level of achievements, and the evaluation reports carried out by an independent third party. All meeting participants also have to sign a written consent that they will obey the rules of the partnership at all times.

The partnership defined six common quantitative targets to be reached by the end of 2021, one of which was a 12.5% or greater reduction of added sugar in the population’s diet. This was supported through one of the six partnership priority areas: Reduction of added sugar in foods and reduction of the population’s intake of added sugar. Monitoring of these voluntary agreements on sugar reduction showed that this collaboration was not leading to the required voluntary reformulation and subsequent reduction in sugar available in processed foods and drinks. The Norwegian government therefore chose to implement regulation through increasing product taxes on chocolate, sugar confectionery and non-alcoholic beverages in the state budget for 2018. This led to a number of companies disengaging with the partnership.

**Country case study 5: Multisectoral and multistakeholder national committee, Oman**

As part of the commitment of the Ministry of Health made at the UN High Level Meeting for NCDs, Oman formed a multisectoral and multistakeholder national committee that includes all related sectors in order to develop a strategy for all interventions related to NCD prevention and control. The National committee has chosen seven elements to focus on, made up of four diseases (diabetes, chronic obstructive airway diseases, cancer, and cardiovascular diseases) and three main risk factors (smoking, physical activity and nutritional issues). The Ministry of Health is currently in the process of finalizing a costing review as well as working on an investment case study, with the support of WHO.

The Ministry of Health was able to form multisectoral subcommittees emerging from the National NCD Committee, aimed at facilitating direct coordination with other concerned sectors namely, Ministry of Commerce & Industry, Ministry of Municipalities, Ministry of Education, Ministry of Youth Affairs and Ministry of Consumer Protection. These subcommittees work at the operational level. Their responsibilities are well-defined in the NCD strategy to implement the recommendations of the NCD committee.

Non-State actors are represented in the national coordination mechanism by four main community associations, Association of Tobacco Control, the Cancer Association, the Omani Women’s Association, along with the Chair of Omani Medical Association. The Ministry of Health has regular meetings with these associations and they support the Ministry through dialogue and implementation support, especially in the screening of breast cancer, and through the organization of campaigns on smoking bans, as well as in raising the awareness among the public of the risk factors of NCDs. All of these associations have representation in the National NCD committee and subcommittees.

Oman received a UN Interagency Taskforce joint mission in 2016, which met with the higher authorities in the Cabinet, and the concerned heads and stakeholders in governmental and non-governmental sectors. A

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report of this visit and discussions has been produced, which is used by the Ministry of Health as a guide to support the implementation of the NCD strategy. An annual report mapping the progress of implementation is shared with WHO.

**Country case study 6: Integrated Strategy for the Promotion of Healthy Eating, Portugal**

In 2018, the Portuguese Ministry of Health tried to implement a single front of pack nutrition labelling system by endorsing the French Nutri-Score model, after careful review and reference to the evidence\textsuperscript{51}. However, in Portugal food labelling falls under the competency of the Ministry of Agriculture, which viewed such legislation as going against agricultural interests. The labelling system was therefore never approved. In response to this, the Portuguese Government brought together all Government Sectors, committing to common health goals in the area of nutrition through an Integrated Strategy for the Promotion of Healthy Eating - Estratégia Integrada para a Promoção da Alimentação Saudável (EIPAS). EIPAS was approved in December 2017, after one year of negotiations under the leadership of the Prime Minister and coordinated by the health sector. EIPAS is structured into four different strategic axes. Foodlabelling is a planned measure in Axis 2: Improve The Quality And Accessibility Of The Information Available To Consumers\textsuperscript{52}. Under the scope of EIPAS, Portugal has already implemented the design of a proposal for an interpretative model of front-of-pack food labelling\textsuperscript{53}.

**Country case study 7: National NCD steering committee, Sri Lanka**

As part of the 2009 National Policy & Strategic Framework For Prevention And Control Of Chronic Non-Communicable Diseases, Sri Lanka created the National NCD steering committee. This steering committee functions as the national monitoring body on National NCD Policy implementation. It is chaired by the Secretary of the Ministry of Healthcare and Nutrition, and constitutes high level representation from all relevant government agencies. Decisions taken by the National Steering Committee for Non-Communicable Diseases regarding implementation of strategies involving different sectors are discussed at the National Health Council (NHC). The NHC functions as the supreme body for promoting inter-ministerial /intersectoral collaboration and multisectoral partnerships, and overseeing progress of implementation of the National NCD Policy for Sri Lanka, as an integral part of the health system development. Instigation for the steering committee came from within the Ministry of Health, who took it to the Minister of Health for support.

This current mechanism does not involve the private sector and aims to start with selected government sectors, to agree on NCM goals and actions, before expanding to include industry. It was felt that the strong political position of the Minister of Health was useful in overcoming many conflicts between government partners, most of which were dealt with through negotiation and sharing of responsibilities between sectors. A major barrier was the lack of funding within other sectors for health issues. To overcome this, the Sri Lanka Ministry of Health and WHO provided funds for other sectors to include targets in their activities that linked to the national multisectoral action plan. This was seen as important in gaining commitment to the NCD NCM from non-health sectors.


\textsuperscript{52} Goiana-da-Silva F, Gregório MJ, Nunes AM, Graça P, Bento A, Araújo F. Bringing government sectors together to address noncommunicable diseases: Portugal’s interministerial healthy eating strategy. 2018 \textsuperscript{link}

Country case study 8: War on Diabetes, Singapore

Singapore gained high level political support in the fight to prevent NCDs and promote healthy eating. This was clearly expressed by the Prime Minister in his annual National Day Rally speech. In particular, in 2016, the Singapore Ministry of Health launched a “War on Diabetes”, a nationwide effort to reduce the burden of diabetes which had been identified as a particular public health problem in the country. To spearhead this initiative, the Ministry of Health (MOH) established the national Diabetes Prevention and Care Taskforce. The ‘Taskforce’ includes representatives from different government sectors, healthcare providers, academia, employers’ associations, unions, and non-profit organizations. This taskforce has three working groups each addressing identified key areas: 1) Healthy Living and Prevention, 2) Disease Management, and 3) Public Education and Stakeholder Engagement.

Partnering with industry was seen by the government as important for developing healthier food options. The MOH supported industry efforts to reduce sugar content of foods and beverages high in added sugars. Through collaboration with the Singapore manufacturing association, which has links to the food industry, voluntary reformulation of foods and beverages high in sugars, salt/sodium and fats was adopted. This agreement was the result of a decade of close communication with the industry bodies, and because of strong consumer demand for healthier products, and it was supported by government educational and health promotion activities.

At the same time the Singapore government had been investigating a number of regulatory approaches, including mandatory labelling, sugar taxation and advertising bans. The conduct of this exercise, along with the implementation of such approaches in other countries, encouraged industry to agree to a voluntary approach. In August 2017, the top seven industry leaders (including Coca-Cola, Nestlé and PepsiCo) committed to a maximum sugar content of 12% for all of their drinks sold in Singapore by 2020. It was recognised, however, that smaller companies were disadvantaged by such changes, as they didn’t have the experience nor the resources to reformulate their products as well. In order to assist SMEs, the Ministry of Health provided grants to in support of reformulation and promotion, and facilitated these SMEs to national polytechnic institutes and food technology centres to provide technical support.

NGO case study 1: NCD Alliance

Many countries described the role of the NCD Alliance as a positive one. The NCD Alliance, formed in 2009, describes itself as ‘a global thought leader on NCD policy and practice, a convener of the civil society movement, a partner to governments and UN agencies, and an advocate for people at risk of or living with NCDs’. Currently the NCD Alliance reports to have close to 60 national and regional alliances, along with a robust global network of more than 2,000 organizations in 170 countries.

The global alliance has become a standalone NGO, but due to this rapid expansion is reviewing and adapting how it works with country and regional alliances. This includes provision of technical support, guidance and training, support in the development of priorities, and funding approaches. Some have raised

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56 Ministry of Health (2018) Singapore’s War on Diabetes. Singapore link
concerns over the Global NCD Alliance’s link to industry, as it holds a number of corporate partners and receives 38% of its total funding from the private sector\(^57\). The Global NCD Alliance deals with conflict of interest issues through transparency in the reporting of partner organizations and companies, disclosure of funding sources and adherence to long term strategic plans and short term business plans. They also distinguish between private sector industries, partnering with pharmaceutical and medical companies but not the tobacco, alcohol, food or beverage industry. In addition, they have a conflict of interest policy for board members and staff, which includes annual financial reports and conflict of interest declarations\(^57\).

**NGO case study 2: Scaling up Nutrition Movement**

The Scaling Up Nutrition (SUN) movement is a global nutrition advocacy effort to mobilize governments and their partners including civil society organizations, businesses, academic institutions, communities and families to prioritize nutrition as central to national development and imperative for achieving the Sustainable Development Goals. The SUN movement was established and launched by the UN Secretary General in September 2010 at the sidelines of the UN General Assembly, demonstrating the political alignment on the way forward among nutrition stakeholders to address malnutrition. To end malnutrition in all forms, SUN calls for more and better multisectoral and multistakeholder action on nutrition focusing on the first critical 1000 days of a child’s life. Currently the SUN movement has 61 member countries and 4 Indian States.

The political leaders in SUN countries agree to engage all sectors of central and local governments in their efforts to improve nutrition. The SUN movement aims to create enabling environments for countries to develop multisectoral and multistakeholder approaches to address malnutrition and diet-related NCDs. Their governments establish priorities and develop costed multisectoral plans which are backed by different stakeholders – including civil society, the United Nations system, development partners, business enterprises and researchers. The different stakeholders are united in their respective SUN networks. It supports countries, through ethics advisors, providing guidance and training on how to recognize and/or manage conflicts of interest (COI). A COI guide was developed for SUN governments focal points.

SUN encourages collaboration with the private sector which certain nutrition stakeholders are critical of. The members of the SUN business network, which is co-facilitated by the Global Alliance on Improved Nutrition (GAIN) and World Food Programme (WFP), need to meet certain requirements related to the non-violation of the International Code on the Marketing Breast-Milk Substitutes, maternity leave, decent food for the workforce and similar goals.

**NGO case study 3: Healthy Caribbean Coalition and Small island states, National NCD Commission, Barbados**

The Barbados NCD Commission (BNC) was established in 2007 following a series of recommendations, including in an EU funded task force report on the development of cardiovascular services in Barbados and in the Port of Spain Declaration of the CARICOM Heads of State and Government Summit on NCDs\(^58\). The BNC and its members are appointed for a time limited period by the Cabinet of the Government of Barbados on the recommendation of the health minister. Membership of the commission consists of

\(^{57}\) CARICOM (2007) Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs [link]

Page 35 of 87
representatives of health and non-health ministries, civil society, including academia, and selected private sector. Technical and financial support is provided by the Health Promotion Unit of the Ministry of Health. Terms of Reference, determined by the health minister, are largely advisory, acting as the national focal point for advancing national multi-sectoral action. Despite some successes and strong advocacy by the BNC it has been felt to underperform as a result of inadequate human and financial resources, insufficient technical assistance, lack of clear direction and restrictions on its ability to execute, along with weak methods of appointments. A need is seen for other types of mechanisms with greater permanence and influence.

A particular challenge in small island states can be a reliance on individual relationships and commitment. One person may be responsible for a number of relevant sectors or responsibilities within sectors, representing these on the commission. A change of individual in that role can lead to different priorities and commitment from these sectors. Without the embedded organisational support this may lead to challenges in redeveloping collaboration and relationships. With the needs of small island states and their regions differing to big countries, support must be adapted to their needs. Although the WHO is highly effective at producing technical documents, additional assistance in implementation and sustaining human resources, along with financial and technical support is required. This is more effectively delivered in small island states using a regional approach, taking advantage of platforms that are already in place.

For example, the BNC has, since its inception, had a close relationship with a regional civil society NCD Alliance, the Healthy Caribbean Coalition (HCC), the formation of which it co-sponsored. Civil society has effectively used its position on the BNC to fulfil an advocacy role whilst the HCC has provided multi-sectoral assistance in the form of assessment of NCD commissions; provision of technical assistance; establishment of an online resource portal and source of information; creation of a tool for strengthening commissions; and the establishment of a Virtual Network of Chairpersons of commissions. A further weakness identified by the HCC was a lack of attention to conflicts of interest (COI). This was a concern due to private sector representation and fears of the adverse influence of the food and beverage industry leading to a reluctance to engage with them. Due to a lack of resources at the level of National NCD Commissions, the HCC has undertaken to address this issue with the production of a COI guide for Caribbean civil society and others working in multi-sectoral approaches to NCD prevention and control, which will be available shortly.

WHO region overview 1: WHO Regional Office for Africa

Countries in the African region are reportedly experiencing conflicting priorities in developing NCD NCMs due to the current burden of emergencies and infectious disease, including Ebola. This can lead to inadequate leadership for NCDs in general, including a lack of high political commitment and challenges in the allocation of resources. There is also a reported insufficiency in information on NCDs for decision makers. Although STEPs surveys have proved useful in collecting country level data on NCDs, some Member States have not completed a STEPs survey for over a decade, thus contemporary information is limited.

The need to bring all relevant stakeholders ‘on board’, such that NCDs are not seen as solely a health sector issue, is recognized. Current discussions on the development of NCD NCMs suggest that instead of creating completely new structures for NCDs, advantage should be taken of existing multisectoral commissions such as

59 Barbados National Commission for CNCDs link
60 Health Caribbean Coalition link
as those developed for preventing HIV and malaria. Although it may not be possible to expand the mandate of HIV commissions to include NCDs, lesson should be learned from these experiences and on the SUN Movement in Africa (which represents 42 countries).

A focus on implementation in the region is recommended. With suggestion that too great a focus has been placed on commission structures. In some countries plans can stay in draft for a long time as NCM structures are developed and agreed. It may be beneficial to implement some plans before waiting for the completion of the NCM, in order to avoid innovation evaporation and lose interest from other sectors and stakeholder.

AFR countries are being targeted by industry and face increasing challenges by industry interference in particular when resources are scarce and legislative loopholes exist. They don’t yet have adequate political support within the countries for the NCD agenda.

In order to help Member States deal with this issue, the WHO Regional Office for Africa provides technical support for countries on developing policies on tobacco control, tobacco legislation advice and a tobacco taxation team, along with public health experts, on top of publication of the ‘National Coordination Mechanism for Tobacco Control. A Model for the African Region’ guidance. They also support countries to disseminate experiences and collaborate such that they can learn from country experiences.

**WHO region overview 2: WHO Regional Office for the Americas**

Countries are at very different stages of NCD NCM development and implementation in the WHO Region of the Americas. National context plays a crucial role in establishing and maintaining the operationality of NCD NCMs. Strategies used to establish NCD NCMs vary according to countries’ structure and capacity. There are countries which have established multisectoral commissions for tobacco control and physical activity at the national or subnational level.

In 2017, 13 Member States reported having an operational NCD NCM. Many larger countries have the necessary capacity to ensure the sustainability of commissions, whereas smaller countries, such as those in the Caribbean struggle to achieve NCM sustainability due to limited human and financial resources available for the response to NCDs. Nevertheless, 4 new Caribbean Countries reported having an operational NCD commission in the 2019 Country Capacity Survey. There is however, still a need for robust evidence on how NCMs could work better. This should include studies on how countries have prioritized NCM actions, related results and lessons learned, and how to avoid fatigue of the multisectoral partners.

Strengthening the regulatory capacity of countries to promote actions to establish an environment where the healthy choice is the easiest choice and to improve national response mainly at the primary health care level, are crucial measures to accelerate progress in order to tackle NCDs.

Surveillance and monitoring, as a core public health essential function, is central to tracking progress and requires data collection beyond the health sector. There are key sources of information needed to monitor NCDs and their risk factors (RFs). These include civil registration and vital statistics that capture mortality data, population-based surveys, NCD registries, and health care information systems, especially primary health care information. Population-based surveys (such as the STEPS survey and Global School-based
Health Survey -GSHS) are the main sources used to monitor NCDs/RFs. They can also assess compliance with public policies and implementation of programs and interventions.

National Statistics Offices (NSOs) often lead and implement population-based surveys, but quite often Ministries of Health have not established formal relationships with NSOs consistent with their role as the agency in charge of periodically carrying out national population health based-surveys. STEPs surveys or their equivalent should be integrated into the NSO survey system and funding should be available every five years for implementation as part of the national surveillance system. Including NSOs in NCMs, will help in this regard.

**WHO region overview 3: WHO Regional Office for the Eastern Mediterranean**

The Eastern Mediterranean Regional Office (EMRO) highlighted contextual differences between Member States in the region as a key issue in the development of NCD NCMs, with a range of socioeconomic, system and political contexts found across the region. Ministries of health within countries recognized that it was important to reach out to other ministries in order to tackle NCDs, with finance, trade and commerce identified in particular. Assistance was provided for countries, through EMRO, in the form of technical support, including regular visits to individual countries.

Leadership support was seen as very important, with good governance and strong regulation crucial to the success of NCD NCMs. In some instances, changes in leadership had led to challenges in developing and implementing NCD NCMs, with political instability remaining a concern for some countries. Support and guidance from the WHO was seen as particularly important in these situations and that it was important that countries learn from the experiences of others.

In October 2012, EMRO developed a Regional Framework for Action to implement Multisectoral Action Plans (MSAPs) for the prevention and control of NCDs. It was thought that previous support in the process of developing and implementing such MSAPs provided by the WHO was developed either conceptually or through expert opinion. It did not, therefore, consider the practical implications countries may encounter when they attempt to follow the recommended steps. WHO EMRO therefore initiated a process to support four selected countries to develop MSAPs. Through working with these countries, they identified key barriers and enablers to their development in the region and established regular opportunities to share national experiences with the aim of helping Member States in the region achieve the time bound target of having an operational NCD MSAPs by 2030.

Surveillance was also seen as central to the development and implementation of NCD NCMs, with the Global Monitoring Framework to 2025 and the Sustainable Development Goals (SDGs) recognized as providing measures that should be included. Such monitoring should also include NCM development and implementation measures and should be mirrored back to countries regularly in order to help them in their efforts.

**WHO region overview 4: WHO Regional Office for Europe**

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In Europe more countries are reporting multisectoral coordination mechanisms than multistakeholder and these are seen as very different by nature. There are a number of examples of multisectoral mechanisms led by Heads of States, that have been in place for a number of years and throughout the region there is a political will to develop and implement NCD NCMs. There is, however, some uncertainty over whether to have multiple NCMs for health, as there are concerns over multisectoral fatigue.

Although monitoring of NCMs is recommended, many countries develop NCM indicators that sit within the responsibility of the ministries of health. This can leave little incentive for other ministries to engage fully with mechanisms. To overcome this, countries should incorporate human capital thinking, health and wellbeing into productivity and economy. It was suggested that SDG coordination mechanisms could be set up to promote this. SDGs are seen to offer an interlinked/intersectoral approach, but it was felt that this had not been built on strongly enough.

Concern over conflicts of interest was seen as a major obstacle in the management of non-State actors on NCD multistakeholder NCMs, which led some countries to refuse collaboration with all non-State actors.

It was felt that the WHO focus on health meant that it did not offer enough in this area and that current frameworks were currently not fit for purpose. To improve this a broader analysis of existing mechanisms is needed, in order to identify facilitating factors, with guidance revisited due to country experience. This could lead to recommendations on the management of conflicts of interest, with improvements in the evidence base on the risk of working with non-State actors needed. An implementation research approach should also be adopted to provide guidance and greater understanding on implementing NCD NCMs.

**WHO region overview 5: WHO South-East Asia Regional Office**

The WHO South-East Asia Regional Office (SEARO) reported that all 11 countries in the region had developed or revised NCD NCMs, although it was acknowledged that this was on paper and there were many differences in their operation. For a number of countries one of the major barriers to success was that initial drafts were too ambitious. Aims were too broad and extensive. This led to the NCM involving every ministry, which would result in a mini cabinet. In some countries, this looked good on paper, as the NCM was made up of high level officers from all sectors. However, as this mirrored the country cabinet, meetings seldom happened.

This could mean that there was insufficient commitment from all sectors with limited partnership and engagement, with the NCD NCMs still perceived as a health sector responsibility. Often this was manifest in other sectors assigning ‘middle level’ representatives to the NCD NCM, who did not hold the type of seniority required for sector wide commitment. It was felt that NCMs were more successful if they started with fewer actions and fewer sectors. These key sectors would form a core that would be added to with other sectors, if required, for certain actions.

Conflicts of interest between government sectors were also seen in a number of countries, including in those in which non-health ministries owned a tobacco monopoly or produced alcohol. It was acknowledged, however, that NCMs could not be successful without non-State actors but there were concerns over the influence of the private sector. It was reported that although guidance was provided through the *Approaches to establishing country-level multisectoral coordination mechanisms for the prevention and control of noncommunicable diseases, 2015*, document more could be provided on working
with non-State actors, particularly as in some countries industry were able to block recommended interventions, including the Best Buys. In addition, on many occasions, the private sector has provided grants to non-health government sectors and it was a challenge to get these sectors to understand why the private sector would want to link to them.

**WHO region overview 6: WHO Western Pacific Region Office**

As with other regions, the Western Pacific Region (WPRO) has a variety of contexts amongst its Member States. Most high-income countries have developed their own mechanisms, whereas low and middle income countries (LMICs) have a more vertical or programmatic approach, with NCD NCMs led by Ministries of Health, that oversee overall action plan development and coordinate its implementation, and varying involvement of other sectors and stakeholders. This set-up precludes commitment from non-health ministries, a major challenge found in WPRO countries. As Ministries of Health do not have jurisdiction over other ministries, higher leadership, such as Head of State or his or her equivalent, is required.

In some countries the strategic or action plan of the NCMs will remain at a higher level, with limited operational details. These are seen to be left at the policy level and often lost. Resources are needed at the ground level if they are to be implemented. This will involve sub-national implementation, such as at the provincial and community level, especially in Member States with decentralized governance, and requires support from civil society and academia in particular.

The most important thing for long term sustainability of NCMs is political commitment, including leadership from the highest level. In the region, parliamentarians have been recognized as key to ensuring successful multisectoral policy development and funding and steps have been taken to involve them more in NCD prevention and control efforts. Recently, WPRO convened two high-level meetings - the 3rd Asia-Pacific Parliamentary Forum on Global Health in 2017, which focused on accelerating action for NCDs and healthy ageing, and the 6th Regional Workshop on Leadership and Advocacy for the Prevention and Control of Noncommunicable Diseases (LeAd-NCD) in 2019, which targeted high-level officials from the parliament and health. Previous LeAd-NCD workshops have also brought together officials from health and nonhealth sectors to share country experiences and learn updates on NCD issues and interventions. These meetings have raised NCD prevention and control through multisectoral and multi stakeholder involvement in the development and legislative agenda of some countries.

A number of Member States are small areas, or island nations, mostly in the Pacific. In these countries and areas, the potential for multisectoral collaboration is high – due to the relatively small government size and this has worked in the favor of Member States such as Tonga and Guam. These countries and areas value traditional village and faith-based leaders and consider these as key stakeholders that need to be involved in NCMs.

Conflicts of interest are an issue, with these differing by context and between countries. In some Member States the government or individual politicians hold investments in certain industries which hamper the passing of relevant laws and regulations. To address this, some countries ask for WHO advice on stakeholders to involve in NCD NCMs. WHO provides a list of possible stakeholders, identified through due diligence. Member States welcome WHO guidance specifically practical tools such as the Tools for National Multisectoral Action Plan for prevention and control of noncommunicable diseases (NCD MAP Tool) as well
as actual country examples from within and outside the region to facilitate translation of recommendations into action.
Health literacy and education to empower the individual to make informed choices and promote healthy lifestyles

The second section of the report considers the effective implementation of HL measures as a complement to policies, programmes and interventions for the prevention and control of NCDs and mental health conditions.

What is health literacy?

**Key message:** The concept of health literacy is closely linked to health equity and can be used to understand who is missing out of current services, why individuals and groups are being left behind, and how NCD policy, programmes and interventions can be developed and/or improved to accelerate impacts on NCDs. Importantly, health literacy can be used to understand how to create environments where healthy choices are the easier choice to make.

*Box 1 Definition and lived experience of health literacy*

**What is health literacy?**

Health literacy is the tasks that individuals and communities undertake to Access, Understand, Appraise, Remember and Apply information about health in everyday life, continuously throughout the life course.

To maximise people’s chances to live a healthy life and prevent and control NCDs and their shared risk factors, individuals and communities need to be enabled to effectively Access, Understand, Appraise, Remember and Apply appropriate, context-specific information about NCD prevention and control throughout the life course.

To make an impact on the growing burden of NCDs we need to understand the contextual information and the support required by individuals, their families, and their communities in order to enable them to take action in support of improving their health and well-being. Given that for many people there are many barriers across the five health literacy tasks (e.g., limited access to information and services, and limited ability to understand, appraise, remember or apply health information), it is important that across Member States, environments are created that make it easy for people and communities to engage in healthy activities and make healthy choices.

Why Health Literacy should be a priority for Member States?

**Key message:** Health literacy provides insights into why interventions may have limited reach or are ineffective in specific contexts. It can be used to improve NCD policies, programmes and interventions to better respond to community needs, and build more effective measures to empower individuals and communities to take action against NCDs and their shared risk factors. It is used to understand why health inequalities exist, how to reduce these, and put in place programmes that ensure on one is left behind.
The past 20 years of research has shown that health literacy is associated with health and equity outcomes. Contemporary research outlines how improving health literacy can lead to positive health outcomes and reduce inequalities. This research has led to the inclusion of health literacy as one of the three pillars in the Shanghai Declaration on Health Promotion 2016 to achieve sustainable health development. Health literacy is also included in a wide range of high level NCD-related policy documents as a way to structure NCD interventions and policies to be more effective and reach more people.

Several countries have developed specific health literacy policies, including Scotland, Germany and Australia and/or have put in place national initiatives, such as the USA and China. In response to the recognised needs, a WHO European Action Network on Health Literacy for Prevention and Control of NCDs has been established: a network inspired by the WHO Global Coordination Mechanism for NCDs National Health Literacy Demonstration Projects (NHLDPs), and has also established an Action Network on Measuring Population and Organizational Health Literacy (M-POHL).

**Box 2 The importance of health literacy**

**Why is health literacy important for Member States to consider in NCD programme design and development?**

A health literacy approach provides valuable data on what individuals understand about health, what they think are the links between risk factors and NCDs, how to prevent and control NCDs, and where and what services individuals think are available to them, as well as their understanding of what self-management supports and services can be used.

In other words, we need health literacy data to:

- Evaluate the quality and impact of information being provided to populations,
- Guide design of policies, programmes and interventions to ensure coverage,
- Evaluate the quality and impact of information being provided to populations,
- Understand what people need to understand and how people can effectively find and use services, and
- Understand why some programmes fail to be effective with, or reach, the full

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range of individuals and communities, and therefore inform how to build and implement interventions that generate enabling environments and reduce health inequality.

What is a health literacy approach to NCD prevention and control?

**Key message:** Individuals, families and communities are highly varied in what they know and do about health, and how knowledge and behaviour changes can generate sustained health benefits. Therefore, context specific, culturally-sensitive and age-appropriate NCD health literacy interventions need to be put in place to complement current policies and programmes in order to effectively address NCD prevention and control.

Health literacy approaches are a useful way to assess what individuals know, think and believe, and how they take decisions about their health. This information can be used to ensure NCD initiatives are as effective as possible in each context and reach each target group. In this way health inequality can be minimised.

For governments to effectively accelerate progress towards meeting health-related SDGs, particularly SDG3.4, current NCD policies, programmes and interventions need to use health literacy as a framework for system and service redesign, ensuring current interventions respond to the health needs of all population groups and reach all sectors, creating enabling environments, and leaving no one behind. Integrating health literacy principles can enhance the reach, acceptability and impact of NCD interventions.

How can health literacy improve the reach and impact of interventions to prevent and control NCDs, mental health conditions and their shared risk factors?

**Key message:** More effective, context-specific approaches to combat NCDs are required. Current policies, programmes and interventions are insufficient in effectiveness and reach to curb the growing burden of NCD and mental health conditions for all populations. Health literacy can be used as an enabling framework to assist with designing more effective approaches for NCDs and mental health conditions across all countries (HIC and LMIC).

As an enabling framework, health literacy provides insight into whether individuals understand, access or act on health information or engage with health services. It also provides insights into why NCD health services and interventions may not be effective for all members of the general population and whether minority or disadvantaged groups can access or engage. In other words, health literacy provides information on limitations (and strengths) community members may have in engaging in NCD prevention and care, and also how to improve health and social care systems, educational systems (for children and health professionals) and workplaces to increase the quality, access and reach of information and services for NCDs.

The comprehensive prevention and control of NCDs and mental health conditions is complex and goes beyond the control of the individual. Therefore, it becomes important to address the various social, economic, environmental and commercial determinants of health by creating enabling environments where people feel confident, empowered and supported to effectively address NCD risk factors.

With this in mind, the simple provision of information, especially when confronted with individuals or communities with low health literacy, is often not enough. With the application of health literacy thinking
Health literacy related mechanisms that hinder individuals and communities from engaging in healthy behaviours

**Key Message:** In many communities and population groups there are individuals who may have insufficient understanding of health in general, of NCDs, mental health conditions and their risk factors and determinants, of where and how to access health services, as well as a lack of skills to follow guidance. Many individuals may also have difficulty understanding the relevance of mass media campaigns, or may not have availability nor access to healthy choices.

**Box 3 Health literacy related mechanisms that may hinder effectiveness and impact of NCD interventions**

**Insufficient health literacy skills as examples of barriers to effective health outcomes.**

**Access:** Can’t read well enough, can’t find good information, can’t find

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services/no services available, feel stigmatised

**Understand:** insufficient experience, low education, incongruent with indigenous knowledge

**Appraise:** Complex messages, conflicting information, too many options

**Remember:** Cognitive problems, complex treatment regimes, competing priorities

**Apply:** Little personal evidence changing is worth the effort, disjointed/hard to navigate services, unsafe places to exercise, nowhere to cook

**Many individuals and groups already know what to do** to prevent and control NCDs and mental health problems and their shared risk factors (e.g., to stop smoking, eat less fat, sugar and salt, consume less alcohol, workplace stress), but they may still be faced with economic, social and environmental barriers and the lack of enabling environments that impede behavioural change.

The lack of skills and understanding on how to effectively counter unhealthy messages being delivered by industry with commercial interests is also a major barrier. Often individuals require high health literacy skills to recognise and resist unhealth options, and also to find and decide what healthy options are available.

### Who may have health literacy challenges?

**Key Message:** Health literacy can be a challenge for anyone at any time. Even individuals with high levels of education can have low health literacy.

**Box 4** All population groups experience health literacy challenges—developing effective NCD policy and interventions requires careful consideration of all groups and their challenges to reduce health inequalities and to leave no one behind

**General population groups who often have health literacy challenges**

- People with limited education
- Children and adolescents
- People living in low socio-economic settings
- People who are ill

**Special groups that may have the biggest health literacy challenges**

- Immigrants, especially those moving to a country with different healthcare systems and languages
- Elderly people living in settings where services increasingly demand digital access
- People newly diagnosed with a disease
- People with multiple conditions
- Educated people with limited exposure to health issues
- People with mental health conditions
- People seeking care in settings with complex or fragmented health care systems

Anyone can have health literacy challenges during their life-course, including health professionals.
What health literacy barriers can individuals present?

While individuals or communities may have overall high or low health literacy levels, it is more helpful to explore their range of health literacy strengths or weaknesses. Health literacy is multidimensional (see Box 1) – some individuals may have weakness in ‘understanding’, but this may be compensated by strong social support (carers) and good communication with their doctor, therefore the ‘weakness’ may not impact their prevention and control of NCDs. Understanding the specific health literacy strengths and weaknesses helps to inform what actions need to be taken.

Box 5 Specific health literacy challenges individuals may experience

A combination of health literacy challenges can be experienced by anyone during their life course. These include:

1. A lack of knowledge about service entitlements
2. Being unaware of resources that support health in the neighborhood
3. Being unable to find and access health services
4. Unable to work out what information and advice is needed for good health
5. Having support system at hand
6. Unable to find suitable health information
7. Unable to evaluate the trustworthiness of health information (from people, web etc)
8. Unable or not recognizing responsibility for one’s own health
9. Having social customs and cultural beliefs that inadvertently promote unhealthy behaviour or limit healthy behaviour

People may have weaknesses (or strengths) in one or more health literacy areas.

Contemporary health literacy approaches to develop and implement public health and health service interventions for NCDs and mental health conditions.

Key Message: Health literacy is useful for informing the development of NCD interventions. The assessment of the health literacy strengths and weaknesses of populations and target groups (i.e., often unreached groups) can ensure an in-depth understanding of why current services do not reach all populations, or current programmes fail to generate healthy behavioural change and reduce health inequalities. We provide 8 principles for developing and implementing intervention, and 6 key learning modalities to optimize learning across populations.

Over three quarters of NCD deaths occur in low- and middle-income countries (LMICs) with about 46% of deaths occurring before the age of 70. Accordingly, large-scale, cost-effective, context-specific and sustainable NCD interventions that are appropriate for these settings need to developed and/or tailored and implemented. These are typically top-down, widely applied interventions. Alongside the large top-down interventions, bespoke context-specific interventions will need to developed and implemented to ensure minority groups and those for whom the mainstream interventions are unsuitable, are delivered appropriate interventions and services that match their health literacy needs and capabilities. WHO National Health Literacy Demonstration Projects (NHLDPS) were developed to progress this approach.

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74 http://www.searo.who.int/entity/healthpromotion/documents/hl_toolkit/en/
In the SEARO Health Literacy Toolkit for Low- and Middle-Income countries \(^7\), the following 8 principles are outlined. These are applied in WHO National Health Literacy Demonstration Projects (NHLDPs) underway in many WHO regions \(^7\).

**The 8 principles** for health literacy interventions:

1. Focus on improving health and wellbeing **outcomes**
2. Focus on increasing **equity** in health outcomes, and access to services for people with varying health literacy needs
3. Engage all relevant stakeholders in the **co-design** and implementation of solutions.
4. Respond to locally-identified **health literacy needs**
5. Prioritise **local wisdom**, culture and systems
6. Focus on achieving **sustainable** improvements through changes to environments, practice, culture and policy
7. **Respond** to the variable and changing health literacy needs of individuals and communities
8. **Systematically** apply improvements at, and across, all levels of the health system

**The 6 key learning and knowledge uptake modalities required to optimise learning across entire populations**

1. Printed materials (pamphlets, posters, written resources)
2. Talking with health staff
3. Media, TV, radio
4. Conversations people have (eg friends, family, neighbours, schools, workplace, religious settings)
5. ICT, Internet, social media, Apps
6. Arts (songs, plays, paintings, drawings)

Health literacy: an integral part of a multisectoral response for the prevention and control of NCDs and their shared risk factors as well as mental health conditions.


Page 48 of 87
It is well recognised that the health sector cannot tackle NCDs alone. Building an effective range of health literacy interventions that will have a significant effect on NCDs at the country-level involves the Ministry of Health, and other ministries such as Education, Trade, Immigration, Information and Communications, Technology, Environment, Industry, Agriculture, Finance, Sport, Transport, and other relevant sectors. The activities of each of these sectors impact on the many determinates that shape the enabling health-promoting environment. If these non-health sectors are not engaged, the efforts of the Ministries of Health will be limited in their attempts to reduce the population’s exposure to NCD risk factors and access to effective prevention and treatment options. It is essential that Member States adopt a multisectoral approach to health and health literacy.

Using health literacy to complement WHO’s recommended interventions and policy options in order to enhance the reach and acceptability of NCD measures.

**Key message:** Highly standardised and widely applied campaigns and interventions tend to be designed for those who speak and read the majority language. It is important to apply health literacy principles to ensure language, cultural and religious minority groups are catered for. Using health literacy thinking to tailor campaigns and interventions will improve reach, uptake and effectiveness.

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77 https://www.bmj.com/content/363/bmj.k4868
78 Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region Governance for a sustainable future: improving health and well-being for all http://www.euro.who.int/__data/assets/pdf_file/0005/371435/multisectoral-report-h1720-eng.pdf?ua=1
WHO has developed a set of recommended interventions and policy options to address the prevention and control of NCDs and their risk factors. The recommendations focus on the four key risk factors for NCDs (tobacco, harmful use of alcohol, unhealthy diet and physical inactivity) and four disease areas (cardiovascular disease, diabetes, cancer and chronic respiratory disease). Recently, the World Health Assembly requested the WHO Secretariat to develop recommended interventions and policy options to address the links between NCDs and mental health conditions and air pollution. It is critical that Member States work with the recommended interventions and implement a carefully selected set that are relevant to their own context and needs.

All of WHO’s recommended interventions and policy options can be strengthened though a health literacy approach. For example, one of the recommended interventions is - *Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems*. This strategy calls for better health literacy of policy makers (‘...*Increase awareness and strengthen the knowledge base on the magnitude and nature of problems...*’), and needs to apply health literacy approaches to ensure broad reach and uptake (‘...*by awareness programmes, operational research, improved monitoring and surveillance systems...*’).

WHO’s health literacy tools for NCDs should aim at improving the understanding of policy makers in regards to the link between risk factors and NCDs, and support the selection of an effective mix of interventions to reach the complete the full breadth of the population, including groups with low health literacy. They should also aim to improve the understanding and acceptance of the general population in regards to policy interventions (such as increased excise taxes and cost of unhealthy products), and ultimately the community’s demand for better policy, systems and services to reduce NCDs and their risk factors.

It is critical that WHO’s recommended interventions and policy options ‘leave no one behind’, enhancing implementation efficiency, reach and impact, by effectively recognising and responding to the health literacy needs of individuals and communities. Highly standardised interventions tend to address the average community member who, for example, speaks and reads the majority language and lives in easily accessible cities or rural areas. It is therefore important to apply health literacy principles to ensure language, cultural and religious minority groups are included. It is also important to note that the vast majority of evidence for the effectiveness of WHO’s recommended interventions and policy options was generated in Western cultures / high income countries. This means that considerable tailoring (using health literacy thinking) may be needed (see Figure 3). Below are some examples from WHO’s recommended interventions and policy options with examples of health literacy thinking that could be applied to improve reach and uptake.

*Box 7 Using health literacy to optimise the impact of WHO’s recommended interventions and policy options*

<table>
<thead>
<tr>
<th>Common NCD issues</th>
<th>Health literacy barriers, and tailoring and/or redesign required to optimise reach and impact (see Table 1 for strategies required across the 5 health literacy task)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Barrier</th>
<th>Health literacy consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass media education campaigns, including specific education to alert the community</td>
<td>People who don’t read, who use a minority language or oral communication traditions. It takes time and multiple exposures to the message from trusted sources before messages is trusted and used.</td>
<td><strong>Health literacy consideration</strong>: use multiple formats (oral, written, social media) in multiple languages, over time (one-off’s are weak interventions)</td>
</tr>
<tr>
<td>Self-management support / lifestyle interventions, complying with medication regimes</td>
<td>Clinicians with limited traditions of, or skills in, communication.</td>
<td><strong>Health literacy consideration</strong>: Clinician skills in Teach Back 80 and supportive media (written, pictorial, video etc) to improve communication. Community health workers, lay workers / peers assist with training (knowledge, confidence building, skills and routines).</td>
</tr>
<tr>
<td>Pre-conception interventions among women with diabetes of childbearing age</td>
<td>Cultural and religious practices, inadequate access to health services, poor social support and mental health conditions. High illiteracy rates.</td>
<td><strong>Health literacy consideration</strong>: The local religious leaders and village elders may have strong influence and be able to promote and endorse young women learning through regular groups using narrative and storytelling.</td>
</tr>
<tr>
<td>Vaccination against human papillomavirus</td>
<td>Lack of awareness, inadequate access and fear it may harm young girls</td>
<td><strong>Health literacy consideration</strong>: to overcome miss-information, frequent radio, television and/or print media presentations by celebrity figures promoting safety and importance of vaccination protection and prevention of cervical cancer in adulthood.</td>
</tr>
<tr>
<td>Appropriate use of medications and blood glucose tests by people with diabetes</td>
<td>Following an appropriate diet may be difficult (i.e., may not provide enough energy for farmers), lack of understanding of what medicines do, belief that sugar in the blood is best countered by sour foods, i.e., lime juice.</td>
<td><strong>Health literacy consideration</strong>: People with limited biomedical knowledge need to get complex information in ‘chunks’ and explained in non-medical terms. Careful explanation of the long term implications of high blood sugar, and benefits of treatment, explained by both a doctor and well trained lay health worker, can promote deeper and more rapid understanding.</td>
</tr>
<tr>
<td>People don’t engage in prevention, especially those with background mental health problems</td>
<td>People with mental health problems have difficulties communicating what’s wrong, and often feel stigmatised. They may have multiple NCDs and a range of risk factors.</td>
<td><strong>Health literacy consideration</strong>: Providing all information needed to fully self-manage is overwhelming. Simple, direct information on the important elements (i.e., ‘chunks’) to improve mental health to feel better and get some energy should be a priority before dealing with risk factors and managing other NCDs.</td>
</tr>
</tbody>
</table>

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Health literacy across the life course and across settings

**Key Message:** To impact on the burden of NCDs and mental health conditions, interventions need to impact at an early stage of life, preconception and with children, as this is where the greatest gains in healthy long term habits and prevention can occur. Overall, among adults in Western cultures, decision making about health is often an individual decision, in communal cultures, common across LMICs, decision making is often made at the family or community level. It is therefore important that NCD interventions are developed and/or tailored to how decisions are made among target populations. The focus of interventions many need be on individual-, community health literacy, or both.
Health literacy is something that affects everyone, all of their life. By taking a life course approach, the prevention and management of NCDs and mental health conditions is fully implemented across the full range of communities and population age groups. While decision making about health for adults is primarily an individual choice (at least in Western societies), this is not the case for children, people with certain disabilities, those suffering debilitating illnesses. For these groups, parents, carers and health professionals are often the health decision makers.

In communal cultures, the most common structure in LMICs across Africa and Asia, decision making about health is often not an individual activity. Health decisions may be made by a family member, village head, religious leader or other individuals with community-designated responsibility and authority.

The development, implementation and evaluation of health literacy interventions needs to consider both the life course and context.

**Box 8 Life course and settings approach to impacting on NCDs through health literacy**

**Where can health literacy be applied?**

**Life course stages**

- **Preconception**: Women of child bearing age (and men) as periconceptual health is a determinant of adult NCDs
- **Children**: From pre-school to high school, across the education sector
- **Adults**: For all persons living with an NCDs (patients, families, carers, communities, health care professionals, etc)

**Settings**

- **Schools**: Curriculum and educational environments
- **Universities**: Health professional training, student wellbeing
- **Community**: Community norms, general knowledge, awareness of commercial interests, knowing who is the health knowledge holder (navigator)
- **Families**: Overall family health knowledge holder and family support
- **Workplaces**: Workplace wellness campaigns, health promoting environments
- **Health Services**: Health professional, health literacy responsiveness skills, health literate-friendly settings
- **Governments**: Knowledge of health literacy for program/intervention planning, development/co-design and implementation

**Mental health and NCD prevention and control**

**Key message:** Mental health literacy is essential when implementing measures to improve mental health and well-being, including by developing comprehensive services and treatments for people living with mental disorders and other mental health conditions and integrating them into national NCD responses. It is also important to address the social determinants of mental health and other health needs, while fully respecting a human rights’ approach.
Mental disorders and other mental health conditions, as well as neurological disorders, contribute to the global NCD burden (depression alone affects 300 million people; each year 800,000 people die from suicide and 1 out of 5 (80%) will occur in developing countries. Suicide mortality rate is an indicator of SDG target 3.4). In addition, individuals with mental disorders and other mental health conditions face stigma and discrimination, being more susceptible to having their human rights violated and abused, and also have an increased risk of other NCDs and therefore higher rates of morbidity and mortality.

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Mental health includes subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others.

**Mental health literacy** has been defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention. The concept of mental health literacy was derived from health literacy, which aims to increase people’s knowledge about physical health, illnesses, and treatments.

The mental health literacy of the general community, people who have experienced mental health problems, as well as the health workforce, is important to understand and improve to:

- reduce stigma,
- improve access for people with lived experience of mental health issues to services,
- improve experience and satisfaction of people with lived experience using services,
- improve overall health outcomes, and to
- reduce health inequalities.

In many settings, people with mental health problems are missing out on services. Given the very high prevalence and burden of disease, Member States should develop mental health strategies that integrate health literacy approaches.

**Measuring health literacy to guide NCD prevention and control**

**Key Message:** The measurement of health literacy among the general population and specific groups with NCDs will assist Member States to develop targeted interventions, evaluate the impact of such interventions, and identify and share good practices. Surveys should assist health authorities, planners, programme managers and others to understand which groups and individuals have strengths (and thus are key local “health literacy facilitators”) and those who are missing out on NCD prevention and management services, and provide rich data on how to develop and improve interventions that address NCD and mental health conditions.

The measurement of health literacy, in the context of the growing burden of NCDs, needs to consider processes to identify who is missing out on appropriate information and services, and determine how people and communities can be better supported. Measurement needs to consider that people with low health literacy may be illiterate (in the majority language, i.e., they may be migrants or from a minority community), have very little understanding of health concepts, have low agency and are disengaged. This can be both at an individual and community level.

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81 https://www.who.int/features/factfiles/mental_health/en/
In cultures with oral communication traditions, people will have ways to obtain and access health information through family and other social network. Consequently, it is important to consider contemporary strengths-based approaches to measurement that account for local contexts, respect cultural and tribal traditions, and that the health literacy mechanisms that determine an individual’s or community’s ability to access, understand, appraise, remember and apply health information can be highly variable.

At the national level, it is important to understand several fundamental health literacy elements amongst community members, for example: what knowledge do people actually have (and not have), how to they obtain knowledge, do they understand the link between risk factors and NCDs, do they understand and value evidence-based approaches to NCD management, and do they have access (real and perceived) to services.

A mixed-methods approach to measuring health literacy is often needed, this is because beliefs (and misconceptions) about health can be highly variable and differ from one setting to another. Consequently, a multidimensional health literacy tool that can be orally administered and combined with qualitative information (such as interviews or community meetings) to supplement and enhance the quantitative data is recommended.  

RECOMMENDATIONS FOR THE WHO INDEPENDENT HIGH LEVEL COMMISSION ON NCDs

In order to effectively prevent and control NCDs and mental health conditions across the life course, governments need to establish and promote healthy environments that are conducive to healthy behaviours. To this end, there is a need to implement a series of complementary measures, as no single intervention will be enough. To maximise people’s chances to live a healthy life and prevent and control NCDs and their shared risk factors, individuals and communities need to have the health literacy skills to effectively Access, Understand, Appraise, Remember and Apply appropriate, context-specific information throughout the life course. Fiscal and other measures, including incentives enabling greater access to healthy products and a healthier environment, need to be complemented by comprehensive health literacy approaches, including through formal education and targeted mass and social media information and communications campaigns, so as to inform individual decisions and behaviours.

Governments have the obligation to regulate in order to guarantee the health of the population. Measures such as front of packaging labelling are not the only options to provide information that allow for individual informed choices but also that compel the industry to reformulate and look for healthier alternatives. On the other hand, well-informed consumers that are looking for healthier choices can also influence industry production, including reformulation and marketing. Therefore, empowering the individual through enhanced health literacy skills, which lead to healthy habits, should be used as complementary interventions together with other enabling regulatory policies.

NCD policies and programmes need to use health literacy as a framework for system and service redesign, ensuring current interventions respond to the health needs of all population groups and reach all sectors, leaving no one behind. Integrating health literacy principles can enhance the reach, acceptability and impact of NCD interventions.
Member States should apply health literacy approaches in an integrated manner in order to enhance the design, implementation and scaling of effective interventions. This requires that programmes focus on a) improving the health literacy at the individual and community level, b) improving the health literacy responsiveness of interventions, programmes, systems (health care providers, integration to PHC packages and UHC access), and c) actively generating environments where the healthy choice is the easy choice, irrespective of an individual’s or community’s health literacy.

Member States, therefore, are encouraged to develop national health literacy action plans, and/or systematically incorporate health literacy principles and practices into NCD-related health policies, regularly measure and monitor health literacy with a special attention to vulnerable/disadvantaged population groups, who usually have the greatest burden of NCDs, including mental health conditions.

The Commission makes the following recommendations that will enable Member States and WHO to apply health literacy in a practical and integrated manner:

**Recommendations for Member States**

3. **Member States should scale-up efforts in integrating health literacy approaches to complement NCDs interventions by:**

- **Focusing on the next generation – embedding health literacy into the education system to create awareness about NCD risk factors, healthy lifestyle, and critical appraisal of health-related information.** When implemented systematically this will enable the empowerment of individuals from early stages of life.

*Please refer to case studies from Nepal, USA and Australia in annexed Report (Case studies 6, 7 and 15).*

Life-long health behaviours are shaped during childhood and adolescence. Preventive interventions undertaken in developmental phases often have greater benefits than interventions to reduce risk and restore health in adults. Consequently, the education sector plays a fundamental role in preventing unhealthy behaviours and promoting children’s health and well-being. Schools provide an efficient and effective way to reach large numbers of people on an equal basis. Empowered children and youth also provide upward pressure that influences families and communities to adopt and maintain healthier lifestyles.

Enhancing children’s health literacy on NCDs risk factors and determinants will improve health outcomes by increasing understanding and recall of health messages and by enabling public health actions that protect and improve health. **Member States should present health concepts and health promoting behaviours in culturally relevant, age-appropriate and socially supported ways, in order to assist children to understand their relevance at an early age.**

Industry tactics induce individuals, in particular children and adolescents, to consume health-harming products setting up lifelong unhealthy habits. **Member States should design health education programmes (across multiple formats, i.e., schools, social media etc) to directly counter the marketing of unhealthy products to children and adolescents (such as tobacco, alcohol, and processed foods and beverages high in

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fat, sugar and/or salt). This will empower children, adolescents and their families to recognise such products, the consequences of unhealthy lifestyles, and to enable them to make healthy choices.

Member States need to integrate health literacy approaches into the school curriculum, using a co-design approach that ensures the interventions to combat NCDs, mental health conditions and their risk factors and determinants are informed by local context and needs. This implies designing tools and didactic educational methods and materials with information in an easy and understandable way, including messages about the risks associated with NCD risk factors and determinants. These have to be targeted and age-adapted to identify and develop the necessary skills for healthy behaviours. Health can be taught as independent subject, supported by other activities like daily physical activity at school, healthy school food, zero tolerance for bullying, and school health services including mental health and social services.

A child’s health literacy is strongly affected by their parents and guardians. This effect begins with the mother’s gestational health, periconception environment, and metabolic and nutritional status. These factors play an important role in determining fetal environment and may impact the risk of developing NCDs in later life. Ensuring a healthy pregnancy and disease-free childhood by enhancing health literacy throughout the life course at both individual, community and health system level is an important way to reduce the growing burden of NCDs and their risk factors and determinants on future generations. It is important to ensure that young women understand the importance of the periconceptual environment, have access to UHC and health information, and have enough material and social support and confidence to resist harmful risk factors that may expose her and her child to develop NCDs.

Member States should ensure that all educational institutions are exemplary health literacy environments, including by measures such as health literacy training of educators and supporting staff, ensuring availability and accessibility of healthy foods and beverages in their premises, while limiting access to unhealthy options.

- Developing and implementing a range of community-based NCD interventions that harness community health literacy, by identifying where local knowledge exists and how it is distributed within the community.

Please refer to case studies from Egypt, India, Brunei Darussalam, Cameroon and Australia in annexed Report (Case studies 2, 3, 4, 5 and 14).

In communal society settings (including most LMICs where the largest burden of NCDs exists), health literacy operates more strongly at the community level rather than the individual level. In these settings Community Health literacy approaches become more relevant. Decision making about health and other issues are often collectively undertaken, primarily by family elders, village leaders, traditional medicine practitioners and religious leaders. The health literacy of specific community or peer leaders can be more important in determining health outcomes than the general health literacy of individuals.

Member States should empower family- and community- level health decision makers by ensuring that these individuals are health literate and resourced, empowering them to positively influence behaviours and ultimately make better decisions for their community. Member States are encouraged to co-design

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interventions, including locally relevant education and support programs, with community leaders, community health workers and community members, which can then be endorsed and promoted by community leaders at all levels.

Some examples of community-based health worker health literacy are: Egypt (Raedat Rifiat)\textsuperscript{89}, India (ASHA workers)\textsuperscript{90}, and Thailand (village health worker)\textsuperscript{91}.

- Developing comprehensive, contextual and targeted mass and social media information and communication strategies about NCDs risk factors and determinants that address the wide diversity of health literacy skills of individuals and communities, paying particular attention to vulnerable and low socioeconomic groups.

*Please refer to case studies from Portugal, Singapore and Nepal in annexed Report (Case studies 1, 8 and 9).*

Mass and social media information and communication campaigns can disseminate critical messages and bring cultural change in society, including educating people about addressing NCDs and their associated risk factors. In many cases, this may be the main source of health information for individuals. In addition, they also need to proactively counter unhealthy messages being delivered by industry with commercial interests, including the key risk factors for NCDs (tobacco use, harmful use of alcohol, unhealthy food, physical inactivity as well as air pollution). *Member States should develop mass and social media information and education campaigns that specifically recognise and respond to people’s health literacy strengths and weaknesses on NCDs risk factors and determinants through diverse strategies, including written, oral, visual, conversational, technology and the arts.*

As the risk factors for NCDs are complex, multiple and interlinked, public education and mass media campaigns often struggle to reach diverse population and achieve the desired behaviour change in target groups, especially when a limited number of modalities are employed (e.g., only written information). Vulnerable and low socioeconomic groups, in particular, are often difficult to reach. *Member States should develop comprehensive, contextual and targeted mass and social media information and education campaigns that address the wide diversity of health literacy skills and learning mechanism of individuals and communities to impact NCDs and reduce health inequalities.*

*Member States should co-design education campaigns within target communities and implement these campaigns using an appropriate range of learning mechanisms to enable individuals to access, understand, appraise, remember and apply health information and knowledge to effectively empower them and communities to undertake tasks required to prevent and control NCDs.*

*Please refer to Table 1 in annexed Report: Overview of what type of communication and education strategies (i.e., learning mechanisms) are useful across the 5 Health Literacy Tasks*

- Promoting and supporting the development and implementation of a range of digital health technologies appropriate to the digital capabilities and the contexts of individuals and to the digital health literacy of communities in order to equitably increase the reach and impact of interventions for the prevention and control NCDs.


\textsuperscript{90} World Health Organization 2013. Assisting community health workers in India: Dimagi’s CommCare.

\textsuperscript{91} https://www.who.int/bulletin/volumes/86/1/08-010108/en/
Please refer to case studies from multiple countries and from Denmark in annexed Report (Case studies 11 and 12).

The rapid growth of interactive web technologies fuels the momentum of eHealth by providing diverse tools and platforms for people to actively improve their own health anytime, anywhere. This provides an opportunity to empower people with low health literacy.

Digital technologies already play an important role in enhancing knowledge and skills of the general population as well as in enhancing capacity and responsiveness of health care systems to respond to the health needs of diverse populations. However, populations across the world (especially in many LMICs and, in rural and remote settings) lack adequate access to advanced digital technology and many lack skills to use them. Therefore, it is important to utilise appropriate digital technology that enables and supports people in an equitable manner, ensuring no one is left behind. Member States should promote the development of digital technologies in response to identified needs, including the needs of disadvantaged groups who typically have the greatest burden of NCDs. The development of digital solutions should use contemporary co-design approaches with the full range of community members to maximise accessibility, usability, effectiveness and sustainability, such as the eHealth Literacy Framework.

Increasingly, reliable health information is assessable only through digital formats. Furthermore, the world wide web is now a crowded platform for both good and bad health information, making health decisions more difficult for people with low health literacy. Member States should systematically develop high quality digital health information platforms, ensuring high levels of population awareness and trust. In parallel, Member States should implement digital literacy programmes to maximise the communities’ engagement in current and emerging digital platforms for prevention and control of NCDs.

Member States’ eHealth strategy or intervention should not only consider the effectiveness of available digital interventions, but also systematically seek to match the services to what people need in order to prevent and manage NCDs in their context. This may vary from simple “low tech” wide-reaching text messaging targeting literate family members (to support low literate family members) through to adaptive technology that can compensate for low health literacy (e.g., translated materials, text reading options, video, adaptive technologies etc).

- Developing and implementing programmes to improve the health literacy responsiveness of healthcare organisations through enhancing the skills of health service providers, both at the professional and undergraduate levels.

Please refer to case studies from India, Indonesia and multiple countries in annexed Report (Case studies 3, 10 and 11).

People with multiple and complex NCDs are particularly at risk of experiencing poor health outcomes due to health literacy challenges. When a healthcare system is poorly coordinated and fragmented, it proves complex for low health literate individuals with NCDs, as they typically require frequent and regular contact with (multiple) health providers and compliance with complex medication and treatment regimes. Member States should implement organisational strategies to improve the health literacy responsiveness of services to ensure that the service provision processes are informed by the health literacy of service users, through tailoring communication to the population, using appropriate language (e.g., readability of signs, use of

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plain language and minority languages), and engaging users in the development of education materials.

While health professionals are often the primary source of health information for patients who need to address NCDs and their shared risk factors, there are significant gaps in the health literacy knowledge and skills of these professionals. The skills required to work with individuals with low health literacy are rarely embedded in health professional training curricula. The skills of health care providers can be improved through specific patient-centred care training such as Teach-Back. Member States should ensure that health professionals respond to the health literacy needs of their patients and are enabled to deliver tailored education, advocacy and support, in order to improve NCD outcomes.

Recommendations for WHO

4. WHO should enhance its work on health literacy for the prevention and control of NCDs, including by:

- Integrating health literacy principles and approaches into the design and implementation of WHO’s recommended interventions and policy options to enhance the reach and acceptability of NCD measures.

WHO should continue to enhance its work on health literacy for the prevention and control of NCDs and mental health conditions and their risk factors and determinants, in collaboration with Members States and other UN agencies. Clear guidance on the delivery of health literacy packages, frameworks, and/or road maps should be provided with a view to an enhanced implementation of WHO recommended interventions and policy options, increasing their reach and acceptability and complementing NCD prevention and control measures, including regulation.

WHO health literacy tools for NCDs should improve the understanding of policy makers in regards to the link between risk factors and NCDs, and support the selection of an effective mix of interventions to reach a wide range of the population, including groups with low health literacy. They should also aim to improve the understanding and acceptance of the general population in regards to policy interventions (such as increased excise taxes and cost of unhealthy products), and ultimately the population demand for better policy, systems and services to reduce NCDs and their risk factors.

- Working with communications and marketing specialists to develop global, comprehensive, targeted mass and social media information and communication strategies in order to increase global health literacy on NCD risk factors and determinants and promote healthy behaviours.

As the global authority on health, WHO has the necessary evidence to advocate in an effective way for health as a global public good. Health communication contributes to all aspects of disease prevention and health promotion. The appropriate, evidenced-based design of health messages and communication products is essential to influence individual and societal behaviours and must be adapted to different segments of the population. Therefore, WHO should implement effective evidenced-based communication...
strategies to support both individual- and communal decision-making towards routine healthy options and to foster health-promoting environments to counter the NCD epidemic.

WHO should actively support Member States efforts to tackle NCD risk factors and determinants, including general, attractive, non-contextual health messages with high levels of evidence such as smoking cessation interventions, reduction of alcohol consumption, promotion of physical exercise and dietary habits, participation in cardiac rehabilitation, among others. It is also important to support Member States in counteracting ‘fake news’, misinformation and commercial pressures towards unhealthy behaviours. The use of influential global champions and personalities could also enhance the reach and uptake of messages, including influencing governments to take action.

- **Actively engaging with international media to promote their understanding and appraisal of NCD risk factors and determinants, enabling them to influence cultural and behavioural change.**

WHO is in a privileged position as the global authority on health to engage with international media raising their awareness and action for health promotion in a globalized world. WHO can harness their relevance, interest and involvement in the dissemination of information that improves health and wellbeing, increasing reach to broader populations. This can be done through a range of actions, such as evidenced-based information packages, toolkits, policy briefs, expert interviews, content for articles and television programmes to inform about NCD risk factors and determinants, as well as to call on the media sector to disseminate the successes and challenges of Member States and the effective actions of non-State actors.

- **Developing, in collaboration with communications and education specialists as well as other UN agencies, a kit with comprehensive information to support Member States in promoting NCD and mental health literacy skills in the formal education system**

WHO should work on targeted approaches for school and high school children that raises awareness and provides practical skills to avoid tobacco use, harmful use of alcohol, increase physical activity, develop healthy dietary habits as well as positive social and emotional skills, and combat air pollution. Relevant general evidence-based information should be provided with age-adapted attractive messages and tools (such as books, apps, short videos, etc.). Context specific messages can be worked upon at regional or national level if and where needed. The kit should also provide guidance on pro-active countering of marketing by commercial sectors promoting unhealthy products.

- **Creating a repository with information, best practices and exemplars from Member States and partners of health literacy interventions for the prevention and control of NCDs and mental health conditions.**

WHO can gather information on Member State’s policies and practices, and effective actions from partner including non-State actors, regarding health literacy for NCDs that could inspire action, exchange of experiences and collaboration at regional and country level.
1. Portugal – Television health education campaigns to promote healthy lifestyle practices

This case study demonstrates how television advertisements can be utilised for mass communication campaigns to educate people about NCDs and associated risk factors.

Portugal is a high income southern European country with a population of around 10.3 million people. All Portuguese have access to health care provided by the National Health Service (NHS) which is a universal and tax-financed system.

Commercial determinants of health such as marketing, advertising and promotion initiatives play a major role in changing and influencing people’s lifestyle. Multinational food and tobacco companies use them to reach large numbers of people. Likewise, such communication channels can be used by government authorities to encourage people to adopt healthy lifestyle practices.

In Portugal, around 46% of the advertising investment share is in television industry. The Portuguese Regulatory Authority for the Media conducted a study and found that 99% of people surveyed regularly watch television. Thus, utilising television platforms to create awareness about NCDs and associated risk factors can help to enhance the reach of public health education campaigns. However, the high costs of broadcasting have affected the use of this platform by health authorities.

In 2018, the Portuguese Ministry of Health approached major television stations and appealed for their social responsibility and role towards health of the community. In response to this appeal, the four major Portuguese television stations realised their role and agreed to a 3-year zero cost plan to the government. The television stations represent 19 television channels, four are free to air and fifteen are paid. Three public health education campaigns per year targeting prevention of NCDs were broadcasted. Each campaign lasts three weeks with minimum of two broadcasts every day. The three campaigns focused on addressing healthy eating, tobacco control and enhancing physical activity.

The preliminary assessment estimated that the average reach to be around 7.5 million people per campaign. The tobacco control campaign was reported to have the biggest reach a public health education campaign ever in Portugal. It used the slogan “Quit Smoking! Choose to love more!” and was watched on an average of 5 times by 73% all Portuguese people older than 4 years of age. This campaign was also ranked as one of the most effective and striking mass media campaign in the annual ranking from Meios de Publicidade.

This innovative collaboration between television stations is enabling the Portuguese national health services to enhance their reach and thus, can act as a potential channel to drive behaviour change. This also exemplifies how the mass media approaches used by big marketing companies can be used in collaborative and innovative way to reverse the unhealthy trends among the general population. However, further evaluation is required to analyse the

96 The World Bank 2019: Country Profile - Portugal.
effectiveness of television health education and promotion campaigns to enable people to lead a healthy lifestyle free of NCDs risk factors.


### 2. Egypt – Understanding and responding to the health literacy needs of an Egyptian fishing community

This case study demonstrates how health literacy approaches can be used with hard to reach communities to support and enhance prevention and management of NCDs at an individual and community level. Egypt is a lower middle-income country (LMIC) of around 100 million residents. It lacks UHC and around 60% of total health spending is in the form of out of pocket expenditure with private sector being the major supplier of health services.

Borollos lake is located in Kafr El Sheikh, one of the Delta region’s governorates, is home to many fishermen and their families. Like fishing village communities in many LMICs, the living conditions are poor, and the region is remote. The fisherman operate in small businesses and spend most of their time working away from home and are often exposed to occupational hazards such as bad weather; scant communication with family and friends leading to isolation; intermittent availability and accessibility of safe water and food; and lack of safe accessible shelter. These hazards, along with unhealthy lifestyle practices, affect their physical and psychological well-being and increase the risk of developing NCDs. They often have difficulty accessing and understanding health information and accessing healthcare services.

A team based at Ain Shams University, Cairo, are undertaking a WHO National Health Literacy Demonstration Project (NHLDP) using the Optimising Health Literacy and Access (Ophelia) process, where they assess the health literacy strengths and limitations of fishermen and their families. These data guided the development of local and regional interventions to create awareness about healthy living and the prevention and management of NCDs.

The results indicated many health low to very low health literacy, especially in relation to people’s ability to find and understand health information and services, managing their health and being able to critical appraisal of health information. The challenges for older people and women were greater as the majority of these groups were illiterate and lacked skills to use the internet to access health information.

Overall the community was found to have great strengths in social support for health, reflecting a communicative society, although many women reported a lack of such social support. They had limited time and resources to look after their own health as, due to cultural practices, they spent the majority of their time at home looking after household chores, raising children and supporting their elders. Also, their husbands were usually away at work, which increased their risk of social isolation and reluctance to engage with health professionals.

This health literacy work is ongoing in Egypt where the community is engaged in co-design of local interventions. Specifically, the Ophelia process is being used to empower individuals to adopt healthy lifestyle practices, magnify community engagement and design tailored interventions to the health literacy needs of fishermen and their

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families. The involvement of fishermen in the community consultation has resulted in interventions that support and enable them to lead a healthier life through avoiding NCDs risk factors and improving their skills and knowledge to actively manage their existing NCDs, including through utilising health services more effectively.

Source: Dr. Wagida Anwar, Professor at Department of Community, Ain Shams University, Egypt.

3. India – building health literacy capacity of community health workers

This case study demonstrates how enhancing the health literacy capacity of community health workers supports access to primary health care services to enhance the prevention and management of NCDs for people living in rural and remote areas.

India is a lower-middle income country with a population of around 1.35 billion people and about 66% of them are living in rural and remote areas\textsuperscript{101}. It has a weak public health system, lacks UHC and have high out of pocket expenditure on health services which is contributing to poverty\textsuperscript{102}.

The health system has the dual burden of infectious diseases and nutritional deficiencies and the rising burden of NCDs. An acute shortage of qualified health professionals with majority located in urban areas, limits access to quality primary health care services for people living in rural and remote areas. Barriers such as high cost of treatment, high travel costs, long waiting time, long distance and poor transport facilities further prevent access to health care for rural population and contribute to health inequities.

To strengthen equitable access to preventive health care services, community health workers (CHWs) are utilised to deliver primary health care and preventive health services at the village level. The female CHWs, known as Accredited Social Health Activist (ASHA) workers, act as a link between the hard to reach community and the health system and thus increase access to health services. The ASHA workers are usually women aged 25 to 45 years that come from the same district. Their role is to promote immunisation, sexual, reproductive and child health, and various other programs. ASHA workers one of the few trusted sources of credible health information and basic health services for people living in rural and remote areas. Moreover, they educate and empower people with low health literacy to follow healthy lifestyle practices and can be described as community health literacy leaders.

In rural Rajasthan, the ASHA worker model was modified to deliver NCD screening and preventive health services \textsuperscript{103}. The intervention included providing education across the population (n=7000) about healthy lifestyle, harmful effects of alcohol and tobacco, diabetes, hypertension, and symptoms of common cancers (breast cancer, cervical cancer and oral cancer) and importance of early detection. The screening services included weight and height, blood pressure, blood glucose, oral and visual examination, and breast examination. Those with raised blood pressure, blood glucose level, BMI or abnormal breast symptoms were referred to nearby primary health care centre for further evaluation. This pilot demonstrated that CHWs are a feasible and effective way to deliver NCD prevention and screening services to people living in rural and remote areas of LMICs.

\textsuperscript{101} The World Bank 2019: Country Profile - India.
\textsuperscript{102} World Health Organisation 2014 (updated May 2018), Country Cooperation Strategy at a glance – India.
\textsuperscript{103} Basu, P., et al., A pilot study to evaluate home-based screening for the common non-communicable diseases by a dedicated cadre of community health workers in a rural setting in India. BMC Public Health, 2019. 19(1).
Further, increasing the health literacy skills and capability of the ASHA workers and other primary health care providers is critical to ensuring they are able to effectively deliver NCD interventions such as public health education campaigns regarding risk factors for NCDs and population-based screening for common NCDs in the region\textsuperscript{104}.

Also, enhancing digital health literacy of ASHA workers through implementing a digital job aid will increase their access to evidence-based learning materials, help them to retain knowledge, facilitate communication with health centres, improve the quality of their decision making and support shared decision making\textsuperscript{105}.


4. Brunei – involving community and religious leaders in co-design to tailor health literacy interventions

This case study demonstrates the important role of community leaders in engaging community members through their involvement in the co-design of health literacy interventions that respond to community needs, including religious and cultural norms.

Brunei is a high-income country with population of around 0.43 million residents\textsuperscript{106}. They have UHC and the health care system is government operated. The majority of health services are free or low cost, provided through public health system and thus out of pocket health expenditure is very low\textsuperscript{107}.

The Community Kitchen Program (CKP) was started by Muslimah group of Perpindaha Lambak Kanan Mosque and was facilitated by the Health Promotion Centre, Ministry of Health. It provides a platform to enhance basic cooking skills of community members in a social, informal and community-based setting. The program seeks to raise awareness and knowledge about healthy eating and to develop skills and confidence for cooking healthy family meals, therefore contributing to prevention of NCDs.

Expert input into the design of the program was provided by nutritionists, dietitians, health education officers, food industry partners, media representatives and support staff (nurses and mosque volunteers). The program has two main components, 1) Education - focusing on improving knowledge about healthy eating behaviours, food safety and hygiene, and understanding of food labels, and 2) Practical – focusing on enhancing cooking skills with a cooking competition and food tasting.

The program consists of weekly or fortnightly practical sessions over 2 to 2.5 hours for 4 to 8 weeks, mainly seeking to engage Muslim women associated with Muslimah women groups. These women are responsible for cooking meals at homes and often make health decisions for their families due to ongoing cultural practices.


\textsuperscript{105} World Health Organization 2013, *Assisting community health workers in India: Dimagi’s CommCare*.


Evaluation of the program demonstrated improved knowledge about healthy eating and healthy cooking, reduced consumption of ready-made and pre-cooked meals. Moreover, it has potential to increase intake of fruits and vegetables. However, participants confidence to cook healthy meals decreased from baseline which may be a result of the ‘learning curve’ as new, non-traditional cooking techniques had been introduced.

The using health literacy principles, including a focus on participation and health outcomes through co-design with religious leaders together with community members during program planning helped to identify the needs of the community, and make the programs widely accessible. The genuine inclusion of community leaders in co-design can help to enhance health literacy in traditional societies where religious and cultural norms prevail.

Source: Dr Norhayati Binti Hj Md Kassim and Khadizah Bakri, Ministry of Health, Brunei Darussalam

5. Cameroon – bridging traditional beliefs and practices with health behaviours to prevent and control NCDs

This case study highlights the cultural context where health care takes place and the potential local approaches for developing health literacy to prevent and control NCDs. Cameroon, a lower middle-income Central African country has a population of 25 million. The health system is insufficiently funded, poorly managed and fails to provide universal access to health care. In Kom, North West Cameroon, many villages have few facilities, including electricity and healthcare. Within these villages, the most trusted individuals are village leaders because the advice they give (including about health) is unison with their revered ancestors. Kom people seldom seek healthcare except when they are clearly ill. When confronted with sickness, they first seek advice from traditional healers who have no formal education but carry deep authority through their special ancestral connections. Most villagers view health and sickness as being directly determined by ancestral linkages. Little external information about health reaches the village and several factors limit new information entering the village, including local dialects, low literacy and limited or no access to mainstream or social media. Nonetheless, exotic foods, including cheap palm oil and sugary foods, alongside compelling visual merchandising has crept into villages in recent decades.

The traditional daily diet of the Kom people is starch-based with an inadequate range of nutrients. Common village practices include rituals and ceremonies requiring a maize derivative (fufu), some local vegetable (huckle) and highly salted bush meat or chicken that is cooked in crude palm oil (high in saturated fats and cholesterol). Obligatorily, social feasting is generally voluminous, determined by strong social norms and regarded as communion with both the living and the ancestors. This lifestyle, over many years, has put people at risk of hypertension and diabetes, yet villagers usually are unaware of their blood sugar level, blood pressure, BMI or cholesterol levels.

On engagement with the local community it was identified that nutrition, physical activity and cultural practices are key NCD determinants. While most individuals are aware of deaths and health complications being linked to these behaviours, most attribute the cause to superstition and ancestral punishment. The ancestral communal meal is tied to pacification of the spirits where defaults may be punishable by spells and mysterious deaths.

Prior to the 1970s, people ate traditional diets, had little knowledge lifestyle risk factors, and walked long distances to their farms and to fetch water and wood etc. However, motor vehicles have reduced physical activity, but the

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108 The World Bank 2019: Country Profile – Cameroon
same eating habits have remained. Also, children through education and exposure to Western culture, pursue exotic foods and lifestyles.

Health literacy development in the Kom community centred on community safety discussions about food (including health attributes of palm oil, bush meat, starch-based foods), and early detection of NCDs by assessing blood pressure, BMI and discussions about data showing the rise of diabetes and hypertension. Repeated community discussion about how to avoid the unhealthy aspects of the traditional meals without harming the ancestral spirits and how to have the ancestral spirits understand that in their earthly days, hypertension and diabetes were not so apparent and that conditions are different today. The community discussions promoted questioning, analysis, decision making and taking actions.

A health literacy package for the Kom community was then developed, focusing on diet, lifestyle and health literacy habits. The powerful roles of traditional and new beliefs were harnessed, including ensuring various men, women and youth groups were identified as the health literacy advocates to lead dialogue for healthy foods and ancestral pacification at the village level. Consequently, the narrative and lifestyle in Kom villages has begun changing.

Source: Kenneth Anchang Yongabi, PhD, Professor of Public Health Infectiology and Phytobiotechnology, Imo State University, Owerri, Nigeria. Director, Global Health Literacy Network Africa, PRF Foundation, Cameroon


This case study demonstrates how effective engagement with students, teachers and parents can empower the future generation to avoid CVDs and other NCDs risk factors from early stages of life.

Nepal is a low-income country with population of about 28 million people\(^{110}\). The health system is inadequately funded with no UHC and majority of health services are provided through primary health care centres, urban health clinics and health posts\(^{111}\).

NCDs account for 66% of total deaths in Nepal with cardiovascular diseases (CVDs) being the biggest killer and are responsible for up to 30% of all deaths\(^{112}\). To reduce the growing burden of CVDs, Bhaskar Memorial Foundation initiated a nation-wide school-based intervention called BISHES (Bhaskar Initiative for School Heart Health Empowerment Studies). The program targets students 10 to 19 year olds and empowers them to avoid the five primary cardiovascular behavioural risk factors: physical inactivity, tobacco use, alcohol use, mental stress and unhealthy diet.

Adolescents form the largest segment of Nepal’s total population (24%) and are vulnerable to exposure to the five primary risk factors. Reducing exposure should lead to reduced premature mortality due to CVDs, as well as other NCDs that share interrelated risk factors.

A needs analysis identified that the school curriculum included education for NCDs, however, there were no practical strategies to empower students to take action against the risk factors. An evidence-based action tool was developed - HEARTS (H- healthy lifestyle, E- evidence based tool, A- access to essential technologies, R- risk based management, \(^{110}\) The World Bank 2019: Country Profile – Nepal, https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y& inf=n&zm=n&country=NPL


The BISHES follows the strategic public health approach based on 4 P’s:

- **Package**: evidence-based integrated interventions to prevent CVDs risk factors;
- **Platform**: nationwide community schools;
- **Providers**: school teachers, parents, students, local youth clubs and community health workers; and
- **Partnership**: various stakeholders such as local leaders, Ministry of Health, Ministry of Education, WHO and others.

This interactive approach effectively engaged students to follow healthy lifestyle practices, improve their knowledge about prevention of CVDs and associated risk factors, and critically empowers them to become health heroes to promote healthy lifestyle in their peer groups and in the community. The BISHES is expanding and has reached 32 public schools in 7 provinces of Nepal.

**Source**: [http://bhaskarmemorialfoundation.org.np/bishes/](http://bhaskarmemorialfoundation.org.np/bishes/)

### 7. USA - a curriculum-based youth health literacy program in schools

This case study shows that introducing health literacy into the school curriculum can help to enhance health knowledge, health literacy skills and self-efficacy of students to resist risk factors for NCDs. The USA is a high-income country with around 327 million residents. The health system is not uniform and lacks UHC. The major barrier for access to health care is its high cost.

The Building Wellness program is a health literacy program that encourages, motivates and empowers children and adolescents to access, question, process and integrate credible health information throughout the life course. It is an 8-level health literacy curriculum targeting grades 1 to 8 in public schools and each level contains 15 lessons. It is designed to promote participant’s self-efficacy and sense of wellbeing to increase their control over the environment they are living in. The focus is to enhance the participant’s ability to act on health information and health knowledge to achieve positive health gains.

The initial needs assessment and associated research helped to identify core areas of this program: enhancing prevention of obesity; asthma; accidental injury; and drug and alcohol abuse. These core areas are important risk factors for developing NCDs during later stages of life.

This program uses interactive and practical approaches to enhance self-efficacy and sense of wellbeing in young people by involving them directly in practical activity lessons, games and interaction with medical guest speakers. Literacy skills such as reading, writing, numeracy, critical thinking, verbal fluency and listening are involved in each activity. These activities develop the participant’s skills to make healthy choices, understand food labels, and enhance understanding of the functioning and development of their body. In addition, they are provided with tools to support them to avoid peer pressure for unhealthy activities, regular exercise tips, and communicate effectively with doctors and other health professionals.

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The activities and lessons are implemented with the help of facilitators which are usually from a non-health background. The facilitators are provided with an easy to follow guide for each level which consist of information about synopsis, goals and objectives, vocabulary to be used, and a script to teach lessons covering wide range of essential health topics ranging from basic hygiene practices to healthy eating to internet safety.

This program is a low-cost approach as it utilises existing resources available in public schools. Moreover, it effectively engages children from migrant communities and low income urban households and thus can promote health equity.


8. Singapore – an online health information platform.

This case study demonstrates how a specifically tailored online health information platform can help to enhance health literacy to impact NCDs and associated risk factors. This is an example of using appropriate technology and mass-communication channels to enhance reach and acceptability of various programs or interventions.

Singapore is a high-income country with population of 5.6 million people. The health care system is publicly financed which offers UHC to all citizens. The Ministry of Health, with support of Health Promotion Board of Singapore provides an online health information portal called HealthHub, a 24-hour access to reliable, credible, evidence-based and locally relevant health information for Singaporeans. HealthHub enhances health literacy by enabling access and retrieval of health information that can be easily understood and used to assist citizens to look after their own health. There is also a dedicated mobile app to increase accessibility.

HealthHub is a health portal consisting of information about various mass communication programmes, health events, health facilities, health definitions and articles to support decision making and use of primary and preventive health care services. It also supports easy access and retrieval of personal health records, as well as health records and immunisation schedules of children.

The resources are targeted towards promoting healthy living throughout the life course. They focus on improving nutrition from early childhood; enhancing physical activity in all age groups; promoting intake of fruits and vegetables and reducing intake of sugary drinks, tobacco and alcohol, combatting obesity to reduce the risk of developing NCDs in later stages of life; early and regular screening for diabetes and cancers to achieve early detection and management; and various health programs and events.

The platform has a specific program called Let’s BEAT Diabetes which focuses on creating awareness about pre-diabetes and how it can be reversed by through lifestyle changes to avoid complications associated with diabetes in later stages of life. It has a Diabetes Risk Assessment tool to help individuals aged 18 to 39 years identify if they are pre-diabetic or are at increased risk of developing diabetes. This program has 4 components called BEAT:

1) **B – Be aware:** This component focuses on creating awareness about diabetes. It contains information about normal blood sugar level, pre-diabetes and type 2 diabetes; associated risk factors; people at increased risk of developing diabetes; signs and symptoms; prevention, early detection and screening; diagnostic tests; and associated complications.

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2) **E – Eat Right:** This component focuses on enhancing healthy eating throughout the life course. It contains information about importance of having balance diet, importance of eating different food groups and provides guidance and support to achieve dietary changes to prevent diabetes and reverse pre-diabetes.

3) **A – Adopt an active lifestyle:** This component focuses on enhancing physical activity for physical and mental health. It contains information about importance of engaging in regular physical activity to achieve healthy BMI and weight that can reduce the risk of developing type 2 diabetes and can help in reversing pre-diabetes. It consists of resources that can support an individual to develop a personalised exercise schedule to lead a healthy life.

4) **T – Take Control** This component focuses on motivating and enhancing confidence of people to increase control over their own health. It contains information about healthy BMI and how one can achieve it; weight management strategies; and support strategies and services to get help to quit smoking. Moreover, it contains stories of hope in which people have shared their stories and experiences to motivate people to adopt healthy lifestyle practices.

*Source: https://www.healthhub.sg/

9. **United Arab Emirates and Nepal – a mass communication program for early detection and prevention of hypertension**

This case study demonstrates how mass communication campaigns can create awareness among the general population about disease and risk factors to encourage people to access preventive health care services. Tailoring these campaigns according to the needs of different communities enhances the effectiveness and sustainability of health interventions. Moreover, involving public figures (celebrities, sports persons and community and religious leaders) to promote these campaigns can help to increase reach of these interventions and motivate people to engage in early detection and screening.

Hypertension or high blood pressure is a global health issue. It is one of the highest contributors to burden of heart diseases, stroke and kidney failure. It is asymptomatic in the beginning and often goes undiagnosed. The rate of late diagnosis is high in low and middle-income countries due to poor preventive health care services and lack of awareness in general population about hypertension and associated risk factors. If people are empowered with appropriate knowledge, skills and health system support, this silent killer can be prevented.

In 2017, the International Society of Hypertension initiated May Measurement Month (MMM) throughout the world to educate people about hypertension and to carry out blood pressure screening. Around 100 countries participated in the event and over 1.2 million people were screened and educated about prevention and management of hypertension.

In UAE, the 2018 MMM screened more than 31,000 adults above 18 years old. If high blood pressure was detected, life style modification advice and referral to a hypertension specialist was offered. The demographic data for each participant were entered using an app developed by the International Society of Hypertension which helped track the number of people screened at each registered centre. This event was promoted using various social media platforms, Ministry of health website and advertisement boards. The hypertension awareness messages were also posted during the promotion. The general population was educated about hypertension, associated risk factors and how to mitigate them, complications, and importance of reading nutritional value and salt content of food products.

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In Nepal, the 2019 MMM was conducted in 7 provinces and screened more than 77,000 people with help of more than 700 volunteers. The volunteers were mainly community health workers and young medical students who acted as public health advocates for their community. If high blood pressure was detected, people received lifestyle counselling and referred to a doctor. Those with normal blood pressure were educated about healthy lifestyle practices to avoid hypertension and other NCDs and advised to have regular screening of their blood pressure.

Source: [https://twitter.com/mmm_nepal](https://twitter.com/mmm_nepal).

10. Indonesia – national policy to promote healthy lifestyles

This case study illustrates how a national policy can support and enable communities to engage in healthy lifestyles and prevent NCDs by targeting known risk factors by working across different sectors in an integrated way. Indonesia is lower middle-income country with around 267 million residents. The health care system does not provide UHC and health services are mainly provided by private sector and thus results in out of pocket expenditure. The burden of disease in Indonesia is shifting from communicable diseases to NCDs. This can be attributed to changes in lifestyle and behaviour, environmental changes due to rapidly growing population, and technological advancement. The Health Ministry of Indonesia has prioritised national policy development to tackle the growing burden of NCDs.

The healthy life community movement (Gerakan Masyarakat Hidup Sehat, GERMAS) is a national program launched by Ministry of Health in 2016. It aims to promote a culture of healthy living by encouraging healthy lifestyle behaviours and providing a supportive environment and infrastructure. The GERMAS activities are directed to align with other sectors to address social determinants of health at individual, community and national level. The program also focuses on reducing social disparity and inequity, which is further adding to the burden of NCDs.

Three pillars of this program are: a) Strengthening Health Services (making the health system more health literacy responsive), b) Implementation of Healthy Paradigm (increasing people’s control over their own health), c) National Health Insurance (universal health coverage).

The GERMAS movement is a family-based approach and encourages people to follow healthy lifestyle practices by:

1. Enhancing Physical Activity at home, schools and work places.
2. Encouraging people to eat healthy food, fruits and vegetables.
3. Reducing the rates of smoking by educating people about ill effects of smoking and by providing counselling services to support people who want to quit smoking.
4. Encouraging people to reduce consumption of alcoholic and sugary beverages.
5. Conducting regular health check-ups at Integrated Health Education Centre for NCDs (IHEC for NCDs). This includes regular checking of BMI, waist circumference, blood pressure, blood glucose level, and screening for cervical cancer and breast cancer.

Plain (simple) local language and graphical characters have been used to simplify and enhance understanding of health information for the general population. Cartoon characters and videos are incorporated into the program to attract young children. Health information videos have also been created to engage the adult population. This

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An integrated approach can be used to make health systems responsive to the health literacy needs of population and can support and encourage people to adopt health lifestyle practices by providing them enabling environment.

11. Multiple Countries - Use of digital aids to increase access to health information and health services

This case study demonstrates how digital technology is being utilised to target groups of people to increase their access to health information and health services to enhance prevention of NCDs. Access to internet and mobile phones has increased dramatically throughout the world. It has empowered people to utilise various services more effectively (e.g., banking, bill payments, knowledge management, research). Advanced digital technology is being utilised in health sector as well. However, to achieve maximum benefits, it is important to consider that many groups globally don’t have access to advanced technology. Therefore, selection of an appropriate digital platform is crucial to enhance the impact of various interventions to tackle NCDs.

Examples of how digital platforms are being used to target NCDs and associated risk factors:

1. Mobile Text Messages:
   ‘Be Healthy Be Mobile’ initiative by the WHO in partnership with International Telecommunication Union is utilising mobile technology to impact NCDs and associated risk factors. It is implemented in 11 countries to tackle issues such as raising awareness about cervical cancer to quitting of tobacco to prevention and management of diabetes.

   In India the mTobaccoCessation program was launched in 2106 to support people to quit tobacco using short-text message mobile health service. It has around 2.4 million registered users and around 70% of respondents reported that this program is helpful and motivating them to successfully quit tobacco. On evaluation, it has been found that mobile text messages can act as low-cost intervention to educate and motivate people to quit tobacco.

   Similarly, both in Senegal and in India, mDiabetes program using mobile text messages to create awareness about diabetes has been found effective and feasible in improving knowledge about diabetes and healthy living and also in improving health seeking behaviour.

   The properly tailored mobile text messages in locally relevant language can be utilised to enhance knowledge of general population regarding NCDs and associated risk factors especially in LMICs. Moreover, SMS reminders regarding medical appointments, early screening, risk factors and risk group for different NCDs, and tips on how to avoid those risk factors through a trustful organisation can act as an effective way to disseminate credible health information to general population.

   Source: https://www.who.int/ncds/prevention/be-healthy-be-mobile/countries/en/

2. Mobile Applications:
   The Ministry of Health and Prevention in UAE have developed a mobile application called Fitfind to promote physical activity among adults. It helps users to locate physical activity facilities (stadiums, grounds, parks, gyms etc.), track their activities (steps, calories burned, duration etc.), locate group activities and events and uses a social approach to encourage individuals to be active.

   Moreover, it allows users to create a public activity/event, promote the event and also invite people to attend this event. The people of UAE are being made aware about this application using radio advertisements, billboards, lampposts, digital advertisements and social media.

   These mobile applications can act as effective way of engaging young people to follow healthy lifestyle practices and to be empowered against NCDs risk factors.

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3. Multimedia Platforms:

The Bigger Picture Project (a partnership with UCSF’s Center for Vulnerable Populations at Zuckerberg San Francisco General Hospital) is inspiring and motivating the young generation to be community health champions by exposing the social and environmental conditions associated with Type 2 diabetes. They are using YouTube as a channel to educate and raise awareness about type 2 diabetes and associated risk factors mainly in young population.

It consists of series of well-directed videos with intense music in background in which a young person or a group of young persons is conveying their life story and how they were exposed to social factors (parental eating habits, peer pressure, cultural norms etc.); environmental factors (availability of cheap fast food, sugary drinks, and alcoholic beverages etc.) and genetic factors (maternal obesity, gestational diabetes etc.). Some of these videos have more than 10K views.

These channels can be effective in engaging and educating young generations as they have good access to multimedia phones.

Source: http://www.thebiggerpictureproject.org/

12. Denmark - The Epital Living Lab: a person-centered model of technology-enabled integrated care model for people with long term conditions

This case study demonstrates how a well-resourced country with advanced technology and well-equipped health system can support people living with chronic health conditions.

Denmark is a high-income country with population of 5.8 million people 122. It has a public funded health system governed well-coordinated through national state institutions, regions and municipalities 123.

Living successfully with chronic conditions generally requires in-depth knowledge and understanding of the condition(s). For many people this can be overly complicated, especially those with low health literacy. Digital technologies have the potential to alleviate the complexity and provide advanced and prompt digital support.

The Epital Care Model (ECM) was established in 2013 to provide supportive services to people living with Chronic Obstructive Pulmonary Disease (COPD) to reduce the burden of this condition by enhancing their independence and well-being. The ECM is a technology supported and integrated model of care which takes advantage of digitalisation to provide supportive services in proactive way. This actively involves participants in the management of their own conditions through digital support with a 24/7 response and coordination center (RCC), which serves as a collaborating link by connecting participants with all required health services and care providers including medical doctors. A prerequisite for ECM is appropriate technology to effectively support the core ECM services, the ECM actors and, information and communication technology functionality, multiple devices and their coordination.

Patients participating in the ECM are provided with an eHealth-Box which provides general health information, clinical examination and medical information. The eHealth Box contains: (1) an Android tabled with a condition app (an algorithm to prioritise a data related to lung function measures) and one-point contact to the 24/7 RCC through video conference; (2) spirometer; (3) pulse oximeter; (4) thermometer; and (5) a medical first aid box.

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The ECM enables participants to self-monitor pulmonary function, temperature and pulse and integrate it into daily living. The participants can self-monitor their data according to their availability. This self-monitored data serves as the principal resource for all the other activities to be stratified in the ECM network. This data are monitored and supervised by the RCC 24/7 and allows them to detect any deterioration in a person’s condition and helps to detect risk of acute or subacute complications so as to initiate preventive and proactive interventions to overcome potential complications. Moreover, the participants can contact RCC at any time or can be contacted by RCC if they detect any deterioration. The RCC usually consist of nurses which are backed up by eDoctors for prescriptions and decision making. In addition to RCC, there is a mobile acute team which consist of nurses trained and certified in handling debilitated people and thus can conduct investigations and clinical assessment in collaboration with an eDoctor. The eDoctor is a specialised medical doctor (general practitioner or internal medicine specialist) with an additional specialisation in eHealth. The eDoctor is responsible for carrying out medical treatment either virtually or physically and is preceded by monitoring and clinical examination.

The ECM serves as an example of an integrated approach for NCDs as it integrates health literacy principles through both education and technology to engage patients in self-care. It also enables the health system to respond to health and health literacy challenges a person may have. Digital technology can be utilised in real world settings to support people (even those with low health literacy) to live independently and actively with NCDs.

**Source:** Phanareth K., et al (2017). The Epital Care Model: A New Person-Centered Model of Technology-Enabled Integrated Care for People With Long Term Conditions. JMIR research protocols, 6(1), e6. doi:10.2196/resprot.6506


This case study demonstrates a strong example of national action plan to enhance health literacy across sectors to improve health outcomes and to reduce health inequalities. Scotland, the United Kingdom’s northernmost country with population of about 5.4 million people.

The Scottish Government published its first national health literacy action plan (Making it Easy) in 2014. The key purpose of this action plan was to address hidden issue of health literacy to make Scotland a health literate society in which people have sufficient skills, knowledge and confidence to effectively manage their health. This action plan raised awareness about health literacy not only as an attribute of individual but also as an attribute of health care system and health professionals; explored association between low health literacy and poor health outcomes; and explained the role of simple communication tools (Teach-back, Chunk and check, Pictures etc,) to establish effective communication between health care providers and health care consumers.

The second plan, that is Making It Easier (2017-2025) was introduced in 2017 to build on what was learned from the first plan and to further improve design, implementation and delivery of services to improve health outcomes and to reduce health inequalities. The action plan focuses on 4 action areas:

2. Embed ways to improve health literacy in policy and practice.
3. Develop more health literacy responsive organisations and communities.

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4. Design supports and services to better meet people’s health literacy levels.
This action plan does not focus specifically on enhancing health literacy for NCDs but provides information about various health literacy services and tools essential to empower individuals, communities and organisations to accelerate the impact on NCDs.

These services and tools includes:

1. A dedicated online platform called NHS inform which is an online source of information. It allows people to access evidence based and credible information about common chronic conditions and types of services available to effectively manage them. Information and support services regarding mental health is one of the priority area in this platform. Moreover, it consists of tailored information to help and support people to understand better their medications to manage chronic conditions effectively.

2. Information and services for health care providers to ensure that they have necessary skills and knowledge to communicate effectively with patients to enhance their understanding and to enhance support shared decision making. Moreover, creating services so that people feel supported and empowered to navigate health care system effectively.

3. Focusing more on developing health literacy responsive organisations and communities to create enabling environment for people to resist NCDs risk factors effectively. It promotes enhancing health literacy throughout the life course by embedding health literacy concepts within schools, universities, communities, hospitals, organisations and health system.


14. Australia - Using Ophelia (Optimising Health Literacy and Access) approach to improve breast screening awareness and participation in Aboriginal, Arabic and Italian Women

This case study demonstrates how identifying health literacy needs of the target population can help to enhance the reach and uptake of preventive health care services especially within hard to reach population groups.

Australia is a high-income country with population of around 25 million people. The health system provides UHC to the Australian citizens and permanent residents. The universal health care scheme is called Medicare which has three major parts – medical services; public hospitals; and medicines

BreastScreen Victoria (BSV) is a part of Australia’s population-based breast cancer screening program. It provides free breast cancer screening to Victorian women 40 years and above. This program has been found effective in reducing breast cancer screening deaths by up to 28%.

BSV aims to ensure equitable access to free breast cancer screening for all women in target target age groups. However, participation is low for some groups compared with the general population. Screening participation data shows that there is low participation among Aboriginal and Torres Strait Islander (ATSI) people and some culturally and linguistically diverse (CALD) groups particularly among women with Arabic and Italian speaking backgrounds.

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The BSV used the Ophelia (OPtimise HEalth Literacy and Access) process \textsuperscript{127} to identify health literacy needs and breast cancer screening barriers faced by these groups and to design, implement and evaluate interventions according to needs of these target groups to enhance their participation and improve their experience about breast screening programs.

Phase 1 of Ophelia included in-depth consultation with target groups using the Health Literacy Questionnaire (HLQ) and phone interviews to identify barriers. These included: 1) Lack of knowledge about breast screening and its importance; 2) Fear of not able to communicate properly with the health care providers, of getting touched by a stranger, and of getting diagnosed; 3) Having other priorities such as employment or taking care of family; 4) Having health beliefs that may oppose screening; 5) Access/logistic issues such as not able to read and understand invitation letter, difficulty to access health system etc.

Based on barriers identified and health literacy needs of the target population, trial interventions were developed upon consultation with key stakeholders to enhance the participation of target population.

Trial interventions were implemented and evaluated. Initially, reminder letters about screening were sent to women in their local relevant language (Italia/Arabic) seeking increase the appointment booking rates but no significant increase in booking rates was identified. However, when reminder phone calls were made to women in their local language, screening participation in Arabic women increased by 10 times and in Italian women by 8 times. Moreover, developing culturally appropriate media in language (Italian/Arabic) to enhance education and understanding about breast screening also prompted women to book appointments. Furthermore, other interventions that magnified the participation included use of peer educators to educate and create awareness among target population, by delivering screening messages through pharmacies verbally and using visual pamphlets, and by providing them with culturally linguistic health care staff which can assist them to access health services more easily.

An addition intervention included the creation of customised shawls by Aboriginal women as they reported feelings of shame and embarrassment of being naked in front of strangers.

The Ophelia approach helped to engage target populations through identifying their health literacy needs. It also helped identifying barriers, to design interventions and to implement and evaluate results. The BSV utilised this engagement to design and implement interventions co-designed with local stakeholders to enhance the participation of women in breast screening programs.

\textbf{Source:} Beuchamp et al. The impact of translated reminder letters and phone calls on mammography screening booking rates: two randomised controlled trials, PLoS One (Under review)

15. \textbf{Australia - Children’s Health Literacy in Schools}

This case study is an example of a whole-of-school approach to support the development of health literacy in children to prevent NCDs and reduce risk factors through introducing interactive health education interventions early in the life course.

Working at a local level with children, their schools, families and communities, the programme aimed to improve collective health literacy in order to support positive health outcomes and educational achievements for children and to narrow the health inequality gap for Tasmanian families. The programme, known as HealthLit4Kids uses co-design

at a whole-of-school level and the classroom level. This ensures the interventions are informed by local wisdom and address the local needs.

Facilitators, including researchers, school nurses, classroom teachers, physical education teachers, conduct three workshops at a primary school during the school year which focus on:

(1) Development of a shared understanding of health literacy and self-assessment of the health literacy responsiveness of the school and Health Literacy Action Plan;

(2) Development of lesson plans and individual classroom learning activities, review exemplars; and

(3) Evaluation of program success and repeat baseline measures.

Schools are encouraged to focus on HealthLit4Kids in the classroom for a whole term. Children within the schools become HealthLit4Kids Heroes to champion healthy messages and participate in activities. Health literacy becomes a common thread throughout curriculum (crosses across multiple units) rather than an add-on to curriculum. The classroom-based activities result in artefacts or creative pieces that illustrate the children’s learning and messages about health and wellbeing.

An exhibition showcases the children’s learning at the conclusion of the first year. Family members and local community health and wellbeing organizations are invited to attend. The creative pieces (health messages) and their accompanying lesson plans are submitted to an Open Education Resource to provide exemplars and resource materials for future HealthLit4Kids schools.

The health literacy knowledge, skills and experience of the teaching staff are assessed at the commencement and at the end of the programme. Teachers also write reflections on their participation and the impact on their teaching practice. These evaluation measures showed that the teachers’ confidence to teach health increased along with their awareness and understanding of health literacy.

Based on the school staff’s assessment of their school environment, a health literacy action plan is developed. The participating schools are encouraged and supported to develop their own health literacy policy which steps out a four-year cycle and supports the continuation of the health literacy action plan. The HealthLit4Kids facilitators from within the school and the HealthLit4Kids Heroes review the action plan annually and work to deliver on the objectives.

HealthLit4Kids increases the confidence and capability of the teachers to teach health in schools in a way that develops the health literacy of children. The children create health messages about NCD risk factors in ways that make sense to them, therefore empowering them to take actions to care for their own health from early childhood. In turn, their health literacy knowledge and skills and understandings of health are shared with their families, thus broadening the influence of this programme. This programme focuses on the next generation and may halt intergenerational health and health literacy challenges.

Source: [https://www.utas.edu.au/hl4k/home](https://www.utas.edu.au/hl4k/home)

16. **Australia: Integrating health literacy into a national quality and safety framework**

The case study demonstrates how the Australian government has integrated health literacy into the national safety and quality framework for health care services through legislation, policy, coordinated action and resources.
In 2006, the Council of Australian Governments established the Australian Commission on Safety and Quality in Health Care (the Commission) to identify, raise awareness of and support organizations to address safety and quality issues within health care. Health literacy has been identified as an issue that requires a national focus and attention. To commence the development of a national approach, the Commission conducted a “stock take” of health literacy activities across Australia in 2012\(^{128}\). The stock take showed there was interest in health literacy from a range of stakeholders and various activities underway.

In 2014, the Commission produced “Health Literacy: Taking action to improve safety and quality”\(^{129}\) which outlines the approach to coordinate health literacy activities and improvements in a systematic way through: embedding health literacy into systems; effective communication; and integrating health literacy into education. This was supported by the Australian National Health Literacy Statement\(^{130}\) which was endorsed by all health ministers.

The Commission developed Australian Safety and Quality Goals\(^{131}\) to focus on priority areas for improvement. Goal 3 is: Partnering with Consumers – that there are effective partnerships between consumers and health care providers and organizations at all levels of healthcare provision, planning and evaluation. Taking action to reduce barriers to health literacy is incorporated within this goal.

The Commission has integrated health literacy into the National Safety and Quality Health Service Standards (NSQHS)\(^{132}\). The NSQHS Standards emphasize the need for organization to work closely with consumers and develop partnerships to ensure that health care is developed in a way that is understood and meets the needs and preferences of consumers. Standard 1: Governance for Safety and Quality in Health Service Organizations and Standard 2: Partnering with Consumers include actions that focus on these areas, and most of the other NSQHS Standards include actions focused on making information easy to understand. For example, Standard 7.10.1: Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful.

The multi-pronged approach of the Commission has raised awareness of health literacy and the actions that can be taken to reduce health literacy barriers across the health care system.

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\(^{132}\)Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Services Standards https://www.safetyandquality.gov.au/standards/nsqhs-standards
Annex E: Situational Analysis

Situational Analysis of NCD-related health literacy activity

This stock take of health literacy interventions and activities, conducted globally, was designed to gather information on the current situation among Member States regarding application of health literacy for the prevention, control and management of NCDs and mental health conditions and their risk factors. Seven health literacy action areas provided the focal points to gather this information.

An invitation to take part in this health literacy stocktake was sent out to all WHO Regional offices, who in turn, each invited several countries to contribute. Invitations to contribute were also sent to members of an earlier WHO Global Coordination Mechanism for NCDs Health Literacy Community of Practice on health literacy, and also to the authors’ networks and via social media. Responses were received from all the WHO regions (see Figure 4). A total of 63 responses were received.

![Figure 4: Responses from WHO regions](image)

Following countries responded to the stocktake exercise (see Table 1)

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Page 80 of 87
The stakeholders that responded to survey were mainly from Academia (including research centres) followed by government (e.g., ministry of health) and by non-government organisations/community-based organisations/civil society (see Error! Reference source not found.Error! Reference source not found.).

![Figure 5: Responses received from various stakeholders](image)

The findings provide insights into the breadth of health literacy approaches currently underway, however, as this is not a self-reported and voluntary survey, and not population-based study, it is not possible to report on the frequency of interventions or other characteristics such as effectiveness.

A summary of activity under each action area is provided in the following pages.

**Action Area 1 - Mass Communication Channels**
The majority of countries are using mass communication channels to educate people and create awareness about NCDs and associated risk factors.

Communication channels commonly used include radio, television advertisements, YouTube, social media platforms (Facebook and Instagram), brochures, posters, community education programs and Ministry of Health websites.

Mass education health programs and campaigns mainly focused on creating awareness about tobacco, alcohol, obesity, healthy eating, physical activity, hypertension, diabetes and cancer. However, health education programs in many countries tended to be implemented on special days such as new year, world cancer day, world hypertension day etc. Moreover, health education programs for mental health conditions were not reported by any country.

Exemplar:

1) **Portugal** - Public education campaigns using television advertisements to create awareness about healthy eating, tobacco control and enhancing physical activity. (Refer to case study 1)

2) **UAE and Nepal** - May-Measurement Month to create awareness about hypertension and its early screening. (Refer to case study 9)

3) **Russian Federation** - “You are Stronger” – a national mass communication campaign using internet and television to create awareness about NCD risk factors.

4) **Singapore** - Online health hub by the Health Promotion Board of Singapore providing 24X7 access to tailored and credible health information. (Refer to case study 8)

5) **Thailand** - Thai people traditionally give bottles of alcohol as gifts to seniors on special occasions as a sign of respect. To counter this, the Thai Health Foundation created an “anti-alcohol” campaign highlighting the dangers of alcohol consumption conveying the message that giving alcohol as a gift is like putting a curse on the receiver, resulting in their injury or death.

**Action Area 2 - Children and Adolescents health**

Education settings such as kindergartens, primary schools and secondary schools were identified as major areas for implementing health literacy interventions to empower children and adolescents to lead a healthy life free of NCD risk factors.

Health education programs in education settings focused on educating children and adolescents about basic hygiene practices; oral health and tooth brushing; healthy and balanced nutrition; enhancing physical activity; resisting tobacco and alcohol consumption; prevention of obesity; and sexual and reproductive health. There were no programs reported focused on mental health.

Most of health education programs for children and adolescents focused on delivering information only and did not focus on enhancing critical thinking and practical skills. Many of these programs were not comprehensive and lacked whole-of-school approaches therefore there is minimal involvement of school staff and parents. Only few countries such as Australia, Nepal and USA reported programs that actively involved children and their parents.

Exemplar:

1) **Nepal** - Bhaskar Initiative for School Heart Health Empowerment Studies (BISHES) to empower adolescents to avoid risk factors to enhance prevention of CVDs. (Refer to case study 6)

2) **USA** – Building Wellness health literacy programs in schools to enable children to avoid NCDs risk factors from early stages of life. (Refer to case study 7)

3) **Mexico** - In May 2014, a law was updated to regulate foods and beverages sold in all public and private schools in Mexico, from pre-school to university. This law prohibits the sale of junk food so only natural (unprocessed) foods should be offered in educational settings.

4) **Australia** – Health Lit4 Kids is incorporating health literacy into school curriculum and is involving
families and communities to improve their collective health literacy to reduce health inequality and to improve health outcomes. (Refer to case study 15)

Action Area 3 - Technology/Digital Health:

Digital technology is being utilised in many different ways to; educate people about NCDs and associated risk factors, provide information and access to NCD-related health services, and establish communication links between the health system and the population.

The common digital technology platforms being used included social media (Facebook and YouTube), mobile applications, emails, mobile text messages (SMS), television, radio and national health system websites. The use of digital technology was found to be more widespread in HICs than LMICs. Digital health interventions using Facebook, SMS and traditional media such as radio and television were more popular in LMICs while National Health Service websites, mobile applications, email and other advanced technology platforms were more popular in HICs. Text messaging (SMS) was found to be frequently used in various countries (both HICs and LMICs) to educate and support people to: quit tobacco, to educate people about diabetes and associated services, and to send reminders for health appointments, medications and support services.

Barriers to the uptake of digital health interventions were also identified. These include; poor access to the internet and digital technology due to high cost and poor infrastructure, low literacy, lack of skills to use the internet, and use of inappropriate technology to target different population groups.

Exemplar:

1) **India** – mTobaccoCessation and mDiabetes a part of ‘Be Healthy Be Mobile’ initiative is utilising mobile text message to effectively support people to quit tobacco and to educate people about diabetes. (Refer to case study 11)

2) **Israel** – Primary health care providers and general physicians are using email to share credible health information about chronic diseases, medical prescriptions and other required information to effectively support self-management of chronic diseases.

3) **USA** - The bigger picture project (a partnership with UCSF’s Center for Vulnerable Populations at Zuckerberg San Francisco General Hospital) is using YouTube channel to inspire young people to change the conversation about Type 2 diabetes. It focuses on creating awareness about environmental and social conditions that lead to diabetes. It contains series of videos in which young people are portrayed as agents for change. (Refer to case study 11)

4) **Denmark** – EPITAL living lab, a digitally operated living lab to support self-management of chronic diseases. (Refer to case study 12)

Action Area 4 – Skills of Health Care and Health Promotion staff

This action area was found to be less frequently reported as an activity across countries. The reasons for this include a lack of awareness and knowledge about health literacy, and poor health system support for capacity building of health care providers. Moreover, health literacy is considered only as an attribute of individuals and not as an attribute and key responsibility of health care providers.

However, health literacy was identified as an important strategy to enhance communication, support behaviour change, build confidence and to make health services more user friendly, accessible and supportive for people with different health literacy needs.
In LMICs, community health workers or village health workers are being trained by various local organisations to enhance their communication and digital literacy skills to effectively deliver various interventions targeting NCDs and associated risk factors. This was through education campaigns, early screening services and referral services through outreach to rural populations.

In HICs, the health literacy approaches such as Teach back, plain language and text, interpreter services, were found to be incorporated into daily practices to enhance communication between health professionals and patients. Moreover, Australia and USA have developed guidelines for enhancing health literacy responsiveness of hospitals, universities and other health organisations.

The important gap identified was lack of health literacy training at undergraduate and postgraduate level for future health care providers which is essential to effectively respond to health needs of people with different health literacy strengths and limitations.

*Exemplar:*
1) **Scotland** – A national health literacy action plan for Scotland focuses strongly on enhancing health literacy skills of health care providers. (Refer to case study 13)
2) **India and Thailand** – Community health workers are being trained to deliver NCDs related education and screening services in rural areas. (Refer to case study 3)
3) **Indonesia** – A national policy to promote healthy lifestyle (GERMAS) is focusing on training health care providers to use different means of communication and plain language to make health services more user friendly. (Refer to case study 10)
4) **Australia** – Integrated health literacy into a national quality and safety framework to reduce health inequalities and to enhance hospital standards to meet health needs of people from different cultural background (Refer to case study 16).

**Action Area 5 – Hard to reach/ left behind population**

Hard to reach population groups include people from low socio-economic backgrounds, rural populations, Aboriginal and indigenous people, refugees, migrants and, culturally and linguistically diverse communities.

In the majority of countries, health systems had inadequate infrastructure and capacity to respond to health needs of hard to reach population groups. These groups usually had poor access to NCD-related health information and health services due low literacy, poverty, cultural and religious practices, and lack of trust and confidence in health care providers. Major barriers to reaching these populations were no Universal Health Coverage or health insurance, lack of action at a national level, insufficient or no health budget and high price of health services. However, in some countries community nurses, medical students and primary health care workers are being utilised to meet health needs of some of these population groups. Also, some countries have started addressing cultural, religious and language barriers using health literacy approaches to meet diverse health needs of these population groups.

*Exemplar:*
1) **Denmark** – Community nurses and bridgebuilders (students in health institutions) are helping and supporting migrants and other vulnerable groups to navigate health system.
2) **Sweden** – Cultural mediators are being trained to educate refugees about mental health conditions and NCD risk factors and are helping them to access health system.
3) **Egypt** – The Ophelia (OPtimise HEalth Literacy and Access) process is being utilised to engage fishermen and their families in healthy lifestyle practices and to enhance their access to health services. (Refer to case study 2)
4) **Australia** – The Ophelia approach is being utilised to improve breast screening awareness and participation of Aboriginal, Arabic and Italian Women. These population groups have low rates of breast
Action Area 6 - Community Health Literacy

In many countries, community-based health interventions to impact NCDs have been carried out for many years. While these are clearly health literacy interventions they are often not referred to as such because they never used term health literacy explicitly.

These interventions and groups are creating awareness about healthy lifestyle practices, supporting older and disabled people to access health services, providing social support to young mothers and fathers, and enabling community members to avoid NCDs risk factors. The common interventions identified were community kitchen programs to promote healthy eating in families; mother’s groups to support young mothers; physical activity networks to enhance physical and mental health; health ambassadors to educate community members and support them in decision making; and community awareness programs on tobacco and alcohol.

To enhance the reach and acceptability of these interventions, some countries have started involving sports personalities, celebrities, religious and cultural leaders, community elders and leaders, and religious and faith-based organisations as these people/organisations are more likely to engage community members and enable them to follow healthy lifestyle practices throughout the life course. However, the availability of funding also plays a major role in enhancing reach of these interventions.

Exemplar:

1) **Brunei** – Community kitchen program to promote healthy eating in families is initiated by health promotion centre at Ministry of Health and have involved religious leaders in co-design and to enhance participation. (Refer to case study 4)

2) **Cameroon** – Community leaders are being involved to address religious and cultural beliefs to promote healthy lifestyle in Kom Villages. (Refer to case study 5)

3) **Bulgaria** - Famous athletes and media stars are actively involved in promoting a healthy lifestyle, promoting sports, including organizing sports events and meetings, awarding scholarships for sports and conducting various TV programs. Politicians from different parties also participate in similar campaigns.

Action Area 7 – Intersectoral Actions and Joint Activities

The majority of countries have established intersectoral actions and joint activities to reduce growing burden of NCDs.

The areas for major intersectoral collaboration identified were: a) collaboration between Ministry of health, Ministry of education and Ministry of finance to strengthen tobacco taxation, laws for smoke free educational settings and public places, and to provide support services to help people to quit tobacco; b) collaboration between Ministry of health and Ministry of education to promote health eating and target childhood obesity in schools; c) collaboration between Ministry of health and Media companies to promote healthy lifestyle practices on mainstream media and to target commercial determinants of health.

Many have introduced a multisectoral action plan or alliance for NCDs which involves joint action from the government, non-government, private and academic sectors to strengthen the prevention and control of NCDs across all sectors.
Exemplar:

1) **Brazil** - “Health at School” program is national level inter-sectoral policy (Ministry of Health and Education) that focuses on promoting positive health behaviours at public schools with focus on diabetes prevention, physical activity, oral health and many other conditions.

2) **Fiji** – Health promoting school network works hand in hand with Ministry of Health and Medical Services, and with the Ministry of Education, Heritage and Art. The program also works with Ministry of Youth and Sports and Ministry of Agriculture.

3) **Argentina** - Intersectoral action for tobacco control has been carried out for 3 years with the Ministry of Finance, the National Tax Collection Agency for the design and implementation of a fiscal policy on tobacco products and for the design of a strategy to strengthen the control of illicit trade in tobacco products.

4) **Singapore** - The NurtureSG taskforce is a collaboration between Ministry of Education and Ministry of Health that aims to enhance preventive health services for the young generation so that they can adopt and maintain healthy living from young to enhance prevention of various NCDs. It involves parents, caregivers and educators as well.
DISCLAIMER

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The WHO Independent High-level Commission on NCDs came together as a diverse group of individuals from various backgrounds, experiences and continents. Discussions took place in an atmosphere of mutual respect, with each of the Commissioners recognizing that the world community as a whole, and each Commissioner, shares a stake in this subject, and that the world can and must do better. Even if the Commissioners did not agree on every detail of this report. the Commission reached broad consensus on most aspects. And most importantly, the Commission was unanimous on the need to act, and to act now.

Where Commissioners could not agree, the Co-Chairs correctly reflected this disagreement in the final report with a footnote. This report does, therefore, not represent an official position of the World Health Organization, the Commission, or Commissioners. It is a tool to explore the views of interested parties on the subject matter. References to international partners are suggestions only and do not constitute or imply any endorsement whatsoever of this report.

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