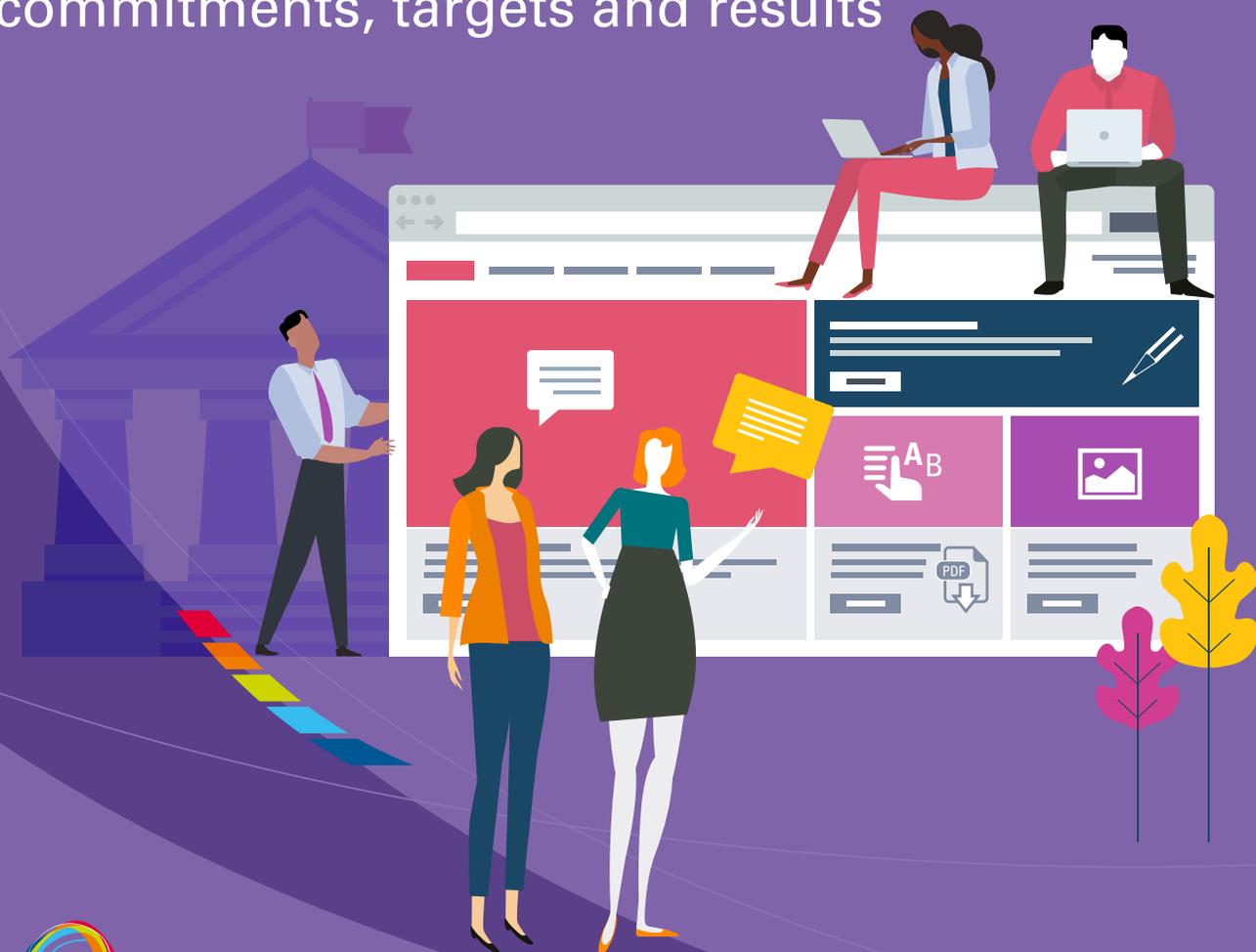# Pushing Progress on NCDs

A toolkit for civil society-led accountability actions to **bridge the gap** between commitments, targets and results

NCD Alliance

Acknowledgements

Table of contents

Key Terms

Accountability

Accountability can be defined as a cyclical process of monitoring, review and action. It entails tracking national and global actions of public and private sector against internationally or nationally agreed political commitments and standards; and subsequent identification of what works and why, what needs improving, and where increased action is needed. Accountability ensures that decision makers have the information required to continuously make improvements, meet health needs, and respect the rights of all people at risk of or living with NCDs, placing them at the heart of related efforts.

Agenda 2030

In September 2015, the United Nations General Assembly formally adopted the universal **2030 Agenda for Sustainable Development**, along with a set of 17 Sustainable Development Goals (SDGs) and 169 associated targets. The SDGs are interdependent and mutually reinforcing and call for countries to mobilise efforts to end all forms of poverty, fight inequalities, tackle climate change, and improve health and wellbeing, while ensuring that no one is left behind.

Appendix 3 "best buys"

Appendix 3 of the **WHO Global NCD Action Plan 2013-2020** has been recently updated under the title of '**Tackling NCDs: "Best buys" and other recommended interventions for the prevention and control of noncommunicable diseases**', and is a menu of policy options and cost-effective interventions to support the implementation of the Global NCD Action Plan. The timeframe of the plan has been extended by the World Health Assembly to 2030, to align with the SDGs. Of the 88 interventions, 16 are identified as "best buys" – those considered the most cost-effective and feasible for implementation.

Benchmarking

In broad terms and as commonly used in a United Nations context, benchmarking can be defined as a type of monitoring that uses a 'benchmark' as a point of reference against which change and progress can be measured. A benchmark can be seen as a target that has been defined by an existing standard, a minimum requirement for something to work, or a best practice. For more on benchmarking, see: **United Nations**.

Capacity development

In the context of accountability: Working with NCD civil society organisations and alliances at national and regional levels to strengthen skills, knowledge and resources. With the goal of CSOs effectively and sustainably stimulating government action on NCD prevention and control and ensure accountability for NCDs.

Civil society (organisations)

Civil society refers to the wide array of non-governmental and not-for-profit organisations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. The term 'civil society organisations (CSOs)' therefore refers to a wide of array of organisations: community groups, non-governmental organisations, labour unions, indigenous groups, charitable organisations, faith-based organisations, professional associations, and foundations. Read more about the **World Bank's definition of civil society here**.

Country Capacity Survey

WHO conducts periodic assessments of national capacity for NCD prevention and control through the **WHO NCD Country Capacity Survey** of WHO member states. It allows countries and WHO to monitor progress and achievements in expanding capacities to respond to the NCD epidemic. The questionnaire covers health system infrastructure; funding; policies, plans and strategies; surveillance; primary health care; and partnerships and multilateral collaboration. It is completed by national NCD focal points or designated colleagues within the Ministry of Health or a different national institute/agency.

Country Profiles

WHO **NCD Country Profiles**, updated in 2018, are a key source for national monitoring. The country profiles present key data on NCD mortality, risk factor prevalence, national systems' capacity to prevent and control NCDs, and the existence of national targets based on the Global Monitoring Framework. These profiles allow WHO member states to track their progress towards achieving **the nine global targets** to reduce premature death from the four major NCDs by 25% by 2025. WHO released a set of country profiles to coincide with each UN High-level Meeting on NCDs – in **2011**, **2014** and **2018**.

Essential Medicines List

Essential medicines are those that satisfy the priority health care needs of the population. The WHO Model Essential Medicines List (EML) serves as an international guide of clinically important interventions, which countries often use to formulate their own national essential medicines lists (NEMLs). Most countries have national lists and some have provincial or state lists as well. National lists of essential medicines usually relate closely to national guidelines for clinical health care practice, which are used for the training and supervision of health workers (**WHO, 2015**). The latest **WHO EML** was published in 2019.

Framework Convention on Tobacco Control (FCTC)

The **WHO FCTC** is the first global public health treaty developed by countries in response to the globalisation of the tobacco epidemic. As of October 2019, there are 168 signatories and 181 parties to the FCTC. It aims to tackle some of the causes of that epidemic, including complex factors with cross-border effects, such as trade liberalisation and direct foreign investment, tobacco advertising, promotion and sponsorship beyond national borders, and illicit trade in tobacco products.

Global Coordination Mechanism on NCDs (WHO GCM)

The **WHO GCM** on prevention and control of NCDs was established by the WHO Director-General in 2014. Its scope and purpose are to enhance the coordination of activities, multi-stakeholder engagement, and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020.

Global Action Plan

Refers to the **WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020**. As its overarching goal, this plan aims to reduce the number of premature deaths from NCDs by 25% by 2025 through nine voluntary global targets. The nine targets focus in part on addressing factors that increase people's risk of developing these diseases, such as tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity. The timeframe of the Global NCD Action Plan has now been extended by the World Health Assembly (**Decision WHA72(11)**) to 2030 in order to align with SDG 3.4. to reduce by one third premature mortality from NCDs and promote mental health and wellbeing by 2030.

Global monitoring framework

Following the adoption of the 2011 UN Political Declaration on NCDs, WHO developed a **global monitoring framework** for the nine voluntary global targets and 25 indicators to enable global tracking of major noncommunicable diseases and their key risk factors.

Intersectoral action

Collaboration across the 'whole of society' (i.e. government, relevant private sector entities, civil society, people living with NCDs, academia, philanthropy and the media).

Multisectoral action

Collaboration across the 'whole of government' (i.e. departments of health, finance, agriculture, environment, etc.).

Noncommunicable diseases (NCDs)

NCDs are diseases which are not transmissible from person to person, including cardiovascular disease, cancer, respiratory disease, diabetes, stroke, mental health conditions and many others. NCDs are the number 1 cause of death and disability worldwide, with 70% of all deaths attributable to NCDs. NCDs currently account for 41 million global deaths annually, including 15 million people between 30-69 years old (WHO). 86% of these premature NCD deaths occur in low- and middle-income countries (LMICs). Most NCDs are preventable and can be avoided by tackling modifiable risk factors, including unhealthy diet, tobacco and alcohol use, and environmental pollution (commercial determinants of health). Poverty and deprivation (social determinants of health) are also a major risk factor for NCDs, and vice versa - NCDs are a major driver of poverty and a barrier to economic and social development.

Official development assistance (ODA)

Government aid designed to promote the economic development and welfare of low- and middle-income countries (**OECD, 2015**).

Progress Monitor

The WHO NCD Progress Monitor is a key source for national monitoring. The progress monitor was first published in 2015 and updated in **2017** and presents information for all 194 WHO member states related to their achievements against progress monitoring indicators. The indicators include setting time-bound targets to reduce NCD deaths; developing all-of-government policies to address NCDs; implementing key tobacco demand reduction measures, measures to reduce harmful use of alcohol and unhealthy diets and promote physical activity; and strengthening health systems through primary health care and universal health coverage. A new WHO NCD Progress Monitor will be published in 2020.

Sustainable Development Goals (SDGs)

See 'Agenda 2030'

United Nations Development Assistance Framework (UNDAF)

A programme document between a government and the United Nations Country Team that describes the collective actions and strategies of the UN towards the achievement of national development. The UNDAF includes outcomes, activities and UN agency responsibilities that are agreed by government. It also shows where the UN can contribute most effectively to the achievement of national development priorities. UNDAF's typically run for three years and include reviews at different points (**UNFPA**).

United Nations High-Level Meeting (UN HLM)

United Nations High-Level Meetings convene Heads of State and Government on particular topics of global urgency, taking place during the UN General Assembly. To date, three HLMs have been convened on the topic of NCDs – in September 2011, July 2014, and September 2018. Before the first UN HLM on NCDs, the only other HLM on a health topic convened at UN Headquarters in New York was on HIV/AIDS. The 2011 UN HLM on NCDs catalysed global coordination on NCD prevention and control. The 2014 and 2018 UN HLMs provided opportunities to undertake a comprehensive review of global and national progress. In 2019, a first UN HLM was convened on the topic of Universal Health Coverage (UHC). Future HLMs are planned on UHC in 2023 and on NCDs in 2025.

Universal Health Coverage (UHC)

Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services (**WHO**).

Key Terms for National / Regional NCD Planning

Health plan / development plan

A broad master plan for attaining national / regional health or development goals through the implementation of a national strategy. It indicates what has to be done, who is responsible (i.e. Ministry of Health or other actors), within what timeframe, and with what resources. It is a framework leading to more detailed programming, budgeting, implementation and evaluation. It specifies, in operational terms, the steps to be taken in accordance with the strategy, keeping in mind the various objectives and targets to be attained and the programmes for attaining them (see also **WHO**).

Guideline

A direction or principle representing current or future rules of policy and clinical practice. Generally a comprehensive guide to problems and approaches in any field of activity. Guidelines are more specific and more detailed than guiding principles, on which they are based.

Indicator

A variable with characteristics of quality, quantity, and time that helps to measure changes in a health situation directly or indirectly and to assess the extent to which the objectives and targets of a programme are being attained. It also provides a basis for developing adequate plans for improvement.

Investment case

NCD investment cases are national economic and political analyses of current and potential interventions to prevent and control NCDs. The aim is to define the costs of inaction of the status quo and quantify the benefits of priority actions. At the request of governments, the United Nations Inter-Agency Taskforce on NCDs provides quantification of the national-level costs of treating NCDs, the cost of NCDs to the economy, the costs and benefits of interventions to prevent and control NCDs, and the return on investment of those interventions, as compared to a baseline or 'business as usual' scenario. (For more information, see **WHO and UNDP, 2019**).

Policy

A policy can be defined as an agreement or consensus on a range of issues, goals and objectives that need to be addressed (Ritsatakis et al., 2000). Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society (WHO).

Programme

An organised aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute.

Strategy

Based on national health policy, a set of decisions that includes the broad lines of action required in all sectors involved in order to give effect to the national health policy and indicate problems and ways of dealing with them.

Target

A defined expected outcome, generally based on specific and measurable changes.

INTRODUCTION

Noncommunicable diseases (NCDs) have emerged as a major impediment to health and development, accounting for 41 million deaths globally every year[1]. Major NCDs include cancer, cardiovascular diseases, diabetes, chronic respiratory diseases, mental health conditions and neurological disorders. These diseases share common risk factors which have become increasingly globalised, including tobacco use, harmful use of alcohol, unhealthy diets, physical inactivity, and exposure to environmental pollution, underpinned by demographic changes such as population ageing and rapid urbanisation. NCDs occur across age groups but are the primary cause of 'premature' deaths, responsible for 57% of global deaths before the age of 70 in 2016. NCDs disproportionately affect low- and middle-income countries, leading to massive out-of-pocket healthcare expenditures, and thus fuelling the poverty cycle. Tackling the burden of NCDs requires a comprehensive whole of society approach, involving a range of health and non-health stakeholders. The role of civil society is critical in supporting and complementing national and global efforts on NCDs.

The fast-changing policy landscape of NCDs offers civil society an opportunity to play a key role in four major areas of NCD prevention and control – namely awareness, advocacy, access and accountability.

AWARENESS	ADVOCACY	ACCESS	ACCOUNTABILITY
Targeting the general public or specific populations with initiatives aimed at increasing knowledge, changing attitudes and behaviours; raising public demand for improved rights and services.	Driving systemic change such as through influencing legislation, funding, or policy for NCD prevention and control and amplifying voices of people living with NCDs	Delivering health services, medications, patient support, legal support, practical support, access to healthcare services in humanitarian situations, etc.	Tracking national progress and actions of private and public sector against commitments and standards.

1 Achieving 25 X 25 Though Civil Society Coalitions. A Situational Analysis of National and Regional NCD Alliances. NCD Alliance, 2015.

Accountability – a cyclical process of monitoring, review and action to assess progress, strengths and weaknesses and identify problems – is a cornerstone of NCD Alliance's work. Independent accountability exercises, undertaken by civil society organisations, are important to hold governments to account for their commitments taken on the global stage, and ensure that they translate into real, national and local action. The results of independent evaluations are useful tools – an external assessment, index or ranking can often spur action by governments shown to be lagging behind or not measuring up to their peers' progress. We believe that accountability actions are essential to bridge the gap between the global commitments to NCD prevention and control that governments have undertaken over the last decade, and national action to reduce the prevalence and burden of NCDs in every region to reach the targets for 2030.

We are especially grateful to the NCD alliances and civil society organisations who have already blazed the trail by publishing Civil Society Status Reports, for sharing the benefit of their experience, which you can find throughout this toolkit. We welcome any questions and particularly any feedback from new users so that we can update this toolkit and continuously improve the information available here.

Whilst the benchmarking tool might seem rigorous, it is about assessing successes as well as gaps and holding governments to their promises to make a real, tangible difference to people's lives. The results from your efforts represent an opportunity to turn data into meaningful change for every country, every community and for every person living with one or multiple NCDs who currently feels left behind.

On behalf of the team at NCD Alliance, we sincerely hope that this accountability toolkit serves as both an inspiration and a practical guide for undertaking your own accountability actions at national or regional level. A heartfelt thank you to the NCD Alliance network around the world for supporting accountability efforts.

A toolkit to develop Civil Society Status Reports

This toolkit has been developed to support national and regional NCD civil society organisations (CSOs), including NCD alliances, to review and monitor in-country and regional responses to NCDs, identify advocacy priorities based on these findings, and strategise on how to best address NCDs within their local context. It builds on the first **NCD Alliance Benchmarking Tool** published in 2013, and integrates the valuable experiences of organisations and NCD alliances that have spearheaded accountability initiatives to date.

The toolkit offers practical guidance to NCD alliances and CSOs on how to conduct a benchmarking exercise and prepare a Civil Society Status report on the national or regional NCD response. The toolkit outlines key themes and indicators which can be used to review and evaluate existing NCD policies and programmes at national or regional level. The resulting Civil Society Status Reports can illustrate strengths and weaknesses in the NCD response in order to give credit to governments where they are doing well and hold them accountable where there are gaps. Civil Society Status Reports can then be used by civil society organisations and NCD alliances in their advocacy efforts to advance and accelerate NCD prevention and control measures. The toolkit includes practical steps and tips, a specific benchmarking tool and suggested indicators, links to further information sources, case studies and templates and is designed to be adapted by NCD alliances and CSOs to their local context, capacity and resources.

The 2013 version of the toolkit NCDs: Join the Fight

How to use this toolkit

This toolkit is comprised of **five sections:**

PART 1

Understanding Accountability provides an introduction to the concept of accountability, including key definitions, NCD Alliance's accountability framework, and an overview of the role of civil society in this arena. It also provides some instructive case studies of different accountability initiatives, led by civil society and other stakeholders.

PART 2

Action Beyond the 2018 UN High-Level Meeting on NCDs: The Role of Civil Society summarises the outcomes from UN High Level Meetings on NCDs and outlines the role of civil society in maintaining momentum globally and stepping up action at national and regional level for the next phase of the NCD response.

PART 3

Holding Governments Accountable: Civil Society Status Reports offers guidance on developing a national or regional Civil Society Status Report, based on previous experience, country-level data and referring to the NCD Alliance Benchmarking Tool described in Part 5 of this toolkit.

PART 4

Civil Society Status Report template provides a suggested outline for producing national civil society status reports on progress in the NCD response.

PART 5

NCD Alliance Benchmarking Tool provides a practical outline for how to assess the NCD response in your country or region. It gives guidance on where to find the relevant data, links to the latest source publications and some key national campaigns run by CSOs, and suggests how to evaluate progress across a range of policy areas with a 'traffic light' (red-amber-green) rating.

Tips and Resources

Throughout this Toolkit, you will find links to other useful resources and practical 'tips from the field'.
We are grateful to the national and regional NCD alliances who have previously carried out benchmarking exercises and published Civil Society Status Reports for sharing these tips and the benefit of their experience.

PART 1
Understanding Accountability

This section provides an introduction to the concept of accountability, including key definitions, NCD Alliance's accountability framework, and an overview of the role of civil society in this arena. It also provides some instructive case studies of different accountability initiatives, led by civil society and other stakeholders.

Accountability is a cornerstone of good governance and a means by which civil society can hold governments to appropriately high standards of policy making and implementation. Accountability can be defined as a cyclical process of **monitoring (data collection)**, **review (analysis)** and **action (advocacy and dissemination of messages)**. It entails tracking national and global actions of public and private sector against commitments and standards; and subsequent identification of what works and why, what needs improving, and where increased action is needed.

While there are a variety of actors involved in different accountability mechanisms (for example, academia and private sector can play a role in holding governments to account, or civil society can hold private sector to account), this toolkit focuses on the role of civil society in holding governments to account on commitments to advance NCD prevention and control. CSOs and NCD alliances are uniquely positioned to ensure that these commitments are upheld. Depending on unique national or regional contexts, their work may be supportive of government efforts, or it may be appropriate to take on a more critical 'watchdog' role. CSOs also play a crucial role as stakeholders in policy discussions, planning and budgeting processes, and scrutinising sector performance. Accountability initiatives may include: Assessing progress of responsible entities in meeting commitments; discussing gaps and solutions with the relevant agencies; advocacy through existing mechanisms such as commissions, public hearings and parliament; and engaging media and the public through information dissemination

The case studies provided here illustrate a range of diverse accountability tools and methodologies that are available to measure progress on NCDs. Accountability tools can be used to monitor and review policy priorities and programmes related to NCDs, their implementation and real-world outcomes, and their costs and benefits. The results can be used to mobilise action for further improvement. Most accountability methods include common components, such as the collection of quantitative and qualitative data, analysis, dissemination of information, mobilising support, and advocating for change.

These activities collectively form the three pillars of accountability: monitoring, review and action.

ACCOUNTABILITY

MONITORING   REVIEW   ACTION
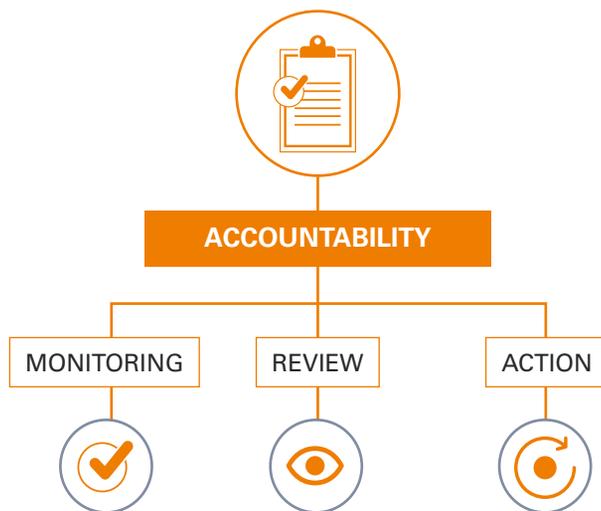
Civil society accountability efforts seek to ensure that that decision-makers have the necessary information to make policy and budgetary decisions to meet health needs and realise the rights of all people at risk of or living with NCDs, placing them at the heart of the policy response. When CSOs and NCD alliances engage in accountability exercises, such as publishing a Civil Society Status Report, it can be a powerful tool to spur governments to action by representing societal demands and amplifying calls for progress.

This toolkit focuses primarily on the collection of qualitative and quantitative data via a benchmarking tool (**presented in Part 5**), which can subsequently be used to analyse and translate findings into an evidence-based advocacy response.

National, regional and global accountability action

The NCD response can be monitored at all levels, from global to national to local. Accountability efforts can also be directed towards various NCD stakeholder groups. As highlighted previously, accountability exercises can be undertaken to focus on governments, UN agencies, regional bodies or industry. In order to achieve a robust 'whole-of-society' response to NCDs, all relevant sectors must be monitored, reviewed and called to action. Civil society must be strategic in their advocacy approach and choose entry points for making their case, such as strategic events, opportunities or channels to maximise the likelihood of their recommendations being actively considered and implemented.

Alongside independent efforts, civil society may also be actively engaged in national, WHO and UN-wide monitoring and review mechanisms for NCD prevention and control. Civil society representatives may be invited to participate in national official review processes. In both cases, the role of civil society in driving accountability efforts is critical. Findings from civil society-led accountability exercises serve as important inputs for supporting and reforming the government's response. Advocacy based on the evidence gathered can be strategically planned to coincide with preparations for official NCD progress reviews, such as regional or global WHO and UN meetings that are pertinent to NCDs.

The following figure is a conceptual framework for accountability on NCDs, inspired by the Every Women, Every Child, Every Adolescent movement and the Unified Accountability Framework (**UAF)** for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The UAF offers a way of organizing and bringing together diverse stakeholders to streamline, monitor, review and act on elements of accountability at all levels.

Figure 1: Proposed Accountability Framework for NCDs

COUNTRY ACCOUNTABILITY

REVIEW
- Health sector reviews
- Human rights monitoring
- SDG National Voluntary Reviews
- Parliamentary committees
- Citizen hearings
- Benchmarking and performance audits
- Mortality and health audits

ACT
- Country plans
- Government
- Civil society organisations
- Private sector
- Development partners
- People Living with NCDs and youth

MONITOR
- Data collection
- Special studies
- Social accountability reports
- WHO NCD Country Profiles
- Score cards

Regional peer review

MONITOR
MONITOR

Global report/report cards

Country and regional reports/report cards

GLOBAL ACCOUNTABILITY

ACT
- United Nations monitoring reports
- Expenditure reports
- WHO Progress Monitor
- Social accountability reports
- Civil society organisation reports
- Academic reports
- NCD Countdown 2025, 2030

- Global initiatives
- Stakeholder commitments
- Advocacy
- Alignment

REVIEW
- WHO NCD Targets and Action Plan
- UN Political Declaration and Outcome Document on NCDs (2011, 2014 and 2018)
- Sustainable Development Goals: Goal 3 and Target 3.4 on NCDs
- Global Health Observatory
- State of Women's, Children's and Adolescents' Health report
- Global Status Report on NCDs

- High-Level Political Forum for the Sustainable Development Goals
- World Health Assembly
- UN High-Level Meetings on NCDs

Adapted from the Unified Accountability Framework for the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, Partnership for Maternal, Newborn and Child Health

CASE STUDIES
Civil society-led accountability initiatives

These case studies are provided as examples of civil society-led accountability initiatives. As highlighted in these examples, there are several approaches and methodologies that can be leveraged by civil society organisations/NCD alliances to support accountability for NCDs, including scorecards, shadow reports, and indexes.

CASE STUDY 1

Shadow reporting to integrate tobacco control into the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Fundación InterAmericana del Corazón Argentina

CASE STUDY 2

'NOURISHING' a bank of policies for healthy diets to reduce the risk of cancer and NCDs

World Cancer Research Fund International

CASE STUDY 3

Assessing political parties' commitment to NCD prevention before and after elections

fare — Foundation for Alcohol Research & Education
Public Health Association Australia
Alzheimer's Australia — Living with dementia
CHF — Consumers Health Forum of Australia

CASE STUDY 4

National Voices coalition - Person-centred care report

National Voices

CASE STUDY 5

Ranking country action to address physical inactivity in young people

ACTIVE HEALTHY KIDS GLOBAL ALLIANCE

CASE STUDY 6

The Healthy Caribbean Coalition Childhood Obesity Prevention Scorecard (COPS)

HEALTHY CARIBBEAN COALITION

CASE STUDY 7

Mexican civil society shadow report: Progress on the action plan for the prevention of obesity in children and adolescents in the Americas

Contra PESO

CASE STUDY 8

NCD Countdown 2030

NCD Countdown 2030

Fundación InterAmericana del Corazón Argentina

Shadow reporting to integrate tobacco control into the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Overview

CEDAW is described as an international bill of rights for women. Parties to the Convention (signatory governments) are obliged to submit regular reports on the measures adopted to implement its provisions to the Committee on the Elimination of Discrimination against Women for review. In addition to these official government reports, civil society organisations may also submit shadow reports to highlight issues not raised by government or where different circumstances are observed to those in official reports.

Strength

In 2016, Fundación Interamericana del Corazón Argentina (Interamerican Heart Foundation, Argentina), together with other CSOs, submitted a **CEDAW shadow** report highlighting the Argentinian State's shortcomings related to protection of women from tobacco use. This event reportedly marked the first time that tobacco was highlighted as a key priority by CSOs before the Committee. The shadow report included recommendations to the government, such as increasing tobacco taxes, banning cigarette additives and flavourings, and promoting tobacco control policies at the subnational level. The CSOs also demanded an explanation of why Argentina remains one of few countries that has signed but not ratified the WHO Framework Convention on Tobacco Control.

Outcome

The **final recommendations of the Committee to Argentina** noted the high consumption of tobacco among girls as compared to boys, and recommended that Argentina ratify the FCTC to reduce the high tobacco consumption among adolescents, in particular girls, and address the health consequences.

World Cancer Research Fund International

'NOURISHING' a bank of policies for healthy diets to reduce the risk of cancer and NCDs

Overview

World Cancer Research Fund International's NOURISHING policy framework is designed to help policy makers worldwide to identify policy actions that promote healthy diets; select and tailor options for different populations; and ascertain how the current approaches in their own countries could be strengthened. The framework formalises a comprehensive package of policies across ten policy areas and three domains (food environment, food system, and behaviour change communication), including nutrition labelling, nutrition standards in schools, affordability measures, advertising regulations, and public awareness initiatives. The NOURISHING policy database accompanies the framework and includes examples of government policy actions from around the world.

Strength

Critically, only government actions that are currently being implemented are included. Draft or model laws, policy proposals, election commitments and laws that have been passed but not come into effect are not included. Policies which have 'expired' remain in the database, where possible with a note explaining why they were removed from force (e.g. a change of government)

Outcome

Civil society organisations can use NOURISHING to monitor what governments are doing around the world, benchmark progress, and hold governments to account. World Cancer Research Fund International's NOURISHING policy framework was used by Health Canada to help shape the development of its Healthy Eating strategy. The strategy includes a package of policies, which is an approach promoted by NOURISHING, to improve Canada's food environment, such as actions to revise dietary guidance to Canadians, restrict the commercial marketing of unhealthy foods and beverages to kids, develop a health claim for fruits and vegetables, update nutrition labelling (including a consultation on proposed front of package labelling), improve the food supply (including reducing salt and eliminating industrially-produced trans-fat from the food supply), develop sodium reduction targets for restaurants and the food service sector, and increase access to and availability of nutritious foods in isolated northern communities.
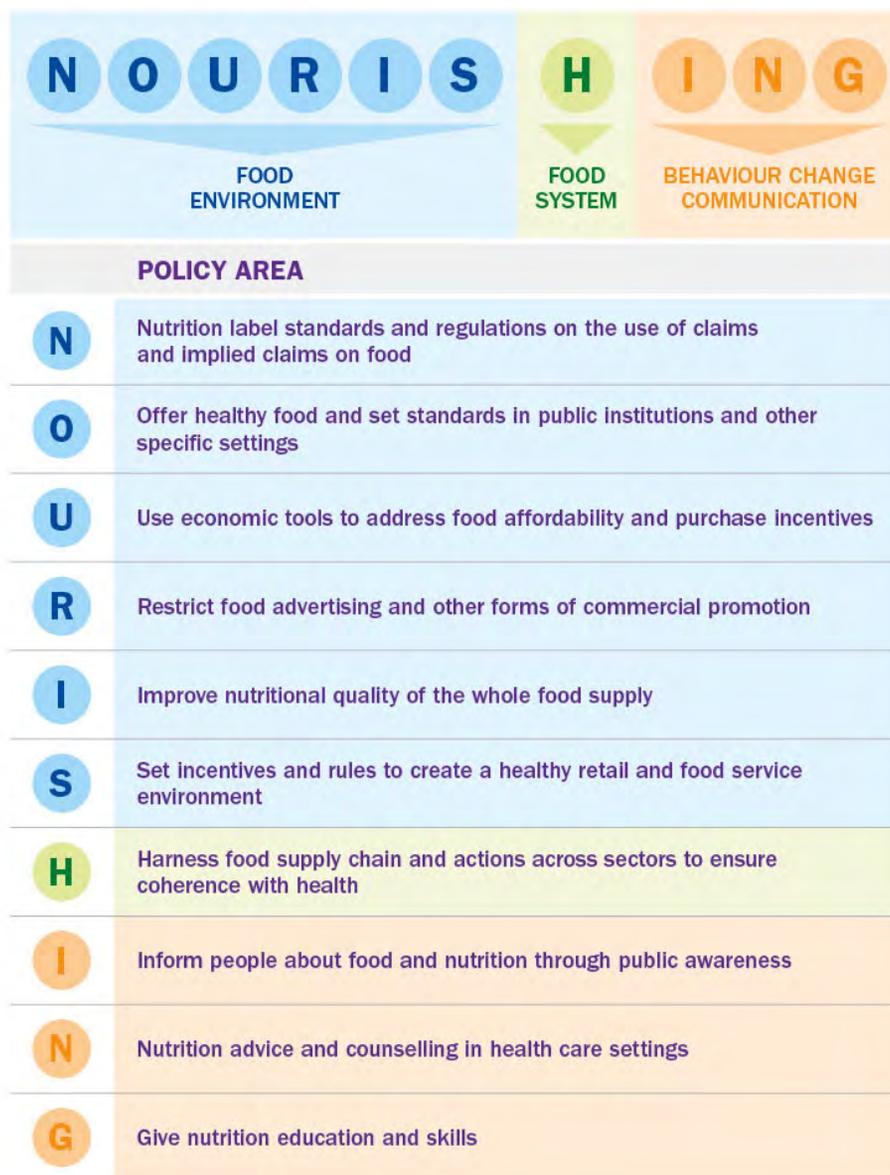
Figure 2: World Cancer Research Fund International, NOURISHING Policy Framework

This material has been reproduced from the World Cancer Research Fund International NOURISHING framework and policy database. www.wcrf.org/NOURISHING

Assessing political parties' commitment to NCD prevention before and after elections

Overview

Prevention 1st 2016 Election Platform was an initiative of the sponsors of Prevention 1st in the lead-up to the 2015 Australian Federal Election. Prevention 1st is a campaign sponsored by the Foundation for Alcohol Research and Education (FARE), the Public Health Association of Australia (PHAA), Alzheimer's Australia, and the Consumers Health Forum (CHF) to put preventive health 'back on the political agenda'. A policy platform was developed and published, and then sent to all the major political parties contesting the election, asking them to respond to ten questions on preventive health policy. This was accompanied by an **open letter**, signed by public health leaders from across Australia. Prevention 1st subsequently published the full responses to the questions online, together with a summary scorecard infographic highlighting the strengths and weaknesses of the parties' responses.

Strength

This tactic ensures a transparent and easy-to-publicise commitment from political parties prior to an election. The tactic encourages parties to publicly commit to sound policies, enables voters to make a more informed decision, and allows civil society to hold political parties to account for their promises once in office. It also reminds the party in power that civil society is monitoring a government's international obligations.

Outcome

Three political parties responded to the initiative. The party assessed to have the weakest preventive health policies was eventually elected in 2016. Nonetheless, this initiative can be used to hold the elected party to account. For instance, the **Prevention 1st Pre-Budget 2017-18 submission** to the Australian Treasury in 2017 identified four actions to reduce exposure to the major NCD risk factors. Furthermore, the information can be used to increase awareness of the stronger policies offered by other parties well in advance of the next election, in order to influence voters and place additional pressure on the party currently in power to improve their policies. This approach has also been replicated to coincide with local State election cycles.

National Voices

National Voices coalition - Person-centred care report

Overview

The 2017 **Person-centred care** report provides a snapshot from the perspective of people living with health conditions, including NCDs, revealing the extent to which person-centred care is happening in the English health and care system, based on how people report their experience of treatment, care and support.

National Voices is an England-based coalition of charities focused on promoting person-centred approaches for health and social care. The coalition's areas of work include promoting Primary Care Networks; patient leadership and social prescribing.

Strength

The report collates patient and service-user reported data from 19 England-wide surveys, and focuses on information, communication, involvement in decisions, care planning and care coordination. By including the perspectives of people living with health conditions and seeking treatment and care, the report highlighted the failure to deliver on two decades of policy promises across various governments. From the perspective of people living with chronic conditions, NHS still does not give people adequate control of their own health and care, and there is no reporting of whether care is coordinated across health and social care.

Outcome

The report highlights that although information and communication with patients has improved over time, large numbers of people are still not as involved in their healthcare decisions as they want to be. The report provides a strong basis for a large group of patient voices to hold the government and NHS managers accountable, and to improve future decision-making to become genuinely people-centred. It demonstrates that 'people-centred care' needs to transform from being an policy ambition to priority.

Ranking country action to address physical inactivity in young people

Overview

The **Global Matrix on Physical Activity for Children** and Youth by the Active Healthy Kids Global Alliance compares indicators across countries including organised sport participation, active transportation, schools, community and the built environment, and government strategies and investments. Dedicated report cards are produced for each country in collaboration with national experts

Strength

A standardised grading framework is used, rating each indicator from A to F. The matrix is updated every two years, with new countries added - enabling global comparisons of current country actions, as well as progress in any given country over time.

Outcome

The country report cards are often well-covered in the media; for example in Denmark, where findings from the latest country report card were featured on three national television programmes, serving to raise community awareness of both the issue of and solutions to physical inactivity.

The Healthy Caribbean Coalition Childhood Obesity Prevention Scorecard (COPS)

Overview

In October 2018, HCC launched the **Childhood Obesity Prevention Scorecard** to raise awareness of national policy responses to childhood obesity as part of the monitoring and evaluation component of the **HCC Civil Society Action Plan for Preventing Childhood Obesity in the Caribbean**. The scorecard identifies 15 priority policy and programming areas needed to effectively combat childhood obesity and tracks progress across the CARICOM region. The priority areas are selected based on national, regional and international policy and programming interventions for the prevention and control of childhood obesity. Key source strategic frameworks include: the CARPHA Healthy Weights Plan, the Pan-American Health Organisation (PAHO) Childhood Obesity Action Plan, the Port of Spain grid, the recommendations in the final report of the WHO Commission on Ending Childhood Obesity, the updated WHO 'best buys', and the HCC Civil Society Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean.

Strength

Using a traffic light approach to measure the presence of a policy, the scorecard is updated quarterly with the support of CSOs, NCD focal points, PAHO and other key partners by scanning the local policy environment to ensure data is accurate and up-to-date. Where policies exist, a link is provided to the current policy or legislative document to assist advocates in their advocacy and to assist other governments in the region in crafting similar policies.

Outcome

The COPS platform is actively used by civil society and public sector stakeholders to track the local policy environment, to inform advocacy and to guide policy development. Various government partners have accessed the policy documents available via the platform to inform the design and development of their own policies. Advocates are also using COPS to hold governments accountable by sharing their poor relative national performance (through the summary regional grid) or reminding policymakers when they have indicated commitment to policy action (this is scored as Partially Implemented/Under Development) with little or no follow up.

Mexican civil society shadow report:
Progress on the action plan for the prevention of obesity in children and adolescents in the Americas

Overview

In 2018, the ContraPESO Coalition, a network of more than 20 CSOs, launched the '**Shadow report of civil society in Mexico: Three years after the PAHO Plan of Action for the Prevention of Obesity in Children and Adolescents**' with the support of the national NCD alliance, Mexico SaludHable. The report analysed publicly available information (e.g. government policy/programme reports, national surveys, etc.) and compiled information obtained via transparency requests to several government agencies, allowing the coalition to obtain official documents and information on existing policies and their impact.

Strength

The information helped to evaluate the progress of obesity prevention policies in Mexico in accordance with PAHO's 2014 Action Plan using a traffic light assessment for the adoption of these policies. The report, which found Mexico to be off-track on recommendations and highlighted industry interference, was launched at a press conference together with the PAHO Country Office in Mexico.

Outcome

The report bolstered the Coalition's advocacy efforts, particularly calling for stronger commitments during the Presidential elections held in summer 2018 and demonstrating the need for stronger obesity prevention policies in accordance with WHO 'best buys' and PAHO Nutrient Profiles (e.g. regulations on marketing to children and front-of-package labelling). National legislation requiring clear, informative front-of-package labelling has subsequently been adopted by the Chamber of Deputies and Senate in Mexico.

NCD
Countdown
2030

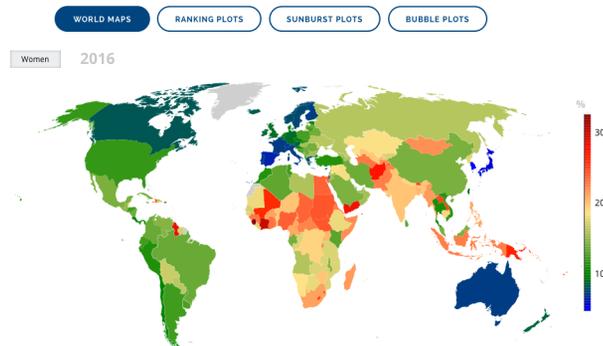# NCD Countdown 2030

NCD Countdown 2030 is an independent collaboration between the WHO, The Lancet, NCD Alliance and the WHO Collaborating Centre on NCD Surveillance and Epidemiology at Imperial College London, which tracks progress on NCDs globally and nationally. The NCD Countdown initiative builds off other similar countdowns, such as Countdown to 2015 for Maternal, Newborn and Child Survival as well as the Countdown for Health and Climate Change. The aim of the NCD Countdown series is to inform policies to reduce the worldwide burden of NCDs and to ensure accountability, by showing national progress – or lack of progress - for every country. The first **NCD Countdown 2030 Lancet** paper focused on tracking progress against the global NCD mortality target (SDG3.4), as well as a more comprehensive indicator that includes wider outcomes (a broader set of NCDs) and age groups (under 30 years and over 70 years) going beyond the narrow indicators of SDG target 3.4.

As well as the Lancet publications, NCD Countdown 2030 has its own website, **ncdcountdown.org**, where the data is available to download (free of change). Data visualisation tools are also available, allowing users to use the data to create maps, rankings and graphs to illustrate burden and progress by country.

The first NCD Countdown 2030 paper was published in The Lancet in September 2018, and launched at a public event in New York, just prior to the UN High-Level Meeting (HLM) on NCDs. Timing of the publication was expressly planned to attract media coverage and political attention just head of the HLM. The country ranking and maps contrasting countries and regions where progress is faster and slower generated a lot of interest from national and international press. The data could be used to compare progress with neighbouring countries, or between countries within a region, showing the countries with the highest and lowest risk for premature mortality (under 70 years) from an NCD.

Figure 3: Data visualisation of progress by country on NCDs from ncdcountdown.org website, NCD Countdown 2030 collaboration.

Some of the findings were attractive to journalists as they were unexpected or counterintuitive, for example that the risk of premature death from an NCD is higher than for all other causes, that poorer countries are more affected than richer countries, but that some of the poorest countries are making faster relative progress, whilst progress is stagnating or reversing in some of the richest countries in the world. As a result, the findings of Countdown were widely reported and set the scene very well for the HLM.

Future NCD Countdown 2030 reports will analyse and report on key NCD risk factors, relevant health system interventions, multi-sectoral policies, and financial commitments by governments and donors to give a comprehensive picture of the NCD response worldwide. NCD Countdown 2030 is meant as an essential tool to support development of evidence-based policies and programmes to reduce the health burden of NCDS and national and global health inequalities and to raise both media and public awareness to stimulate demand for further policy change. The second report in the series is scheduled for publication in 2020 and will be published at ncdcountdown.org as well as in the Lancet.

Further examples

→ **SEATCA**, the South-East Asia **Tobacco Control Alliance, publishes a Tobacco Industry Interference Index**, on the implementation of the WHO Framework Convention on Tobacco Control Article 5.3 in Asia.

→ **HelpAge** has published a **Global Age Watch ranking** of countries, based on how well their older populations are faring, including country report cards

→ It is increasingly common for CSOs, especially in human rights related sectors, to undertake shadow reporting (or 'alternative reports') to submit to United Nations treaty monitoring bodies or other international institutions, as an alternative to a government's official report regarding the human rights situation in its respective country. The **Global Network of People Living with HIV (GNP+)** has published GIPA Report Cards to monitor and evaluate governments' and organisations' application of the GIPA principle (Greater Involvement of People Living with HIV). As an advocacy tool, the **GIPA Report Card** aims to increase and improve the programmatic, policy and funding actions taken to realise the greater involvement of people living with HIV in a country's HIV response.

Links to further resources:
Civil society scorecards

Scorecards have been developed by global CSOs help to track progress on various NCDs at the country level using globally applicable indicators (on the epidemiological situation, policy and programme response, and risk factor exposure), and then aggregate this data at global level to provide a comparative analysis between countries. Scorecards also highlight good practices as well as gaps that can be addressed through strategic advocacy to propel government action. Regional comparisons by way of scorecards on policy progress, for example, can help create healthy competition among countries and trigger national action. Below are several examples of scorecards, in addition to the more in-depth examples outlined in the present document:

→ A **global scorecard on diabetes** is published by the International Diabetes Federation

→ A **CVD scorecard** is produced by the World Heart Federation

→ GRAND South, a network of 11 centres working on NCDs, have developed and implemented an **NCD Scorecard** with analyses of 23 countries stratified across income groups.

→ In relation to policies in the climate and environment sectors, which are also highly relevant for NCDs as environmental pollution and climate change are major NCD risk factors, the **European Climate Foundation** releases national scorecards of European Union Member States' national climate and energy plans for 2030.

→ In relation to mental health, a new Countdown Global Mental Health 2030 has been announced as a follow-up to the **Lancet Commission on Global Mental Health and Sustainable Development**. The Countdown will aim to improve data for conditions including depression and anxiety and establish metrics to compare countries. A scorecard will be produced every two years.

Accountability matrix
Opportunities for NCD civil society accountability action

This accountability matrix provides a snapshot of available mechanisms, entry points and target groups for civil society to explore while planning accountability exercises. This matrix can be adapted to include additional regional and national mechanisms and opportunities, both within the health and broader SDG context.

	Mechanism	Description	Entry point	Target
Global	WHO Global NCD Monitoring Framework (GMF)	Nine voluntary targets and 25 indicators to monitor progress on the WHO Global NCD Action Plan.	**World Health Assembly**, held annually in May in Geneva, UN General Assembly High-Level Meetings	Ministries of Health, Finance, Economy; other relevant ministries; Country Mission Office in Geneva
	WHO NCD Progress Monitor	WHO defined 10 indicators which the WHO Director-General used to report to the UN General Assembly in 2017 on the progress made by countries in implementing their 2011 and 2014 commitments to develop ambitious national NCD responses. An update is expected in 2020.	UN High-Level Reviews; UN General Assembly High-Level Meetings; World Health Assembly	Ministries of Health, Finance and Economy; other relevant ministries; Country Mission Office in Geneva
	United Nations Agenda 2030 for Sustainable Development	While target 3.4 is the only target specifically on NCDs, many other targets relate to NCDs, both in the health Goals (SDG 3.5, 3.8, 3.9, 3a, 3b, 3c) and beyond (SDG 1, 2, 5, 7, 11, 13, 17).	**UN High-Level Political Forum** held annually in July in New York – different SDGs are the focus for review each year, and governments submit **Voluntary National Reviews** (VNRs) of progress; UN General Assembly High-Level Meetings	Ministries of Health, Development and Finance – especially those responsible for compiling Voluntary National Reviews; Country Mission Office in New York
Regional	WHO Regional NCD Monitoring Frameworks	Monitoring frameworks applicable to regional contexts developed by WHO Regional Offices with input from Member States.	WHO Regional Committee Meetings held from August to October each year	Ministry of Health
National	National Health and NCD Monitoring Frameworks	Health and NCD Plans established by national governments. These vary widely from country to country, with distinct monitoring frameworks. Priority targets should be identified for accountability purposes.	Dependent on country review mechanisms	Ministry of Health, especially NCD Department; also Ministries of Finance, Development, Education, Agriculture, Trade, Environment, Industry, etc. as applicable

Examples of non-civil society accountability initiatives

UN initiatives

The UN Secretary-General's Independent Accountability Panel (IAP) for Every Woman, Every Child, Every Adolescent

Overview

The UN IAP is the only fully independent accountability mechanism established by the United Nations on women's, children's and adolescents' health under the 2030 agenda for sustainable development. The IAP was founded in 2015 to provide an independent review of progress on the implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016-30), from the specific lens of who is accountable to whom, for what and how.

Strengths

The IAP is composed of an autonomous group of internationally recognised independent experts and leaders appointed by the UN Secretary-General in 2016. The IAP is hosted by the Partnership for Maternal, Newborn & Child Health (PMNCH), based at the World Health Organization. The IAP framework builds on the framework previously used by the Commission on Information and Accountability (CoIA) and the independent Expert Review Group (iERG), but draws on international human rights law, which lies at the core of the Global Strategy and is set out in instruments accepted by states through intergovernmental processes. The IAP extends the monitor, review, act and remedy framework articulated by CoIA. This framework recognises existing legal accountability mechanisms at national level (e.g. courts and national human rights institutions, and others already listed in the revised Global Strategy, such as parliamentarians, civil society organisations, development partners and private sector actors) and international level (e.g. UN treaty-monitoring bodies, regional bodies and the UN Human Rights Council's Universal Periodic Review). Including 'act' and 'remedy' makes the accountability framework consistent with the 2030 Agenda for Sustainable Development, which notably sets out the importance of rule of law and access to justice in order to achieve sustainable peace and development (Sustainable Development Goal 16). This includes equal access to justice for all, and developing effective, accountable and inclusive institutions at all levels.

Outcome

The IAP publishes annual reports on different aspects of accountability for the health of women, children and adolescents; for example, in 2018 on the role of the private sector: **Private Sector: Who is Accountable for women's, children's and adolescents' health?**

Private sector monitoring of NCD progress

EIU-Novartis Heart Health Scorecard

Overview

The Economist Intelligence Unit has produced a **Heart Health Country Scorecard** to help assess the burden of, and policy approaches to diseases of the heart. Sub-indicators across five areas (strategic plan, public health policy, best practice, access and provision, and patient focus) are scored on a scale of 0 to +3. Thus far, this has been completed for 28 countries.

Strengths

The partnership between the EIU and Novartis behind the scorecard is rich in technical expertise and robust in resources, enabling extensive research and stringent analysis. Countries can be easily ranked according to their performance in any area, or overall. In terms of content, an area which sets this initiative apart from many others, there is an emphasis on the extent to which countries are deemed to focus on patients. The use of patient health status surveys, patient education programmes, patient advocacy by heart health organisations, and the use of information and communication technology all enable better delivery of care and patient experience for people living with heart diseases, but are not commonly monitored alongside more conventional indicators.

EIU-UCB Patient-Centred Care Scorecard

Overview

The Economist Intelligence Unit, sponsored by biopharmaceutical company UCB, published a 2019 White Paper: Creating healthy partnerships: The role of patient value and patient-centred care in health systems. The white paper was followed by a research report on the assessment of the adoption of the principles of patient-centred care in nine countries titled '**Adoption of Patient-Centred Care: Findings and Methodology**'. The report explores the key factors that nine high- and middle-income countries should consider to better integrate patient-centred care. It includes a scorecard, which looks at the transition toward patient-centred care.

Strengths

It combines 26 data points to provide a comprehensive overview of how well countries are doing, and also draws on a survey including 45 patient groups.

Academic collaboration to monitor local NCD progress

Australia's Health Tracker

Overview

Australia's Health Tracker by Area by the Australian Health Policy Collaboration tracks subnational progress on indicators adapted from the targets set out in the WHO Global NCD Action Plan.

Strength

In addition to data being disaggregated by gender and for adults and children for some indicators, it is also possible to view statistics for specific and extremely localised areas: by population health area, primary health network, and local government area. This makes it possible to pinpoint exactly which geographical areas are most in need of support, and to identify good practice from other areas which can be applied to accelerate progress. Access to such detailed data enables highly targeted action and a tailored approach to yield more rapid progress than might be possible with national level data alone.

PART 2
Action beyond the 2018 UN High-Level Meeting on NCDs: The role of civil society

This section summarises the outcomes from UN High Level Meetings on NCDs and outlines the role of civil society in maintaining momentum globally and stepping up action at national and regional level for the next phase of the NCD response.

Global commitments for NCD prevention and control: The story so far

The first UN High-Level Meeting on NCDs in September 2011 set in motion a chain of events which yielded global commitments at the level of both WHO and the UN. Priorities set out in the **Political Declaration** from the 2011 UN High-Level Meeting on NCDs were reflected in the **Global Action Plan on NCDs (2013-2020)** and the accompanying **WHO Global Monitoring Framework**. Advances in global NCD prevention and control were reviewed at the second UN High-Level Meeting in New York in July 2014.

With the **Outcome Document** of the meeting stipulating four time-bound commitments, progress on which is recorded by WHO. NCDs are also included as a standalone target in Agenda 2030, with progress reviewed at the UN High-Level Political Forum and by the WHO. Most recently, Heads of State and Government adopted a **Political Declaration** at the 2018 UN High-Level Meeting.

On NCDs and a **Political Declaration on Universal Health Coverage** in 2019. While these political declarations do not feature time-bound commitments on the road to 2030, they set out key priorities and actions for which governments can be held accountable.

NCD Response timeline: global and regional milestones

2019 — First UN High-Level Meeting on Universal Health Coverage, New York. Political declaration adopted.

2018 — Third UN High-Level Meeting on NCDs, New York. Political Declaration adopted.

2017 — Regional framework for integrating essential NCD services in primary health care adopted at WHO AFRO Regional Committee Meeting.

2015 — NCDs included as a standalone target in 2030 Agenda for Sustainable Development, along with other targets relevant to the NCD response.

2014 — Western Pacific Regional Action Plan for the Prevention and Control of NCDs (2014-2020) adopted at WHO WPRO regional committee meeting.

2014 — Second UN High-Level Meeting on NCDs, New York. Outcome Document adopted, including time-bound commitments for NCD prevention and control.

2013 — Action Plan for the Prevention and Control of Noncommunicable Diseases in Southeast Asia 2013-2020 adopted at WHO SEARO RCM.

2013 — Action Plan for the Prevention and Control of Noncommunicable Diseases in the Americas 2013-2019 adopted by PAHO Directing Council.

2013 — WHO Global Action Plan for the Prevention and Control of NCDs (2013-2020) and accompanying Global Monitoring Framework adopted by World Health Assembly in Geneva.

2012 — WHO EURO Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016 adopted at WHO EURO RCM.

2012 — Target to reduce NCD mortality 25% by 2025 adopted by World Health Assembly in Geneva.

2011 — WHO EMRO publishes plan of action for the prevention and control of noncommunicable diseases in the Eastern Mediterranean Region.

2011 — First UN High-Level Meeting on NCDs in New York – the first time that NCDs have ever been discussed at UN level, and the second only health issue prioritised in this way (the first being HIV/AIDS). UN Political Declaration on NCDs adopted.

Follow-up from the 2018 UN High-Level Meeting on NCDs

The Political Declaration of the 2018 UN High-Level Meeting on NCDs had notable strengths. Heads of State and Government committed to provide political leadership for the NCD response, including through policy coherence and coordination, and to scaling up implementation of commitments made in 2011, 2014 and Agenda 2030. The Declaration recognises that engagement of civil society and people living with and affected by NCDs in the NCD response is key. It is noted that social, economic and environmental determinants, as well as commercial and market factors, affect the risk factors for NCDs. The Declaration also sets the scene for expansion from a four-by-four to a five-by-five response to NCDs, with integration of mental health and neurological conditions and of indoor and outdoor air pollution as significant NCD risk factors. There is also language on access to affordable medicines, diagnostics, technologies and palliative care.

However, the 2018 Political Declaration also has shortcomings. With regard to accountability, there is no gap analysis of unmet commitments from the 2011 and 2014 UN HLMs, or of pledges of reinvigorated political leadership to meet those commitments. Language on fiscal measures is weak and there is no recognition of price and taxation as effective public health policies. Nonetheless, this is improved in the 2019 Political Declaration on UHC. Language on the need to integrate other NCDs – such as renal, oral, and eye diseases – into national NCD plans and responses (as done in the 2011 and 2014 outcome documents and recommended by the WHO High-Level Commission on NCDs) was not repeated in 2018, but some more inclusive language on other NCDs was included in the 2019 UHC Declaration. Finally, both the 2018 and 2019 Declarations are disappointing with regard to the absence of a new call to action on the engagement and responsibilities of the private sector and their failure to manage conflicts of interest.

The 2018 Political Declaration failed to include any time-bound commitments to which governments can be strictly held accountable. Furthermore, the document states that the next UN High-Level Meeting on NCDs will not be held until 2025 – a gap of seven years – while the intervals between previous UN High-Level Meetings on NCDs have been three and four years. However, updates of the NCD Progress Monitor and Country Capacity Survey are due for publication due in 2020, as well as a new publication of the Lancet NCD Countdown 2030 collaboration, which can help CSOs in their accountability exercises and be used to call on political leaders to urgently realign the trajectory of progress in order to meet the targets that they have committed to for 2025 and 2030.

In the 2019 Political Declaration on UHC, there are strong commitments recognising prevention as the bedrock of UHC, and primary health care (PHC) as the foundation on which resilient, people-centred health systems must be built in order to deliver quality care throughout the life course. The UHC Declaration reiterates the SDG mantra of 'no one left behind'. Heads of State and Government have recommitted to ensure that the 'last mile' is prioritised, ensuring that marginalised and excluded groups should be given first consideration in the development of healthcare systems and prevention programmes.

The third UN HLM on NCDs and the first HLM for UHC must therefore be regarded as springboards for action and not as a cliff edge: Accountability exercises as proposed in this toolkit can help to maintain and accelerate the momentum generated by civil society and the broader NCD community, to ensure follow-up of the points that were prioritised in the Political Declarations, and especially to exert pressure to redouble efforts to bridge the gap between political commitments and local action.

PART 3
Holding governments accountable: Civil Society Status Reports

This section of the toolkit offers guidance on developing a national or regional Civil Society Status Report, based on previous experience, country-level data and referring to the NCD Alliance Benchmarking Tool described in Part 5 of this toolkit. Producing and disseminating such a report is a concrete and practical advocacy option for CSOs, including NCD alliances, focused on advancing their national or regional NCD accountability efforts.

What is the purpose of Civil Society Status Reports?

Civil Society Status Reports (CSSR) are a potent advocacy tool, which compile civil society perspectives on the national or regional progress on NCDs. The CSSRs seek to complement and support government surveillance, monitoring and reporting on NCDs. In the reports, civil society advocates identify progress, good practice, gaps and challenges. Newly formed NCD alliances can leverage the exercise to strengthen their capacities on stakeholder engagement and data gathering, while experienced alliances can strengthen their advocacy message and promote greater civil society engagement in the national and regional NCD response.

A CSSR aims to describe the country or region's NCD scenario from a civil society perspective. It highlights national/regional success stories and good practices, and identifies gaps and challenges in realising political commitment to improve NCD prevention and control. The CSSR utilises a benchmarking approach to assess if countries and/or regions have progressed or regressed with regard to global and national benchmarks or NCD-related commitments. NCD Alliance's benchmarking tool proposes a 'traffic light' rating (red, amber, green) against a broad range of indicators, open for adaptation by CSOs and NCD alliances.

Dissemination of the report presents an important advocacy opportunity for national and regional NCD alliances to highlight the successes and gaps in tackling NCDs. It seeks to promote distilled, evidenced and actionable recommendations to strengthen future government efforts, and facilitate civil society engagement in national and/or regional policy making processes.

Examples of Civil Society Status Reports
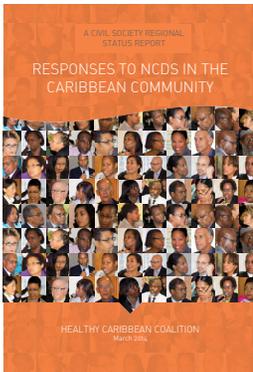
CARIBBEAN

Responses to NCDs in the Caribbean Community: A Civil Society Regional Status Report

Healthy Caribbean Coalition (HCC), March 2014

As a mature and well-connected alliance, the HCC tailored NCD Alliance's benchmarking tool to create adapted surveys for civil society, government, and regional organisations in nine chosen countries. The process helped to establish the HCC and its members as credible voices on NCDs within the region.
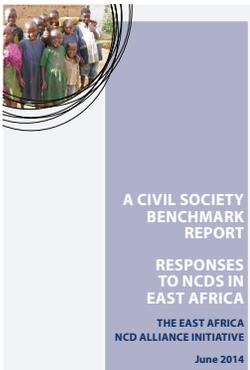
EAST AFRICA

A Civil Society Benchmark Report: Responses to NCDs in East Africa

The East Africa NCD Alliance (EA NCDA), June 2014

Focused on Rwanda, Uganda, Kenya, and Tanzania, the national NCD Alliances in East Africa collaborated to create an evidence-based snapshot of the regional NCD response. It was used as an advocacy tool during the development of an East Africa Civil Society NCD Charter.
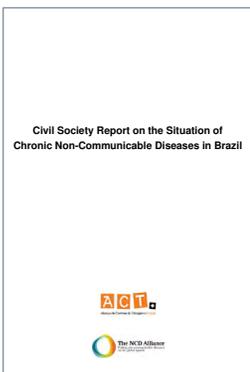
BRAZIL

Civil Society Report on the Situation of Chronic Non-Communicable Diseases in Brazil

Aliança de Controle do Tabagismo+Saúde (ACT+), August 2014

Equipped with years of experience in producing shadow reports for tobacco control, ACT+ created this CSSR as part of a larger transition towards working within the realm of NCDs more broadly, while applying tobacco-related experiences and lessons learned.

SOUTH AFRICA

Civil Society Status Report 2010-2015: Mapping of South Africa's Response to the Epidemic of Non-Communicable Diseases

South African Non-Communicable Diseases Alliance (SANCDA), September 2015

Despite being produced on a short timeline by a newly formed alliance, this report analyses approximately 600 data sources, primarily government documents, resulting in a 'Call for Urgent Action' which was presented to the Deputy Minister of Health.
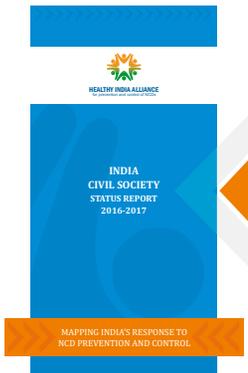
INDIA

India Civil Society Status Report: Mapping India's Response to NCD Prevention and Control

Healthy India Alliance (HIA), 2016-17

As a newly launched national alliance, HIA developed an evidence-based report of the NCD response in India, which highlighted policy successes, challenges, and gaps; and at the same time, utilised the data gathered to set out its own advocacy roadmap. The process was also a valuable capacity building exercise for members of the alliance.

Steps to create a Civil Society Status Report

This section provides a suggested outline for steps in the process to prepare your own national or regional CSSR.

STEP 1
Establish key stakeholders

→ For CSOs and NCD alliances producing the CSSR in collaboration with different members: Form an initial working group with representatives from selected (or all) member organisations in order to develop the report framework and write the first draft.

→ Reach out to key NCD country contacts for support in obtaining and verifying the data included in your benchmarking exercise.

→ **Engage government NCD focal points** `S1 / TIP 1 ✎` and `S1 / TIP 2 ✎` WHO country representatives in the early planning stages of developing the CSSR. This will encourage buy-in from government/WHO, and it could inform the timing of the initiative (i.e. to align with official government reporting cycles on NCDs).

→ You may wish to involve **academic** `S1 / TIP 3 ✎` partners, who can be especially valuable in gathering and analysing data.

→ If you have any national or regional NCD Champions, it will be helpful to reach out to them early to let them know you will develop the report. This might be a celebrity, youth leader, or member of parliament. This support will be valuable when the time comes to disseminate the report, especially if they are willing to promote the headline advocacy messages, which the report will help to identify.

→ Identify **communities** `S1 / TIP 4 ✎` working on other health priorities that have carried out a similar exercise. Whether it was successful or not, try to meet with them to better understand the local challenges and success factors.

STEP 2
Define a timeline

→ Establish desired outcomes: Is there a specific end point, or a window of opportunity like a national election or a political meeting, which will **define your timeline?** `S2 / TIP 5 ✎` It could also be extremely beneficial to develop and launch the report in parallel to official government reporting cycles on NCDs.

→ Apart from forthcoming opportunities in the near term, the UN HLM on NCDs proposed for 2025 would be an ideal political milestone to launch Civil Society Status Reports around the world. It will be a key moment to take stock on the global NCD response, particularly in light of the global NCD targets to be delivered by 2025 as well.

STEP 3
Adapt the benchmarking tool

→ The benchmarking tool suggests indicators to capture a high-level **view of the national or regional response to NCD prevention and control** `S3 / TIP 6 ✎`.

→ It is highly recommended that national and regional NCD alliances carefully consider their own local context as well as national/regional circumstances to adapt the tool to their specific needs. Alliances are encouraged to expand any or all of the four sections of the tool to include additional indicators or remove those which are less relevant to their context.

→ CSOs and NCD alliances can choose indicators based on their relevance to the specific work being carried out, or merge them with indicators from other accountability exercises (e.g. WHF Scorecard / IDF Scorecard / other sources, depending on the specific areas of interest).

Adapting the NCD Alliance benchmarking tool: Experience of the Healthy Caribbean Coalition

Rationale for adapting the tool

HCC adapted the NCD Alliance 2013 benchmarking tool to reflect priority mandates and reporting requirements in the Caribbean region, most notably the mandates of the Port of Spain Declaration (POSD). The 15-point POSD contains 27 commitments, which are reported on annually. The final modified tool captured progress against these 27 commitments from the perspective of the six objectives of the WHO Global NCD Action Plan 2013-2020. The tool also had to be adapted to reflect a multi-country assessment, as this was not merely the assessment of the national response in one country but rather a regional assessment reflecting the NCD response across nine sovereign territories within CARICOM.

How was the tool modified?

HCC modified the tool to include six additional, yet complementary, questionnaires in order to capture perspectives of a variety of distinct stakeholder groups across different sectors at national and regional levels. The 'whole of society' contribution to the NCD response was measured in large part as a result of expanding the respondent pool beyond the public sector. The unique role of CSOs in NCD prevention and control was explored through questions assessing the scope of service provision, contribution to policy formation and/or implementation, education and outreach, and advocacy. Open-ended questions explored challenges, successes and lessons learned in responding to NCDs from the perspectives of the public and NGO sectors. Finally, HCC sought to ascertain the efficacy of regional bodies in adequately supporting national and regional NCD efforts.

Improved outcomes

The modified tool that integrated the POSD reporting requirements ensured that the data collection was not burdensome, as countries were already reporting on these indicators. Furthermore, the findings and recommendations in the final report were regionally relevant and provided baseline information for the 2015 IDRC-funded regional evaluation of the Port of Spain Declaration. It was important to HCC that the report had strong civil society ownership; therefore, the inclusion of CSOs as valued stakeholders in the consultation process secured the civil society voice throughout the document and created ownership of the report's 'call to action'.

STEP 4
Collect the data `S4 / TIP 7` ✎

→ While a considerable amount of evidence should be available on the websites of **Ministries of Health** `S4 / TIP 8` ✎ or WHO Country Offices, you may be able to gain more in-depth information from an in-person meeting with relevant **officials** `S4 / TIP 9` ✎. To secure this opportunity, it may be helpful to emphasise that you are producing the report to support the progress made by the government.

→ In some cases, it will **not be possible to access 'hard' / official data** `S4 / TIP 10` ✎ at all and therefore you may wish to supplement the data with anecdotal evidence or notable observations. If you choose to do this, it is important to clarify that that the data is not from an official source in order to preserve the credibility of the report. Of course, the lack of data may be **noteworthy** `S4 / TIP 11` ✎ in itself.

→ Other information may be available on the websites of other ministries, at global level, or from academic partners. Links are provided to sources of useful information.

STEP 5
Analyse the data

→ For each indicator, the tool suggests criteria for RAG (red-amber-green) traffic light ratings to be assigned. This is the first step in identifying the advocacy priorities that most urgently need to be addressed in your country or region.

→ This point is the most important of all the steps outlined in developing the tool: While there is some value in collating data from different sources into a single report, your Ministry of Health will already be aware of many of the issues. In order for the CSSR to add value, and to gain recognition for its authors as key players in future policy processes, it is essential that the report does not only describe what the national or regional status is for any given indicator, but why it is currently at the described stage. The existence of a written policy or guideline is almost meaningless if it is not implemented – the CSSR should be an opportunity to report on whether policies are budgeted, implemented, and monitored, and if laws are enforced or have an associated penalty. It should also be used to record any evidence or observations for why this may not be the case - for example, policy gaps, industry interference, limited funding, or limited engagement from multisectoral and intersectoral stakeholders. Was progress initially rapid but slowed down later? How has this changed depending on national political cycles?

→ This level of detail may not be feasible for every single indicator, but must be carried out at least for the advocacy priorities identified as the most urgent, as such reflections will be important in order to address them.

STEP 6

Write the report `S6 / TIP 12 ✎`

→ Identify a working group including representatives of member organisations to develop the **first draft of the report** `S6 / TIP 13 ✎`, which can then be reviewed by a wider set of members.

→ The Civil Society Status Report should be a short and concise document (maximum of 10 pages). Annexes can be used for any detailed data tables.

→ A template is available for you to use as a guide for the report writing (see Part 4 of the toolkit).

→ Use the report to highlight the priorities you have identified through the benchmarking analysis – including the evidence for where your country is behind on progress, any perceived obstacles, and recommended actions to improve the situation.

→ Include a 'call to action' in the conclusion of the report.

STEP 7

Disseminate the report `S7 / TIP 14 ✎`

→ Along with writing the report, it is important to strategically plan dissemination of the findings.

→ Plan a report launch event contingent on resources available and identify a "**window of opportunity**" `S7 / TIP 15 ✎` to launch the results (e.g. coinciding with a political event or date related to NCDs).

→ Carefully identify spokespeople – people living with NCDs and young people can add particular value and insights to accompany your report recommendations and build a compelling call to action. Use real life stories to illustrate gaps in policies and programmes.

→ Invite NCD opinion leaders and other groups **with an interest in NCDs** `S7 / TIP 16 ✎` (business leaders, community and religious groups, health professional networks, health rights organisations, philanthropic organisations, foundations, researchers, sports organisations, women's organisations, and groups representing the elderly, the disabled, etc.) to your event and share your report with all partners and respondents **involved in the development of the report** `S7 / TIP 17 ✎`.

→ Ensure that the CSSR is **sent to appropriate government officials and decision makers** `S7 / TIP 18 ✎` (national, regional) with an accompanying cover letter that summarises the report and its call to action. Consider also sharing the CSSR with your country's representative Mission in Geneva and New York ahead of key UN meetings on NCDs and UHC. NCD Alliance can help to identify contact details for the Missions.

Disseminate the report

→ **Develop a media strategy** `S7 / TIP 19` ✎ : Take the time to develop advocacy messages and talking points based on the call to action of the report. Media work could involve a press release, fact sheets, press conferences, letters to editors, working closely with journalists to educate them about the results of the report, and submitting an opinion editorial to a credible media outlet. Brief your spokespeople to address the media and deliver your key advocacy messages.

WEDNESDAY, 2 APRIL 2014

Regional Status Report on NCDs a major achievement

THE Healthy Caribbean Coalition (HCC) is at present celebrating a landmark initiative, that of the production of a Regional Status Report on NCDs in the Caribbean, which the HCC says will be a major step towards the reduction of Non-Communicable Diseases (NCDs) across the Caribbean islands.

Professor Sir Trevor Hassell, President of the Healthy Caribbean Coalition, spoke of the key report, which is a response to the NCDs epidemic in the Caribbean Community, during a press briefing held at Sagicor Headquarters, Wildey, St. Michael, Barbados on Monday, to discuss the Report and other landmark HCC initiatives.

Edward Clarke (left), Chief Operating Officer at Sagicor Life Inc. and General Manager of the Barbados Operations, listens as Professor Sir Trevor Hassell, President of the Healthy Caribbean Coalition (HCC), speaks about the recently launched Regional Status Report on NCDs.

Regional governments urged to ban sale of high salt foods and beverages to children
Friday, March 21, 2014 · 1 comment

→ Consider developing a social media strategy to release the results of the report. This includes using Twitter, Facebook, blogs and other relevant platforms to draw attention to the results, mobilising public support for your positions and leveraging partner and stakeholder networks online to promote your call to action.

→ Hold face-to-face meetings with your main target audience (i.e. policymakers, parliamentarians) to present the report and its recommendations.

→ As an NCD alliance, consider pooling together a database of media contacts.

STEP 8
Shaping an advocacy trajectory `S8 / TIP 20` ✎

→ Understand who the main national/regional NCD decision-makers and influencers are, as well as their positions, priorities and motivations.

→ As an immediate follow-up to the dissemination activity, prepare relevant supplementary materials including factsheets, policy briefs, letters to decision makers and a media/social media package with your key advocacy messages.

→ **Consider incorporating the CSSR in a long-term advocacy** `S8 / TIP 21` ✎ **strategy** `S8 / TIP 22` ✎ : Develop follow-up advocacy activities related to the report and engage multisectoral groups in strategising about how to bridge the gaps identified in it. Consider adopting a phased approach to advocacy in order to mitigate any capacity constraints, focusing attention on specific gaps and challenges identified.

→ Discuss who your advocacy targets are: NCD focal points in **Ministries of Health** `S8 / TIP 23` ✎ ; government representatives from other sectors beyond health such as finance, economy, agriculture, education, trade; WHO country representatives; parliamentarians; private sector; and non-health CSOs.

Part 4
Civil Society Status Report template

In this section, we provide a suggested outline for national or regional reports on progress in the NCD response.

1. Executive summary

→ Provide a stand-alone narrative, scoping briefly the NCD scenario in your country/region, and outlining the objectives of the CSSR.

→ Provide a concise summary of the purpose and approach adopted to develop the report.

→ Outline the main findings of your report.

→ Highlight key recommendations for actions addressed to relevant stakeholders (e.g. government representatives, international and regional bodies, the private sector, civil society, etc.).

2. Who we are

→ Outline the mission, objectives and characteristics of your civil society alliance/organisation.

→ Describe briefly the nature of membership and the alliance's core strengths.

3. Background and introduction

→ Set the stage by providing a background of the NCD scenario in your region/country (prevalence, burden, risk profile) in no more than one or two paragraphs. This information must rely on scientifically sound and officially recognised data sources.

→ Outline in moderate detail the scope and objectives of your report, which seeks to deliver a unique civil society perspective to the status of NCDs in your country/region and the government's response to advance its NCD related commitments.

→ Briefly describe the approach and methods adopted to develop the report. This paragraph can include your process of adapting the benchmarking tool provided by the NCD Alliance and the methods adopted to undertake the exercise (e.g. key informant interviews, surveys, desk review) and describe any partnerships (e.g. academia, think tanks) forged to undertake the exercise.

→ Acknowledge any partners, peer reviewers, etc. who contributed to the report.

→ Establish briefly how your alliance/organisation interpreted and validated the findings and if there were any limitations during the process.

4. Global commitments to action on NCDs

Note: This section summarises your government's commitments to NCDs from a global/regional perspective. It should be succinct. You will delve deeper into the national/regional response in **Section 6.**

→ Describe the landmark inclusion of NCDs in the UN Sustainable Development Goals in 2015 and highlight your country/region's commitment to integrate NCDs into national health and development agendas.

→ Recall the 2011, 2014, 2018 UN High-Level Meetings on the Prevention and Control of NCDs and 2019 UN HLM on Universal Health Coverage and progress made. Highlight your country/region's commitments at the HLMs.

→ Recall the WHO Global Action Plan on NCDs 2013-2030 (n.b. mandate extended from 2020 to 2030 by the World Health Assembly in 2019) and emphasise the Global Monitoring Framework with its global targets and indicators.

→ Recall the Agenda 2030 for Sustainable Development and the inclusion of an NCD-specific targets under Goal 3 and other major UN agreements and reports citing NCDs as a development priority for countries.

→ Mention any other relevant global policies and resources, and any regional NCD commitments (e.g. the Caribbean's Port of Spain Declaration, etc).

5. Status of the national NCD epidemic

Note: This section provides an overview of the NCD epidemic in your country/region. It should be a maximum of four paragraphs. Any data should be included in tables as annexes.

→ Briefly outline the public health burden and impact of NCDs in your country/region, in order to provide the context and rationale for action. This should include NCD mortality and morbidity (both total and ideally also by age group: under 30, 30-70 years, over 70 years), as well as the mortality of each of the five main NCDs as percentages of total country deaths for all ages.

→ You could also specify any of the following for further support in stating the impact of NCDs to your country/region: Behavioural risk factor prevalence (current daily smoking, alcohol intake, physical inactivity, unhealthy diet, air pollution), metabolic risk factors (high blood pressure, blood glucose, overweight, obesity, blood cholesterol) and infection rates (hepatitis B virus, human papilloma virus).

→ Refer to the impact of NCDs on human development: NCDs as contributors to poverty, a burden on health systems and burden on country economies. Highlight the concept of equity and health as human rights and the moral imperative to address NCDs.

6. The national/regional NCD response

→ Summarise your country or region's progress to date on its NCD response and associated NCD capacity: national NCD plans, allocation of budgetary resources, allocation of additional human resources, policies and implementation (referring to your benchmarking exercise).

→ Describe to what extent PLWNCDs can access health services, including prevention, promotion, screening, diagnosis, treatment and care, rehabilitation, palliative care, etc.

→ As well as referring to current policies and practices, please highlight any significant national or regional commitments to action on NCDs made prior to the 2011 UN High-Level Meeting on NCDs.

→ Provide an analysis of stakeholder engagement. How has civil society been engaged in NCDs? Have people living with NCDs been involved in the dialogue? What are the strengths of the civil society response to NCDs? Has there been active involvement of civil society in national (and regional) NCD planning efforts? How can civil society be further leveraged to complement national (and regional) NCD efforts? How have other sectors of society been involved in NCDs?

→ Be sure to highlight national/regional best practices and success stories. The purpose of this section is to share lessons learned with other countries.

7. Challenges and gaps – a civil society perspective

→ Describe the main national/regional challenges and gaps in response to NCDs, based on your national/regional civil society NCD benchmarking exercise.

→ This narrative could cover, for example:

- Policies
- Prevention and health promotion
- Health systems response (early detection, diagnosis, treatment and palliation)
- Balance of efforts across the range of NCDs; particularly cancer, diabetes, cardiovascular diseases and chronic lung diseases
- Access to affordable medicines and technologies
- Integration of NCD commitments into work on existing health services and the MDGs
- Research
- Surveillance
- Human rights
- Resources (financial, infrastructure, health care workers)
- Civil society participation/voice

8. Call to action

→ Outline a "call to action" with the main policy, resourcing, service development and implementation "asks" that stem from your assessment of your country's response and capacity for NCD prevention and control.

→ Specify your 'asks' and recommendations according to different target audiences: national government(s), international and regional bodies, private sector, the media, civil society, etc. Add subnational (regional, state, municipal) government level actions if you have sufficient data to base them on.

→ Contextualise your recommendations within reaching the globally agreed targets:

→ Reduction of premature mortality from NCDs by 25% by 2025

→ Reduction of premature mortality from NCDs by one-third by 2030 (SDG 3.4)

→ Achieving Health for All (UHC) by 2030 (SDG 3.8)

→ Be sure to include recommendations on how to improve and increase civil society participation in NCD and UHC planning, and on how civil society can better support policy implementation.

→ Clarify how you intend to follow up on your national/regional CSSR in the lead up to the next UN HLM on UHC in 2023 and on NCDs in 2025.

PART 5
NCD Alliance Benchmarking Tool

This section of the toolkit provides a practical outline for how to assess the NCD response in your country or region. It gives guidance on where to find the relevant data, links to the latest source publications and some key national campaigns run by CSOs, and suggests how to evaluate progress across a range of policy areas with a 'traffic light' (**red - amber - green**) rating.

Key considerations when using the tool to produce Civil Society Status Reports

→ We recognise that not all the indicators listed in the tool may be of relevance to all national/regional NCD alliances and/or CSOs, and encourage you to focus on areas of interest and adapt the tool to your own context.

→ Throughout the benchmarking exercise, we recommend focusing mainly on national level policies and plans. However, if time and resources are available to explore subnational plans (i.e. those at federal, state or district level) or if a good practice is being implemented at the subnational level and would be useful as an example for other countries/regions to follow, we encourage you to include them in your benchmarking exercise.

→ In some policies, NCDs may be included but referred to with different terminology, for example 'chronic diseases' or by name of the major diseases like 'cancer', 'diabetes', etc. Broadly, NCDs refer to a wide range of chronic conditions including cancer, diabetes, cardiovascular and respiratory diseases, mental health conditions and neurological disorders among others. Policies, plans and strategies related to NCD risk factors including tobacco and alcohol use, unhealthy diets, physical inactivity, and air pollution must also be considered as part of the benchmarking exercise.

→ For any policy or plan mentioned in your responses, please provide a link or reference in the CSSR as evidence. This will also support dissemination of good practice to other NCD stakeholders and strengthen your advocacy efforts. Inclusion of case studies with additional insights and/or stakeholder quotes/lived experiences into the findings of your benchmarking exercise will add value to your CSSR. This can also help to promote examples of good practice that you would like to see highlighted from your country/region.

→ If a policy or law has existed in the past but no longer exists, or if this was recently strengthened or weakened, this information is also useful to include in the CSSR.

→ In some cases, it might be difficult to verify the existence of a policy or plan. In all cases, we recommend corroboration to ensure the reliability of a given source. Where an assertion is made on the existence of a policy or plan, this can be verified using the **WHO NCD Document Repository,** your Ministry of Health website, government contacts, or other sources. If a strategy, action plan, or policy is stated to exist in international reporting, such as the **2017 WHO NCD Progress Monitor**, but no public record or copy of the plan can be found, this is worthy of comment in the report. It is important to note that, in most cases, these sources will only confirm the existence of a document; not the degree to which any actions within it are implemented (see note on implementation).

→ You are encouraged to modify this tool, including but not limited to: omitting indicators, merging with indicators from other surveys, and adapting traffic light/guidance notes to best suit your unique context.

→ Depending on the individual focus of your organisation or NCD alliance and its strategic priorities and areas of interest, you may wish to consider also incorporating indicators in the covered in the **following accountability tools**:

- International Diabetes Federation's **Global Diabetes Scorecard**

- World Heart Federation **CVD Scorecard**

- International Union Against Tuberculosis and Lung Disease (The Union) **Index of Tobacco Control Sustainability**

- Union for International Cancer Control's **World Cancer Declaration Report**

- Framework Convention Alliance's 2012 **Tobacco Watch** global shadow report

- American Cancer Society and Vital Strategies co-led **Tobacco Atlas**.

→ Results gathered during this benchmarking exercise should not be considered as a stand-alone document. Rather, they should be embedded in a CSSR where tool findings are supported and expanded upon through the report narrative.

→ If you require additional support or guidance while using the tool, please contact info@ncdalliance.org.

Notes on using the tool

→ When writing the CSSR, we urge national and regional NCD alliances to consider the unique role of civil society in accountability. The CSSR is an opportunity for civil society to show where governments are doing well, and where there is need for improvement and to present alternative information for reports that governments are mandated to submit under global commitments. CSOs can also add assessment and evaluation on implementation, in addition to indicators provided by WHO and the UN.

→ The existence of a policy or plan in many cases does not guarantee its implementation or enforcement. Therefore, rather than reporting only on the existence of a policy, plan, strategy or programme, CSOs should comment on the extent to which they are implemented and working as intended. For existing policies, we recommend exploring the extent to which the policy is implemented. For example, is it budgeted, monitored and evaluated (i.e., is there an associated indicator framework) or actively enforced. Any implementation issues and enforcement gaps should be mentioned.

→ Civil society can also provide an assessment of the extent to which progress has been made on a particular indicator, and provide information on success factors and challenges which may be valuable for other CSOs and NCD alliances seeking to accelerate action in a given area of interest.

→ Anecdotal evidence / personal experience of the extent to which a policy / strategy / plan is enacted may supplement official evidence. However, such observations should always be cited as anecdotal evidence to maintain the credibility of the report.

→ Due to the great range of factors that can be used to assess how effectively a policy, plan, strategy or programme is being implemented or enforced, it is not feasible to integrate them all into the traffic light guidance for every indicator. The traffic light guidance is therefore based only on policy / strategy / plan / programme content, and not extent of implementation. However, policy is almost meaningless unless it is implemented, and we therefore strongly recommend that you consider this when making a final choice on the traffic light category of each indicator. Wherever an evaluation of implementation and its related impact on trends in NCD mortality can be featured in the report, it will be invaluable for defining longer-term advocacy strategies and as a resource for other country representatives.

→ We therefore suggest the following questions to be adapted and answered for any indicator listed throughout the report:

- Is the policy / strategy / action plan / programme budgeted? NCD plans and policies are made more often than they are implemented – and this can be due to hugely inadequate financial and trained human resources.

- Is progress in this area monitored?

- Has progress been made in this area? If yes, why? If not, why not?

- Is this policy actively enforced? Is there a penalty for non-compliance?

- If there is evidence of severe barriers to implementation or of non-enforcement, the traffic light indicator level may be downgraded from green to amber, or from amber to red.

The Tool

ANNOTATIONS

Resources

Where to find the information. Valuable resources for completing this benchmarking tool include the **2017 WHO NCD Progress Monitor (and future updates)**, WHO NCD **Country Capacity Survey**, the WHO NCD **Document Repository** and WHO NCD **Data finder application**, and national (e.g. Ministry of Health websites), subnational, and regional (e.g. PAHO) authorities.

Importance

Why the indicator matters. This can also be used in advocacy if the answer to the indicator is classified as red or amber.

Case study

If there is a notable case study or example, either to help explain the indicator, or to use in advocacy.

Further information

Further available information.

Rating

Red, **Amber** or **Green**. The aim of the traffic light/RAG rating is to help respondents identify their own priority action/advocacy areas.

Red denotes that the current context is far below international standards, and will have a significant negative impact on NCD prevention and control.

Amber denotes a need for subsequent action or operationalisation, although the need is less critical than that of red.

Green suggests that the current context is good and does not pose a significant threat to NCD prevention and control.

Boundaries detailed in this tool are based on content or quality of a given policy or plan, rather than the extent to which it is implemented. (Please also   on implementation). Areas for initial action should be those, which are deemed most urgent (i.e. are red), but also those that offer the greatest potential for change according to concrete advocacy opportunities (i.e. amber). In very few instances, it might not be possible to clearly define traffic light/RAG boundaries for an indicator – in these cases, we recommend that you define boundaries based on your national context and experiences. Indicators classified 'green' on account of being a good practice or 'best buy' should also be duly noted for advocacy purposes.

Advocacy

Recommendation for advocacy in the case that the current status of an indicator is unsatisfactory; including whom to approach, an appropriate political window or process, and any evidence that could strengthen the advocacy ask.

The Tool

GOVERNANCE

Are NCDs recognised as a national health priority?

→ Are NCDs included in your government's main health sector strategic document (e.g a national health plan / policy / strategy or alternative priority setting documents for health)? Sometimes such a strategy may be integrated within a larger national document.

→ If no reference is made to NCDs overall, is there mention of specific diseases or risk factors? If so, which ones? If all are mentioned, does there seem to be a balanced focus proportional to the disease burden in your country?

National Government websites, especially Ministries of Health.

The inclusion of NCDs in a country's health plan/policy strategic document and/or the existence of a focused NCD plan demonstrates the government's commitment to NCD prevention and control. In the absence of such instruments, civil society must hold the government accountable to adopt NCD-related goals and align themselves with global action.

WHO webpage on national NCD policies, strategies and action plans
IEG Evaluation of SWAps for Health
WHO OneHealth Tool

if there is no mention of 'NCDs', even if specific diseases are mentioned;

if NCDs and minimum of 3 major diseases and 3 risk factors are mentioned;

if 'NCDs', all major diseases, and their risk factors are mentioned.

Outline proportion of national mortality (with a focus on premature deaths as appropriate) and disability burden attributable to NCDs to Ministry of Health. See **WHO Global Health Estimates** (links under 'statistics') for global and country level breakdown of data.

Progress towards the NCD goals for 2025 and 2030 will be reported to the UN 2024 for a comprehensive review in 2025. Click to see commitments made by Heads of State and Governments in the **political declaration of the 2018 HLM on NCDs**.

2018 Political Declaration of the UN HLM on NCDs

18 *Scale up the implementation of the commitments made in 2011 and 2014 for the prevention and control of non-communicable diseases* through ambitious multisectoral national responses and thereby contribute to the overall implementation of the 2030 Agenda for Sustainable Development, *including by integrating, across the life course, action on the prevention and control of non-communicable diseases and the promotion of mental health and well-being*;

19 *Implement, according to own-country-led prioritization, a set of cost-effective, affordable and evidence-based interventions and good practices, including those recommended by the World Health Organization, for the prevention and control of non-communicable diseases, that can be scaled up across populations to promote health, treat people with non-communicable diseases* and protect those at risk of developing them, with a particular emphasis on the needs of those in vulnerable situations;

20 *Scale up the implementation of the commitments made in 2011 and 2014 to reduce tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity, taking into account, as appropriate, World Health Organization-recommended interventions for the prevention and control of non-communicable diseases*, in line with national priorities and *targets*;

21 *Promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors* for non-communicable diseases, and promote healthy diets and lifestyles;

22 *Accelerate the implementation of the World Health Organization Framework Convention on Tobacco Control by its States parties, while continuing to implement tobacco control* measures without any *tobacco industry interference* and to encourage other countries to consider becoming parties to the Convention;

23 *Implement cost-effective and evidence-based interventions to halt the rise of overweight and obesity*, in particular childhood obesity, taking into account *World Health Organization recommendations* and national priorities;

24 *Develop, as appropriate, a national investment case on on the prevention and control of non-communicable diseases to raise awareness about the national public health burden caused by non-communicable diseases*, health inequities, the relationship between non-communicable diseases, poverty and social and economic development, the *number of lives that could be saved and the return on investment*;

28 *Take the necessary measures to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course*, in respecting human rights obligations and addressing the *specific health needs of children, women, older persons, persons with disabilities and others who are more vulnerable to non-communicable diseases*;

29 *Take measures to better prepare the health systems to respond to the needs of the rapidly ageing population, including the need for preventive, curative, palliative and specialized care* for older persons, taking into account the disproportionate burden of non-communicable diseases on older persons, and that population ageing is a contributing factor in the rising incidence and prevalence of non-communicable diseases;

31 *Increase global awareness, action and international cooperation on environmental risk factors, to address the high number of premature deaths from non-communicable diseases attributed to human exposure to indoor and outdoor air pollution*, underscoring the particular importance of cross-sectoral cooperation in addressing these public health risks;

32 Promote healthy communities by *addressing the impact of environmental determinants on non-communicable diseases, including air, water and soil pollution, exposure to chemicals, climate change and extreme weather events*, as well as the ways in which cities and human settlements are planned and developed, including sustainable transportation and urban safety, to promote physical activity, social integration and connectivity;

33 *Encourage the adoption of holistic approaches to health and well-being through regular physical activity*, including sports, recreation and yoga, to prevent and control non-communicable diseases and promote healthy lifestyles, including through physical education;

34 Empower 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 the harms of smoking and/or tobacco use and second-hand smoke, the harmful use of alcohol and the excessive intake of fats, in particular saturated fats and trans-fats, sugars and salt, promote the intake of fruits and vegetables*, as well as healthy and balanced sustainable diets, and reduce sedentary behaviour;

35 *Strengthen health systems and reorient them towards the achievement of universal health coverage and improvement of health outcomes, and high-quality, integrated and people-centred primary and specialized health services for the prevention, screening and control of non-communicable diseases and related mental health disorders and other mental health conditions throughout the life cycle*, including access to safe, affordable, effective and quality essential diagnostics, medicines, vaccines and technologies, and palliative care, and understandable and high-quality, patient-friendly information on their use, as well as health management information systems and an *adequate and well-trained and equipped health workforce*;

37 *Implement measures to improve mental health and well-being*, including by *developing comprehensive services and treatment* for people living with mental disorders and other mental health conditions and *integrating them into national responses for non-communicable diseases*, and addressing their social determinants and other health needs, fully respecting their human rights;

38 *Promote access to affordable diagnostics, screening, treatment and care, as well as vaccines that lower the risk of cancer*, as part of the comprehensive approach to its prevention and control, including cervical and breast cancers;

39 *Integrate, as appropriate, responses to non-communicable diseases and communicable diseases, such as HIV/AIDS and tuberculosis*, especially in countries with the highest prevalence rates, taking into account their linkages;

40 *Strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure* to treat people living with non-communicable diseases and prevent and control their risk factors *in humanitarian emergencies*, including before, during and after natural disasters, with a particular focus on countries most vulnerable to the impact of climate change and extreme weather events;

45 *Establish or strengthen transparent national accountability mechanisms* for the prevention and control of non-communicable diseases, taking into account *government efforts in developing, implementing and monitoring national responses* for addressing non-communicable diseases and existing global accountability mechanisms;

46 *Commit to mobilize and allocate adequate, predictable and sustained resources for national responses* to prevent and control non-communicable diseases and to promote mental health and well-being, through domestic, bilateral and multilateral channels, including international cooperation and official development assistance, and continue exploring voluntary innovative financing mechanisms and partnerships, including with the private sector, to advance action at all levels.

Are NCDs recognised as a national health priority?

→ Is there a dedicated multisectoral NCD strategy / action plan?

→ The multisectorality of such a plan could be indicated by mention of words such a 'whole of government', 'cross sectoral' or 'multisectoral'. Are specific sectors or stakeholders mentioned?

→ Does the plan address both prevention of NCDs and treatment/care for PLWNCDs?

→ Are there national timebound targets and indicators for NCDs based on the 9 targets and 25 indicators in the **WHO Global Monitoring Framework**?

WHO NCD Document Repository
2017 WHO NCD Progress Monitor
Ministry of Health Website

With the adoption of the **WHO Global Monitoring Framework** in 2013, countries now have guidance on adoption of national targets and indicators in response to their NCD burden. The global targets envision achieving 9 NCD reduction targets by 2025. Having timebound targets helps governments, civil society, and other stakeholders to monitor the progress and actions within the agreed timeframe. NCDs have their root causes in multiple sectors including trade, education, environment, agriculture and beyond. A united approach involving different sectors of government is essential for progress.

WHO Global NCD Monitoring Framework

WHO definitions of 'whole of society' / 'whole of government' approach

NCD Alliance Infographic NCDs across the SDGs: A Call for an Integrated Approach

WHO Tools for developing, implementing and monitoring the National Multisectoral Action Plan (MAP) for NCD Prevention and Control

WHO Health in All Policies: Framework for Country Action

UNDP Government Ministry Sectoral Briefs at global level, WHO and UNDP have a **joint programme** to facilitate national responses to NCDs.

⬤○○ if any are missing out of targets, indicators OR action plan;

○⬤○ if all exist but have a narrower focus than global level (unless this is not applicable to national context – e.g. alcohol consumption is banned entirely);

○○⬤ if all exist and reflect or exceed global targets and indicators.

Governments committed to establishing national multisectoral NCD plans in the **Outcome Document of the 2014 High Level Meeting on NCDs** and committed to establishing and strengthening national multisectoral dialogue mechanisms for implementation of national multisectoral action plans in the **2018 UN Political Declaration on NCDs**. If not all major NCDs and their risk factors are included in the NCD strategy / action plan, demonstrate the disease burden attributable to the disease / risk factor, present interventions to address it (drawing on **Appendix 3** of the WHO Global NCD Action Plan), and advocate for its integration. Demonstrate the impact of NCDs on non-health sectors. For example, mention the negative impact of NCDs on health and outputs of the workforce when discussing with Ministry of Employment; when discussing with Ministry of Environment mention the opportunities for **co-benefit solutions for environment and NCDs**:

2018 Political Declaration of the UN HLM on NCDs

15 Reaffirm the primary role and responsibility of governments at all levels in responding to the challenge of non-communicable diseases *by developing adequate national multisectoral responses for their prevention and control*, and promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and underscore the importance of pursuing whole-of-government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches;

25 *Establish or strengthen national multi-stakeholder dialogue mechanisms, as appropriate, for the implementation of the national multisectoral action plans* for the prevention and control of non-communicable diseases in order to attain the national targets;

31 Increase global awareness, action and international cooperation on *environmental risk factors*, to address the high number of premature deaths from non-communicable diseases attributed to human exposure to indoor and outdoor air pollution, underscoring the *particular importance of cross-sectoral cooperation in addressing these public health risks*;

42 *Promote meaningful civil society engagement* to encourage Governments to develop ambitious national multisectoral responses for the prevention and control of non-communicable diseases, and to contribute to their implementation, forge multi-stakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and *amplify the voices of and raise awareness about people living with and affected by non-communicable disease*s;

46 *Commit to mobilize and allocate adequate, predictable and sustained resources for national responses* to prevent and control non-communicable diseases and to promote mental health and well-being, through domestic, bilateral and multilateral channels, including international cooperation and official development assistance, and continue exploring voluntary innovative financing mechanisms and partnerships, including with the private sector, to advance action at all levels.

Are NCDs recognised as a development priority?

→ Are NCDs reflected in documents which define your country's development priorities?

→ In the case of LMICs, this question refers to domestic priorities, an indication of which may be found in your country's National Development Plan, UN Development Assistance Framework (UNDAF)* or Poverty Reduction Strategy Paper (PRSP).

→ For HICs, this question refers to international priorities. Are NCDs included as a health priority in strategies to support development overseas? If information is available, are NCDs specifically included in development assistance for health (DAH)?

*A United Nations Development Assistance Framework (UNDAF) is the main platform for the collaboration of the UN system at country level. Not all countries have an UNDAF. An UNDAF describes the collective and coherent vision and response of the UN to national development priorities. Inclusion of NCDs in the UNDAF shows that the country is collaborating at UN level to address NCDs.

National Development Plans should be available on government websites. A list of which countries have NCDs included in their UN Development Assistance Framework results matrix is available here. Poverty Reduction Strategy Papers are **listed by the IMF**.

For HICs, the relevant information is best sought from your country's development agency.

NCDs are interlinked with other SDG priorities and should be recognised as an integrated and essential area to address within sustainable development. Failure to address NCDs will hinder national social and economic development. NCDs account for the major part of the global burden of disease but are relatively underprioritised in overseas development strategies. They receive only 1.3% of development assistance for health.

UNIATF Mission to Mozambique

Saving Lives, Spending Less: A Strategic Response to NCDs (WHO, 2018)

UNDP Issue brief on NCDS (UNIATF, 2019)

UNDP Government Ministry Sectoral Briefs (UNDP, 2018)

NCD Alliance infographic (NCD Alliance, 2015)

Guidance note on integrating NCDs into the UNDAF (WHO, UNDP, 2015)

2019 BMJ series on NCD solutions

For HICs:

Where Have All the Donors Gone? Scarce Donor Funding for Non-Communicable Diseases (2010). Update forthcoming 2020

Financing Global Health 2016: Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage

●●● if there is no mention of NCDs;

●●● if mentioned in overall background or objectives;

●●● if included in an indicator.

If NCDs are not included in the development plan, gather support from the Ministry of Health to advocate to non-health ministries for inclusion of NCDs in national development plans.

Governments should be encouraged to approach the UN Interagency Task Force on NCDs (UNIATF) to offer support with integrating NCDs into UNDAF, if an UNDAF exists but NCDs are not yet included.

Data on the economic cost of NCDs can be useful when speaking with non-health ministries - cost of action on NCD prevention and control is lower than cost of inaction.

For HICs, demonstrate the relevance of NCD prevention and control to your government's existing priorities (i.e. highlight how action on NCDs can help governments to achieve/protect progress on existing priorities). Highlight disease burden / mortality in the countries they work in and the threat to achieving/ maintaining development gains.

THEME

Does the government engage and support civil society and people living with NCDs (PLWNCDs) in the response to NCDs?

INDICATOR AREAS TO EXPLORE

→ How are NCD civil society and PLWNCDs involved in the policy and programmatic response to NCDs? Are there key areas where their input is sought (e.g. a specific technical issue, shaping national NCD policies or programmes, or particular skills which they are recognised to have)? Openness to working with such groups could be indicated by whether they are mentioned in the national NCD strategy / action plan, or with a reference to a 'whole of society' or 'multi-stakeholder' approach.

→ Is there a government mechanism to formally engage civil society and PLWNCDs in the response to NCDs? E.g. via participation on National NCD Commission, task force, or expert committee?

→ If there is no institutionalised mechanism, is there other evidence of partnership (e.g. civil society participation in government-led consultations or conferences relating to NCDs, regular meetings between an NCD alliance and a government representative to discuss respective work and progress, etc.)?

→ Are there any official mechanisms for social oversight and social participation in the design and monitoring of policies? (Note: this doesn't only relate to NCDs but reflects how civil society is perceived in a country.)

→ Does the government invest in civil society capacity building (either in country, or if you are based in a HIC, overseas)?

ANNOTATIONS

! Civil society has unique and valuable competencies ranging from technical expertise, capacity for independent monitoring and accountability, opportunity for social mobilisation, and skills in advocacy and campaigning. Meaningful involvement of people living with or affected by a health issue ensures that a society's governing laws, policies and health systems are robust and responsive to the needs of those directly and indirectly affected (e.g. family/carers). PLWNCDs are powerful change agents and are able to leverage their lived experience and increase the impact of advocacy efforts.

In Ethiopia, the national NCD alliance was asked by the Ministry of Health to draft the outline for a national NCD action plan (see page 64 of **NCD Civil Society Atlas**) and in the United Kingdom, the National Health Service is mandated by law to involve people with lived experiences in planning and decision making that impacts (see page 27 of NCD Alliance's report on **Meaningfully Involving People Living with NCDs**).

i **Healthy Caribbean Coalition Publications** on NCD Commissions in the Caribbean

WHO SEARO **Infographic on whole of society response to address NCDs**

(●●●) if there is no evidence of engagement;

(●●●) if there is informal or limited engagement;

(●●●) if there is formal or consistent engagement.

Advocate with Ministry of Health and high-level champions for the establishment/strengthening of initiatives to support civil society and engage PLWNCDs. Different sectors have distinct and valuable roles to play, as recognised in the **2011 UN Political Declaration on NCDs**, **Outcome Document of the 2014 UN Review on NCDs** as well as the **2018 UN Political Declaration on NCDs**:

2018 Political Declaration from HLM on NCDs

42 *Promote meaningful civil society engagement* to encourage Governments to develop ambitious national multisectoral responses for the prevention and control of non-communicable diseases, and to contribute to their implementation, forge multi-stakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and *amplify the voices of and raise awareness about people living with and affected by non-communicable diseases*.

Demonstrate the valuable competencies of non-government sectors, how these sectors complement government capacity, and how they can support government in achieving its mission.

Are there mechanisms in place to manage conflict of interest and guard against industry interference?

→ Is there a government policy to manage conflict of interest and guard against industry interference, either for specific industries or overall? This could for example set out ways in which it is appropriate and inappropriate to engage sectors from outside the government in NCD policy development and implementation. It could make specific reference to financial transactions, or representation on bodies responsible for shaping policy.

Interference from industry or other parties (especially the tobacco, alcohol, and food and beverage industry) is often intended to delay or prevent policy development or implementation and weakens the NCD response.

At international level, article 5.3 of the WHO FCTC reads: 'In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.'

Ranking of countries' levels of interference by the tobacco lobby: **STOP: Global Tobacco Industry Interference Index 2019**.

Recent journal publications have also illustrated attempts by producers of sugar-sweetened beverages to influence national Centres for Disease Control in the **USA** and **China**.

The **WHO Framework of Engagement with Non-State Actors (FENSA)** outlines WHO's main consideration and protocol for engagement with non-Member State entities, **WHO presentation on managing conflicts of interest in nutrition**, WHO publication '**Addressing and managing conflicts of interest in the planning and delivery of nutrition programmes at country level**'

if such a policy does not exist and there are incompatible partnerships between government and tobacco / alcohol / companies that produce junk food or sugar-sweetened beverages / polluters (particularly fossil fuels companies);

if it does not exist but there is no clear industry interference;

if it exists and there is no interference.

Bring government attention to past examples (ideally at national level, or an area of particular concern where industry interference has been observed abroad) to show effects of industry interference.

2018 Political Declaration from HLM on NCDs

43 Engage with the private sector, taking into account national health priorities and objectives for its meaningful and effective contribution to the implementation of national responses to non-communicable diseases in order to reach Sustainable Development Goal target 3.4 on non-communicable diseases, while giving due regard to managing conflicts of interest;

44 Invite the private sector to strengthen its commitment and contribution to the implementation of national responses to prevent, control and treat non-communicable diseases to reach health and development objectives […].

The Tool

PREVENTION AND REDUCTION OF RISK FACTORS

What systems are in place for tobacco control (to regulate smoking and tobacco products)?

Recommendations from **WHO MPOWER** technical package

INDICATOR AREAS TO EXPLORE

→ Is your country Party to the WHO Framework Convention on Tobacco Control? Is the FCTC ratified and properly implemented? The FCTC Protocol to limit illicit trade in tobacco products?

ANNOTATIONS

List of Parties to FCTC; **List of Parties to Illicit Trade protocol.**

If your country is a Party to the WHO FCTC and protocol, they are legally bound to implementing the actions set out within it. This is a powerful advocacy point to follow up on many of the areas in this section on tobacco control.

WHO Framework Convention on Tobacco Control
WHO MPOWER
WHO Report on the Global Tobacco Epidemic 2019
WHO FCTC 2018 Global Progress Report
WHO Technical note on evaluation of existing policies and compliance (2019)

●●● if **not signed** (Andorra, Dominican Republic, Eritrea, Indonesia, Liechtenstein, Malawi, Monaco, Somalia, South Sudan) or if signed but not ratified (Argentina, Cuba, Haiti, Morocco, Mozambique, Switzerland, USA);

●●● if ratified but not properly implemented, or if Illicit trade protocol is not yet ratified;

●●● if ratified and fully implemented, including Illicit trade protocol.

If your country has not yet ratified the WHO FCTC, make the case for how tobacco use is the single largest preventable cause of NCDs.

INDICATOR AREAS TO EXPLORE

→ Tobacco control: Is there legislation mandating pictorial health warnings and plain packaging for tobacco products?

ANNOTATIONS

WHO undertakes regular assessments of tobacco policy implementation, including a 2019 report which includes evaluation of smoke-free places: **WHO Report on the Global Tobacco Epidemic 2019**, especially Table 6.5: Characteristics of health warnings on cigarette packages by country; Table 6.6: Characteristics of health warnings on smokeless tobacco packages; Table 6.7: Additional characteristics of health warnings on cigarette packages; Table 6.8 Additional characteristics of health warnings on smokeless tobacco packages; **WHO Technical note on evaluation of existing policies and compliance (2019)**; **Cigarette Package Health Warnings – International Status Report**; **2017 WHO NCD Progress Monitor** country profiles, including indicators on graphic health warnings and plain packaging (indicator 5c) (Update expected in 2020).

Large sized, graphic, pictorial health warnings are a cost-effective means to increase public awareness about the dangers of tobacco use. In addition, mandatory plain (unbranded) packaging is the best practice.

In December 2012, Australia became the first country to implement plain packaging on tobacco products. The measure aimed at reducing the appeal of the product packaging, increasing the effectiveness of health warnings, and reducing the ability of tobacco companies to use packs as a means of advertising to mislead consumers. The Australian Government's strict health policy adoption met with opposition from the tobacco industry, who took the issue to the World Trade Organization on grounds of trademark violations. However, the Government won the litigation, paving the way for plain packaging to be adopted as an important public health measure and for other countries to follow Australia's example. More information about the Australian legislation is available **here**. A post-implementation review of the plain packaging law conducted by the Australian Department of Health in 2016 is available **here**. A number of countries like United Kingdom and France have since passed similar laws.

WHO FCTC Health Warnings Database

Cigarette Package Health Warnings – International Status Report

if there is less than 50% front of pack pictorial health warning;

if above 50% pictorial warning, but not plain packaging;

if mandatory pictorial warning and plain packaging.

If your government is a signatory of the FCTC, remind them that pack labelling is legally required within a period of three years after entry into force of this Convention. Advocate for plain packaging regulation, following proven success in Australia.

INDICATOR AREAS TO EXPLORE

→ Does tobacco excise tax account for 70% or more of retail price of tobacco products in the country, as recommended by WHO? Does this cover all tobacco products (including "smokeless")?

→ Also consider any tobacco tax in relation to impact on the affordability index (i.e., affordability of cigarettes relative to per capita GDP, for example.)

→ If so, what is the resulting revenue used for? Is it, for example, reinvested into health systems?

ANNOTATIONS

WHO undertakes regular assessments of tobacco policy implementation, including a 2019 report which includes evaluation of smoke-free places: **WHO Report on the Global Tobacco Epidemic 2019** including Appendices VII, VIII and IX on tobacco tax rates, revenues, retail prices, use of revenues and affordability; **2017 WHO NCD Progress Monitor** country profiles include indicators on increased taxes and prices (indicator 5a) (Update expected in 2020).

WHO prescribed cost-effective measure for tobacco control (Appendix 3).

In the Philippines, a tax on tobacco and alcohol generated 141 billion pesos (7.7 billion USD), with 85% intended for reinvestment in health-related programmes – more information here and here.

Types of tobacco taxes

For affordability index - **An Analysis of Cigarette Affordability**

The Lancet Taskforce Series on NCDs and Economics

(•••) if no taxation;

(•••) if excise tax is below 70%;

(•••) if excise tax is above 70% (if your country implements a different tax structure aside from excise tax, please adapt these boundaries as you see fit).

As appropriate to the national context, advocate to raise taxes to a sufficiently high level relative to affordability to reduce demand; and/or use of revenues to create a 'double dividend' - strengthen health systems and/or roll-out effective preventative programmes to benefit PLWNCDs and people at risk of NCDs.

INDICATOR AREAS TO EXPLORE

→ Are smoke-free policies in place and effectively enforced; for example banning smoking in outdoor public places? Sub-national and local policies may also be especially relevant here.

→ Ideally, smoke-free policies should cover both indoor and outdoor public places, and workplaces.

ANNOTATIONS

WHO undertakes regular assessments of tobacco policy implementation, including a 2019 report which includes evaluation of smoke-free places: **WHO Report on the Global Tobacco Epidemic 2019; WHO Technical note on evaluation of existing policies and compliance** (2019); **Table 6.1 Places with smoke-free legislation by country**; Table 6.2 Characteristics of smoke-free legislation; Table 6.3 Subnational smoke-free law; **WHO NCD Document Repository**; **2017 WHO NCD Progress Monitor** country profiles include indictor on smoke-free policies (indicator 5b) (Update expected in 2020).

As there is no safe level of exposure to (second-hand) tobacco smoke, uptake of rules requiring 100% smoke-free environments including public places and indoor workplaces has gained momentum. WHO recommends smoke-free policies as a 'Best Buy' for countries to adopt in combination with other tobacco control policies to reduce smoking prevalence and protect people from the hazards of tobacco smoke.

In 2006, Uruguay became the first Latin American country to implement a comprehensive national smoke-free law banning smoking in public places and indoor workplaces. Research showed that the 100% smoke-free law was followed by a decline in hospital admissions for cardiovascular diseases and asthma. In 2016, Uruguay celebrated 10 years as a smoke-free country. Government initiative supported by a vibrant civil society movement contributed to the success of the policy. Read more **here**.

Guidance in **WHO Technical note 2019**:

●●● if there is no legislation or only 1-2 completely smoke-free places;

●●● 3-7 completely smoke-free places or if legislation has been adopted but is not effectively enforced;

●●● if there is legislation at national level which is effectively enforced: all public places completely smoke-free or 90% of the population covered by subnational smoke-free legislation.

Ensure legislation is in force nationwide. Where legislation is in place, ensure that the measure is properly enforced, monitored and evaluated to ensure effectiveness.

INDICATOR AREAS TO EXPLORE

→ Are policies in place to regulate the use of / limit demand for smokeless and/or electronic tobacco products?

ANNOTATIONS

The **Tobacco Atlas**; WHO undertakes regular assessments of tobacco policy implementation, including a 2019 report which includes an evaluation of smoke-free places: **WHO Report on the Global Tobacco Epidemic 2019** including Table 6.6: Characteristics of health warnings on smokeless tobacco packages; Table 6.8 Additional characteristics of health warnings on smokeless tobacco packages; **WHO Technical note on evaluation of existing policies and compliance** (2019).

Over 300 million users of smokeless tobacco products worldwide, particularly in South Asia.

In 2011, India prohibited the use of tobacco and nicotine as ingredients in any food product. This led to a ban in 2012 on the manufacture, storage, and sale of gutka (a popular form of chewing tobacco) and pan masala containing tobacco in the vast majority of states and Union Territories of India.

In November 2019, India also announced a ban on the production, import and sale of e-cigarettes.

if no policies are in place;

if there are at subnational but not national level;

if at national level.

Smokeless tobacco has traditionally remained outside tobacco control regulatory frameworks, but growing evidence on the association of smokeless tobacco use with cancers of the head and neck and other harms strengthens the case for regulation of smokeless tobacco products. The health impacts of other "smokeless" tobacco products (including vapes, e-cigarettes, etc.) are coming under increasing political and regulatory scrutiny due to growing evidence of association with severe respiratory illness and injury.

INDICATOR AREAS TO EXPLORE

→ Is there a ban on sale to and by minors (below 18 years, or as defined by domestic law)?

ANNOTATIONS

Tobacco and Youth

A majority of tobacco users begin before the age of 18 and there is growing evidence of youth being the primary targets of the tobacco industry. The WHO FCTC recommends that countries must adopt measures prohibiting the sale and free distribution to minors (age as defined under domestic law).

if there is no ban;

if yes but limit is below 18 years,

if yes and minimum age is 18 or higher.

See also CTFK's **campaign to raise the age limit to buy tobacco to 21**.

INDICATOR AREAS TO EXPLORE

→ Is there a ban on direct and indirect forms of tobacco advertising, promotions and sponsorships?

ANNOTATIONS

WHO undertakes regular assessments of tobacco policy implementation, including a 2019 report which includes evaluation of smoke-free places: **WHO Report on the Global Tobacco Epidemic 2019** including Table 6.10 Bans on direct advertising; Table 6.11 Bans on indirect advertising; Table 6.12 Additional bans on indirect advertising; Table 6.13 Subnational bans on tobacco advertising, promotion and sponsorship. **2017 WHO NCD Progress Monitor** country profiles include indictor on bans on tobacco advertising, promotion and sponsorship (indicator 5d) (Update expected in 2020).

Country examples of best practices in implementation of tobacco advertising and Point of Sale display ban (WHO).

if there is no ban;

if legislation exists but has clear loopholes or is loosely enforced;

if strong legislation exists and is enforced.

See also **CTFK campaign on advertising, promotion and partnership**

INDICATOR AREAS TO EXPLORE

→ Is there an overarching national law encompassing any or all of the elements above?

ANNOTATIONS

National Ministries of Health; **Best Practices for Effective Tobacco Control Programs (CDC, USA)**.

While the most important issue is the existence of individual policies for tobacco control, having an overarching strategy can help to consolidate the response.

India has a national law and national programme for tobacco control.

WHO FCTC 2018 Global Progress Report

if there is no law,

if partial,

if there is an overarching national law.

What interventions or policies are in place to reduce alcohol harm?

INDICATOR AREAS TO EXPLORE

→ Are taxes applied across all alcohol product concentrations, or to a specific concentration range?

→ Is there an established system for domestic taxation of alcohol?

→ If so, what are the generated revenues used for? Are they, for example, reinvested into health systems or harm prevention programmes?

ANNOTATIONS

National Ministries of Economy, Finance, Taxation, Health; Pricing policies mentioned in **2017 WHO NCD Progress Monitor**; **WHO Global Status report on alcohol and health** (2018) including country profiles; **WHO Global information system on alcohol and health** (GISAH). **2017 WHO NCD Progress Monitor** country profiles include indictor on alcohol taxes (indicator 6c) (Update expected in 2020).

Recommendations from WHO Global Strategy to Reduce Harmful Use of Alcohol and SAFER technical package.

Pricing measures, including taxes, demonstrate an impact on prevalence of hazardous and harmful drinking which varies according to rates of current tax, (un)recorded use and demand elasticity.

Alcohol taxation is a measure which is widely used worldwide, with 155 countries (95%) reporting taxes on beer in 2016. However, less than a quarter of countries adjust taxes according to inflation to maintain their effectiveness.

Alcohol use kills 3 million people worldwide every year. More than three quarters of these deaths were among men. Overall, the harmful use of alcohol causes more than 5% of the global disease burden. Of all deaths attributable to alcohol, over a quarter are due to injuries, including road crashes, self-harm and violence; one-fifth due to digestive disorders; one-fifth due to cardiovascular diseases; and the remainder due to infectious diseases, cancers, mental disorders and other health conditions. The burden of disease and injuries, as well as wider societal harms such as crime and abuse, is unevenly distributed among regions and is highest in Europe and the Americas. Globally, an estimated 237 million men and 46 million women suffer from alcohol-use disorders.

🔴 if taxation is not applied to all types of alcoholic drinks or is too low to have an impact on demand;

🟡 if taxes are applied to all alcoholic drinks but do not rise in line with inflation;

🟢 if taxes on all alcoholic drinks rise in line with or above the rate of inflation, and revenues are allocated to health systems or programmes to reduce alcohol harm or health inequalities.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. NCD Alliance's submission to the consultation can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there legislation mandating a Minimum Unit Price (MUP) for alcoholic drinks?

ANNOTATIONS

National Ministries of Health, Economy, Finance, Taxation; Minimum pricing policies mentioned in **2017 WHO NCD Progress Monitor**; **WHO Global Status report on alcohol and health** (2018); **WHO Global information system on alcohol and health** (GISAH).

Pricing measures have been shown to be effective in different resource contexts. Minimum unit pricing can be a complementary approach to raising taxation, and offers an additional advantage of being most effective in reducing consumption among the most high-risk drinkers who consume high-strength, very cheap products.

Scotland implemented MUP legislation in 2018. A **government report** of the first year of operation suggests it is even more effective than projected. The volume of alcohol sold per adult in Scotland has fallen to its lowest level in 25 years. A **compliance report** found that MUP was implemented smoothly and that compliance is high. Ireland and Wales have also approved legislation to introduce MUP.

See for example the **#MUPSavesLives campaign by Scottish Health Action on Alcohol Problems (SHAAP)**

Minimum pricing campaign by Alcohol Action Ireland

(●●●) if there is no MUP legislation in place or under consideration;

(●●●) if MUP legislation is adopted but not yet in force;

(●●●) if MUP legislation in force and well enforced.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. NCD Alliance's submission to the consultation can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there an established minimum age for purchase and consumption?

ANNOTATIONS

National Ministries of Health, Economy, Trade; **WHO Global Status report on alcohol and health** (2018) including country profiles; **WHO Global information system on alcohol and health (GISAH)**.

Increasing the national legal minimum age for purchase of alcohol can reduce alcohol consumption and related harms among young people, and particularly drink-driving crashes. Age restrictions can apply to the consumption of alcohol both on-premises or off-premises.

In 2016, 152 countries (93%) reported a national or subnational minimum legal purchase age for on-premises beer and wine sales and 151 countries (92%) reported a minimum legal age for purchase of spirits. In countries that have minimum legal purchase ages for alcohol, the minimum ages range from 13 years to 25 years. The most common age limit is 18 years. However, some (mostly low- and lower-middle income, particularly in Africa) countries report having no on-premises age limits for beer and wine sales/consumption or for spirits.

🔴🟡🟢 if there are no minimum age restrictions or under 16,

🔴🟡🟢 if 16-18 years or older but not well enforced,

🔴🟡🟢 if above 18 years and well enforced.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. Consultation details can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there legislation in place to restrict or regulate marketing of alcoholic beverages?

→ Are there regulations in place to control or restrict minors' exposure to marketing of alcohol? Are there specific regulations in place that address different types of media, format, times, and traditional and digital media?

→ Do such restrictions cover sport or event sponsorship?

→ Are any restrictions in place government legislated, co-regulated, or self-regulated by industry?

ANNOTATIONS

National Ministries of Health, Economy, Trade; **WHO Global Status report on alcohol and health** (2018) including country profiles; **WHO Global information system on alcohol and health (GISAH)**. Media included in WHO reporting include: national television, private television, national radio, local radio, print, billboards, point of sale, cinema, Internet and social media. **2017 WHO NCD Progress Monitor** country profiles include an indictor on restrictions on alcohol advertising (indicator 6b) (Update expected in 2020).

Young people who are exposed to alcohol marketing are more likely to start drinking or and to drink more. Marketing restrictions are one of the three WHO 'best buys' to reduce alcohol harm and the Global Strategy recommends setting up regulatory or co-regulatory frameworks, with a legislative basis, to regulate the content and volume of direct or indirect marketing, sponsorships and promotions in connection with activities targeting young people, including social media.

As part of a comprehensive national package of measures to reduce harm from alcohol consumption, Russia introduced a ban on advertising on all public transport infrastructure in 2008; Finland was one of the first countries to ban alcohol advertising on social media in 2015 (although traditional alcohol advertising is still permitted online). Finland's ban includes any social media content to promote alcohol, whether produced by commercial actors or consumers (e.g. social media posts and shares including videos). The Finnish regulation also applies to transnational advertising from outside Finland. Lithuania's Law on Alcohol Control (2018) includes a comprehensive alcohol advertising ban including digital media.

According to the WHO 2018 Global status report, thirty-five countries, including 17 in Africa and 11 in the Americas, reported having no regulations on any media type. Whilst most countries have some kind of restrictions on beer advertising on national radio and television, almost half of countries have no restrictions on internet or social media.

●●● if there are no marketing restrictions, only voluntary codes of practice for the alcohol industry which are ineffective, and alcohol advertising is still present in sports venues and sports coverage;

●●● if regulations are in place to protect minors from exposure to alcohol marketing, covering some media, and restrictions on alcohol advertising but not sponsorship in sport;

●●● if regulations are in place to protect minors from exposure to alcohol marketing across all media, including internet and social media, restrictions on alcohol advertising and sponsorship in sport.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. Consultation details can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there a licensing system for retailers?

→ Is there evidence to suggest that suppliers lose their license if they are not compliant?

→ Are the number of licences being increased or reduced?

→ Are there restrictions on times and dates when alcohol can be purchased?

ANNOTATIONS

National Ministries of Economy and Trade; **WHO Global Status report on alcohol and health** (2018) including country profiles; **WHO Global information system on alcohol and health (GISAH)**.

Reducing accessibility / availability of alcohol is recognised as a WHO best buy, as it is effective at reducing alcohol harm, is cost-effective and is feasible in all countries. This includes regulating retail hours and days, and density of alcohol retail outlets, as well as age restrictions on buying and consuming alcohol. The Global Strategy recommends implementing licensing systems to monitor the production, wholesaling and serving of alcoholic beverages; regulating the number and location of retail alcohol outlets; regulating the hours and days during which alcohol may be sold; establishing a national legal minimum age for purchase and consumption of alcohol; and restricting drinking in public places. Systems include government monopolies and, more commonly, licensing systems (141 countries).

Since 2005, Russia has implemented a series of evidence-based national alcohol policies in a stepwise manner within a comprehensive framework, to combat extremely high levels of per capita alcohol consumption and related premature mortality and illness as well as poisonings, road crashes and broader societal harms. This includes several measures to limit availability, including stricter control on production, distribution and sale; bans in some spaces; improved enforcement of the age limit and tougher penalties; and a ban on sale at petrol stations. For more information, see **WHO Euro (2019) Alcohol policy impact case study: the effects of alcohol control measures on mortality and life expectancy in the Russian Federation**

Recent trends show an increase in the number of licenced outlets – particularly in Southeast Asia and Africa – or longer licenced opening hours.

(•••) if no;

(•••) if licensing laws in place have been weakened (more retail outlets, longer opening hours, etc.);

(•••) if licencing laws in place have been maintained or strengthened.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. Consultation details can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there a national drink driving law?

ANNOTATIONS

National Ministries of Transport; **WHO Global Status report on alcohol and health** (2018) including country profiles; **WHO Global information system on alcohol and health (GISAH)**. **WHO Global Status report on road safety (2018)**

It is estimated that up to 35% of all road deaths are reported as alcohol related. Driving after drinking alcohol significantly increases the risk of a crash and the severity of that crash.

The number of drink-driving laws in place around the world is steadily increasing. According to the WHO's global status report on road safety (2018), only 45 countries have drink-driving policies in place in line with best practice. According to the WHO, 97 countries report setting a maximum permitted blood alcohol concentration (BAC) to prevent drink-driving at or below 0.05%. However, 31 countries have no limits at all. 37 countries have a BAC of 0.08%. 37 countries report using neither checkpoints nor random breath-testing to ensure enforcement.

While blood alcohol concentration (BAC) limits provided for in legislation need to be at the core of efforts to address drinking and driving, an integrated approach to intervention involves combined publicity and high visibility police enforcement. Best practice for drink–driving laws includes a BAC limit of 0.05 g/dl for the general population and a BAC limit of 0.02 g/dl for young or novice drivers.

(•••) if no limit or above 0.06%;

(•••) if 0.02-0.059% or if weakly enforced;

(•••) if limit is 0.02% or below and well enforced

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. SDG 3.6 calls for a reduction in the absolute number of road traffic deaths and injuries by 50% by 2020, relative to a baseline estimate from 2010. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. NCD Alliance's submission to the consultation can be found **here**.

INDICATOR AREAS TO EXPLORE

→ Is there an overarching strategy / action plan / programme / law encompassing any or all of the elements above?

ANNOTATIONS

WHO Global Status report on alcohol and health (2018) including country profiles; **WHO Global information system on alcohol and health (GISAH)**.

While the most important issue is the existence of individual policies for alcohol control, having an overarching strategy can help to consolidate the response.

The National Alcohol Policy in the Russian Federation has been credited with delivering one of the sharpest decreases in alcohol consumption per capita (from 20.4l in 2003, reduced to 11.7l in 2016) and as a major contributor to increasing life expectancy in recent years. In 2003, almost half of all deaths in working-age men in Russian cities were attributed to hazardous drinking. Policy reforms began in 2004 and included a package of coordinated measures including marketing restrictions, monitoring alcohol production, a ban on internet alcohol sales, and a 50% tax increase on ethyl alcohol, followed by further actions since 2011 including increasing excise taxes, raising the minimum unit price of alcohol, and substantially reducing the availability of retail alcohol. Having previously been one of the heaviest-drinking countries in the world, Russia is now seen as an example of how stringent policy reforms can reverse the devastating harm from alcohol use at both individual and national level.

WHO (2019) Alcohol policy impact case study: the effects of alcohol control measures on mortality and life expectancy in the Russian Federation

●●● if no;

●●● if partial or not well enforced;

●●● if yes and well enforced.

The WHO Global Action Plan on NCDs includes a voluntary global target to reduce the harmful use of alcohol by at least 10% by 2025, compared to 2010. Under SDG3.5, Heads of State and Government have committed to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. In 2020, the World Health Assembly will consider the first ten years of the WHO Global Strategy on Harmful Use of Alcohol and consider measures to further curb harm from alcohol use. NCD Alliance's submission to the consultation can be found **here**.

What interventions or policies are in place to create a healthy food environment?

→ Are all forms of malnutrition, including overweight and obesity and diet-related NCDs included in your country's Nutrition Plan, and/or Food Security Plan?

→ Is this plan multisectoral (i.e. involving the Ministries of Food and Agriculture, Commerce, Education, Health and Social Protection)?

Nutrition plans may be developed under the Health Ministry or Ministry of Food and Agriculture; **Global Nutrition Report Nutrition Country Profiles**; **WHO Global Database on the implementation of nutrition action (GINA).**

Poor diet has become the primary risk factor for NCDs worldwide. Globally, malnutrition in all its forms – including overweight and obesity – is a key risk factor for NCDs. Nearly one in three people around the world has at least one form of malnutrition, projected to reach one in two by 2025, primarily due to rising prevalence of overweight. 38 million children under 5 are currently overweight. Malnutrition in childhood has impacts on health later in life. In addition to NCD plans, nutrition-specific plans and budgets exist to address a country's malnutrition problems. A coordinated and integrated approach including obesity and NCDs is important to meaningfully address the determinants of unhealthy diets.

Brazil 2nd National Food and Nutrition Security Plan 2016-2019

Malaysia 3rd National Plan of Action for Nutrition (NPAM III)

Nordic Plan of Action on better health and quality of life through diet and physical activity

General resources in relation to food environments include: **NOURISHING Framework** by World Cancer Research Fund International; **Healthy Food Environment Policy Index** (Food-EPI) by INFORMAS and others.

(•••) if not included;

(•••) if included with associated activities but no multisectoral approach described;

(•••) if included AND plan is proactively multisectoral with ambitious activities.

Connect with civil society organisations active on malnutrition in any of its forms, Nutrition focal point at Ministry of Health (or Food and Agriculture) and potentially networks such as the Scaling-up-for-Nutrition (SUN) Movement to advocate for integration of Nutrition and NCD plans.

INDICATOR AREAS TO EXPLORE

→ Does your country implement taxation of unhealthy food and/or beverages?

→ Please include a list in your Status Report of which products are taxed and at what rate. Examples could include taxation of products high in sugar, salt or saturated fat.

→ Are these taxes intended and designed to decrease consumption? Has this been successful?

→ Is the revenue of these policies earmarked for health-promotion? If yes, what percentage?

ANNOTATIONS

National Ministries of Health, Finance, Taxation; **WHO e-library of evidence for nutrition actions**.

Over-consumption of sugar is a major contributor to obesity, diabetes and tooth decay. In the current food environment, it is very easy to consume too much sugar. Sugary drinks are a major source of sugar in the diet, and consumption is increasing in most countries, especially amongst children and adolescents. On average, a single can of a sugary drink contains the equivalent of around 10 teaspoons of sugar. People who consume sugary drinks regularly – 1 to 2 cans a day or more – have a 26% greater risk of developing type 2 diabetes than people who rarely consume such drinks.

In Mexico, a soda tax of just 1 peso (0.05 USD) per litre of sugary drink, caused a 5.5% drop in the first year after the tax was introduced (2015-2016), followed by a 9.7% decline in the second year (2016-2017), averaging 7.6% over the two-year period. A part of the revenues from the soda tax in Mexico is used for programmes to promote, prevent, detect, treat and control and combat malnutrition, overweight, obesity and non-communicable diseases, as well as to support the increase in the coverage of drinking water services in rural areas and schools.

Norway has had a sugar tax in place since 1922. Since 2018, taxes have been increased on chocolate, candy and sweetened drinks. The national directorate of public health reports that annual sugar consumption has dropped from 43kg per capita in 2000 to 24kg in 2018, a lower level than in 1975 and in marked contrast to increasing consumption in most of Europe. In Norway, one in six children are obese, compared to one in three in the UK.

Unicef (2019) Implementing Taxes on Sugar-Sweetened Beverages: An overview of current approaches and the potential benefits for children, March 2019, including several country and city case studies and how revenues have been used; **WHO (2017) Taxes on sugary drinks: Why do it?**

● if there is no taxation;

● if taxation exists but is too low to be effective;

● if taxation exists and has an impact on consumption, additional credit if some of revenues are reinvested in health systems or public health.

Citing the evidence of effectiveness of fiscal measures in countries with similar economic contexts around the world and potential revenue generation to contribute towards universal health coverage to realise a 'double dividend' for health and secure public support.

INDICATOR AREAS TO EXPLORE

→ Does your country implement policies to improve affordability and incentivise consumption of healthy foods? Examples could include subsidies for fruits and vegetables or import taxes for unhealthy foods.

ANNOTATIONS

National Ministries of Agriculture, Food, Health, Trade.

In the USA, according to Robert Wood Johnson Foundation, "There is strong evidence that fruit and vegetable incentive programs increase affordability, access, purchase, and consumption of fruits and vegetables".

In a study in Massachusetts, USA, produce incentives were found to reduce the gap between baseline fruit and vegetable consumption and recommended levels for a healthy diet by about 20% for people receiving income support to buy food.

See for example the **County Health Rankings information** on fruit and vegetable incentives, by the Robert Wood Johnson Foundation in the USA.

●●● if there are no incentives for healthier foods (vegetables, fruit, pulses, nuts, etc.);

●●● if an incentive programme exists for more nutritious foods but is not widely used or well monitored;

●●● if an incentive programme is in place and evaluations demonstrate effectiveness in increasing consumption of vegetables, fruit, etc.

Consider forms of incentives (subsidies, stamps, other support) in the context of groups 'left behind' and most at risk of all forms of malnutrition in local context, and whether proposing a redirection of incentives or revenues from taxation of unhealthy foods/SSBs will persuade policy makers.

INDICATOR AREAS TO EXPLORE

→ Does your country have national food-based guidelines that are based on food products, rather than individual nutrients?

ANNOTATIONS

National Ministries of Agriculture, Food, Health; **WHO Global Database on the implementation of nutrition action (GINA)**

As noted in **final report of Commission on Ending Childhood Obesity**, it is not sufficient to rely on nutrient labelling or simple codes such as traffic light labels or health star ratings. All governments must lead in developing and disseminating appropriate and context-specific food-based dietary guidelines for both adults and children. The necessary information should be provided through media and educational outlets and public health messaging in ways that reach all segments of the population, so that all of society is empowered to make healthier choices.

Canada's Food Guide

Brazil Food Based Dietary Guidelines

if no;

if yes.

INDICATOR AREAS TO EXPLORE

→ Does your country have a national nutrient profile to provide a tool to classify food and drink products that are in excess of free sugars, salt, total fat, saturated fat, trans-fatty acids, etc?

ANNOTATIONS

National Ministries of Consumers, Health, Food, Agriculture; **WHO Global Database on the implementation of nutrition action (GINA).**

Nutrient profiling is the science of classifying or ranking foods according to their nutritional composition, for reasons related to disease prevention and health promotion. The classification of products must also align with national dietary guidelines and expectations of the nutritional quality of foods. Testing and monitoring of the criteria are required to avoid labelling anomalies whereby less healthful foods are portrayed as healthful. As described by WHO EURO, one of the reasons for the less than optimal progress in policy development to regulate, for example, the marketing of foods to children, may be the difficulty in overcoming the challenge of classifying foods for which marketing should be restricted, which in turn results from the lack of an appropriate nutrient profile model or other means of classifying foods. A national nutrient profile can help to address this.

Nutrient profile underpinning 'NutriScore' 5-colour labelling in France; UK profile for 'traffic light' label; profile for 'Health Stars' in Australia and New Zealand – although the respective labelling systems are criticised for being only voluntary and so less healthy foods may not be labelled.

See **PAHO Nutrient Profile Model**, **WHO EURO Nutrient Profile Model**, and **WHO WPRO Nutrient Profile Model**; the WHO Regional Office for Africa is currently (2019) in the process of finalising their regional nutrient profile model for release.

(•••) if no;

(•••) if yes but not in line with WHO regional model;

(•••) if yes and in line with WHO model.

INDICATOR AREAS TO EXPLORE

→ Does your country have regulation on front-of-pack nutrition labelling?

ANNOTATIONS

WHO NCD Document Repository; WCRFI NOURISHING Database (N).

Front-of-pack (FOP) nutrition labels are recommended by the WHO for promoting healthier diets, providing accessible and transparent information to assist people to understand what is in their food and select their food. It is distinct from detailed nutrient profile panels and other food labelling standards and guidelines provided through **CODEX Alimentarius** in that FOPL is a way to provide consumers with information in a quick and easy format that is recognisable, understandable, interpretive and clear. Certain types of front of pack labelling can also nudge healthier choices and influence food reformulation to improve nutrient profiles.

European Public Health Alliance (EPHA): Mapping of government-endorsed front-of-pack nutrition labelling in Europe

WHO (2019) Guiding principles and framework manual for front-of-pack labelling for promoting healthy diet

WCRFI Building Momentum – Lessons on implementing robust FOPL

World Obesity Federation Policy Dossier on Front of pack labelling

(●●●) if no;

(●●●) if yes but voluntary;

(●●●) if yes and mandatory also all foods including those high in fat, sugar and salt.

INDICATOR AREAS TO EXPLORE

→ Are there national policies and mandatory regulatory controls on marketing (for example, advertising on radio, television, or public billboards) of unhealthy foods and beverages to children and adolescents?

ANNOTATIONS

WHO NCD Document Repository; **2017 WHO NCD Progress Monitor** country profiles include indictor on restrictions on marketing to children (indicator 7c) (Update expected in 2020).

Exposure of children and adolescents to marketing of foods and beverages influences food preferences and behaviours. Marketing comes in many forms and often policies are not keeping up with the changing landscape, and include traditional radio, television and static billboards, promotional gifts, sport and other event sponsorship, and more recently digital advertising techniques which can cross national borders and infiltrate children's lives through games, apps and computers. Comprehensive restrictions on marketing work to improve children's diets and preferences endure into adulthood.

Evaluating implementation of the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children. Progress, challenges and guidance for next steps in the WHO European Region Report (2019)

WHO recommendations on the marketing of foods and non-alcoholic beverages to children

World Obesity Federation Policy Dossier on Digital Marketing

Report of the commission on ending childhood obesity (2016)

⦿⦿⦿ if no;

⦿⦿⦿ if yes but not fully in accordance with WHO guidance;

⦿⦿⦿ iif yes and in accordance with WHO guidance.

INDICATOR AREAS TO EXPLORE

→ Does your country have food and nutrition policies for educational settings such as school? Subnational policies will be relevant here and should be referred to alongside any national policies in the report.

ANNOTATIONS

WHO Nutrition Friendly Schools Initiative.

Schools are among the key settings for providing food and nutrition interventions according to several of the Best Buys, and SMART nutrition policies in school settings can have double duty actions to tackle multiple forms of malnutrition. They are particularly important to create a nourishing and enabling environment for children and adolescents, and also support community nutrition through families. **UNICEF State of the World's Children Report 2019**.

Could include (i) food-based nutrition standards, including access to clean drinking water; (ii) ban on sale and provision of junk food in schools; (iii) healthy meal options provided via government school food schemes; (iv) health and nutrition literacy within or alongside curriculum.

World Obesity Federation Policy Dossier on School based interventions
Report of the commission on ending childhood obesity (2016)

School food policies will be highly varied between different parts of your country. Rather than assigning a traffic light boundaries which would not be able to take into account the positive and detrimental effects of the full range of policies, we encourage you to assess the positive and negative aspects of different policies and promote good practice to your government.

INDICATOR AREAS TO EXPLORE

→ Has your country implemented the **International Code of Marketing of Breastmilk Substitutes**?

→ Does your country implement the UNICEF Baby Friendly Hospital Initiative?

→ Is your country taking steps to incorporate the **WHO Guidance on inappropriate marketing** of commercial foods for infants and children into national law? These are more recent guidelines and may not yet be in the process of being taken up at national level.

ANNOTATIONS

Marketing of breastmilk substitute restrictions included in 2017 WHO NCD Progress Monitor (indicator 7d and 7c) (update expected 2020).

Detailed case studies are included in **WHO/ UNICEF/IBFAN report.**

WHO/ UNICEF/IBFAN report.

if International Code of Marketing is not implemented;

if only basic guidelines are adhered to;

if all guidelines are adhered to.

INDICATOR AREAS TO EXPLORE

→ Does your country have the following food or beverage product reformulation targets? Are these mandatory or voluntary?

- Salt reduction target
- Sugar reduction target
- Saturated fat reduction target
- Others?

→ Does your country have a ban on trans-fats?

ANNOTATIONS

WHO TFA Country Score Card; **WHO NCD Document Repository**; **2017 WHO NCD Progress Monitor** country profiles include indictors for policies on salt/sodium (indicator 7a) and saturated fatty acids and transfats (indicator 7b) (Update expected in 2020).

NCD Alliance case study report Transfat Free by 2023 (2019).

WHO REPLACE package (transfats); **WHO SHAKE technical package** (salt/sodium); see also UK civil society campaigns **Action on Sugar and Action on Salt.**

(•••) if no targets are in place;

(•••) if voluntary target/s are in place;

(•••)if co-regulated or mandatory targets are in place.

What interventions or policies are in place to address physical inactivity?

→ Is there a national physical activity action plan, strategy and/or guidelines incorporating all ages and a range of settings – such as workplaces, schools and communities?

WHO NCD Document Repository; **2017 WHO NCD Progress Monitor** country profiles include indictor on public education and awareness campaigns on physical activity (indicator 8) (Update expected in 2020).

Nordic Plan of Action on better health and quality of life through diet and physical activity.

Global Physical Activity Matrix 2.0 by Active Healthy Kids Global Alliance and the **Global for Physical Activity** Country Cards and Global Physical Activity Almanac.

(•••) if none;

(•••) if only one group covered;

(•••) if two or more groups are covered.

→ Is there promotion of safe, active transport (usually walking and cycling, but in some contexts also swimming, running, skiing, etc.) This may vary sub-nationally, between cities and regions.

→ Is there availability of safe, accessible public transport? This may vary sub-nationally.

UN Environment Programme country profiles on cycling and walking around the world; Reporting on SDG sub-target 11.2: Provide access to safe, affordable, accessible and sustainable public transport systems for all […] notably by expanding public transport.

Promotion of walking and cycling encourages people to integrate active transport into their daily routine; public transport encourages people to walk a little as part of their commute to or from a public transport stop.

Indicators for SDG11.2.

if there are no pavements/cycle lanes in large areas of most cities, or if public transport is too expensive or infrequent to be useful;

if it exists in some cities;

if it exist in all cities.

See campaign by European Cyclists' Federation, **Cycling delivers on the global goals**

What interventions or policies are in place to address air pollution?

INDICATOR AREAS TO EXPLORE

→ Does your country / region have a national / regional clean air plan or strategy, with an associated target on air pollution (either household, outdoor/ambient, or both)?

→ Is air pollution reduction included in / related to the national NCD action plan?

→ Are there national or regional policies or regulations to limit industrial emissions?

→ Are there national policies or regulations to limit transport emissions?

ANNOTATIONS

WHO is currently supporting development of relevant SDG indicators for reporting on relevant SDG sub-targets including: SDG target 3.9, which calls for a substantial reduction in deaths and illnesses from air pollution; SDG target 7.1, which aims to ensure access to clean energy in homes; SDG target 11.2, which aims to provide access to safe, affordable, accessible and sustainable transport systems for all; SDG target 11.6, which aims to reduce the environmental impact of cities by improving air quality.

Air pollution kills an estimated seven million people worldwide every year. WHO data shows that 9 out of 10 people breathe air with dangerous levels of pollutants, which pose a risk to health.

WHO Air Quality Guidelines; **NCD Alliance publications on air pollution and NCDs**, including 2019 'Clean Air Now' which includes case studies of effective air pollution reduction policies, how quickly they work to improve health, and their cost-effectiveness.

if no clean air plan or strategy is in place;

if yes but not aligned with WHO Guidelines, or not enforced by legislation;

if yes, well enforced and aligned with WHO Guidelines

In May 2015, WHO Member States took a major step forward in addressing air pollution issues, through the adoption of the resolution WHA68.8 (Health and the environment: addressing the health impact of air pollution). A road map for an enhanced global response to the adverse health effects of air pollution was adopted at the 69th World Health Assembly in 2016. The World Health Assembly in 2019 confirmed the mandate of the 2018 High-Level Meeting on NCDs to include air pollution as one of the five main NCD risk factors worldwide. WHO is mandated to propose a set of recommended interventions to reduce premature mortality from air pollution at the World Health Assembly in 2020.

INDICATOR AREAS TO EXPLORE

→ Are there fiscal measures in place to reduce fossil fuel usage, such as taxes on carbon?

→ Are there fiscal measures in place to incentivise renewable energy use, such as renewable energy subsidies?

ANNOTATIONS

National Ministries of Finance, Taxation, Energy and Transport. **OECD database** of fossil fuel subsidies and incentives; **OECD data** on fossil fuel taxation.

Energy generated by fossil fuels is far more damaging to human and planetary health than that generated from renewable sources, due to release of air pollutants and accelerating climate change.

Please see case studies in Vital Strategies and NCD Alliance briefing: **Fuelling an unhealthy future** (2019).

if fossil fuels are subsidised or not taxed;

if fossil fuels are not subsidised and are taxed;

if fossil fuels are not subsidised and are taxed at a high enough level to reduce consumption and emissions, if renewable energies receive public support, or if revenues are directed to health systems or health promotion.

INDICATOR AREAS TO EXPLORE

→ Is there a national policy or plan to reduce household air pollution to increase availability of sustainable, clean energy sources for indoor cooking, heating and lighting?

ANNOTATIONS

This indicator will not be relevant in all settings and can be omitted if household air pollution is not a concern. Household air pollution is a particular issue in many low- and middle-income countries, and often mainly in rural areas and slum areas of cities. Household air pollution accounts for four million deaths annually.

Burning Opportunity: Clean Household Energy for Health, Sustainable Development, and Wellbeing of Women and Children, by World Health Organization.

if no;

if yes or if not required.

Are there policies in place to address socio-economic inequalities?

→ Are there strategies in place to address social determinants of health and reduce NCD inequities in marginalised groups, such as people in lower income groups; women, children and adolescents; refugees; or indigenous populations?

This is a complex indicator, and we recommend investigating it only if time and resources allow adaptation to the national context.

WHO information resources on social determinants of health, including for African, Americas, Europe and Western Pacific regions.

Social and economic determinants of health, such as level of education and salary, and quality of housing, impact of likelihood of exposure to NCD risk factors and on access to care. For example, a parent with a lower salary may need to work longer hours, and may not have the time to cook healthy, fresh food for their family, resorting instead to fast food options.

Inequalities in non-communicable diseases and effective responses, Di Cesare, Lancet 2013; 381: 585–97

WHO Commission on Social Determinants of Health - final report

Social determinants of health inequalities, Marmot, Lancet 2005; 365: 1099–104. Update '10 Years on from the Marmot report' is due for publication in 2020

It is particularly important to tailor this indicator to the local socio-economic and demographic context and risk factors, particularly considering marginalised groups, which may include indigenous communities, refugees, ageing populations or populations with a high proportion of children and youth, as well as gender and LGBT+ equity and safety considerations. Considering NCDs such as cervical and prostate cancer, HPV, liver cancer (Hep B, Hep C) Kaposi's sarcoma, it is also necessary to consider marginalised groups such as sex workers and men who have sex with men.

What government-led initiatives exist for health promotion?

→ Are there national government-led efforts to raise public/population awareness and literacy on NCDs and their risk factors? This could include national campaigns / mass media strategies to promote nutrition guidelines, benefits and available support for tobacco cessation, cancer awareness or screening services.

→ Is there an integrated campaign across the major NCDs and risk factors?

→ What channels are used for information dissemination? Are these accessible to different population groups? For example, are adverts only on television, and hence directed to more affluent households who can afford a television, or are there adverts in public places?

→ Are activities carried out in collaboration with civil society partners?

WHO NCD Document Repository; 2017 WHO NCD Progress Monitor country profiles include indictors on public education and awareness campaign on physical activity (indicator 8) (Update expected in 2020).

5-a-Day campaign in UK

Jamaica Moves campaign

Rwanda's Kigali Car-Free Days

●●● if no;

●●● if yes but without civil society collaboration in most cases;

●●● if yes and with civil society collaboration.

If campaigns not carried out in collaboration with civil society, this should be encouraged, in order to increase the reach and impact of campaigns.

The Tool

HEALTH SYSTEMS

Are NCDs included / covered in UHC?

INDICATOR AREAS TO EXPLORE

→ To what extent is treatment and care for (all) NCDs included in universal health coverage in your country? Which NCDs are covered and which are excluded? Is treatment and care available to everyone or are some groups excluded?

→ What percentage of NCD services listed in the **WHO PEN Package** are included in UHC schemes? Notably, the PEN Package is limited to cancer, diabetes, heart disease and stroke, chronic respiratory disease. Comments should also be made on mental health and, if deemed appropriate, other NCDs.

→ Is it an integrated system, spanning the continuum of care (health promotion, prevention, screening and diagnosis, treatment, rehabilitative and palliative care)?

→ How many PLWNCDs lack access to essential health services? How many PLWNCDs are pushed into poverty (related to SDG indicator 1.1.1) or spending too much (>10%) of their household budgets on health care expenses (SDG indicator 3.8.2)?

ANNOTATIONS

National Government websites, especially that of the Health Ministry.

The inclusion of NCDs and availability / equitable access to essential medicines in a country's UHC plan/ policy strategic document. WHO defines UHC as 'ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO.' NCDs must be given proportional priority within UHC frameworks, as over 60% of PLWNCDs have experienced catastrophic expenditure due to care and management of their NCDs.

Lived experiences of PLWNCDs in relation to access to the full range of health services from prevention, promotion, screening, diagnosis, rehabilitation, treatment and care, including palliative care.

WHO UHC indicator framework; **WHO PEN Package**; a list of essential services for mental health (but from 2003) is also available **here** if a useful starting point.

(•••) if PLWNCDs are being pushed into poverty by having to pay for their own treatment and care, or having to spend over 10% of household income on treatment and care;

(•••) if any population groups or NCDs are excluded from / cannot access prevention and health promotion, screening, diagnosis, treatment and care provision and/or if 5-10% of household income is spent on treatment and care;

(•••) if prevention and promotion, screening, diagnosis, treatment and care if available and accessible for all PLWNCDs throughout the lifecourse, without pushing people into poverty.

UHC and NCDs are intrinsically linked: UHC cannot be achieved without an adequate response to NCDs, while a comprehensive response to NCDs will be impossible without investment in access to essential medicines and care, and health systems strengthening.

Heads of State and Governments will meet at the UN General Assembly in 2023 to review progress towards achieving Universal Health Coverage. Leaders committed in the political declaration of the 2019 HLM on UHC to scale up efforts to:

2018 Political Declaration from HLM on NCDs

24 Accelerate efforts towards the achievement of universal health coverage by 2030 to ensure healthy lives and promote well-being for all throughout the life course, and in this regard re-emphasize our resolve:

(a) *To progressively cover 1 billion additional people by 2023* with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to *covering all people by 2030*;

(b) *To stop the rise and reverse the trend of catastrophic out-of-pocket health expenditure* by providing measures to ensure financial risk protection and *eliminate impoverishment due to health-related expenses by 2030*, with special emphasis on the poor as well as those who are vulnerable or in vulnerable situations;

33 *Further strengthen efforts to address non-communicable diseases*, including cardiovascular diseases, cancer, chronic respiratory diseases and diabetes, *as part of universal health coverage*;

34 *Strengthen efforts to address eye health conditions and oral health*, as well as rare diseases and neglected tropical diseases, *as part of universal health coverage*;

36 *Implement measures to promote and improve mental health and well-being as an essential component of universal health coverage*, including by scaling up comprehensive and integrated services for prevention, including suicide prevention, *as well as treatment for people with mental disorders and other mental health conditions as well as neurological disorders*, providing psychosocial support, promoting well-being, strengthening the prevention and treatment of substance abuse, addressing social determinants and other health needs, and fully respecting their human rights, noting that mental disorders and other mental health conditions as well as neurological disorders are an important cause of morbidity and contribute to the non-communicable diseases burden worldwide;

37 *Increase access to health services for all persons with disabilities*, remove physical, attitudinal, social, structural and financial barriers, provide quality standard of care and scale up efforts for their empowerment and inclusion, noting that persons with disabilities, who represent 15 per cent of the global population, continue to experience unmet health needs;

39 *Pursue efficient health financing policies*, including through close collaboration among relevant authorities, including finance and health authorities, *to respond to unmet needs and to eliminate financial barriers to access* to quality, safe, effective, affordable and essential health services, medicines, vaccines, diagnostics and health technologies, *reduce out-of-pocket expenditures leading to financial hardship and ensure financial risk protection for all throughout the life course, especially for the poor and those who are vulnerable or in vulnerable situations, through better allocation and use of resources, with adequate financing for primary health care, in accordance with national contexts and priorities*;

40 *Scale up efforts to ensure there are nationally appropriate spending targets for quality investments in public health services*, consistent with national sustainable development strategies, in accordance with the Addis Ababa Action Agenda, and transition towards sustainable financing through domestic public resource mobilization;

43 *Optimize budgetary allocations on health, sufficiently broaden fiscal space, and prioritize health in public spending, with the focus on universal health coverage*, while ensuring fiscal sustainability, and in this regard encourage countries to review whether public health expenditure is adequate to ensure sufficiency and efficiency of public spending on health and, based on such review, *to adequately increase public spending, as necessary, with a special emphasis on primary health care*, where appropriate, in accordance with national contexts and priorities, while noting the *World Health Organization recommended target of an additional 1 per cent of gross domestic product or more*;

44 *Promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for non-communicable diseases*, and promote healthy diets and lifestyles, consistent with national policies, noting that price and tax measures can be an effective means to *reduce consumption and related health-care costs and represent a potential revenue stream for financing for development in many countries*;

79 *Set measurable national targets and strengthen national monitoring and evaluation platforms*, as appropriate, in line with the 2030 Agenda for Sustainable Development, to *support regular tracking of the progress made for the achievement of universal health coverage by 2030.*

What is the national context regarding essential medicines and technologies for NCDs?

INDICATOR AREAS TO EXPLORE

→ Has your government updated the national EML list since the last global EML update? (The current versions are the 21st WHO Essential Medicines List (EML) and the 7th WHO Essential Medicines List for Children (EMLc) and were updated in June 2019).

→ If so, are all NCD essential medicines / technologies included in the global updated list also in the national list?

→ In practice, are the NCD medicines included in the national EML list available?

ANNOTATIONS

National Ministry of Health. Where there is no official data for the availability of drugs; unofficial or anecdotal may be supplemented but should be described as such when writing the report.

World Health Organization defined essential medicines as medicines that satisfy the health care needs of the population, hence they should be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price that the individual and the community can afford. WHO provides a global model list which is updated every two years and which should be adopted at national level. Wider policies such as trade agreements have a significant impact on the availability and affordability of essential medicines and technologies for NCDs.

Global Essential Medicines List

WHO webpage on Trade, **Intellectual Property Rights and Access to Medicines**

if national list contains less than 60% of EMLs for NCDs;

if it contains 60-80% of EMLs for NCDs;

if it contains >80% EMLs for NCDs.

This is necessary in order to achieve the target in the WHO Global NCD Action Plan to attain an 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.

INDICATOR AREAS TO EXPLORE

→ Does the national government have established standards for availability / affordability of these essential medicines / technologies?

→ If not, are any studies published on availability / affordability of essential medicines and technologies?

ANNOTATIONS

Ministry of Health website or contact; **WHO NCD Document Repository**; **2017 WHO NCD Progress Monitor** country profiles include indictors on guidelines for management of cancer, CVD, diabetes and CRD (indicator 9) and drug therapy/counselling to prevent heart attacks and strokes (indicator 10) (Update expected in 2020).

NCDs account for high out-of-pocket expenditures; regulated pricing can promote more equitable access to treatment and care.

WHO guideline on country pharmaceutical pricing policies

WHO roadmap on access to medicines 2019-2023

See also WHO Technical report of Pricing of Cancer Medicines and its impact

if no standards are in place;

if standards are in place for some essential medicines for NCDs;

if standards are in place and working effectively to improve access to essential medicines for PLWNCDs.

Are there national guidelines for management of NCDs?

→ Are there government approved, evidence-based national guidelines / protocols / standards of care for major NCDs?

→ If yes, are they available for all of the below? If not, for which?

- Cancer (as there are many different types of cancer, focus on the top two causes of death among men and top two causes of death among women in your country)
- CVDs (stroke and heart attack)
- Chronic respiratory diseases
- Diabetes (type 2, type 1 and GDM)
- Hypertension
- Mental health conditions and / or neurological disorders (focus on the most prevalent conditions)

WHO NCD Document Repository; **2017 WHO NCD Progress Monitor** country profiles include indictors on guidelines for management of cancer, CVD, diabetes and CRD (indicator 9) and drug therapy/ counselling to prevent heart attacks and strokes (indicator 10) (Update expected in 2020).

For LMICs in particular, health systems and healthcare professional trainings are often aligned to reflect a greater burden of infectious and acute conditions, rather than NCDs. Specific guidelines for treating NCDs are therefore necessary for providing adequate care and to streamline implementation of NCD related programmes at all levels (national, state, and local).

If an NCD programme has been adopted, a lack of guidelines will be a major barrier to effective implementation. Governments seeking to develop guidelines may wish to consult the **WHO Handbook for Guideline Development**.

(•••) if available for 0-40% of the conditions you have identified as justifiable national priorities;

(•••) if available for 41-80% conditions;

(•••) if available for >80% conditions

INDICATOR AREAS TO EXPLORE

→ Are there guidelines for tobacco dependence treatment aligned with criteria set out in the FCTC?

→ Are there guidelines for alcohol dependence treatment – brief intervention?

ANNOTATIONS

Prevention is recognised as a cornerstone of universal health coverage and primary healthcare, including in the 2019 political declaration of the UN High-Level Meeting on UHC.

In the USA, **substance abuse costs over 600 billion USD annually**. For countries in comparable situations, there is a clear rationale for investment in cessation services for both tobacco and alcohol.

For tobacco control, see Article 14 of the **WHO Framework Convention on Tobacco Control**

WHO training manual on alcohol brief interventions (2017)

- if it does not exist or if there is evidence of industry interference in developing the guidelines;
- if some guidelines are in place in accordance with criteria set out in the FCTC for tobacco control and/or **WHO training manual on alcohol brief interventions**, and there is little to no evidence of industry interference;
- if guidelines are in accordance with criteria set out in the FCTC for tobacco control and WHO training manual on alcohol brief interventions, with no evidence of industry interference.

If a tobacco/alcohol control programme has been adopted, a lack of treatment guidelines will be a major barrier to effective implementation. Governments wishing to develop guidelines may wish to consult the **WHO Handbook for Guideline Development**.

Are there government programmes delivering NCD detection, treatment and care?

→ Are there government programmes / initiatives delivering NCD detection, treatment and care?

→ If yes, are they available for some or all of the below?:
- Cancer (as there are many different types of cancer, choose the top two causes of death among men and top two causes of death among women in your country to focus on)
- CVDs (stroke and heart attack)
- Chronic respiratory diseases
- Diabetes (type 2, type 1 and GDM)
- Hypertension
- Mental and / or neurological disorders (choose the top three most prevalent conditions in the adult population to focus on)

→ If available, do they address:
- Screening and early detection
- Treatment and referral
- Rehabilitation
- Palliative care
- Advice on prevention and health promotion

National quantitative and qualitative data from Ministry of Health, empirical / anecdotal evidence from PLWNCDs; **WHO NCD Country Profiles (2018)**: see section in each country profile on national system's response, which includes indicators on drug therapy to prevent heart attacks and strokes, and availability of essential NCD medicines and basic technologies to treat major NCDs; **2017 WHO NCD Progress Monitor** country profiles include indictors on Guidelines for management of cancer, CVD, diabetes and CRD (indicator 9) and drug therapy/counselling to prevent heart attacks and strokes (indicator 10) (Update expected in 2020).

An instructive example from another area of global health is the UNAIDS Treatment for All initiative, including the **'90-90-90' targets** for 2020: 90% of all people living with HIV know their HIV status (screening and diagnosis); 90% of all people diagnosed with HIV receive sustained antiretroviral therapy, and 90% of people receiving therapy have viral suppression (referral and treatment, advice on health promotion).

See also NCD Country Profiles evaluation.

(●●●) if available for 0-40% of the conditions you have identified as justifiable national priorities;

(●●●) if available for 41-80% of conditions;

(●●●) if available for >80% of conditions.

THEME

What training exists for health care professionals in primary prevention and secondary care?

INDICATOR AREAS TO EXPLORE

→ Is NCD prevention and management literacy integrated into training programmes for health care professionals, including medical (doctors, nurses), allied health (physiotherapists, counsellors)?

→ While there may be limited official sources for community health workers, a comment should be made on the level of training for community health workers, noting if the assessment is based on informal or anecdotal evidence.

ANNOTATIONS

Curriculums are often available on Ministry of Health website.

Human resources for health can be a lever for health system change, and achieving an optimised health workforce will help to both deliver on the NCD targets and attain (UHC).

WHO WPRO Training Manual for Health Workers on Healthy Lifestyle: An Approach for the Prevention and Control of Noncommunicable Diseases.

Protecting Populations, Preserving Futures: Optimising the health workforce to combat NCDs and achieve UHC (NCD Alliance, 2019).

(●●●) if it does not exist or is severely inadequate (e.g. very short time for training proportional to burden / if less than 2 NCDs, or if only focussed on management);

(●●●) if it covers at least 2 NCDs and spans prevention AND management;

(●●●) if covers all major NCD risk factors and management and training as a whole is perceived as adequate.

The Tool

MONITORING, EVALUATION, AND SURVEILLANCE

Are national-level disease surveillance mechanisms in place?

INDICATOR AREAS TO EXPLORE

→ Does the Government undertake nationally representative periodic surveillance of NCDs (overall, or single diseases) in terms of their prevalence, associated morbidity, and mortality?

→ Is data stratified by e.g. age / gender / urban-rural?

→ How often is such reporting completed? When was data last submitted?

→ Is data available on the estimated cost of the disease burden?

→ If the government does not undertake periodic surveillance on NCDs specifically, is NCD-related information included in any other national health information system/mechanism?

ANNOTATIONS

2017 WHO NCD Progress Monitor for Mortality and Risk Factor surveillance (Update expected in 2020).

Surveillance of diseases and their risk factors is vital to see where action is needed, to mandate investment, and to monitor trends. Where high prevalence of a given disease can be demonstrated, this strengthens the case for funding prevention and management initiatives. Nationally representative surveillance is important and often lacking – hospital based data is simpler to gather but is not reflective of the overall national burden.

See for example **UICC's Global Initiative for Cancer Registries**; work by **Vital Strategies on civil registration and vital statistics**.

World Health Statistics 2019: Monitoring Health for SDGs

(●●●) if data not collected, or is not nationally representative (e.g. is hospital-based);

(●●●) if collected but not stratified;

(●●●) if collected and stratified.

Surveillance of disease burden enables governments to identify where investment of resources will have the greatest impact. Government and civil society should be alert to the possibility that high levels of risk factor exposure may be indicative of industry tactics.

Are national-level NCD risk factor surveillance mechanisms in place?

→ Does the Government undertake nationally representative periodic assessment of exposure to modifiable NCD risk factors?

→ Is data stratified by e.g. age / gender / urban-rural?

→ How often is such reporting completed? When was data last submitted?

→ If the government does not undertake periodic assessment, are such indicators included in any other national health surveys?

Search for a 'STEPS' survey for your country. **WHO STEPS Country Reports**; FCTC Reporting will provide feedback for tobacco risk factor exposure.

Enables identification of populations most at risk where interventions should be most urgently implemented; enables progress on risk factor reduction to be tracked to see which interventions are most effective.

E.g. for tobacco control – see Prevention section of the tool, plus **Global Adult Tobacco Survey, Global Youth Tobacco Survey**, Global Health Professionals Student Survey. There may be other surveys specific to different risk factors.

WHO STEPwise Approach to Risk Factor Surveillance.

if data is not collected, or is not nationally representative (e.g. is hospital-based);

if collected but not stratified;

if collected and stratified.

Surveillance of risk factor exposure enables governments to identify where investment of resources will have the greatest impact.

Representation at UN High-Level Meetings on NCDs

→ What has the engagement of your government been at the UN High-Level Meetings on NCDs in 2011, 2014 and 2018, and the High-Level Meeting on UHC in 2019?not undertake periodic assessment, are such indicators included in any other national health surveys?

National government statements delivered at the 2019 HLM on UHC; for the list of governments attending the HLMs on NCDs, please ask the NCD Alliance secretariat.

Attendance of HoG/HoS indicates that NCDs are a national priority, increases likelihood of operationalising priorities set out in the outcome document, and will build global political momentum for the NCD response.

⬤ if no representative or representative from NY mission only;

⬤ if representative from any level of national government (e.g. Ministry of Health, Finance, Foreign Affairs);

⬤ if HoG/HoS has attended in any year.

Share lists of other countries who have had HoG/HoS in attendance, strategise regionally in advance of the next UN HLM to build national pressure, based on likelihood of attendance of other HoS/HoG; send a letter based on NCDA's template letter.

Are NCDs a research priority?

→ Is there a domestic research budget for NCDs and their risk factors?
This indicator may be especially difficult to track. If it is helpful to redefine it, please feel free to do so.

Ministry of Health, Science, Research, Innovation contacts or website.

Research is at the heart of medical and public health advances. Interventions which are cost-effective will likely be sustained and scaled up. One of the six objectives of the WHO Global NCD Action plan is to 'promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases.' However, the research landscape is highly complex, and we recommend only including a brief answer to these questions.

The Indian Council of Medical Research and the UK National Institute of Health Research are both funded by government and work on NCDs. Funds may also be available in the form of PhD grants, for example.

WHO Implementation research in Health: A Practical Guide
WHO Prioritized research agenda for prevention and control of NCDs

●●● if no;
●●● if not a specific budget line but other budgets are / can be used for NCD research;
●●● if yes.

Are there any mechanisms for independent accountability in your country?

→ Is there a national mechanism for independent accountability to evaluate government progress on NCD prevention and control in your country? Independent accountability is that which is initiated by non-governmental entities, especially civil society, to complement or build on existing government mechanisms, or to provide accountability where these are absent. Completion of this benchmarking exercise is an example of independent accountability, and could form part of a longer term established mechanism.

Independent accountability mechanisms provide a means for entities outside of government to corroborate information included in official government reporting, or to highlight where official reporting may not reflect the actual state of affairs in practice.

●●● if no mechanism is in place;

●●● if mechanism in place undertaken by non-civil society stakeholders (academic, private sector);

●●● if there is an independent, civil society-led accountability mechanism.

Since these mechanisms are outside of government, no direct advocacy to government is needed. However, in many countries it will be important to maintain a positive and collaborative relationship with government in order to maximise the likelihood of recommendations being taken on-board.

TIPS FROM THE FIELD

S1 / TIP 1

Balancing the roles of watchdog and partner for progress

S1 / TIP 2

Participatory approach to interpreting data and report writing

S1 / TIP 3

Collaborating with academia

S1 / TIP 4

Value of diverse partnerships

S2 / TIP 5

Allow ample time for analysing findings and report writing

S3 / TIP 6

Adapt the methodology to suit your alliance

S4 / TIP 7

Expect a learning curve

S4 / TIP 8

Look beyond the usual suspects

S4 / TIP 9

Consider cross-referencing data

S4 / TIP 10

Balancing the roles of watchdog and partner for progress

S4 / TIP 11

Look out for data gaps

S6 / TIP 12

Balancing the roles of watchdog and partner for progress

S6 / TIP 13

Status Report writing for alliance consolidation and priority setting

S7 / TIP 14

Identify low-hanging fruit

S7 / TIP 15

Plan launch timing strategically

S7 / TIP 16

Adapt findings to different audiences for advocacy impact

S7 / TIP 17

Publishing for an academic audience

S7 / TIP 18

Targeted dissemination

S7 / TIP 19

Spread awareness through the media

S8 / TIP 20

Lasting influence

S8 / TIP 21

Taking a leap

S8 / TIP 22

A process, not a product

S8 / TIP 23

Recognise the value of incremental change

Balancing the roles of watchdog and partner for progress

As CSOs seeking to hold governments accountable, NCD alliances or coalitions producing Civil Society Status Reports must ask difficult questions and address sensitive topics. Simultaneously, it is important to kindle and preserve constructive working relationships with government agencies in order to complement efforts and collaborate on potential solutions. If balanced thoughtfully, these two roles do not necessarily contradict each other, particularly when progress is also recognised and applauded.

STEP 1: Establish key stakeholders

Participatory approach to interpreting data and report writing

The Healthy Caribbean Coalition brought 61 individuals representing CSOs, regional organizations, and governments at an NCD Multi Stakeholder Meeting to review preliminary findings of the status report and solicit feedback on the contents and emerging recommendations. This ensured the report was developed as the product of a participatory approach. While this option may be too resource intensive for many alliances, making a conscious effort to consult stakeholders on preliminary findings before launching the report may help increase a sense of ownership of the results and consequently maximise advocacy buy-in at later stages.

STEP 1: Establish key stakeholders

TIP FROM THE FIELD

CARIBBEAN

Collaborating with academia

The HCC collaborated with academics based at the University of the West Indies, who worked extensively on data collection. This partnership lent the entire project credibility from the onset, partly thanks to the University's extensive networks among regional organisations.

STEP 1: Establish key stakeholders

TIP FROM THE FIELD

SOUTH AFRICA

Value of diverse partnerships

The lead report researcher in South Africa found it valuable reaching out to advocates who had done similar work within the AIDS movement as well as Section 27, a public interest law centre that had been active in accountability.

STEP 1: Establish key stakeholders

TIP FROM THE FIELD

CARIBBEAN

Allow ample time for analysing findings and report writing

Finding all the data called for by the Benchmarking Tool can be a time-consuming task even for experienced alliances. For example, the Healthy Caribbean Coalition was forced to revise its initial timeline by three months due to unanticipated delays in data collection and writing. If aiming to launch the report in time for a key event or opportunity, such as the UN High Level Meeting in 2018, ensure that you begin the process early.

STEP 2: Define a timeline

TIP FROM THE FIELD

SOUTH AFRICA

Adapt the methodology to suit your alliance

After the first draft of the report was completed to meet external deadlines, the SANCDA took time to add more detail before publishing a second edition. While a preliminary version may not be suitable for widespread dissemination, the exercise is still valuable as a situational analysis and internal agenda-setting tool.

STEP 3: Adapt the benchmarking tool

TIP FROM THE FIELD

SOUTH AFRICA

Expect a learning curve

Researching the report as a relatively new entrant to the NCD field, the SANCDA describes the beginning of the process as overwhelming and confusing. However, these initial obstacles were overcome as the names and acronyms became more familiar. In this sense the Status Report was a valuable way of building the secretariat's knowledge and confidence in working with NCD-related topics and terminology.

STEP 4: Collect the data

TIP FROM THE FIELD

INDIA

Look beyond the usual suspects

In addition to health ministry or WHO websites, the HIA recommends seeking data and information in other places, such as the reports of other UN agencies including UNICEF. Particular sources may also be necessary to consult due to the government structures of individual countries. In India, for example, the Ministry of Social Justice and Empowerment is the one responsible for alcohol control as opposed to the Ministry of Health and Family Welfare.

STEP 4: Collect the data

TIP FROM THE FIELD

SOUTH AFRICA

Consider cross-referencing data

Instead of relying purely on WHO documents, SANCDA found it more revealing to piece together various government data sources, including the open source parliamentary monitoring group information and provincial reports. Throughout the research process, the SA NCD Alliance also adopted an open, transparent and all inclusive approach, sharing the benchmarking results online for public consultation and validation.

STEP 4: Collect the data

TIP FROM THE FIELD

SOUTH AFRICA

Find the facts

SANCDA focused heavily on fact-finding in the process of writing their Status Report, maintaining that 'an accountability tool can't be just based on opinion'. The Healthy Caribbean Coalition adopted a methodology of triangulation (comparing the responses to specific items from the NCD focal point, to those from the CSO key informant, and the extent to which either are corroborated by documentation) in order to arrive at the facts and avoid relying on a single source. To some extent, engaging regional organisations such as CARICOM, CARPHA, and PAHO also made it possible to verify information originating from the public sector.

STEP 4: Collect the data

TIP FROM THE FIELD

CARIBBEAN

Look out for data gaps

Finding all the data required to complete the benchmarking tool can often be difficult, and at other times it is impossible simply because the information is not available. The HCC realised that identifying these data gaps was a very useful exercise itself, as it identified blind spots that had not previously been acknowledged.

STEP 4: Collect the data

TIP FROM THE FIELD

EAST AFRICA & CARIBBEAN

Creating regional reports

When compiling regional reports, the East Africa NCD Alliance points out that it is important to strike a balance in content and tone in order to accommodate for the differences in national contexts. For example, it may not be possible for civil society to openly pursue 'accountability'-related projects in some countries. To ensure the conversation is more productive, the report may have to be framed differently in these circumstances. Additionally, creating regional Civil Society Status report does not require repeating the research process in every country. For example, the HCC selected nine of the twenty CARICOM countries to investigate based on set criteria including socio-economic conditions and population size. As a result, nine national reports were created in addition to the regional one. The East African Status Report also focused on a subset of four countries.

STEP 6: Write the report

BRAZIL & INDIA

Status Report writing for alliance consolidation and priority setting

As a newly formed NCD Alliance, the HIA in India took the opportunity of producing a status report to bring members together and agree upon a collective agenda by deciding what to prioritise as a coalition.

STEP 6: Write the report

INDIA

Identify low-hanging fruit

While recognizing the importance of compiling a comprehensive advocacy roadmap with no important topics omitted, the HIA points out that when deciding how to act upon the findings, it may help to identify any overlaps with budding movements and campaigns nationally or regionally in order to piggyback on and contribute to existing efforts.

STEP 7: Disseminate the report

TIP FROM THE FIELD

CARIBBEAN

Plan launch timing strategically

The HCC launched its Status Report four months before the 'high-level meeting of the UN General Assembly to undertake the comprehensive review and assessment of the 2011 Political Declaration on NCDs', which took place in July of 2014. This meant they were able to use findings to motivate relevant policymakers and ministers to attend.

STEP 7: Disseminate the report

TIP FROM THE FIELD

INDIA

Adapt findings to different audiences for advocacy impact

The HIA recommends translating relevant portions of the report into policy briefs or other formats appropriate for the media, governments, or wider civil society.

STEP 7: Disseminate the report

TIP FROM THE FIELD

SOUTH AFRICA

Publishing for an academic audience

If your status report adopts an academic approach or was produced in partnership with a university, consider sharing on academic platforms such as ResearchGate. For example, SA NCDA's Status Report published in 2015 continues to be viewed each month by users of this forum.

STEP 7: Disseminate the report

TIP FROM THE FIELD

CARIBBEAN

Targeted dissemination

The Healthy Caribbean Coalition ensured that their Regional Status Report reached key individuals within regional organisations, CSOs, and government bodies by arranging one-to-one meetings to discuss the findings.

STEP 7: Disseminate the report

TIP FROM THE FIELD

CARIBBEAN

Spread awareness through the media

Many of the national and regional NCD Alliances who have published a Status Report reached out to the media to reach a broader audience. In the case of the Caribbean regional report, media contacts were identified in each individual country (an effort generally led by the regional coalition's civil society partners), so as to ensure national awareness. This process also helped national partners gain new contacts and exposure as a valuable partner in NCD prevention and control. The media was also heavily involved in covering the report launce on March 20th, 2014. A reporter from the Caribbean Media Corporation was flown in for the event, press packs were prepared and shared widely, and over twenty other local media outlets were contacted to set up press events leading up to the day. Report launch was also covered on television, radio, print, and online media.

STEP 7: Disseminate the report

TIP FROM THE FIELD

CARIBBEAN

Lasting influence

The Healthy Caribbean Coalition describes referring back to the 'Call to Action' from their Civil Society Status report even three years after its publication. This illustrates the value of such a project for internal agenda setting over and above external accountability and advocacy goals. They also describe how many still refer to the report, which constitutes the only easily accessible and approachable document that paints a clear snapshot of the status of NCDs in the region.

STEP 8: Shaping an advocacy trajectory

TIP FROM THE FIELD

BRAZIL

Taking a Leap

ACT+ in Brazil undertook the status report project as one of its first NCD-related activities after deciding to broaden its mandate beyond tobacco control. Consequently, the process offered useful opportunities to establish new and lasting relationships with NCD focal points in the country and to take priorities forward.

STEP 8: Shaping an advocacy trajectory

TIP FROM THE FIELD

SOUTH AFRICA

A process, not a product

Instead of viewing the Status Report as a one-off research project, SA NCDA stresses its longer term value as a key contributor to an organisation's advocacy agenda. In the words of Dr. Pinkney-Atkinson, 'it becomes part of what you do every day'. Indeed, SANCDA still presents the report to delegates at meetings and other events. The East Africa NCD Alliance also describes the report as a 'reference point in our advocacy'.

STEP 8: Shaping an advocacy trajectory

SOUTH AFRICA

Recognise the value of incremental change

Despite communicating findings to the NCDs Directorate in writing, the SANCDA never received an official response. Despite the lack of official acknowledgement, the Director General did reportedly received the publication, and instructed that civil society be more actively involved in activities. Subsequently, the SANCDA did begin feeling more engaged from December 2015 onwards.

STEP 8: Shaping an advocacy trajectory