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GUIDANCE NOTE ON THE INTEGRATION OF NONCOMMUNICABLE DISEASES INTO THE UNITED NATIONS DEVELOPMENT ASSISTANCE FRAMEWORK

MARCH 2015

CHECKLIST

This checklist summarizes key actions and outcomes for the four main steps in integrating NCDs into the UNDAF process.

UNDAF STEP	KEY ACTIONS	OUTCOMES
Build the roadmap	• Engage across government, across the UN system and with other stakeholders • Align the roadmap with key UN frameworks, strategies and action plans • Agree on a time-frame, lead agencies and roles and responsibilities for tasks assigned	High national awareness of NCDs and their risk factors; NCDs and their risk factors have national priority Governments, UN agencies and other stakeholders recognize the determinants of NCDs; UN agencies and government departments recognize the importance of policy alignment with regards to NCD risk factors Consultations reflect a whole-of-society approach All stakeholders at all levels in UNDAF development contribute to the roadmap
Conduct a country analysis	• Identify existing plans, data and case studies on the magnitude and impact of NCDs and their risk factors • Make the business case for investing in NCDs • Describe how NCDs intersect with UN Programming Principles • Assess and avoid conflict of interests	Priority NCDs and risk factors identified Current country responses to NCDs and/or risk factors identified along with stakeholders Priority populations identified Country capacities and gaps identified
Prepare the strategic plan and develop the results matrix	• Agree the comparative advantage for the UN system and individual agencies • Assess where global and regional momentum supports action • Include NCDs in the results matrix, with links to other programmes • Identify and organize Results Group(s)	NCDs are a cross-cutting theme in the UNCT/ Results Group(s) joint workplan Prevention and control of NCDs and/or their risk factors are reflected as outcomes, outputs and/or targets as: part of non-health sector development; specific to health sector development; and/or specific to an NCD or risk factor intervention Development assistance in non-health sectors is consistent with protection and promotion of population health and recognizes in particular the prevention and control of NCDs UNDAF and WHO CCS are coordinated regarding actions on NCDs and/or risk factors Measurable indicators are identified in the results matrix of Results Group(s)
Develop a monitoring and evaluation plan	• Use national data for monitoring • Use existing structures, mechanisms and tools where possible • Check assumptions and risks in the results matrix	Lessons learnt Key indicators, data sources, and collection mechanisms identified Strategic plan adjusted

GUIDING QUESTIONS FOR THE ANALYSIS*

1. MAGNITUDE OF NCDS

What is the epidemiology, public health and socioeconomic impact of NCDs in the country?

Does the country have surveillance in place to derive national trends in mortality and morbidity due to NCDs and their risk factors?

Is there risk factor-specific information on tobacco use, unhealthy diet, physical inactivity and/or harmful use of alcohol?

To what extent are data disaggregated by social "stratifiers" e.g. by age, sex and socio-demographic determinants, e.g. income, education, ethnicity, place of residence?

What data are available on broader socioeconomic determinants of health?

2. NCD POLICY AND PLANNING

To what extent has prevention and control of NCDs been given high priority at the country level?

Is there a national plan for the prevention and control of NCDs containing priorities, targets, strategies and indicators? Is it multisectoral? If so, what are the mechanisms to ensure coordination and coherence between health and non-health sector initiatives? What are the interventions? Are there local plans? If so, are they coherent with national ones?

Is there a national plan to reduce exposure to the main modifiable risk factors for NCDs, namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity? If so, what are the interventions?

Have NCDs and their risk factors been identified in current and future national development plans?

3. RESPONSE TO NCDS

What are the current or anticipated development interventions that address social, economic and environmental determinants of health e.g. poverty reduction, social protections, gender equity? Are there interventions within non-health sectors underway that have a demonstrable impact on NCDs and their risk factors?

Within the priority sectors to which UN assistance is being directed for development, have risks and benefits to population health been identified/addressed?

Is there a focus on the most cost-effective interventions identified in the WHO Global NCD Action Plan 2013-2020?

4. PARTNERSHIPS FOR RESPONDING TO NCDS

Are there partnership platforms, agreements or other entities or mechanisms in the country that could be further mobilized and strengthened to deliver a multisectoral approach relevant to dealing with NCDs or their risk factors?

Are there NGOs, civil society organizations or associations involved with NCDs, risk factors and determinants?

** Pages 18-19 provides resources on sources of data for the questions in the table.*

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CONTENTS

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ACRONYMS

CCS	WHO Country Cooperation Strategy
CVD	Cardiovascular disease
ECOSOC	United Nations Economic and Social Council
DaO	Delivering as One
LMIC	Low- and middle-income country
NCD	Noncommunicable disease
SDG	Sustainable Development Goal
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
WHO	World Health Organization
WHO FCTC	World Health Organization Framework Convention on Tobacco Control

1. EXECUTIVE SUMMARY

Noncommunicable diseases (NCDs) – cardiovascular disease (CVD), cancers, chronic respiratory disease and diabetes – make the largest contribution to mortality in the majority of developing countries and require concerted, coordinated action. These diseases are largely preventable by means of effective interventions that tackle shared risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. NCDs have significant negative impacts on human and social development. Premature deaths from NCDs reduce productivity, curtail economic growth and trap populations in poverty. The underlying determinants of these diseases and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required to prevent and control NCDs.

In view of the impact of NCDs on socio-economic development, the complex responses required to tackle NCDs and the clear need for a whole-of-government and whole-of-society response, Heads of State and Government called for urgent action in the 2011 Political Declaration of the High-level Meeting of the UN General Assembly on the Prevention and Control of NCDs. The Political Declaration called upon the World Health Organization (WHO), as the lead UN specialized agency for health, and all other relevant UN system agencies, funds and programmes, the international financial institutions, development banks and other key international organizations, to work together in a coordinated manner to support national efforts to prevent and control NCDs and to mitigate their impact. In 2013, therefore, a United Nations Inter-Agency Task Force on the Prevention and Control of NCDs was established. The importance of NCDs in the development agenda is likely only to increase with the anticipated adoption of the post-2015 Sustainable Development Goals (SDGs).

In almost all countries, the magnitude of NCDs, their socio-economic and development impacts and, in particular, their multisectoral nature, gives the UN system a significant comparative advantage in supporting governments in preventing and controlling NCDs. To this effect, in 2012 a joint letter from the Administrator of the United Nations Development Programme (UNDP) and the Director-General of WHO proposed that UN Country Teams (UNCTs) work with government counterparts to integrate NCDs into United Nations Development Assistance Framework (UNDAF) design processes and implementation. A second joint letter in 2014 reiterated the importance of mainstreaming NCDs into UNDAF roll-out processes and encouraged UNCTs to scale up their capacities to support governments in implementing these priority actions.

This Guidance Note is intended to assist those who are developing UNDAFs to strengthen the integration of NCDs into the UNDAF process, within the context of the United Nations Development Group's (UNDG) guidance for developing UNDAFs. The Note highlights the importance of ensuring that linkages are made between the prevention and control of NCDs and broader development issues included in UNDAFs, such as universal health coverage, social protection, governance and wider social determinants of health. It highlights linkages with other sectors such as finance, trade, urban development and education. The guidance highlights the importance of engaging with all parts of government and all parts of society when integrating NCDs into the UNDAF process.

Outcomes and outputs for NCDs in the UNDAF should focus on a menu of policy options and cost- effective interventions and in particular the "very cost-effective interventions" that are included in the WHO Global NCD Action Plan 2013-2020. The results matrix should be aligned with existing and emerging national policies and plans, including the national multisectoral NCD action plan and national NCD targets. It is important that, wherever possible, monitoring and evaluation should use data and information collected through national surveys and surveillance systems.

2. INTRODUCTION AND CONTEXT

Purpose of this Guidance Note

The audience for this Guidance Note are governments and UN Country Teams. The purpose of this publication is to provide guidance on how to integrate NCDs into the UNDAF.[1] The guidance is in line with the "*WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020*" and other relevant global, regional and national mandates and frameworks.

The Guidance Note is structured along the four main steps of UNDAF development: (i) building the roadmap; (ii) conducting a country analysis; (iii) strategic planning and (iv) monitoring and evaluation. It recognizes the importance of "Delivering as One" to make the UN system more coherent, effective and efficient, and the Guidance Note encourages countries to work with the UN system to capitalize on the strengths and comparative advantages of the different members of the UN family.[2]

The Guidance Note should be read in conjunction with the comprehensive set of programming tools and procedures for developing UNDAFs that is available on the United Nations Development Group website.[3] In addition, guidance is available on integrating implementation of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) into national development planning.[4]

What are NCDs and their risk factors?

Noncommunicable diseases (NCDs)—mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes—are the world's biggest killers. More than 36 million people die annually from NCDs (63% of global deaths), including more than 14 million people who die prematurely from NCDs (between the ages of 30 and 70). Low- and middle-income countries (LMICs) already bear 82% of the burden of these premature deaths, resulting in projected cumulative economic losses of US$7 trillion for LMICs over the next 15 years and millions of people trapped in poverty.

Most premature deaths from NCDs are largely preventable by influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

In addition, enabling health systems to respond more effectively and equitably to the health care needs of people with NCDs can reduce morbidity, disability, and death from NCDs, and contribute to better overall health outcomes.

1. Throughout this Guidance Note the term UNDAF is used but the same principles apply to countries developing a One UN Plan in Delivering as One countries.

2. Delivering as One: Making the UN system more coherent, effective and efficient.

3. United Nations Development Group. UNDAF Guidance and Support Package. "How to prepare an UNDAF (Part I)" and "How to Prepare an UNDAF (Part II)" – technical guidance to UN Country Teams and United Nations Development Group, Programming Reference Guide: Common Country Programming Processes.

4. Development Planning and Tobacco Control Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments. UNDP and WHO. 2014.

Rationale for integrating NCDs into UNDAFs

The UNDAF is the strategic programme framework that describes the collective response of the UN system to national development priorities. NCDs matter for sustainable and equitable development.

As the international community has intensified efforts to combat the global burden of communicable diseases such as AIDS, tuberculosis and malaria, a growing burden of NCDs has emerged relatively unnoticed in the developing world. Today, the burden of NCDs in developing countries exceeds that in high-income countries. While popular belief holds that such diseases afflict mostly high-income populations, the vast majority of premature deaths from NCDs (82% or 12 million) between the ages of 30 to 70 occur in developing countries. The probability of dying from any of the major NCDs between the ages of 30 and 70 ranges from 10% in developed countries to 60% in developing countries. It is estimated that up to two-thirds of premature deaths from NCDs are linked to exposure to risk factors and up to half of all such deaths are linked to weak health systems that do not respond effectively and equitably to the health care needs of people with NCDs.

The social, economic and physical environments in developing countries afford their populations much lower levels of protection from the risks and consequences of NCDs than in developed countries. Poverty exposes people to behavioural risk factors for NCDs and, in turn, the resulting NCDs may become an important driver to the downward spiral that leads families towards poverty (see Figure 1, next page). In developed countries, the population often benefits from Governments' multisectoral national policies and plans to reduce risk factors and to enable health systems to respond.

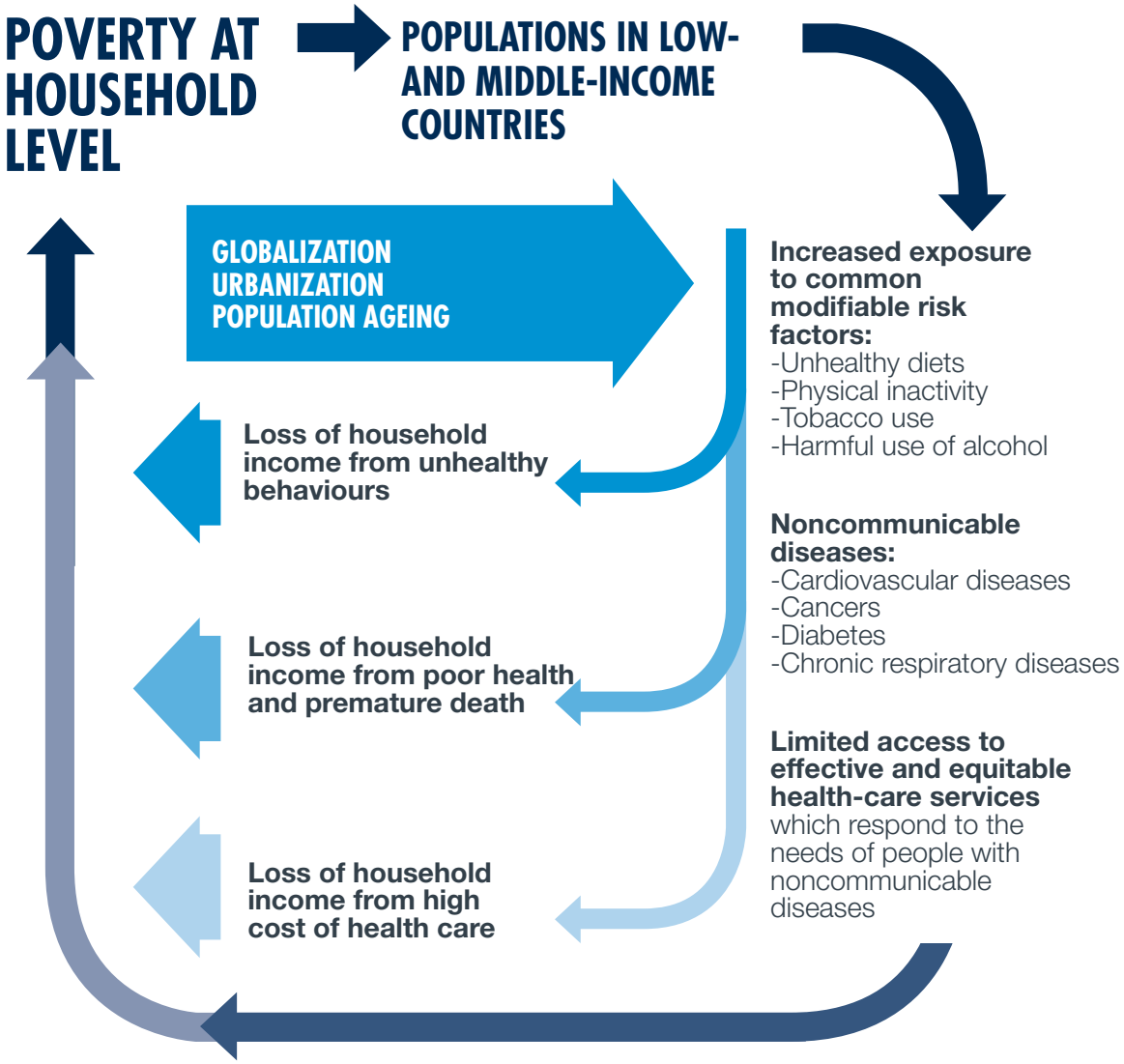
NCDs have significant negative impacts on human and social development. Premature deaths from NCDs reduce productivity, curtail economic growth and trap populations in poverty. A report from the African Union in April 2013 underscored the fact that the exorbitant costs of NCDs are forcing 100 million people in Africa into poverty annually, stifling development. The differential prevalence of NCDs within and across populations in developing countries constitutes one of the major challenges for development in the 21st century, which undermines social and economic development throughout the world and threatens the achievement of internationally-agreed development goals.

In developing countries, treatment for cardiovascular disease, cancer, diabetes or chronic lung disease can quickly drain household resources, driving families into impoverishment. NCDs exacerbate social inequity because most payments for health care in developing countries are private and out-of-pocket; such costs weigh more heavily on those least able to afford them, increasing their risk of impoverishment. The chronic nature of NCDs, and the projected increase in prevalence, means that the economic impact may grow cumulatively over many years and have dramatic economic impacts.

The rise of NCDs among younger populations in developing countries now jeopardizes the "demographic dividend" – the economic benefits expected when a relatively large proportion of the population is of working age.[5] Macroeconomic simulations predict that over the period 2011-2025, the cumulative global economic losses due to the four main NCDs will surpass US$ 51 trillion.[6] Relative to the size of their economies, developing countries will be disproportionately affected. Developing countries' projected losses amount to an average of nearly US$ 500 billion per year, equivalent to approximately 4% of their gross domestic product in 2010.[7]

For the reasons outlined above, NCDs are now recognized as a development challenge for all developing countries, and are thus an essential component for all UNDAFs.[8]

Figure 1. Poverty contributes to NCDs and NCDs contribute to poverty.[9]



5. World Bank Human Development Network, 'The Growing Danger of Non-communicable Diseases – Acting Now to Reverse Course. Conference Edition, September 2011' World Bank, Washington DC.

6. Losses are estimated by linking the value of economic output to quantities of labour and capital inputs as well as to technology. Labour and capital inputs are adjusted according to population health i.e. labour is diminished by disability and death caused by NCDs. Capital is reduced because costs of screening, treatment and care claim resources that would otherwise be available for public and private investment.

7. World Economic Forum and Harvard School of Public Health, 'From Burden to "Best Buys": Reducing the economic impact of NCDs in low- and middle-income countries, WEF and WHO, Geneva, 2011.

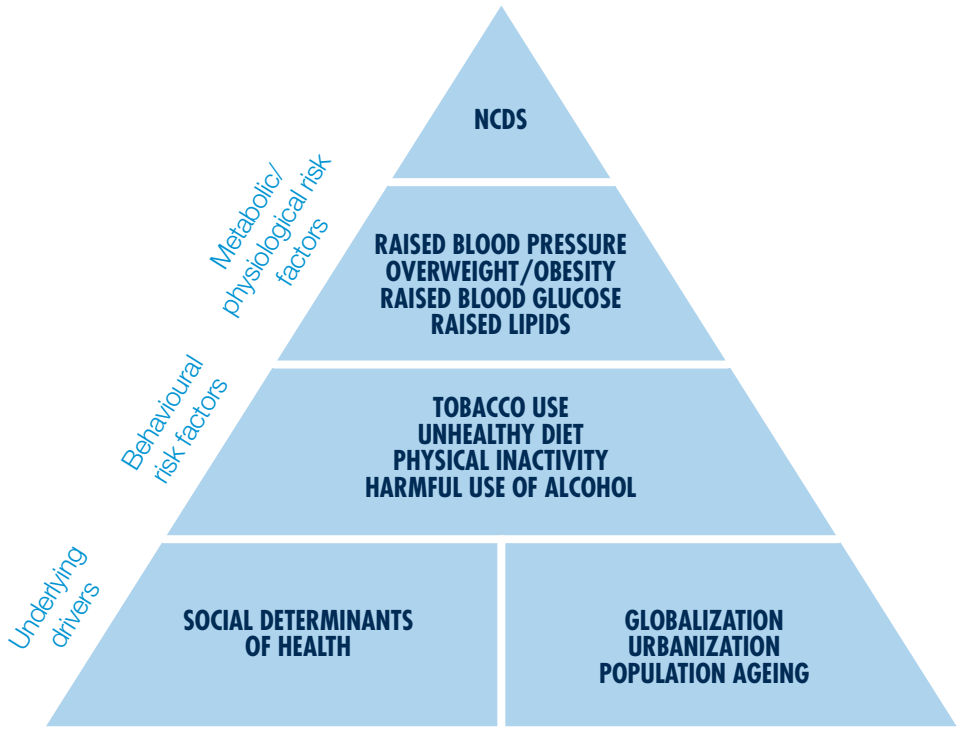
8. Joint letters from the Administrator of UNDP and the Director-General of WHO to UNCTs, 2012 and 2014.

9. Adapted from the 2010 WHO Global Status Report on NCDs, page 35.

A whole-of-government and whole-of-society approach

Up to two thirds of premature deaths from the major NCDs are linked to four shared modifiable risk factors – tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. These risk factors result in a series of metabolic and physiological changes that eventually lead to NCDs. Broader social, economic and environmental determinants of health and inequities associated with globalization and urbanization, alongside population ageing, are the underlying drivers of the behavioural risk factors, and thus the NCD epidemic.

Figure 2. Causal links between underlying drivers for NCDs, behavioural risk factors, metabolic/ physiological risk factors and NCDs.



While the risk factors imply personal behaviours, national public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production have a major bearing on risk factors for NCDs at the population level. Throughout the life course, inequities in access to protection, exposure to risk, and access to care are the cause of major inequalities in the occurrence and outcome of NCDs.[10]

While these social and economic determinants and their pathways are multifaceted and complex, they are also the keys to how national policies in developing countries with UN assistance can narrow the disparities in health outcomes. The challenge with NCDs is to make the broader social and economic policies and programmes, whose core business is not health, become NCD-sensitive.

10. Commission on Social Determinants of Health. "Closing the gap in a generation: health equity through action on the social determinants of health. 2008". Final Report of the Commission on Social Determinants of Health. WHO; Marmot M, Friel S, Bell R et al, "Closing the gap in a generation: health equity through action on the social determinants of health", Lancet 2008; 372:1661-69; World Health Organization, "Equity, social determinants and public health programmes", WHO, Geneva, 2010; "Hidden cities: Unmasking and overcoming health inequities in urban settings, 2010. WHO and UN Habitat". "Addressing social, economic and environmental determinants of health and the health divide in the context of sustainable human development". UNDP, 2014.

The Commission on Social Determinants of Health frames its recommended actions to those that improve daily living conditions and tackle the inequitable distribution of power, money and resources.[11] The UNDP Discussion Paper on Addressing the Social Determinants of NCDs describes action from non-health sectors for tackling the causes of NCDs.[12]

Effective NCD prevention and control requires political leadership, coordinated multistakeholder engagement and multisectoral action, not only in government but also across the UN and other development partners. Health-in-all-policies and a whole-of-government approach for NCDs extends to sectors such as agriculture, communication, education, employment, energy, environment, finance, food, foreign affairs, housing, justice legislature, security, social welfare, social and economic development, sports, tax and revenue, trade and industry, transport, urban planning and youth affairs. Relevant stakeholders and partners include civil society and private sector entities.

NCDs: a development priority for Member States and the United Nations

In summary, the objectives of the **WHO Global Strategy for the Prevention and Control of NCDs,** which was endorsed by the World Health Assembly in 2000, are:[13]

- To map the emerging epidemics of NCDs and to analyse the social, economic, behavioural and political determinants of NCDs with particular reference to poor and disadvantaged populations;
- To reduce the level of exposure of individuals and populations to the common risk factors for NCDs; and
- To strengthen health care for people with NCDs.

In the **2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs**, Heads of State and Government expressed a commitment to a world free of the avoidable burden of NCDs, an issue that the Millennium Development Goals (MDGs) did not address.[14] Heads of State and Government committed themselves to a whole-of-government and whole-of-society approach to tackle NCDs and to integrate NCD policies and programmes into health-planning processes and the national development agenda of each Member State.

In 2013, the World Health Assembly endorsed the **WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020**.[15] This action plan provides Member States, international partners and WHO with a road map and menu of policy options which, when implemented collectively between 2013 and 2020, will contribute to progress on nine voluntary global NCD targets to be attained by 2025, including a 25% relative reduction in premature mortality from

11. World Health Organization, 'Closing the gap: policy into practice on social determinants of health, discussion paper' [to inform proceedings at the World Conference on Social Determinants of Health, Brazil, 19-21 October 2011].

12. United Nations Development Programme, 'Discussion Paper: Addressing the Social Determinants of NCDs', UNDP, New York, 2013.

13. Adapted from A53/14. Global strategy for the prevention and control of NCDs. WHO 2000.

14. 66/2. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs. Resolution adopted by the General Assembly. United Nations. 2012.

15. Global action plan for the prevention and control of NCDs 2013-2020. WHO 2013.

NCDs by 2025 (see Annex 1).The WHO Global NCD Action Plan 2013-2020 describes the need for the UN system to work together with governments to reduce NCDs, including by integrating NCDs into the UNDAF.

In 2013, the Economic and Social Council (ECOSOC) established the **United Nations Inter-Agency Task Force on the Prevention and Control of NCDs**[16] (UN IATF) and in 2014 ECOSOC endorsed endorsed its terms of reference including a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations.[17] The purpose of the Task Force is to coordinate the activities of the relevant United Nations funds, programmes and specialized agencies and other intergovernmental organizations to support the realization of the commitments made in the 2011 Political Declaration, in particular through the implementation of the WHO Global NCD Action Plan, 2013-2020.[18]

Also in 2014, Member States undertook a **comprehensive review and assessment of the progress achieved on NCDs since the 2011 Political Declaration**. The Outcome Document described the need to address NCDs as a matter of priority in national development plans and policies, including the design process and implementation of the UNDAF.[19] The Outcome Document also committed to giving due consideration to addressing NCDs in the elaboration of the post-2015 development agenda.

The importance of UN country teams (UNCTs) in responding to NCDs has been highlighted in **two joint letters UNCTs from the Administrator of the United Nations Development Programme (UNDP) and the Director-General of WHO to UNCTS**. The first letter, in 2012, proposed UNCTs integrate NCDs into UNDAF design processes and implementation.[20] A second joint letter, in 2014, reiterated the importance of mainstreaming NCDs into UNDAF roll-out processes and encouraged UNCTs to scale up their capacities to support governments in implementing these priority actions.[21] These letters are in Annex 2.

The key NCD international milestones since the launch of the WHO Global Strategy for the Prevention and Control of NCDs in 2000 are shown in Annex 3.

3. NCDS IN UNDAFS – CURRENT STATUS

In 2014, WHO reviewed 62 UNDAFs rolled-out in 2012 and 2013 (from the 106 available on the UNDG website - http://www.undg.org/?P=234). UNDAFs were reviewed in terms of whether NCDs were referenced as a priority (in the Executive Summary, Introduction or Support/Focus Area under UNDAF results), as an outcome (in the UNDAF Outcomes section), or as part of the results matrix (in the Results Matrix).

16. *E/RES/2013/12. United Nations Inter-Agency Task Force on the Prevention and Control of NCDs. Resolution adopted by the Economic and Social Council. ECOSOC 2013.*

17. *E/RES/2014/10. United Nations Inter-Agency Task Force on the Prevention and Control of NCDs. Resolution adopted by the Economic and Social Council. ECOSOC 2014.*

18. *Further details on the Task Force are available at: http://www.who.int/nmh/ncd-task-force/en/.*

19. *68/300. Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of NCDs. Resolution adopted by the General Assembly on 10 July 2014. United Nations 2014. It prioritized the implementation of a set of agreed commitments under governance, prevention and reduction of risk factors, health care and surveillance.*

20. *Joint Letter from Director-General, WHO and Administrator, UNDP to UNCTs to UNCTs. 2012.*

21. *Joint Letter from Director-General, WHO and Administrator, UNDP to UNCTs to UNCTs. 2014.*

Table 1. The results of the analysis are shown in the table below. The results demonstrate that NCDs are not currently well represented in UNDAFs.

NCDS REFERRED IN THE UNDAF AS:	NUMBER OF COUNTRIES (N=62)
A priority	*16 (26%)*
An outcome	*4 (6%)*
Part of the results matrix	*15 (24%)*
A priority and outcome	***1 (2%)***
A priority and as part of the results matrix	***3 (5%)***
An outcome and as part of the of the results matrix	***2 (3%)***
A priority, an outcome and as part of the results matrix	***0 (0%)***

The analysis shows that, as of 2013, NCDs were insufficiently integrated into UNDAFs.

WHO has also reviewed its Country Cooperation Strategies (CCS) to determine the extent to which NCDs have been addressed. There is a general absence of situation analyses with data on NCDs and risk factors disaggregated by sex, age, locality, ethnicity, education and income.

In terms of causal analysis and planning, NCDs were often inconsistent between the CCS and UNDAF for the same country. As of 2014, only four countries had integrated NCDs into both the CCS and UNDAF.

The above reviews suggest that NCDs are most likely to be integrated into the UNDAF process when there is:

- High national awareness of NCDs and their risk factors, along with robust data;
- National prioritization of NCDs in the development planning process;
- National NCDs policies and plans in place;
- Ongoing national implementation of the WHO FCTC;
- Good representation of NCDs in the CCS;
- Strong WHO presence throughout the planning stages of the UNDAF; and
- Application of multisectoral and human rights-based approaches for NCDs highlighted in the WHO CCS and other sectoral plans.

The WHO NCD Country Capacity Survey[22] provides useful information on capacity at country level for taking forward NCD prevention and control. This provides useful additional information for the UNDAF analysis, identifies specific outcomes, outputs and indicators that refer to process.

22. The NCD country capacity survey includes an assessment on whether there is/are: (i) capacity for population level surveillance dedicated to NCDs and risk factors; (ii) a unit/branch/department in the ministry of health or equivalent that has explicit responsibility for NCDs; (iii) evidence of government ministries other than health addressing NCDs and/or risk factors; (iv) funding directed to specific NCD and risk factor initiatives; (v) national policies, strategies or action plans that integrate a number of NCDs and risk factors; (vi) formal multisectoral mechanisms to coordinate NCD-sensitive policies; and (vii) partnerships or collaborations for implementing the policies across sectors. Further information can be found at http://www.who.int/chp/ncd_capacity/en/.

4. INTEGRATING NCDS INTO THE UNDAF

A comprehensive set of programming tools and procedures for developing UNDAFs is available on the United Nations Development Group website.[23,24] The four main UNDAF development steps are:

- Building the roadmap;
- Conducting a country analysis;
- Preparing the strategic plan and developing the results matrix;
- Developing a monitoring and evaluation plan.

Forty-three countries have formally adopted the Delivering as One (DaO) modalities in an effort to ensure interagency coherence and to strengthen alignment with national priorities. While UN priorities are guided in DaO countries by the more comprehensive One Programmes, UNDAF creation remains as a core element of planning frameworks. The guidance offered here applies to both Delivering as One and other countries. More on the UNDAF's role in One Programmes can be found in the DaO Standard Operating Procedures.[25]

A set of WHO tools to prevent and control NCDs is available at http://www.who.int/nmh/ncd-tools/en/.[26] Additional resources published by UNDP on addressing the social determinants of NCDs and health more broadly are also available.[27]

The roadmap

Engage across government, across the UN system and with other stakeholders

The starting point for integrating NCDs into the UNDAF is a roadmap which in particular orients non-health actors across government, the UN system andothers at national and local levels, to their role in mitigating the impact of NCDs as a development issue. The roadmap illustrates how preventing and controlling NCDs can have a positive effect on development outcomes in sectors other than health.

The roadmap maps current stakeholder activities, the process for UNDAF development and the expected deliverables. For all actors to take ownership of their roles in UNDAF development, consultations must be inclusive. It is essential that, when it comes to NCDs, stakeholders engage those working outside the health sector, as well as across the UN.

A division of tasks and responsibilities for the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs was endorsed by the UN Economic and Social Council (ECOSOC) in 2014 (see Annex 4).[28] It can be used to support discussion around the contributions that UN agencies can make toward implementing the WHO Global NCD Action Plan 2013-2020 at country level.

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23. United Nations Development Group. Common country programming processes. Note: Additional guidance - Delivering as One.

24. Both UNDP and WHO have professional development initiatives that provide resources for orientation on NCDs and UNDAFs. The UNDP webinar series on NCDs and development is a key information resource for orientation (UNDP Orientation Webinar Series on NCDs).WHO is currently rolling out a series of regional training programmes for WHO staff at regional and country levels, complemented by the development of an electronic programme for staff as well as NCD programme managers in national ministries of health, important for UNDAF development. WHO and UNDP websites provides links to selected tools, guidelines and frameworks relevant to NCDs, their risk factors and social determinants.

25. Standard Operating Procedures for countries adopting the "Delivering as One" Approach 2014. UNDG.

26. These are available for each of the 9 voluntary global NCD targets and 25 indicators, the 6 objectives of the WHO Global NCD Action Plan 2013-2020, the 4 major NCDs and their risk factors.

27. Examples include: (i) Issue Brief: Tobacco Control for Health and Development; (ii) Discussion paper addressing the social determinants of health; (iii) Trade, Trade Agreements and Noncommunicable Diseases in the Pacific Islands; (iv) Development Planning and Tobacco Control: Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments; and (v) Addressing Social, Economic and Environmental Determinants of Health and the Health Divide in the Context of Sustainable Human Development.

28. http://www.who.int/nmh/events/2014/ecosoc-20140401.pdf?ua=1.

Table 2. Sectors and UN system action to reduce NCD risk factors.[29]

	TOBACCO	HARMFUL USE OF ALCOHOL	PHYSICAL INACTIVITY	UNHEALTHY DIET
Desired outcomes	*Reduced tobacco use.* *Reduced exposure to second-hand smoke.* *Reduced reliance on production of tobacco and tobacco products.*	*Reduced harmful use of alcohol.*	*Increased physical activity.*	*Reduced intake of salt, saturated fat and sugars.* *Substitution of healthy foods for energy-dense nutrient-poor ones.*
Multisectoral action	*Full implementation of the WHO FCTC, including:* *Reducing affordability of tobacco products by increasing tobacco excise taxes;* *Creating by law completely smoke-free environments in all indoor workplaces, public places and public transport (including smoke-free cities);* *Warning people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns;* *Banning all forms of tobacco advertising, promotion and sponsorship.*	*Full implementation of the WHO global strategy to reduce the harmful use of alcohol, including:* *Regulating commercial and public availability of alcohol;* *Restricting or banning alcohol advertising and promotions;* *Using pricing policies such as excise tax increases on alcoholic beverages.*	*Urban planning/ re-engineering for active transport and walkable cities;* *School-based programmes to support physical activity;* *Incentives for workplace healthy lifestyle programmes;* *Increased availability of safe outdoor environments and recreational spaces; Mass media campaigns; Economic/fiscal interventions to promote physical activity (taxes on motorized transport, subsidies on bicycles, sports equipment).*	*Full implementation of the WHO global strategy on diet, physical activity and health, including:* *Reduced amounts of salt, saturated fat and sugars in processed foods;* *Limit saturated fatty acids and industrially produced trans-fats eliminated from foods;* *Restricted advertising and marketing of non-alcoholic beverages and unhealthy food to children;* *Increased availability and affordability of fruit and vegetables to promote intake;* *Offer of healthy food in schools and other public institutions and through social support programmes;* *Economic/fiscal interventions to drive healthy food consumption (taxes, subsidies);* *Food security.*
Potential sectors/ ministries involved	*Agriculture, customs/ revenue, economy, education, environment, finance, health, foreign affairs, labour, state media, statistics, trade, urban planning.*	*Agriculture, education, finance, industry, justice, trade, urban planning.*	*Education, finance, labour, sport, transport, urban planning.*	*Agriculture, education, energy, environment, industry, social welfare, trade, transport, urban planning.*
Possible UN agencies	*IAEA, ITU, UNDP, UNFPA, UNICEF, WHO, World Bank, WTO.*	*WTO, UNDP, UNFPA, UNICEF, WHO, World Bank, ITU.*	*UNDP, UNFPA, UNICEF, ILO, UN-HABITAT, ITU, UNECE for European countries, WHO, World Bank.*	*FAO, ITU, UNDP, UNFPA UNICEF, UNSCN, UN-WOMEN, WFP, WHO, WTO.*

29. Adapted from Appendix 4 and Appendix 5 of the WHO Global NCD Action Plan 2013-2020.

It is important to engage a broad range of civil society networks, professional groups, philanthropic foundations and trade associations when developing the NCD roadmap.

Align the roadmap with key UN frameworks, strategies and action plans

It is important that all stakeholders with an interest in NCDs are aware of the key mandates, frameworks and action plans described in Annex 3. These frameworks are all action-orientated and have important time-frames. They should be reviewed alongside national and regional frameworks to ensure alignment for developing the roadmap.

Agree on a time-frame, lead agencies and roles and responsibilities for tasks assigned

The UNCT and the government coordinating body agree that the road map with respect to NCDs is aligned to the national development planning process.

A number of UN agencies have NCD focal points in regional offices and at headquarters. They provide support for including NCDs in UNDAF discussions. WHO and UNDP specifically have NCD teams in regional and headquarter offices. With regards to NCDs, the UNCT may wish to consult on the roadmap with the UN Inter-Agency Task Force on NCDs. For NCDs to be included in the UNDAF process, it is important that the roadmap for NCDs is part of the UNDAF-wide roadmap. Those who are advocating for NCDs to be included in the UNDAF need to ensure they are fully engaged throughout the planning stages of the UNDAF.

Country analysis

Identify existing plans, data and case studies on the magnitude and impact of NCDs and their risk factors

National and UN system agency NCD policies, strategies and action plans provide a useful starting point for the analysis, with the greatest benefit coming from those that are multisectoral. Other partners besides government may have readily available information for the analysis, in particular WHO. WHO country profiles for NCDs are often available and these are an additional source of information. WHO Step-wise approach to surveillance (WHO STEPS) and other survey data are valuable sources of information on NCDs.[30] There may be additional valuable data for the analysis from academic institutions.

Case studies can also be useful and provide country-specific insights. These may assist in identifying appropriate entry points for action. The reliability and comprehensiveness of such analyses are enhanced by including the key sectors and partners that impact on NCDs.

A useful exercise is to develop an inventory of all reports available. With NCD reports, it is especially important to be aware of potential conflicts of interest because of the links between NCDs, their risk factors and the private sector. It is critical, therefore, to assess authorship and sources of funding for the report before including them in the analysis. Work funded by the tobacco industry, for example, should not be used.

The table below summarizes elements for analysis with examples of questions relevant for NCDs. The answers to these questions will enable an NCD situation analysis to be made.

30. *STEPS Country Reports, Global Health Observatory and Urban HEART.*

Table 3.

GUIDING QUESTIONS FOR THE ANALYSIS	SOURCES OF DATA
1. Magnitude of NCDs *What is the epidemiology, public health and socioeconomic impact of NCDs in the country?* *Does the country have surveillance in place to derive national trends in mortality and morbidity due to NCDs and their risk factors?* *Is there risk factor-specific information on tobacco use, unhealthy diet, physical inactivity and/or harmful use of alcohol?* *To what extent are data disaggregated by social "stratifiers," e.g. by age, sex and socio-demographic determinants, e.g. income, education, ethnicity, place of residence?* *What data are available on broader socio-economic determinants?*	*National epidemiological and public health surveys and other studies, including Demographic and Health Surveys, WHO Global Health Observatory and Urban HEART.*[31] *Surveillance data from WHO STEPS (STEP-wise approach to surveillance).*[32] *WHO FCTC country reports.* *WHO report on the Global Tobacco Epidemic.*[33] *WHO Global Information System on Alcohol and Health.* *National household budget surveys, food balance sheets (e.g. from the FAO statistical database, FAOSTAT).* *Other sources of information on risk factors.*
2. NCD policy and planning *To what extent has prevention and control of NCDs been given high priority at the country level?* *Is there a national plan for the prevention and control of NCDs containing priorities, targets, strategies and indicators? Is it multisectoral? If so, what are the mechanisms to ensure coordination and coherence between health and non-health sector initiatives? What are the interventions? Are there local plans? And if so, are they coherent with national ones?* *Is there a national plan to reduce exposure to the main modifiable risk factors for NCDs, namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity? If so, what are the interventions?* *Have NCDs and their risk factors been identified in current and future national development plans?*	*National development plans.* *National Nutrition Plans and the Nutrition Landscape Analysis.* *NCD-specific policies, strategies and plans. Previous UNDAFs.* *Current WHO Country Cooperation Strategy.* *WHO Country Capacity Survey on NCDs.*[34] *WHO report on the Global Tobacco Epidemic.*

31. http://www.dhsprogram.com and http://www.dhsprogram.com/data/available-datasets.cfm.

32. WHO 'STEPwise approach to surveillance (STEPS)'.

33. http://www.who.int/tobacco/global_report/en/.

34. The capacity survey collects information on: public health infrastructure; status of NCD relevant policies, strategies and action plans including financing; health information systems, surveillance and surveys on NCDs; health system capacity for NCD early detection, treatment and care within the primary healthcare system; and health promotion, partnerships and collaborations. If the country has not responded to the survey, the questions are useful for a thorough assessment of capacities, processes and responses for the country analysis.

GUIDING QUESTIONS FOR THE ANALYSIS	SOURCES OF DATA
3. Response to NCDs *What are the current or anticipated development interventions that address social, economic and environmental determinants of health e.g. poverty reduction, social protections, gender equity? Are there interventions within non-health sectors underway that have a demonstrable impact on NCDs and their risk factors?* *Within the priority sectors to which UN assistance is being directed for development, have risks and benefits to population health been identified/addressed?* *Is there a focus on the most cost-effective interventions identified in the WHO Global NCD Action Plan 2013-2020?*	*Case studies collected by WHO, UNDP and other UN system agencies.*
4. Partnerships for responding to NCDs *Are there partnership platforms, agreements or other entities or mechanisms in the country that could be further mobilized and strengthened to deliver a multisectoral approach relevant to dealing with NCDs or their risk factors?* *Are there NGOs, civil society organizations or associations involved with NCDs, risk factors and determinants?*	

Make the business case for investing in NCDs

It is essential to make the economic and business case for investing in developing and implementing policies and programmes for the prevention and control of NCDs so that government departments including ministries of finance understand that NCDs are a drain on the economy. An economic or business case based on national data on determinants, risk factors and NCDs can provide additional information on where investments will bring the greatest returns in terms of reduced burden of disease, and thus reduced productivity losses down the line.

Linkages need to be made between NCDs and broader development issues, including poverty reduction, that are being analysed in the UNDAF. These include universal health coverage, nutrition and social protection, but also governance, trade, economic and wider development objectives. Multisectoral policy options to reduce NCDs in low- and middle-income countries are shown in Annex 5.

Interventions to prevent NCDs may benefit more than one sector. An example is revenue from increased tobacco and alcohol taxation, which benefits both public health and domestic revenue. In turn, governments may wish to earmark such taxation for the prevention and control of NCDs or the health sector more broadly. Identifying the impact of non-health sector policies on NCDs is a useful exercise. In the agricultural sector, policies can impact positively and negatively on encouraging healthy nutrition and wider food systems, e.g. a diet high in fruit and vegetable intake and low in animal protein and fat. Trade is another example where policies impact on NCDs and the table below illustrates the potential benefit and harm to NCDs associated with a range of trade provisions (Table 4).

Table 4. Trade and NCDs: potential benefits and harm.

PROVISION	POTENTIAL BENEFITS	POTENTIAL HARM
Trade in goods – reducing tariffs (import taxes) and other barriers to trade such as import quotas.	*Cheaper imports of a range of goods including fuel, food, farming equipment etc., which can lead to higher living standards and better health e.g. improved dietary diversity.* *Improved access to export markets can lead to increased economic activity with flow on effects e.g. local investment, employment and better living standards.*	*Reduced government revenues from tariffs can mean less money for health care and social determinants, e.g. education.* *Reduced import taxes can lower the cost of unhealthy products, e.g. fatty processed meats, soft drinks, alcohol, tobacco.* *Commitments in trade agreements can make government policies and laws to control the supply and price of unhealthy food difficult.*
Trade in services – opening up markets to foreign investment.	*More investment in new facilities and technologies.*	*Agreements can restrict government policy space to regulate health care quality, access and efficiencies.* *Resources may be diverted to private health care, thereby increasing inequities to access.*
Protection of intellectual property in particular WTO's TRIPS.	*Trade in goods – reducing tariffs (import taxes) and other barriers to trade such as import quotas.*	*May increase the cost of medications, restrict the use of generic drugs.*
Protections for foreign investment.	*Contributions to economic development, improved living standards.*	*Can constrain public health legislation such as tobacco and alcohol control.*

Synergies between sectors and possible entry points to reducing the harmful use of alcohol and to dietary salt reduction are presented in Annexes 6 and 7, respectively.

Describe how NCDs intersect with UN programming principles

Five UN programming principles guide the formulation of the UNDAF. They are: (i) a human-rights based approach; (ii) gender equality; (iii) environmental sustainability; (iv) capacity development and (v) results-based management. NCDs intersect with each of these principles and, in turn, addressing NCDs strengthens each of them. These principles should be identified in the roadmap. Examples of intersections between NCDs and the programming principles are shown in Annex 8.

Assess and avoid conflict of interests

Today's health and development landscape has become more complex in many aspects, including the increase in the number of players in health governance. Non-State actors play a major role in all aspects of health. Governments and UN Country Teams can only fulfil their

role in supporting national NCD efforts if they engage proactively with non-State actors in the creation and protection of public goods. The aim of such proactive and constructive engagement is to foster the use of non-State actors' resources (including knowledge, expertise, commodities, personnel and finances) in favour of national efforts to promote public health and to encourage non-State actors to improve their own activities to protect and promote health.

Such engagement by governments and UN Country Teams with non-State actors at country levels, in mutual respect and trust, also calls for a number of measures of caution. In order to be able to strengthen its engagement with non-State actors for the benefit of health and in the interest of all actors, governments and UN Country Teams simultaneously need to strengthen their management of the associated potential risks. The risks include influence by a non-State actor to obtain a competitive advantage or undue endorsement, limiting the benefits to public health, whitewashing a non-State actor's image through its association with public health objectives, or affect the independence and objectivity of the work of the government and/or UN Country Team. This requires robust frameworks for engagement that encourage and increase involvement, but serve also as instruments to identify the risks, balancing those risks against the expected benefits while protecting and preserving the integrity and reputation of the government, the concerned UN agency and the UN Country Team.

Additional guidance is given in Annex 9.

Strategic planning and the development of a results matrix

Agree the comparative advantage for the UN system and individual agencies

The country analysis is the basis for strategic planning and developing a results matrix. In most countries, the magnitude of NCDs, their socio-economic and development impacts and, in particular, their multisectoral nature, means the UN system will have a significant comparative advantage in supporting governments in the prevention and control of NCDs.

In strategic planning, the UNCT should refer to the division of tasks and responsibilities for members of the UN Inter-Agency Task Force in Annex 4 and the UN Inter-Agency Task Force biennial workplan to assist in defining roles and responsibilities for the UN system in country.[35]

While the specific mandates of each UN agency need not necessarily be highlighted in the UNDAF, the UNDAF should show clearly how the UN system can bring its unique strengths to taking the NCD agenda forward, in line with existing and emerging national policies and plans, including national NCD targets that Member States have committed to develop in alignment with the nine voluntary global targets.

In developing priorities for NCDs in the UNDAF, outcomes should first and foremost focus on the "very cost-effective interventions"[36] included in the WHO Global NCD Action Plan 2013-2020. These "very cost-effective interventions" are shown in Box 1 and are included as part of WHO's set of tools to prevent and control NCDs.[37]

35. *UN Inter-Agency Task Force on the Prevention and Control of NCDs biennial workplan, 2014-2015.*

36. *Very cost-effective interventions are described as those that generate an extra year of healthy life for a cost that falls below that average annual income or gross domestic product per person.*

37. *WHO tools to prevent and control NCDs.*

Box 1.

SET OF EVIDENCE-BASED COST-EFFECTIVE AND AFFORDABLE INTERVENTIONS FOR ALL MEMBER STATES (ALSO KNOWN AS THE "BEST BUYS") FOR THE PREVENTION AND CONTROL OF NCDS*

Tobacco use+

- *Reduce affordability of tobacco products by increasing tobacco excise taxes*
- *Create by law completely smoke-free environments in all indoor workplaces, public places and public transport[38]*
- *Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns*
- *Ban all forms of tobacco advertising, promotion and sponsorship*

Harmful use of alcohol

- *Regulate commercial and public availability of alcohol*
- *Restrict or banning alcohol advertising and promotions*
- *Use pricing policies such as excise tax increases on alcoholic beverages*

Unhealthy diet and physical inactivity

- *Reduce salt intake (and adjust the iodine content of iodized salt, when relevant)*
- *Replace trans fats with unsaturated fats*
- *Implement public awareness programmes on diet and physical activity*

Cardiovascular disease (CVD) and diabetes

- *Provide drug therapy and counselling to individuals who have had a heart attack or stroke and to persons with high risk of a fatal and nonfatal cardiovascular event in the next 10 years*
- *Provide acetylsalicylate acid for adults with acute myocardial infarction*

Cancer

- *Prevent liver cancer through hepatitis B immunization*
- *Prevent cervical cancer through screening linked with timely treatment of pre-cancerous lesions*

Adapted from Appendix 3 (pages 65-70) of the WHO Global NCD Action Plan 2013-2020 http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1.

38. Note: the term "completely" means that smoking is not permitted, with no exemptions allowed. Ventilation and any form of designated smoking rooms and/or areas do not protect from the harms of second-hand smoke, and the only laws that provide protection are those that result in the complete absence of smoking in all public places.

** The measures listed are recognized as very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person. In addressing each risk factor, governments should not rely on one single intervention, but should have a comprehensive approach to achieve desired results. WHO will update this set of very cost-effective interventions on a regular basis.*

+ Tobacco use: Each of these measures reflects one or more provisions of the WHO FCTC. The measures included are not intended to suggest a prioritization of obligations under the WHO FCTC. Rather, these measures have been proven to be feasible, affordable and cost-effective and are intended to fulfil the criteria established in the chapeau paragraph of Appendix 3 of the WHO Global NCD Action Plan 2013-2020 for assisting countries to meet the agreed targets as quickly as possible. The WHO FCTC includes a number of other important provisions, including supply-reduction measures and those to support multisectoral action, which are part of any comprehensive tobacco control programme.

Assess where global and regional momentum supports action

The UNCT should assess where there is particular global or regional momentum, resources and examples of transferrable practice when determining country-level priorities. The WHO FCTC, as a legally-binding treaty, is a prime example. Others include global and regional initiatives to reduce dietary salt[39] and initiatives to increase people's physical activity[40] as well as the Rome Declaration on Nutrition and Framework of Action from the Second International Conference on Nutrition.[41]

Include NCDs in the results matrix, with links to other programmes

The UNDAF results matrix may consist of outcome-level information only or information at both the outcome and output level. A national multisectoral NCD plan with national targets will usually provide the necessary information for defining baseline and target indicators, as well as means of verification. Ideally, the national NCD plan should have the role of partners included, which will assist in identifying the role of partners for any NCD outcomes to be included in the results matrix. National targets, the "very cost-effective interventions" described above, and the broader set of policy options described in the WHO Global NCD Action Plan 2013-2020 will provide the necessary information for the development of suitable outcomes and outputs. The complex multisectoral nature of NCDs means that particular attention must be given to assessing the risks and assumptions associated with individual outcomes and outputs. The impact of NCDs and their risk factors on broader development issues means that NCDs can also be integrated at both outcomes and/or output level in areas such as poverty reduction, effective governance, social inclusion and social capital.

A number of UNDAFs include HIV/AIDS, TB and other communicable diseases, as well as sexual and reproductive health and maternal and child health. The 2014 Outcome Document of the High-level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs calls for the integration, as appropriate, of responses for the areas above with the prevention and control of NCDs.

The UNDAF should highlight outputs that strengthen governance in the area of NCDs. Efforts should be made to understand the various governance structures and mechanisms operating in a country and to take advantage of past UN experience in encouraging and documenting multisectoral interventions and mechanisms. The global response to addressing HIV provides lessons for NCDs, in particular the criticality of adopting key democratic governance principles to build a whole-of-society response.[42] Civil society can play a key role in advocacy to secure a human rights and social justice perspective in the legal, regulatory and policy decision making on NCDs. This is particularly important in relation to trade policy and the rights of governments to retain regulatory control of products harmful to health and access to essential medicines. The NCD Alliance provides an online advocacy toolkit to support civil society in national and regional NCD advocacy efforts and there is much potential for working with those civil society groups not traditionally part of the health or NCD sectors.[43]

39. World Action on Salt and Health [WASH].

40. Ciclovias recreativas de las Americas (CRA).

41. FAO/WHO Second International Conference on Nutrition (ICN2).

42. United Nations Development Programme, 'A post-2015 development agenda: lessons from governance of HIV responses in Asia and the Pacific', UNDP, Bangkok, 2014.

43. NCD Alliance, 'Non-communicable Diseases: Join the Fight, An online advocacy toolkit'.

BARBADOS AND THE ORGANISATION OF EASTERN CARIBBEAN STATES (OECS), UNDAF 2012-2016

Analysis: *Many Caribbean countries have experienced a shift in nutrition patterns that has resulted in increasing rates of obesity, which in turn have contributed to an increase in nutrition-related NCDs including diabetes and hypertension. A common pattern observed in Barbados and the OECS is the increase in life expectancy at birth for both males and females, and the epidemiological transition from communicable to non-communicable diseases such as hypertension, cardiovascular disease and diabetes. PAHO 2011 NCD Basic Indicators show that prevalence of diabetes type 2 among adults varies from 7.6% to 25%. The limited data on NCD and other health indicators is a common challenge for OECS and Barbados.*

Results Framework:
Outcome 5: Public health within the context of the development agenda using rights-based approach, maintaining focus on HIV/AIDS and noncommunicable diseases (NCDs)

Output 5.4: Advocacy, capacity building and technical assistance to increase availability and access to user friendly, quality health care services for prevention and treatment of HIV and NCDs supported.

Target:
Obesity in females and males reduced by 25%. Policies and updated legislation in place to restrict use of alcohol among minors, support counselling in schools to address the problem of drug and alcohol abuse by students.

http://www.bb.undp.org/content/dam/barbados/docs/legal_framework/UNDAF%20Barbados%20and%20OECS%202012-2016.pdf

REPUBLIC OF BELARUS, UNDAF 2011-2015

Analysis: *The leading causes of death are cardiovascular diseases and cancer and injuries. In Belarus the rate of premature (0–64 years) mortality due to both ischemic heart disease and malignant neoplasm is one of the highest in Europe. Tobacco use is high especially among men (50% of whom are smokers). Smoking among men has shown a minimal decline from 55% in 1998 to 51% in 2011. At the same time smoking has increased among women and adolescents. It is estimated that about 15,500 people die each year from tobacco use. This represents about 14% of all deaths.*

Moreover, tobacco is estimated to cause about 40% of all male deaths in middle age (35-69), and about one-half (40%) of all cancer deaths. Alcohol abuse is a huge problem among males. There is also an increase in illicit drug consumption. Many premature deaths can be attributed to the consumption of alcohol. In 2001, the standardized mortality rate for selected alcohol-related causes was 188 per 100,000 population. The 2004 average rates for the WHO European Region amounted to 100 per 100,000 population. High levels of alcohol consumption and smoking are therefore key public health challenges in Belarus.

Results Framework:
Outcome 2.4: Population has necessary knowledge and skills on healthy lifestyles
Output 2.4.1 Prevention of alcohol and tobacco abuse…

Key actions:
Develop national system for monitoring alcohol consumption; revise national policy for alcohol; Scale up implementation of the WHO Framework Convention on Tobacco Control…

Identify and organize Results Group(s)

UNCTs should identify the most appropriate mechanisms for UN agency collaboration to address priority NCDs and/or risk factors and/or country capacity needs e.g. surveillance or policy development. Such groups should include government partners and also other partners where appropriate. Joint workplans should be developed to meet the NCD outputs and outcomes in the results matrix.

Monitoring and evaluation

Use national data for monitoring

It is important that wherever possible monitoring progress towards NCD outcomes uses data and information collected through national surveys and surveillance systems, with particular attention to disaggregation by key determinants (e.g. age, gender, income, urban/rural and education). Data routinely collected at local level are also useful, especially in the context of local decision making. These were described earlier in the Guidance Note.

Use existing structures where possible

With the development of an increasing number of multisectoral NCD action plans and mechanisms for taking forward action on NCDs across government and with non-governmental partners, there will be increasing opportunities for the UNCT to engage with national NCD reviews. In the future, UNCTs can be expected to develop NCD thematic groups or to incorporate NCDs into existing groups (Delivering as One countries may refer to them as Results Groups). The UNCT should use evidence available from these groups to assess the UN's contribution towards NCD outcomes in the UNDAF.

Check assumptions and risks in the results matrix

When assessing progress towards outcomes, it is useful to consider not only quantitative indicators/targets but also qualitative factors that affect the likelihood of achieving the outcomes. The extent to which each outcome adheres to and furthers the five programming principles provides a good basis for such considerations.

General policy and guidance for monitoring and evaluation are available in the UNDAF Guidance and Support Package.

CASE STUDIES

Case Study 1. Moldova: selected elements of the UNDAF UN Partnership Framework / UNPF and action plan specific to NCDs

Drafting for the UNDAF (UN Partnership Framework / UNPF) for the Republic of Moldova, 2013-2017 started in 2011. NCDs are integrated into Human Development and Social Inclusion, with one outcome in the UNPF and two related outputs in the UNPF action-plan (from five covering areas such as life course approach and adolescence health, communicable diseases, NCDs and healthy choices, health system and public health services, and right to health and access) on NCDs and tobacco use as selected priorities.[44]

PILLAR 2: HUMAN DEVELOPMENT AND SOCIAL INCLUSION	
National development priorities or goals: one of Moldova's main objectives is to eradicate poverty. In the national context, poverty and the lack of access to quality education, quality health care, decent public services, employment and economic opportunities, along with regional development, are considered priorities and reflected in Moldova 2020 [national development strategy], national sectoral strategies and programmes, and in national MDG targets on poverty, education, health, gender equality, international and regional treaties and related commitments and various EU-Moldova documents.	
Outcome 2.2 *People enjoy equitable access to quality public health and health care services and protection against financial risks* ***Agencies involved:*** *WHO, IAEA, IOM, UNAIDS, UNFPA, UNODC, UNICEF.* ***Indicators, baselines, targets*** *(in total 5 indicators selected as life expectancy, under 5 mortality rate, private household out-of-pocket payments, ARV treatment rate among children and adults, and maternal mortality rate)*	***Output 2.2.3*** *Public and private sector has increased capacity to manage NCDs and developed improved environments enabling healthy choices to address key risk factors* ***Agencies involved:*** *IAEA, UNDP, UNFPA, WHO.*

44. United Nations Development Operations Coordination Office, 'Desk review of UNDAFs commencing in 2013, Country examples May 2013'; Government of the Republic of Moldova and UN Moldova. 'Towards Unity in Action: UN – Republic of Moldova Partnership Framework, 2013-2017'; and Government of the Republic of Moldova and UN Moldova, 'Towards Unity in Action – UN and Republic of Moldova Partnership Framework 2013-2017 Action Plan'.

PILLAR 2: HUMAN DEVELOPMENT AND SOCIAL INCLUSION

Life expectancy at birth, disaggregated by urban/ rural, sex, ethnicity, income quintiles, education, geographical area (if available)
Baseline: Total 69.1 years (2010); men 65 (2010); women 73.4 (2010)
Target: Increase in total figure to 75.5 in 2017; reduction in gap between sexes of 2 years by 2017
Means of verification: MOH data

Private households' out-of-pocket payment on health as % of total health expenditures, disaggregated as per indicator (a)
Baseline: 48.4%
Target: Decrease by 35% by 2017
Means of verification: MOH data

Roles of partners: *MOH, agencies in health sector and national health insurance company determine priorities and resources, and develop and monitor policies and regulations. Government and ministries include health issues in their respective policies. Health authorities at local level determine priorities and allocate resources. The EU, WB, SDC, GFATM and bilateral agreements provide budget support and technical assistance. NGOs and organizations such as the Red Cross provide services and develop innovative models for national adoption.*

Risks: *Political instability slows down the health reform agenda. The international economic crisis leads to lower economic growth, decreasing public revenues and budget cuts (including to pooled health insurance). Lower priority given to health sector, relative to other national priorities, results in cuts to public health budget. Donor interest and availability of resources in the health sector can decrease in the medium-term. Introduction of co-payments in primary care. Necessary reforms in the health sector infrastructure (e.g. public health, primary care, hospitals) are not taken forward with necessary speed to ensure access, quality and efficiency of preventive and curative services.*

Assumptions: *Health reform progress with continue to be led by MOH and subordinate institutions and adjustments are made based on available evidence and ongoing monitoring. Continuous commitment to national health policy and health system strategy as guiding documents.*

Indicators, baselines, targets

Premature mortality from NCDs (cardiovascular disease, cancer, diabetes and chronic respiratory diseases) in the age group 30-70 years. (rate per 100,000 population disaggregated by sex and rural/urban)
Baseline: rate per 100,000 (2011) 591.5 (of which male 772.2; female 429.7; rural 679.9; urban 477.4)
Target: 10% reduction (based on the annual reduction by 2%, same disaggregation will be applied by sex and rural/urban)

% of regular daily smokers in the population, age 15+ (disaggregated by rural/urban and age groups)
Baseline: (disaggregation by rural/urban and age groups tbd 2013) male 51% (DHS 2005), 51% (WHO European Tobacco Control Report, 2007), 47% (WHO KAP study, 2012); female 7.1% (DHS 2005), 5% (WHO European Tobacco Control report, 2007), 6% (WHO KAP Study, 2012)
Target: (disaggregation by rural/urban and age groups tbd in 2013) male 3% reduction annually; female 0.5% reduction annually

Means of verification: *MoH Annual Health Report (other age-groups could be considered according to data availability); Various sources available as follow up KAP studies, MICS, WHO Reports on Global Tobacco Epidemic, WHO European Tobacco Control Reports.*

Case Study 2. Viet Nam – Selected elements of the One Plan specific to NCDs

The Viet Nam One Plan 2012-2016 highlights in particular national capacity development.

Country Analysis: NCDs account for 63% of all deaths in Viet Nam. Diabetes prevalence has almost doubled in the period 2002-2008 (now >5%), approximately 120,000 new cases of cancer are identified each year, and levels of cardiovascular diseases are increasing.

Together, the non-communicable 'conditions' (NCCs) significantly impact on society. Burden of disease studies have shown that NCCs (mainly neuropsychological conditions, cardiovascular diseases and cancer) and injuries accounted for 87% of the disability adjusted life years lost in Viet Nam in 2008.

Effectively dealing with NCCs requires improved information and evidence about the scope of NCCs and relevant risk factors in Viet Nam, the prevention and reduction of risk factors, as well as effective treatment of injuries and diseases when they occur.

Some information on risk factors is available. For example, there is a very high smoking rate of 47% in men over the age of 15 years (1.4% of women) and 2/3 of non-smoking Vietnamese (including women and children) are exposed to second-hand tobacco smoke. Driving or riding after consuming alcohol is also recognized as an issue requiring attention. Environmental and occupational risks are also a concern.

However, interventions to reduce risk factors are complex and require multisectoral actions.

There is very little support from other partners on NCCs, despite their increasing importance. The UN is able to provide, and draw on substantial technical expertise and normative guidance for: (i) improving the surveillance of NCC risk factors, and monitoring trends in prevalence and effectiveness of intervention programmes; (ii) providing advice to strengthen and implement multisectoral policies, as well as to improve community awareness and knowledge; (iii) strengthening the capacity of services to respond effectively to NCCs, as many are chronic in nature and require longer-term support; and (iv) advising on occupational and environmental health issues and risks.

NCD RELATED OUTCOMES	NCD RELATED OUTPUTS	INDICATORS	UN AGENCY PARTNERS
Priority: Access to quality essential services and social protection. *Outcome: By 2016, increased quality and effective management of a comprehensive national health system, including health promotion and health protection, with a focus on ensuring more equitable access for the most vulnerable and disadvantaged groups.*	*Output: Policy advice and technical support provided to improve evidence about, preventing and effectively managing NCCs at national and sub-national levels.* **Note: The term 'conditions' is used instead of 'diseases' as it encompasses diseases, injuries, and health conditions related to work and to the environment.*	*Number of policy studies/options developed with UN support during 2012-2016 on prevention, control and management of NCCs.* *Number of regulatory, policy, planning, strategy and guideline development processes supported by the UN during 2012-2016 related to the prevention, control and management of NCCs.*	*WHO, FAO, ILO UNICEF, MoH.*

ANNEXES

Annex 1. NCD Global Monitoring Framework

FRAMEWORK ELEMENT	TARGET	INDICATOR
MORTALITY & MORBIDITY		
Premature mortality from NCDs.	*1. A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.*	*1. Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases.*
Additional indicator.		*2. Cancer incidence, by type of cancer, per 100 000 population.*
BEHAVIOURAL RISK FACTORS		
Harmful use of alcohol[1]	 *2. At least 10% relative reduction in the harmful use of alcohol* [2]*, as appropriate, within the national context.*	*3. Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context.* *4. Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context.* *5. Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context.*
Physical inactivity.	 *3. A 10% relative reduction in prevalence of insufficient physical activity.*	*6. Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily.* *7. Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent).*
Salt/sodium intake.	 *4. A 30% relative reduction in mean population intake of salt/sodium*[3]*.*	*8. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.*
Tobacco use.	 *5. A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years.*	*9. Prevalence of current tobacco use among adolescents.* *10. Age-standardized prevalence of current tobacco use among persons aged 18+ years.*
BIOLOGICAL RISK FACTORS		
Raised blood pressure.	 *6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances.*	*11. Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) and mean systolic blood pressure.*
Diabetes and obesity[4]*.*	 *7. Halt the rise in diabetes & obesity.*	*12. Age-standardized prevalence of raised blood glucose/ diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose).*

FRAMEWORK ELEMENT	TARGET	INDICATOR
BIOLOGICAL RISK FACTORS		
		13. Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex). *14. Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/ m^2 for overweight and body mass index ≥ 30 kg/m^2 for obesity).*
Additional indicators.		*15. Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years[5].* *16. Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day.* *17. Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration.*
NATIONAL SYSTEMS RESPONSE		
Drug therapy to prevent heart attacks and strokes.	*8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.*	*18. Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.*
Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases.	*9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities.*	*19. Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities.*
Additional indicators.		*20. Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.* *21. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes.* *22. Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies .* *23. Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt.* *24. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants.* *25. Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies.*

Annex 2. Joint letters to UNCTs on NCDs from the Administrator of UNDP and the Director-General of WHO

World Health Organization

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In reply please refer to: HLM/NCD/UNDP/WHO

26 March 2012

Dear Colleagues,

As you are aware, a new and landmark agreement was adopted in September 2011, in the form of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (NCDs). This Political Declaration on NCDs is timely, and acknowledges the challenge of epidemic proportions that NCDs represent.

The World Health Organization (WHO) estimates that in 2008, 36 million of the 57 million (63%) global deaths were due to non-communicable diseases, mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, including 9 million before the age of 60. These four diseases are largely preventable by means of effective interventions that tackle four risk factors, namely: tobacco use; harmful use of alcohol; unhealthy diet; and physical inactivity.

Deaths from NCDs in low- and middle-income countries are projected to rise by almost fifty per cent by 2030, with the largest increases projected for Sub-Saharan Africa, the Middle-East and South Asia. The rapidly increasing burden of these diseases is affecting the poor disproportionally. NCDs lead to increasing health care costs, while also impoverishing millions of households and disabling workers. They create barriers to the achievement of the Millennium Development Goals (MDGs) and to the elimination of human poverty. The cumulative projected costs in low- and middle-income countries associated with NCDs are estimated at US$7 trillion over the period 2011-2025.

The growing international awareness that premature deaths from NCDs reduce productivity, curtail economic growth, and pose a significant social challenge in most countries means that they must be taken into account when the post-2015 development agenda is being devised.

Preliminary discussions with UN partners convened by WHO last December have elaborated further options for our collective action in support of the Political Declaration on NCDs. The identified actions are aligned with how we address today's key development challenges of reducing poverty and achieving inclusive growth and gender equality.

We propose that:

1. The United Nations Country Teams (UNCTs) integrate, according to country context and priorities, NCDs[1] into the United Nations Development Assistance Framework (UNDAF) design processes and implementation, with initial attention being paid to the countries where UNDAF roll outs are scheduled for 2012-2013.

2. The UNCTs design and implement joint NCDs programmes through UNDAFs considering the multi-sectoral nature of the response required, working with and beyond the health sector. This would in turn help to respond to the General Assembly's request for 'options for strengthening and facilitating multi-sectoral action for the prevention and control of non-communicable diseases through effective partnerships' (paragraph 64).

3. NCDs should, as mentioned above, be integrated into the MDG Acceleration Framework (MAF) efforts being carried out at the country level by UN Country Teams (UNCTs), including to inform and influence the global and national consultations for the post-2015 development agenda. The MAF can effectively build on existing global strategies endorsed by the governing bodies of the various organizations of the UN system.

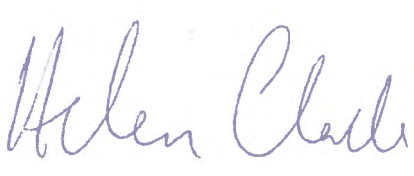
To support this country-level work in a coordinated manner, WHO, members of the UN Development Group and the development banks will develop guidance notes and technical training materials as required, along with the provision of targeted technical support. In addition, WHO will continue its work on the development of a comprehensive global monitoring framework and targets for NCDs.

The development of a comprehensive approach to achieving improved health outcomes is best achieved by multiple sectors and constituencies. Such a comprehensive approach is essential to tackling NCDs and to advance human development.

Our collective efforts in addressing HIV and AIDS provide us with lessons learned and precedents for best practice in how to engage jointly, for accelerated responses now, and to the long term challenges posed by NCDs.

We look forward to working with you closely as we take this agenda forward.

Yours sincerely,



Helen Clark
Administrator
United Nations Development Programme

Margaret Chan
Director-General
World Health Organization

[1] Including activities in relation to the implementation ofthe WHO Framework Convention on Tobacco Control (WHO FTCC), the first international treaty negotiated under the auspices of WHO

World Health Organization

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In reply please refer to: HLM/NCD/UNDP/WHO

24 February 2014

Dear Colleagues,

On 26 March 2012, we wrote to you proposing that United Nations Country Teams (UNCTs) integrate, according to country context and priorities, non-communicable diseases (NCDs) into the United Nations Development Assistance Framework (UNDAF) design processes and implementation. This was in response to the acknowledgement that the growing global burden of NCDs constitutes one of the major challenges for development in the twenty- first century, and in light of the commitments set forth in the September 2011 UN *Political Declaration on the Prevention and Control of Non-Communicable Diseases*.

Today, we write to you following the recent release of the Note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on the prevention and control of non-communicable diseases.[1] The report underscores that some remarkable advances have been made since September 2011. However, overall progress has been insufficient and highly uneven and bolder measures are needed for achieving a world free of the avoidable burden of NCDs.

We reiterate the importance of continuing to mainstream NCDs into UNDAFs; a preliminary review of 109 UNDAFs in April 2013 showed that 52 (48%) included action to prevent and control NCDs. Only twenty-two (20%) of these specifically highlighted tobacco prevention and control. While trends are encouraging, there is a still a long way to go.

We also highlight two significant developments during 2013 regarding NCDs that facilitate the work of the United Nations System.

Firstly, WHO, based on the *Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020* endorsed by the World Health Assembly in May 2013, and on regional plans, has developed a global NCD framework with clear targets and accountabilities. More broadly, the WHO Global Action Plan comprises a set of actions which, when performed collectively by Member States, international partners and WHO, will achieve the global target of a 25% reduction

[1] http://www.un.org/ga/search/view_doc.asp?symbol=A%2F68%2F650+&Submit=Search&Lang=E

in premature mortality from NCDs by 2025 and attain the commitments made in the Political Declaration.

Secondly, on 22 July 2013, in a resolution co-signed by 104 Member States, ECOSOC requested the Secretary-General to establish a UN Interagency Task Force (IATF) on the Prevention and Control of NCDs[2] to coordinate the activities of relevant UN funds, programmes and specialized agencies and other intergovernmental organizations to support the realization of the commitments made in the Political Declaration, in particular through the implementation of the WHO Global Action Plan, including the implementation of the *WHO Framework Convention on Tobacco Control*, which now has 177 Parties. This Task Force, convened by WHO, is now operational and ready to support UN technical assistance and Member State design and implementation of comprehensive NCD responses.

As we commit to a coherent UN System response, UNCTs are now encouraged to:

1. Accelerate the development of multi-sectoral joint programmes on the prevention and control of NCDs with a clear determination of financing, agency roles and coordination in the UNDAFs.

2. Support governments to develop national targets that build on the WHO Global Action Plan, including the 9 voluntary global targets to be attained by 2025.

3. Assist governments in the development, implementation and monitoring of national multi-sectoral policies and plans to achieve their national targets, in line with the WHO Global Action Plan.

The UN General Assembly will conduct a comprehensive assessment of the progress achieved in the prevention and control of NCDs later in 2014. This will be an important opportunity to highlight progress at country level and demonstrate how the UN System is working together to support countries to respond to the health and development challenges posed by NCDs.

We count on your continued support and commitment.

Yours sincerely,

Helen Clark
Administrator
United Nations Development Programme

Margaret Chan
Director-General
World Health Organization

[2] http://www.who.int/nmh/events/2013/E.2013.L.23_tobacco.pdf

Annex 3. NCDs – major events between 2000 and 2014

May 2000 – The World Health Assembly endorses the WHO Global Strategy for the Prevention and Control of NCDs and urges Member States to establish national NCD programmes that: (i) map the epidemic of NCDs; (ii) reduce the level of exposure to risk factors for NCDs; and (iii) strengthen health care for people with NCDs.

September 2002 – Plan of Implementation of the World Summit on Sustainable Development calls for developing programmes to address NCDs and conditions.

May 2003 – The World Health Assembly adopts the WHO Framework Convention on Tobacco Control and urges Member States to take all appropriate measures to curb tobacco consumption and exposure to tobacco smoke.

May 2004 – The World Health Assembly endorses the WHO Global Strategy on Diet, Physical Activity and Health and urges Member States to implement actions recommended in the Strategy. The World Health Assembly also urges Member States to strengthen national capacities for multisectoral health-promotion policies and programmes, with particular attention to poor and marginalized groups.

May 2005 – The World Health Assembly urges Member States to develop cancer-control programmes for prevention, early detection, diagnosis, treatment, rehabilitation and palliative care, and to evaluate the impact of implementing such programmes. The World Health Assembly also urges Member States to continue to protect, promote and support exclusive breastfeeding for six months as a global public-health recommendation and to provide for continued breastfeeding up to two years of age or beyond.

May 2006 – The World Health Assembly requests the WHO Director-General to mobilize technical support for Member States in the implementation and independent monitoring of the International Code of marketing of Breast-milk Substitutes.

December 2006 – The United Nations General Assembly recognizes diabetes as a chronic, debilitating and costly disease, and designates 14 November as World Diabetes Day.

May 2007 – The World Health Assembly urges Member States to strengthen national political will to prevent and control NCDs as part of a commitment to achieving the target of reducing death rates from NCDs by 2% annually for the next 10 years and requests the WHO Director-General to prepare a WHO Global NCD Action Plan 2008-2013.

September 2007 – CARICOM Heads of State and Government adopt the Port-of-Spain Declaration on NCDs declaring that Ministers of Health will establish plans for NCDs so that, by 2012, 80% of people with NCDs will receive quality care and have access to prevention.

May 2008 – The World Health Assembly endorses the WHO Global NCD Action Plan 2008-2013 and urges Member States to consider the proposed actions in the action plan in accordance with national priorities.

August 2008 – The Commission on Social Determinants of Health releases its report documenting the importance of health inequities, and the contribution of multiple sectors of society to these inequities, and to possible solutions.

January 2009 – UNDESA, UNDP and WHO conduct an e-discussion on global health in which the necessity to better relate NCDs to the MDGs and develop national NCD response plans emerge as important themes.

April 2009 – ECOSOC/WHO Asian-Pacific Ministerial Meeting on Promoting Health Literacy.

May 2009 – ECOSOC/WHO Western Asia Ministerial Meeting on Addressing NCDs adopts the Doha Declaration on NCDs and Injuries.

July 2009 – ECOSOC High-level Segment explores challenges to including NCDs in global discussion on development and recommends convening an international conference on NCDs under the patronage of the General Assembly.

April 2010 – Adelaide Statement on Health in All Policies is adopted by the participants of a meeting co-sponsored by WHO.

May 2010 – The World Health Assembly endorses the WHO Global Strategy to Reduce the Harmful Use of Alcohol and urges Member States to mobilize political will and financial resources to implement the strategy in accordance with national priorities.

September 2010 – WHO organizes a side-event on NCDs on the occasion of the MDG Summit 2010.

October 2010 to June 2011 – WHO organizes six regional consultations on NCDs, which serve as an input to the preparatory process leading toward the first High-level Meeting on NCDs.

November 2010 – United Nations General Assembly considers the first report of the Director-General of WHO on the global status of NCDs, with a particular focus on the development challenges faced by developing countries.

November 2010 – Release of WHO/UN HABITAT global report on urbanization and health, 'Hidden Cities: Unmasking and overcoming health inequities in urban settings', which includes impact on, and lessons for, NCDs.

January 2011 – NCDs feature prominently on the agenda of the World Economic Forum annual meeting, which includes statements from the UN Secretary-General and the WHO Director-General.

April 2011 – WHO and the Russian Federation convene the first WHO Global Ministerial Conference on healthy lifestyles and NCD control in Moscow, which results in the Moscow Declaration on NCDs. On the occasion of the Conference, WHO launches the first WHO Global Status Report on NCDs.

September 2011 – UN General Assembly convenes the High-level Meeting on NCDs with the participation from Heads of State and Government, which results in the 2011 Political Declaration on NCDs. On the occasion of the High-level Meeting, WHO launches findings of a study on reducing the economic impact of NCDs in developing countries, and on the cost of scaling up action against NCDs. WHO also publishes a first series of WHO NCD Country Profiles.

November 2011 – WHO opens regional centre for tobacco control in Africa.

December 2011 – First meeting of UN Agencies on the implementation of the 2011 Political Declaration on NCDs.

March 2012 – Joint letter from the UNDP Administrator and the WHO Director-General proposing that UN Resident Coordinators integrate NCDs into UNDAFs. UNDP and the development banks to develop guidance notes and technical training materials as required.

May 2012 – World Health Assembly adopts a global target of 25% reduction in NCD-associated premature mortality by 2025.

June 2012 – The UN Rio+20 Conference on Sustainable Development takes place. The outcome document, "The Future We Want", recognizes concerted action on NCDs as essential and stresses the importance of national policy and plan development.

July 2012 – Secretary-General launches a High-level Panel of Eminent Persons to provide guidance and recommendations on the post-2015 development agenda.

May 2013 – The 66th World Health Assembly endorses the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020, which includes nine voluntary global targets to be attained by 2025, and an accountability framework and reporting cycle to the World Health Assembly based on 25 outcome indicators to track progress.

July 2013 – ECOSOC adopts a resolution on the establishment of a UN Inter-Agency Task Force (UN IATF) on the Prevention and Control of NCDs that builds on the UN Ad Hoc Inter-Agency Task Force on Tobacco Control to be convened and led by WHO, to coordinate the UN system response to NCDs.

February 2014 – UNDP, with the WHO FCTC secretariat, publishes the Guidance Note for integrating the WHO FCTC into UN and national development planning instruments, including the UNDAF.

February 2014 – Second joint letter from the UNDP Administrator and the WHO Director-General to UN Resident Coordinators reiterates the call to integrate NCDs into UNDAFs.

February 2014 – General Assembly considers the report of the WHO Director-General on the progress made in addressing NCDs since the adoption of the 2011 Political Declaration on NCDs.

May 2014 – World Health Assembly endorses the terms of reference for the WHO Global Coordination Mechanism on the Prevention and Control NCDs, and approves 9 indicators to measure progress of implementing the WHO Global NCD Action Plan 2013-2020.

June 2014 – ECOSOC endorses the terms of reference for the UN Interagency Task Force on NCDs.

July 2014 – High-level Meeting of the UN General Assembly takes place to undertake the comprehensive review and assessment of the progress made in achieving the 2011 Political Declaration on NCDs, resulting in the 2014 Outcome Document on NCDs.

July 2014 – General Assembly welcomes the Report of the Open Working Group on Sustainable Development Goals, which includes a target to, by 2030, reduce by one-third premature mortality from NCDs through prevention and treatment.

Annex 4. Division of tasks and responsibilities for the UN Inter-Agency Task Force on the Prevention and Control of NCDs[45]

OBJECTIVE[a]	CONVENING INSTITUTIONS	SUGGESTED AREAS OF WORK	PARTNER INSTITUTIONS
1. To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.	*WHO*	*1.1 Advocacy for attention to/ integration of NCDs in the international development agenda/ goals.*	*IAEA* *UNAIDS* *UNDP* *UN-Habitat* *UNICEF* *UNSCN*
		1.2 Multistakeholder partnership management and resource mobilization.	*IAEA* *UNAIDS* *UNDP* *UN-Habitat* *WFP*
		1.3 Mainstreaming of the prevention and control of NCDs in international development cooperation initiatives.	*FAO* *IAEA* *UNAIDS* *UNDP* *UNEP* *UNICEF* *UNSCN* *World Bank*
2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs.	*UNDP* *WHO* *UNAIDS* *(for 2.3 only)*	*2.1 Multisectoral action planning and coordination.*	*UNAIDS*
		2.2 Mainstreaming of the prevention and control of NCDs in national development plans/poverty reduction strategies.	*FAO* *IAEA* *IARC* *UNAIDS* *UN-Habitat* *UNFPA* *UNHCR* *UNICEF* *UNSCN* *WFP* *World Bank*

45. Adapted from http://www.who.int/nmh/events/2014/ecosoc-20140401.pdf?ua=1

OBJECTIVE[a]	CONVENING INSTITUTIONS	SUGGESTED AREAS OF WORK	PARTNER INSTITUTIONS
		2.3 Integrate NCDs and HIV responses where appropriate.	*ILO* *UNFPA* *UNHCR* *World Bank*
		2.4 Innovative financing for national NCD responses.	*World Bank*
		2.5 Supporting enabling legal and regulatory environments that promote favourable health outcomes for NCDs (including universal access to essential medicines and basic technologies).	*IDLO* *UNFPA* *WIPO* *WTOc* *World Bank*
		2.6 Addressing gender and human rights dimensions of NCD prevention and control in national NCD responses.	*IDLO* *UNFPA*
3. To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments.	*Secretariat of the WHO Framework Convention on Tobacco Control*[d] *FAO* *ILO*[e] *UNFPA*[f] *UNICEF*[F] *WHO*	*3.1 Implementation of the WHO Framework Convention, taking into account the matrix summarizing the areas of collaboration included in para. 61 of document E/2012/70.*	*Secretariat of the WHO Framework Convention* *UNCTAD* *UNDP* *World Bank*
		3.2 National capacity development to implement the Global Strategy to Reduce the Harmful Use of Alcohol.	*UNDP* *UNICEF* *World Bank*
		3.3 Implementation of the WHO Global Strategy on Diet, Physical Activity and Health.	*IAEA* *UNDP* *UNEP* *World Bank*
		3.4 National capacity development to reduce the risk of NCDs among children/adolescents.	*FAO* *IAEA* *UNFPA* *UNICEF*[g] *WFP*

OBJECTIVE[a]	CONVENING INSTITUTIONS	SUGGESTED AREAS OF WORK	PARTNER INSTITUTIONS
		3.5 National capacity development to reduce the risk of NCDs among women and girls.	*IAEA* *UNDP* *UNICEF* *UNFPA[g]* *UNHCR* *WFP*
		3.6 NCD prevention and care integrated into maternal health.	*IAEA* *UNAIDS* *UNFPA[g]* *UNICEF* *UNHCR* *WFP*
		3.7 Health promotion in environment and energy policies.	*UNDP* *UNEP* *World Bank*
		3.8 Health promotion in the education sector.	*ILO* *UNEP* *UNICEF[g]* *World Bank*
		3.9 Health promotion in the labour sector, including occupational safety and health.	*ILO* *UNEP*
		3.10 Health/nutrition promotion in the agricultural sector and in food systems.	*ILO* *UNEP* *UNSCN*
4. To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage.	*WHO* *IAEA (for 4.4 only)*	*4.1 Health system strengthening to address NCDs.*	*ITU* *UNAIDS* *UNDP* *UNFPA* *UNHCR* *UNICEF* *World Bank*

OBJECTIVE[a]	CONVENING INSTITUTIONS	SUGGESTED AREAS OF WORK	PARTNER INSTITUTIONS
		4.2 Resource mobilization for financing of universal health coverage that incorporates NCD prevention and care.	*UNAIDS UNDP UNFPA UNICEF World Bank*
		4.3 Promote the development of electronic communications technologies and the use of mobile devices.	*IAEA UNICEF*
		4.4 Support increased access to radiation medicine.	*IAEA*
5. To promote and support national capacity for high- quality research and development for the prevention and control of NCDs.	*WHO*	*5.1 Promote an international research agenda that ensures the next generation of medicines and technologies for NCDs.*	*IAEA IARC UNDP*
		5.2 Support national efforts to increase access to existing essential medicines and basic technologies to treat NCDs.	*IAEA ITU UNAIDS UNCTAD UNDP UNHCR UNFPA WIPO WTO[c]*
6. To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.	*WHO*	*6.1 National NCD monitoring and surveillance systems.*	*IARC UN-Habitat UNICEF World Bank*
		6.2 Regular reporting against global voluntary targets.	*UN-Habitat*

Note: The United Nations Office on Sport for Development and Peace will assess opportunities to contribute as a convening or partner institution in a number of areas in the table, for example through the establishment of a "Sport and health" thematic working group in the context of the Sport for Development and Peace International Working Group.

Abbreviations: FAO, Food and Agriculture Organization of the United Nations; IAEA, International Atomic Energy Agency; IARC, International Agency for Research on Cancer; IDLO, International Development Law Organization; ILO, International Labour Organization; ITU, International Telecommunication Union; NCD, non-communicable disease; UNAIDS, Joint United Nations Programme on HIV/AIDS; UNCTAD, United Nations Conference on Trade and Development; UNDP, United Nations Development Programme; UN-Habitat, United Nations Human Settlements Programme; UNICEF, United Nations Children's Fund; UNEP, United Nations Environment Programme; UNFPA, United Nations Population Fund; UNHCR, Office of the United Nations High Commissioner for Refugees; UNSCN, Standing Committee on Nutrition; WFP, World Food Programme; WIPO, World Intellectual Property Organization; WTO, World Trade Organization.

[a]The six objectives in this table are those in the WHO Global Action Plan 2013-2020. These objectives are linked to the nine voluntary global targets, as referenced in Appendix 3 to the Global Action Plan.[b] Included in the WHO Global Action Plan 2013 -2020.[c] In carrying out this task, WTO will provide technical and factual information regarding relevant WTO agreements in order to support, upon request, relevant minis tries and government departments to address the interface between trade policies and health issues in the area of NCDs.[d] As pertains to area of work 3.1.[e] As pertains to area of work 3.9.[f] As pertains to areas of work 3.5 and 3.6.[g] Will facilitate this area of work.

Annex 5. Multisectoral policy options to reduce NCDs in low- and middle-income countries[46]

DIFFERENTIAL SOCIO-ECONOMIC CONTEXT AND POSITION			
DETERMINANTS AND PATHWAYS	**SECTORS**	**ENTRY POINTS FOR NCDS**	**INTERVENTIONS (*BEST BUYS)**
Social status. *Parents' social status.* *Education.* *Occupation.* *Poverty.* *Poor governance.* *Physical environment.*	*Economy and employment.* *Welfare.* *Education and early life.* *Environment.*	*Defined, institutionalized, protected and enforced human rights to education, employment, living conditions and health.* *Power and resources redistributed equitably to populations including the chronically ill and disabled.* *Progressive taxation.* *Environmental protection, e.g. air and chemical pollution.*	*Poverty reduction with removal of barriers to secure equitable employment.* *Tax-financed universal primary education with equitable early childhood education.* ***Tax-financed UHC with financial protection.*** *Poverty reduction strategies alleviate under-nutrition in women of childbearing age and pregnant women.* *Legislated and regulated labour practices.*

46. Adapted from: (i) Di Cesare M, Khang Y, Asaria P et al on behalf of The Lancet NCD Action Group. 'Inequalities in NCDs and effective responses.' Lancet. 2013; 381: 585-597; (ii) 'Equity, social determinants and public health programmes', WHO, 2010; (iii) The 2010 Adelaide Statement on Health in All Policies; and (iv) the WHO Global NCD Action Plan 2013-2020.

DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK			
DETERMINANTS AND PATHWAYS	**SECTORS**	**ENTRY POINTS FOR NCDS**	**INTERVENTIONS (*BEST BUYS)**
Lack of social safety nets. *Poor living conditions in childhood.* *Poor community infrastructure, highly deprived neighbourhoods.* *Lack of control over life and work.* *Unemployment.* *Attitudes towards health, unhealthy behaviours.* *Subjected to marketing of unhealthy products.* *Psychosocial and work stress.* *Lack of preventive health services.* *Poor urban or rural residence.* *Environmental pollution.*	*Trade.* *Advertising and broadcasting.* *Sports.* *Education and early life.* *Infrastructure planning and transport.* *Housing.* *Interior/local government.* *Welfare and communities.* *Land use.* *Agriculture, rural living.* *Food and nutrition.* *Environment.* *Public health and health care.*	*Social protection of education, employment, living conditions and health.* *Reduced exposure to advertising and marketing, access to and affordability of harmful products.* *Increased availability of and access to healthy foods.* *Protection of indoor and outdoor air quality.*	***Tobacco and alcohol tax*.*** ***Bans on tobacco and restrictions or bans on alcohol advertising, promotion and sponsorship*.*** ***Create by law completely smoke-free environments in all indoor workplaces, public places and public transport*.*** ***Health information and warnings on tobacco*.*** ***Restricted access to retail alcohol*.*** ***Elimination of unsaturated fats and reduced salt intake*.*** ***Mass media promotion of healthy diet and physical activity*.*** *International trade agreements that promote availability and affordability of healthy foods.* *Agricultural and nutrition policies for food security.* *Agricultural policies for sustainable rural development and protection of biodiversity.* *Laws and regulations to protect environments and eco systems.* *Policies for sustainable urban development.* *Policies on urban infrastructures to facilitate physical activity and active transport.* *Agreements to limit marketing of foods and non-alcoholic beverages to children.*

DIFFERENTIAL SOCIO-ECONOMIC CONTEXT AND POSITION			
DETERMINANTS AND PATHWAYS	**SECTORS**	**ENTRY-POINTS FOR NCDS**	**INTERVENTIONS (* BEST BUYS)**
	Health.		*User-friendly food labelling.* *Subsidies to promote the use of cook stoves that use cleaner fuels.* *Reduction of emissions of harmful urban pollutants from vehicles through better technology and greater use of mass transit.* *Reduction in exposure to agro-industrial chemicals and waste by ensuring clean water for irrigation and managing pesticide use for crops and vegetables.*
DIFFERENTIAL VULNERABILITY OF INDIVIDUALS			
Gender, disability, ethnicity. *Loss of employment.* *High expenditure on healthcare.* *Premature death, early onset of illness, disability.* *Limited or no access to education.* *Comorbidity.* *Lack of social support.* *Limited or no access to welfare assistance.* *Poor health care seeking behaviour.* *Inaccessibility of health services.* *Malnutrition is all its forms.* *Physical inactivity.* *Limited or no access to health education.* *Poor engagement of communities and poor governance.*	*Economy and employment.* *Health care and public health.* *Nutrition.* *Education and early life.* *Local government.*	*Empowerment, resilience, information.* *Social protection.*	*Tax-financed UHC with financial protection.* *Primary care targeting early detection of elevated blood pressure and elevated blood glucose.* *Health information and warnings on tobacco targeting vulnerable groups.* *Health information on diet and physical activity targeting vulnerable groups.* *Healthy free or subsidized meals to school children.* *Subsidized/facilitated pricing structure to promote purchase of healthy food.* *Poverty reduction strategies combined with incentives to use health services especially preventive care.* *Gender-focused education, employment and business development.*

DIFFERENTIAL HEALTH CARE OUTCOMES OF INDIVIDUALS			
DETERMINANTS AND PATHWAYS	**SECTORS**	**ENTRY POINTS FOR NCDS**	**INTERVENTIONS (*BEST BUYS)**
Unaffordable appropriate care. *Inappropriate drug prescribing.* *Poor adherence to treatment protocols.* *Discrimination in service delivery.* *Poor access to essential medicines.* *Lack of education.* *Comorbidity.*	*Economy.* *Welfare.* *Health care.*	*Payment/ reimbursement mechanisms for health service providers.* *Equitable access to primary care.*	*Tax-financed UHC with financial protection.* ***Counselling and multi-drug therapy for people with high risk of developing heart attacks and strokes and those with established CVD*.*** ***Treatment of heart attacks with acetylsalicylic acid*.*** ***Hepatitis B immunization*.*** ***Screening and treatment of pre-cancerous lesions to prevent cervical cancer*.*** *Awareness raising among healthcare practitioners of ethical norms and patient rights.* *Health care providers incentivized to serve vulnerable groups.* *Dedicated services for vulnerable groups.*

Annex 6. Reducing the harmful use of alcohol[47]

	DIFFERENTIAL SOCIOECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
Determinants and pathways	*The harmful use of alcohol causes an estimated 2.5 million deaths every year, a significant proportion of which occur in young people between 15 and 29 years of age. It is a development issue because laws and interventions to protect against and discourage harmful use are weak or absent in developing countries compared to high-income countries. It is an equity issue because for a given amount of consumption, poorer populations can experience disproportionately higher levels of alcohol-attributable harm.*	*Social and work environments that cause stress, general cultural attitudes towards unhealthy behaviours, a lack of community level interventions to prevent harm, aggressive marketing and easy access to alcohol can lead to harmful protracted drinking.*	*Individuals with poor health-seeking behaviour, a comorbidity or disability, limited or no health literacy, who are unemployed with limited or no education and a lack of social supports can resort to harmful use of alcohol when it is affordable and accessible.*	*Alcohol use is among the leading risk factors for poor health globally. It is a major avoidable risk factor for neuropsychiatric disorders and other NCDs such as cardiovascular diseases, cirrhosis of the liver and various cancers.* *Causal relationships have now been established between the harmful use of alcohol and TB, pneumonia as well as the progression of AIDS.* *As an addiction, it can perpetuate poor adherence to treatment protocols. It can also lead to discrimination in service delivery.*
Interventions (* best buys)	*Tax-financed universal primary education with equitable early childhood education.* *Removal of barriers to secure equitable employment.* *Poverty reduction.*	*Enforcing bans on alcohol advertising*.* *Restricting access to retail alcohol*.* *Drink-driving policies and countermeasures.* *Reducing the negative consequences of drinking and alcohol intoxication.* *Reducing the public health impact of illicit alcohol and informally produced alcohol.*	*Alcohol tax*.*	*Tax-financed UHC with financial protection e.g. screening for harmful use of alcohol; preventive treatment and care for alcohol use and alcohol-induced disorders.* *Payment/ reimbursement mechanisms for health service providers to incentivize preventive care.* *Health care providers incentivized to serve vulnerable groups.* *Dedicated health services for vulnerable groups.*

47. World Health Organization, 'Global strategies to reduce the harmful use of alcohol', WHO, Geneva, 2010.

	DIFFERENTIAL SOCIOECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
Sectors	*Almost all.*	*Trade.* *Industry.* *Urban and retail planning.* *Road safety.*	*Finance.* *Trade.* *Industry.*	*Finance* *health care.*
Entry points/ synergies	*Poverty reduction to tackle the inequities in social status, education, occupation and low income.* *Marginalized and minority populations targeted.*	*Licensing systems for retail outlets and tax on sales can generate revenue that can be directed to health promotion or tax-financed public services such as UHC and education.* *Common market platforms to standardize regulatory approaches and coordinate customs and border response to alcohol importation.*		*UHC as a target for the broader goal of ensuring healthy lives.*

Annex 7. Improving diet – reducing the overconsumption of salt

	DIFFERENTIAL SOCIOECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
Determinants and pathways	*High blood pressure is a leading underlying cause of premature deaths. At any given age, the risk of dying from high blood pressure in developing countries is more than double that in high-income countries. In addition, in high-income countries, 7% of deaths caused by high blood pressure occur under age 60; in the African region for example, this figure reaches 25%. There is abundant evidence of a causal relation between high salt intake and elevated blood pressure. People of lower socioeconomic status have nutrient-poor diets of which one characteristic is high salt intake.*[48]	*In developing countries, salt is used predominantly to preserve food and is added during cooking or at the table, as table salt and often in seasonings or sauces. As purchasing power increases with economic development and global food manufacturers enter local food markets, households are transitioning to highly processed food products often with high salt content (and high fat and sugars) that are being aggressively advertised and marketed. There is corresponding growth in informal unorganized food vendors and small food establishments whose cooking practices are uncontrolled. Particularly vulnerable are children and youth.*[49] *Whether fresh produce is available and affordable influences the extent to which highly processed food products are consumed.*	*Psychosocial stress and poor physical fitness correlate with lower socioeconomic status and also with elevated blood pressure.* *Limited or no health care is a barrier to preventive care and health promotion.* *Limited or no education is a barrier to health literacy.* *Low fruit and vegetable consumption contributing to low potassium intake, losing the benefits of potassium in lowering blood pressure.*	*Inappropriate drug prescribing, poor or no access to essential medicines and poor adherence to treatment protocols are barriers to treating and controlling high blood pressure.*

48. World Health Organization, 'Global Health Risks: mortality and burden of disease attributable to selected major risks', WHO, Geneva, 2009.

49. Popkin BM, Adair LS and SW Ng, 'Now and then: the global nutrition transition: the pandemic of obesity in developing countries', Nutr Rev 2012;70:3-21.

	DIFFERENTIAL SOCIOECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
Interventions (*"best buys")	*Tax-financed universal primary education with equitable early childhood education.* *Removal of barriers to secure equitable employment.* *Poverty reduction.*	*Reduced salt intake* (voluntary or regulated reductions in the salt concentrations in most common processed and prepared foods; reduced use of salt by informal food establishments and street food vendors).* *Promotion of healthy diets* (reduced use of salt in home cooking and at the table; reduced salt in home preserved foods).* *Restricted advertising and marketing of non-alcoholic beverages and foods to children.* *Taxes on unhealthy foods; subsidies/price incentives for fresh produce.* *Healthy free or subsidized meals to schoolchildren.* *Food procurement policies for schools and public institutions have standards on nutrient quality of foods.* *Subsidized/facilitated pricing structure to promote purchase of healthy food.* *User-friendly nutrition labelling.*	*For vulnerable groups primary care targeting early detection of elevated blood pressure.* *Health information on diet and physical activity targeting vulnerable groups.*	*Tax-financed UHC.* *Counselling and multi-drug therapy for people with high risk of developing heart attacks and strokes and those with established CVD*.* *Treatment of heart attacks with ASA*.* *Healthcare providers incentivized to serve vulnerable groups.* *Dedicated health services for vulnerable groups.*

	DIFFERENTIAL SOCIOECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
Sectors and stakeholders	*Social protection and welfare.*	*Global food manufacturers.* *Local food manufacturers and associations of local artisanal bread makers.* *Trade.* *Nutrition, food security and agriculture.* *Education.* *Finance.* *Broadcasting and media.* *NGOs and civil society oriented to e.g. hypertension, CVD, school nutrition.* *Active transport/urban planning.* *Sports clubs, youth clubs, women's associations.*	*Health care and public health.*	*Finance health care.*
Entry points/ synergies	*Poverty reduction to tackle the inequities in social status, education, occupation and income. Marginalized and minority populations targeted.*	*Commitments of the International Food and Beverage Alliance to WHO on product composition and availability[46]; adoption of WHO set of recommendations for responsible marketing and advertising to children.* *National commitments to protect children.* *Agricultural incentives/subsidies to promote availability, accessibility and affordability of local fruits and vegetables.* *Nutrition labelling following CODEX guidelines that include salt/sodium.* *Common market platforms to standardize nutrition labelling across borders, adopt marketing and advertising restrictions.*		*Payment/ reimbursement mechanisms for health service providers to incentivize preventive care and health promotion.*

Annex 8. UN programming principles and intersections with NCDs

The five UN programming principles are guiding the formulation of the UNDAF: human rights-based approach, gender equality, environmental sustainability, capacity development and results-based management. NCDs intersect with each of the principles, and addressing NCDs strengthens them.

A human-rights based approach in analysis of risk to NCDs

- Avoidable NCD morbidity and mortality jeopardize the right to health enshrined in numerous international legal instruments and in some national constitutions. NCDs and poor health generally may also impede other human rights, such as access to education and freedom from discrimination.

- Human rights violations can in turn put people at greater risk for NCDs. Underlying social exclusion, marginalization and discrimination can create conditions that increase vulnerability to risk behaviours for NCDs. High rates of NCDs in various indigenous communities that have faced land displacement and various forms of exclusion are a case in point.[50]

Gender and NCDs[51]

- Women experience poorer health than men despite their longer life expectancy, due to a higher prevalence of non-fatal chronic illnesses. Two in every three deaths among women are caused by NCDs – largely heart disease, stroke, cancer, diabetes and chronic respiratory diseases – and risk factors for NCDs are similar for men and women. But the global discourse on health largely views women in terms of their reproductive capacity, reflecting a gender bias that distracts from NCDs as well as violence against women and other injuries. In the area of diagnosis and treatment, gender bias can result in women being asked fewer questions, receiving fewer examinations and receiving fewer diagnostic tests for NCDs, compared to men with similar symptoms.

- Gender inequities in individual income appear to contribute largely to women's poorer health. Women's history of limited access to the labour market and the degree of independence and power within the household may contribute to inequities in income. Policies to facilitate women's participation in the labour market, close the gender pay gap, and raise non-contributory pensions can improve women's health.

50. *NCD Alliance, 'Health inequalities and indigenous people' December 2012.*

51. *Bonita R and R Beaglehole, Women and NCDs: overcoming the neglect', Glob Health Action 2014;7:23742; Malmusi D, Vives A, Benach J and C Borrell, 'Gender inequalities in health: exploring the contribution of living conditions in the intersection of social class', Glob Health Action 2014,7:23189.*

NCDs and environmental sustainability

- The environments in which people live and work are key determinants of health. For NCDs, multiple environments are directly implicated, including: rural settings and proximity to industrial sites where people, particularly children, can be exposed to hazardous chemicals and radiation[52]; in-built environments, particularly due to rapid urbanization and growing motorized traffic, wherein physical activity can decrease; increased industrial production, which can compromise outdoor and indoor air quality and render certain work settings conducive to NCDs such as chronic obstructive respiratory diseases, ischemic heart disease, cerebrovascular disease and lung cancer.[53]

- Climate change, including higher temperatures, heat waves, and other extreme events can threaten food security, resulting in poor nutrition.[54]

- Unfettered agricultural development can lead to deforestation, soil degradation, agro-chemical pollution and depletion of ground water. These, in turn, lead to ecological disruptions that cause a loss of ecosystem services, including land resources, biodiversity and food sources. Tobacco farming in developing countries is a case in point.[55]

- Conversely, the increased food energy and car travel associated with obesity have an impact on greenhouse gases.[56]

- Development that respects environmental sustainability, either by directly reducing exposures to NCD risk factors or through being sensitive to broader determinants of health, will have protective effects on health.

Capacity development and NCDs

- Since 2000, WHO has monitored country capacities to respond to NCDs. Using a survey instrument, countries are asked, for example: whether there are multisectoral initiatives to address NCDs[57] and mechanisms in place to coordinate them; whether ministries of health have dedicated NCD units or personnel; and whether there are national NCD- and risk factor-specific strategies, and, if so, their status of implementation and budgets.

- The most recent survey results, from 2010, showed a generally weaker capacity in lower-income countries, namely weak infrastructure, inadequate implementation and funding of high-quality policies and plans to address NCDs, inadequate population-based surveillance and funding for surveillance, and gaps in health system responses.

The UNDP examination of UNDAFs also found capacity gaps. To allow a causal analysis of NCDs, risk factors and social determinants, data on NCDs and their risk factors, disaggregated by sex and age, are needed, as is additional granularity on locality, ethnicity, education and income.

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52. Norman RE, Carpenter DO, Scott J et al., 'Environmental exposures: an under-recognized contribution to noncommunicable diseases', Rev Environ Health 2013, 28: 59-65.

53. World Health Organization, 'Preventing disease through healthy environments – towards an estimate of the environmental burden of disease', WHO, Geneva, 2006.

54. Friel S, Bowen K, Campbell-Lendrum D et al., 'Climate change, noncommunicable diseases and development: the relationships and common policy opportunities', Annu Rev Public Health 2011; 32:133–47. International Diabetes Federation, 'Diabetes and Climate Change: Interconnected Global Risks to Health and Development', 2012.

55. Lecours N, Almeida GEG, Abdallah JM and TE Novotny, 'Environmental health impacts of tobacco farming: a review of the literature', Tob Control 2012; 21:191-96.

56. Edwards P and I Roberts, 'Population adiposity and climate change', Int J Epidemiol 2009, 38: 1137-40.

57. World Health Organization, 'Assessing national capacity for prevention and control of NCDs', WHO, Geneva, 2010.

Results-based

- The Global NCD Monitoring Framework with 25 indicators and the set of nine global NCD targets for 2025 (see Annex 1) can be used to develop potential outputs for the results-based matrix/joint work plans in the UNDAF. The results matrix should also consider best buys and other priority interventions, as elaborated in Table 2.

Annex 9. Conflict of interests

In accordance with the WHO Global NCD Action Plan 2013-2020, public health policies for the prevention and control of NCDs must be protected from undue influence by any form of commercial and other vested interests[58,59]. Engagement of non-State actors on NCDs shall demonstrate a clear benefit to public health, and support and enhance the scientific and evidence-based approaches that underpin the WHO Global NCD Action Plan 2013-2020. These engagements shall be activity managed so as to reduce and mitigate any form of risk to the concerned government, the UN agency and the UNCT (including conflict of interests), and shall be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.

Hence, engagement with non-State actors shall be limited by clear boundaries. Heads of State and Government have recognized the fundamental conflict of interest between the tobacco industry and public health[60]. WHO and UNDP, for example, do not engage with industries making products that directly harm human health, including specifically the tobacco or arms industries. WHO's processes in setting norms and standards must be protected from any undue influence, and WHO's engagement with non-State actors must not comprise WHO's integrity, independence, credibility and reputation.

Within the context of integrating NCDs into UNDAFs, the engagement by governments and UN Country Teams with non-State actors can take different forms, be subject to different levels of risk, and can involve different levels and types of engagement:

- Participation at meetings organized by the government and/or UN Country Teams;
- Resources, i.e. funds, personnel or in-kind contributions;
- Evidence, i.e. gathering and generation of information and management of knowledge and research;
- Advocacy, i.e. action to increase awareness of NCD issues; and
- Technical collaboration.

58. In accordance with the overarching principles and approaches included in paragraph 18 of the WHO Global Action Plan 2013-2020 which states that multiple actors, both State and non-State actors including civil society, academia, industry, non-governmental and professional organizations, need to be engaged for NCDs to be tackled effectively. Public health policies, strategies and multisectoral action for the prevention and control of NCDs must be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed.

59. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control on the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry.

60. Paragraph 38 of resolution of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs.

Synergies between sectors and possible entry points to reducing the harmful use of alcohol and dietary salt reduction, for example, are presented in Annexes 6 and 7.

Before engaging with any non-State actor, and in order to preserve its integrity, UN Country Teams shall conduct due diligence, which implies at least the following:

- Clarify the interest of the non-State actor in engaging with the UN Country Team on UNDAFs and what they expect in return;
- Establish a general screening of the non-State actor;
- Determine status, area of activities, governance, sources of funding, constitution, statutes and by-laws, affiliation;
- Define main elements describing the history of the non-State actor (human and labour issues, environmental, ethical and business issues, reputation and image, as well as the financial stability of the examined non-State actor); and
- Identify “red lines”, such as activities that are incompatible with the WHO Framework Convention on Tobacco Control, WHO Global NCD Action Plan 2013-2020, WHO Global Strategy to Reduce the Harmful Use of Alcohol, WHO Global Strategy on Diet, Physical Activity and Health, WHO Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children, International Code of Marketing of Breast-milk Substitutes, etc.

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