1. **Global Monitoring Framework (GMF) on NCDs**:
   - General recognition for the work of WHO and Member States in agreeing a comprehensive and ambitious [global monitoring framework](#), with 9 targets and 25 indicators.
   - The baseline for all targets will be 2010. Member states will report on targets every five years to WHA – in 2015, 2020 and 2025. **It was pointed out that reporting every 5 years on the GMF is insufficient – it should be more regular.** In the case of HIV/AIDS, member states are required to submit country progress reports to UNAIDS every two years, and the UN Secretary General also reports regularly to the UNGA on country progress.
   - Question was raised about progress WHO Secretariat had made on *interim targets for 2015 and 2020*. This was included in the GMF paper and is referenced in the GAP, but to date, have not seen evidence of progress.
   - In the UN Political Declaration on NCDs, also commits member states to adopt national targets. WHO is developing a Toolkit on NCD Surveillance, which will include a module on setting national targets and measuring results.

   - Scope of [Global Action Plan (GAP)](#) needs to be [applicable for all countries](#), not just low- and middle-income countries. High-income countries have significant NCD burdens, and the GAP needs to drive action in these countries.
   - In general, GAP is very long with vague language. Needs to be tightened up to be more concise and action-oriented. Suggestion was made for a [companion shorter plan for communication purposes](#) – to raise awareness/understanding of issues/actions to broad non-expert audience. The [UN Global Strategy for Women and Children’s Health Executive Summary](#) was pointed to as a good example.
   - More work needs to be done to [incorporate overarching principles](#) into the objectives and actions points (particularly life course and gender). It was suggested that an additional principle – conflict of interest – is added, as this is an issue that runs throughout the GAP.
   - GAP needs to be [costed and fully resourced](#). Need a new section in the GAP on this, as was the case with the previous GAP 2008-2013. WHO needs to estimate their own cost of implementing the GAP. WHO said they will be developing a WHO Business Plan based on the GAP, outlining . It is important this cost is reflected in the WHO biennial Programme Budgets starting with 2014-2015.
   - Greater [synergies needed between the GAP and other plans currently being developed](#) – including [Global Mental Health Action Plan 2013-2020](#) and the [Blindness Plan](#). Issues such as dementia, including Alzheimer’s, overlap between the plans. And as more people are suffering from multimorbidities, important that the different plans accommodate for that, particularly in terms of the health system response.
   - **Objective 3**: Suggestion was made to integrate physical activity across other objectives - for example as a therapeutic tool in the treatment section of GAP. On tobacco control, the differences in the legally binding nature of the FCTC compared to the GAP was emphasized, and the need to leverage this to strengthen one another. Caution should be exercised to prevent opponents from instead using the two to exploit weaknesses. Caution also raised on alcohol industry, as outlined in a [statement of concern](#), misinterpreting recommendations in the GAP.
   - **Objective 4**: Issue of “affordability” of essential medicines was raised. Focus should not be so much on developing new products, but improving availability and affordability of existing NCD
medicines. Greater emphasis needed on health system strengthening under this objective, particularly to drive progress in awareness, risk assessment and early detection/screening services at primary care level, and referral mechanisms to diagnosis, treatment and palliative care services at secondary and tertiary service levels. Also more emphasis on multidisciplinary teams was stated, and support for more tools from WHO Secretariat to assist Member States in translating action points on patient-centred care and self-management.

- **Objective 5:** Need more investment in good research to improve quantity and quality of data on NCDs in LMICs. Three areas of improvement were identified: capacity-strengthening through inclusion of researchers under workforce in GAP; retention; and more explicit consideration of how to build capacity in-country.

- **Appendix 1** identifies synergies between NCDs and other health issues. Although mental health is highlighted as an important synergy, the GAP action points do not reflect this, particularly for dementia including Alzheimer’s. There needs to be greater focus on social determinants of health, and more action points to galvanise health-in-all-policies approach. These synergies can also be leveraged through the Global Coordination Mechanism.

- **Appendix 3** and **Appendix 8** on priority actions are the “implementation” section of the GAP. These need to be living documents – so they can reflect new evidence/tools etc. WHO secretariat supported this. They are currently missing key elements though – including palliative care and actions for chronic respiratory disease. Their exclusion is based on cost-effectiveness criteria – NCD Alliance is providing evidence on both.

- **Appendix 6** on process indicators was not separately discussed during the consultation. WHO explained current list of process indicators are drawn from country capacity survey. However NCD Alliance believes currently proposed set needs to be strengthened. Will provide recommendations in detailed submission.

- Need to further integrate the targets and indicators into the GAP. Each objective needs to have dedicated targets/indicators/process indicators to measure progress. WHO stated reason for not having comprehensive table on “measuring progress”, as suggested by NCDA, is because GMF is negotiated text by Member States, and therefore do not want to confuse. But if Member States support, they can develop this.

- **WHO presented on the proposed reporting framework for NCDs:**
  
  - **World Health Assembly:**
    - Every 2 years starting 2015 on implementation of the GAP and process indicators. **Unclear if this means NCDs will not discussed every year at WHA.** Important NCDs have an agenda item at WHA annually.
    - Every 5 years starting 2015 on the 25 global monitoring framework indicators (i.e. measuring trends). **Need to clarify if this includes the 9 targets too, as this was not clear in WHO presentation and follow-up discussions. NCDA believes every five years is inadequate frequency for reporting.**

  - **UN General Assembly:**
    - UN Secretary General Progress Report on NCDs due end of 2013. WHO will present to SG in August, and the report will then be discussed at the UNGA in Nov-Dec 2013. The report will include 2 parts: progress on WHO commitments from the Political Declaration; and national progress via country capacity surveys.
    - Important to note that **reporting on NCDs to UNGA must continue** beyond this UNSG progress report. Needs to happen regularly. Also, the review and assessment due in 2014 is critical, and must be high-level and one day in length. The **Modalities Resolution for this review/assessment will need to be in Dec 2013 or Jan 2014, and should include references to an Outcomes Document.**
Global Status Report on NCDs:

- In addition, it was proposed that WHO convene a representative group of stakeholders (including civil society and private sector) to do a mid-term evaluation of the GAP in 2015. This was included in the GAP 2008-2013 as an action for the WHO Secretariat (para 39 d.), however it did not happen last time. 2015 will be good timing in light of the new post-2015 development agenda and potential links to be made within the GAP. This group could be linked to the Global Coordinating Mechanism.

3. Global Coordination Mechanism for NCDs:

- UN Task Force on NCDs likely to be formalized at ECOSOC in July 2013. The Task Force will be the means to coordinate across UN agencies/programmes on NCDs. It will include approximately 20 members. WHO will be the secretariat. Rather than establish a stand-alone Task Force, it is likely that the UN Task Force on Tobacco Control will be expanded to all NCDs, with new terms of reference. Next meeting of the Task Force is 13-15 March in Geneva. Important that when the Task Force is expanded, it fully reflects the full NCD agenda. There will be significant differences from the tobacco control TF’s current mandate – i.e. FCTC is legally binding, while the GAP and Political Declaration on NCDs is not. And NCD Alliance recommended a focal point in New York is identified to support facilitating this Task Force.

- General agreement that the schematic in appendix 4 on Global Coordination Mechanism (GCM) requires greater detail. Schematic is insufficient – it has no explanation of the different elements. Needs to be fleshed out, with detail on the different components of the GCM and how it will report.

- In response, WHO presented their thinking behind the GCM. It is a combination of options 2 and 3 from the UN Secretary General Report on partnerships from November 2012 (i.e. a coordinated network and a social movement). It will be a light-touch mechanism, housed within WHO to drive 6 functional gaps (coordination; advocacy; financing; capacity building; product access; product development). Would include secretariat in WHO; an advisory council; forum or market place; database with current activity; and working groups. WHO explained that their proposal is similar to the Road Safety Partnership, and is essentially an updated version of WHO NCDnet from a few years ago.

- Major difference from the NCD Alliance proposal for a global coordinating mechanism is that the WHO proposal recommends it is informal, rather than formal. Formal entails a legal entity and “agenda setting”, like other WHO hosted partnerships. Current hosted partnerships were discussed at the WHO Executive Board this year, in an attempt to harmonise them and address their shortcomings. A ‘formal’ mechanism would take longer to set up, as it has to go through the Programme, Budget and Administration Committee of the Executive Board (PBAC) and would therefore not be ready for WHA in May when the GAP will be adopted.

- Support for a phased approach to the GCM. NCDA maintains that a formal structure is essential, as piecemeal/informal approaches to date have been ineffective. But in order to get things moving, propose to start off with an informal collaborative arrangement (as proposed by WHO) included in the GAP for WHA to adopt in May. But with the long term aim of making it formal.

- Leadership and resourcing of the GCM is key. Setting up the GCM and ensuring it is sustainable and effective will have a cost, either if it is formal or informal. If WHO is to be the secretariat, it is critical they have sufficient resources to ensure the GCM is successful. In WHO Programme Budget, NCDs have 3 lines (implementation of GAP; international cooperation and partnerships; and monitoring and surveillance). Through the partnerships line in the budget, it will be possible to mobilise funding/resources. Leadership of Member States in the GCM will also be critical.
• **Question of how the GCM would report** – if it is informal, it would have no formal reporting. But should report regularly to the WHA via reporting cycles of the GAP. It is also important that this reporting of the GCM links into reporting up to the UN General Assembly.

• **Social movement element of appendix 4 was also raised.** General agreement that it is inappropriate in this context – WHO is not the body to be catalyzing a social movement. Has to happen organically, and we all are contributing to it. Also, it is too vague in the current appendix. **Recommend removing from schematic.**

• **Issue of conflict of interest** was raised, and the need for “private sector” to be more clearly defined. Should clearly state which parts of the private sector are in/out.

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1 These are informal notes by the NCD Alliance. NGO’s in attendance at the WHO Informal Consultation were: Alzheimer’s Disease International (ADI), European Alcohol Policy Alliance (Eurocare), Framework Convention Alliance (FCA), World Dental Federation (FDI), Global Alcohol Policy Alliance (GAPA), Global Advocacy for Physical Activity (GAPA), Global Alliance for Chronic Diseases (GACD), Health Action International (HAI), International Alliance of Patient’s Organizations (IAPo), International Insulin Foundation (IIF), International Olympic Committee (IOC), International Union for Health Promotion and Education (IUPHE), NCD Alliance, Worldwide Palliative Care Alliance (WPCA), Union for International Cancer Control (UICC), World Lung Foundation (WLF), World Heart Federation (WHF), World Stroke Organization (WSO).