Guidance note for UN Country Teams on ensuring that Health and equity issues, Health *2020* Policy framework, and Non-Communicable Diseases prevention and control are integral parts of UNDAF in fulfillment of the mandate of the UN Political Declaration

I. Purpose

This Guidance Note aims to assist the United Nations Country Team (UNCT) to ensure that Health, Equity and NCDs prevention and control are integrated into the United Nations Development Assistance Framework (UNDAF). This will provide added value in national efforts to address the Social Determinants of Health (SDH) and Non Communicable Diseases (NCDs), and better position health in the context of social and sustainable development agendas. The note contains key messages, entry points, narratives and evidence.

II. Background

Given a) the new prominence and recognition of Health in all development processes and the growing interest of Member States in the implementation of the European Policy for Health, *Health 2020*, which addresses the inverse relationship between socio-economic factors and health outcomes;

Given b) the UN General Assembly Political Declaration on NCDs[1] , governance for Health needs to feature very high in the formulation of the UNDAF outcomes. Depending on the country's context, the UNCT may decide together with the Government and the civil society that Health should become an UNDAF outcome in its own right or have a prominent focus in the social development agenda but also in all the other domains of cooperation.

There are also several programming principles for UNDAF including the following which are directly linked with health: human rights-based approach; gender equality; environmental sustainability; and results-based management (RBM).

Health 2020's central goal is to achieve well-being by improving health overall and reducing inequities, using amongst its four strategic priorities a life course approach as inequalities and the health divide are perpetuated between generations. WHO will continue to advocate that such a lens, with healthy people at the centre of development processes, is catalytic to support countries to develop capacities to lead towards sustained and inclusive growth, peace building, human rights, and gender equality.

At the heart of *Health 2020*, NCD control and the sustainable development concept is the belief that social, institutional, economic and environmental objectives are interdependent, complementary, mutually reinforcing and coherent. UNDAF-supported analysis and programming are ways to bring these concerns to the centre of the national development debate and framework.

There are four mandatory steps for the UNCTs in the process of developing an UNDAF:

1. Road map outlining the preparation process of the UNDAF
2. Country analysis (CA) to inform the strategic planning step of the UNDAF

[1] UN General Assembly Resolution 66/2, annex: High-level Meeting of the UN General Assembly on the Prevention and Control of Non Communicable Diseases (NCD)

3. Strategic planning, including:
    - Priorities, i.e. which national development priorities are supported for UN action?
    - Set of outcomes to support each national development priority
    - A results matrix (i.e. indicators, baselines, targets, means of verification, risk and assumptions, role of UN partners, and resources)
4. Monitoring and evaluation

Each of these stages provides key opportunities for WHO to highlight health needs and identify potential ways to include Health 2020 and NCDs into the UNDAF.

III. WHEN and HOW can *Health 2020* and NCDs be integrated in the UNDAF?

1. Roadmap preparations:

- From the beginning close involvement of all UN Agencies and programmes to co-organize workshops with the Government on intersectoral action, including health , education, social protection etc.
- Conduct a round of consultations and negotiations with agencies, civil society and other relevant partners to present the relevance of H2020 and NCDs for the UNDAF. Building partnerships and identifying programmatic synergies is essential while UNDAF priorities are identified.

2. Country Analysis (CA):

- Engage with all key sectors before and during the CA – not just on the health problems and the health sector response. Demonstrate how population health is important for inclusive growth and social development through, for example, the impact on employment and labour market productivity. See the key messages in next section.

3. Strategic planning:

- Engage development partners during the planning stages to ensure that the Social Determinants of Health (SDH), the reduction of inequalities and the prevention and control of NCDs are integrated. See annex 2 for examples of joined-up government action.
- Engage key non health sectors while promoting H2020 and NCD concepts when identifying UNDAF priorities. Strategic positioning for UNDAF preparation will require assessing entry points and ensuring that other major country policies are "fertilized" with H2020 and NCD policy principles. Several countries are developing UNDAFs that are coordinated with or even aligned with World Bank Poverty Reduction Strategy (PRSPs) or the EU's National Strategy for Social Economic Development (NSSED).
- Utilize legislative tools for setting up structure for health promotion.
- Estimate systematically investments needed for joint UN and broader action - Whole of Society (WOS) and Whole of Government (WOG).

Tips for greater impact when advocating and promoting *H2020* and NCDs concepts

- ✓ Work with high-level champions such as mayors or celebrities
- ✓ Advocate for dedicated resources based on taxation of specific products e.g. tobacco, alcohol for the coordination of inter-sectoral action

- ✓ Utilize institutional structures whenever they exist, such as health promotion agencies, advisory task forces, local government.
- ✓ Promote joint quality planning with stakeholders, including community-based organizations.
- ✓ Identify accountable parties within or out of the health sector

4. Monitoring and evaluation:

- Incorporate the Health 2020 and NCD framework for evaluation and indicators of success. Results are important as show case for advocacy
- See Annex 3 and 4.

IV. WHAT? Rationale and content of the messages on Social Determinants of Health, Health 2020 and NCDs for UNDAF

The Table below outlines examples of entry points for each UNDAF cooperation domain (a deeper discussion of these issues is found in Section VI: Pathways for Cooperation)

UNDAF possible domains of cooperation	**SDH entry points**	**Health 2020 entry points**	**NCDs entry points**
Governance (electoral reform, rule of law, anti-corruption regulations, accountability)	Discriminatory laws and regulations. Use of common data frameworks to monitor NCDs and risk factors in all populations and social groups.	Leadership and participatory governance for health, community empowerment.	WHO Framework Convention on Tobacco Control. Reduce harmful use of alcohol. Regulations and voluntary agreements for salt and fat in processed food.
Social development	Housing tenure and security, employment conditions, education and lifelong learning. Combat stigma and discrimination towards vulnerable population.	Life course approach and intergenerational solidarity, Universal Health coverage, Health promotion and Ottawa charter.	Develop evidence-based and culturally competent integrated models of prevention and care. Develop culturally competent approaches on diet and physical activity.

Inclusive Economic growth	Economic and health inequalities analysis, Employment conditions, community-municipality participation and empowerment in decision making processes. Access to quality education. Value of reducing health gaps to the attainment of inclusive development objectives	Highlight interaction between health and welfare. Highlight financial contribution that the health sector Universal Health coverage. Social protection floor. Local authorities and associations' empowerment in decision making processes.	Highlight the cost of NCDs to the economy (see below key messages and the pathways section). Ensure health promotion to most disadvantaged and vulnerable populations.
Crisis Management	housing tenure and security, employment conditions, education and lifelong learning	Community resilience, Emergency preparedness, surveillance and response.	Ensure continuity of care for chronically ill people during the acute period of crisis.
Environment and Climate Change	Differential exposure to indoor/outdoor air pollution, radioactivity, U.	Document health benefits of low-carbon economy. Expanding interdisciplinary and intersectoral collaboration between human, environmental and animal health.	Protect population from passive smoking, indoor and outdoor air pollution. Provide green areas and facilitate active transport.
NCD control and SDH	Housing tenure and security, employment conditions, education, physical activity, differential exposure to processed food products or toxic wastes, nutrition habits…	Strengthen health promotion and disease prevention by reallocating resources. Remodel the continuum of care, people-centered primary health care approach.	Ensure universal coverage with an evidence-based package of essential interventions in primary care. Ensure financial protection from catastrophic costs of illness.

The key messages below provide selected supportive narratives.

- Social determinants of health are the conditions in which people are born, grow up, live, work and age. These include housing tenure and security, employment conditions, participation in education and lifelong learning, and the richness of community resources. These determine a person's opportunity to be healthy, his/her risk of premature illness and overall life expectancy. Social determinants are important in achieving the health and well-being goals of modern societies. They are also the keys to explaining the avoidable differences in health across our societies (i.e. the social inequities in health). All these are factors that can be modified and improved by policies.

- National, regional and local government policies designed to a) reduce poverty: b) increase social cohesion: c) reduce vulnerability and d) promote inclusive and sustainable development, offer major entry points to address the determinants of health. If due attention is given to the health and equity impacts of such policies they offer one possible route to transform health from being perceived as a medically dominated money-consuming sector to a major public good that brings economic and security benefits and contributes to attainment of key social objectives.

- Making the case for health in development policies and frameworks requires i) economic arguments for addressing the social determinants of health, ii) demonstrating the value of reducing health gaps to the attainment of inclusive development objectives iii) highlighting the financial contribution that the health sector makes to local and national economies e.g. employment procurement, research. iv) reorientation of health sector activities towards integrated models of prevention and care and through strengthened public health and health promotion.

- There are different entry points for cross sectoral policies for health and equity, including those designed to ensure universal health and social protection and including wider public policies for social inclusion, poverty reduction and inclusive development. Some of these approaches have been used in the social development cooperation domain of recent UNDAFs e.g. in Georgia and Ukraine. A more integrated approach, partnering with the civil society and using a Whole Of Society (WOS) approach in addition to a Whole of Government (WOG) approach appears promising if early engagement is sought with UN sister Agencies and different sectors involved in social development (education, labour, transport etc.)

- Social determined health inequities are not only unfair, but they also carry significant costs to society. The avoidable cost of health inequalities to EU Member States is up to €980 billion every year (Mackenbach, Meerding and Kunst, 2011).With the right mix of policy measures, strong political commitment and the use of good governance approaches, we can reverse trends for the better of all in our societies.

- Addressing effectively and comprehensively the prevention and control of NCDs in particular requires a strong focus on inter-sectoral governance, the social determinants of health, human rights and gender as well as a adopting life-course and people centered approaches.

- NCDs are the leading causes of death worldwide; more people die from NCDs than from all other causes combined. In the WHO European Region, the four major NCDs (cardiovascular disease, cancer, respiratory diseases and diabetes, account for 77% of the burden of disease and almost 86% of premature mortality *(European NCD Action Plan)*

- Premature death, or living long term with an NCD or related disability has socioeconomic consequences and constitutes a double burden to sustainable social and economic development. Reduced income and early retirement caused by NCDs can lead individuals and households into poverty. At the societal level, in addition to surging health care costs are increased demands for social care and welfare support as well as the burdens of the impact of absenteeism from school or work, decreased productivity and employee turnover *(from burden to best buys)*

- Premature mortality can be prevented: estimates indicate that at least 80% of all heart disease, stroke and type 2 diabetes and at least one third of cancer cases are avoidable. Early death can be partly countered by effective action dealing with four key behavioural risk

factors: unhealthy diet, physical inactivity, tobacco use, the harmful use of alcohol and, in particular, the social determinants of these risk factors *(from burden to best buys)*

- The Global NCD Action Plan 2013-2020 explains a set of core actions that constitute a package of interventions that are cost-effective and affordable for countries of all income categories. The Global Action Plan unites governments, international partners and WHO around a common agenda *(Global NCD Action Plan)*

- Fiscal policy can be used to improve health outcomes by encouraging positive behavior (e.g., healthy eating) and discouraging negative behavior (e.g., smoking)

Selected evidence for Economic Gain and Cost-Effectiveness of addressing SDH and NCDs

- The avoidable cost of health inequalities to EU Member States is up to €980 billion every year (Mackenbach, Meerding and Kunst, 2011).

- Cardio vascular disease costs 169 billion Euro annually in the EU with health care accounting to 62% of cost.

- Alcohol related harm costing 125 billion Euro annually to the EU, equivalent to 1.3 % of Gross Domestic Product.

- Tobacco 10% price increase in taxes could result in up to 1.8 million fewer premature deaths at a cost of US$ 3–78 per disability-adjusted life-year (DALY) in eastern European and central Asian countries

- Hungary in 2011 earmarked tax on sugary drinks, confectionery, and sugary/salty snacks: early results show product reformulation and reduced consumption

- In Denmark , modeling shows reducing tax on vegetables and fruit by 25% and increasing tax on foods high in fats and sugars by 33% is most effective scenario for people on low incomes

- Reducing mortality rate for ischaemic heart disease and stroke by 10% would reduce economic losses in LMICs by an estimated US$ 25 billion per year, which is three times greater than the investment needed for the measures to achieve these benefits

V. Pathways for Cooperation: Deepening the links between social determinants, development, and NCDs linked to UN agency mandates

In September 2011, at a High-Level Meeting of the United Nations, Heads of State and Government adopted a Political Declaration on the prevention and control of NCDs. They recognized that NCDs profoundly undermine sustainable human development goals particularly in low- and middle-income countries and that NCDs cause substantial economic burden – over the next 20 years, NCDs are predicted to cause a cumulative output loss worth US$47 trillion, representing 75% of the 2010 global GDP. Developing countries, especially those at middle-income level now, are expected to assume a growing share of the losses. [i,ii]

The Secretary-General, in collaboration with the Director-General of WHO and in consultation with Member States, UN funds and programmes and other international organizations, called for accelerated action to strengthen and facilitate multisectoral approaches and partnerships directed at equitable social and economic development.

Why do we need to integrate NCD into the UN response to the achievement of development priorities?

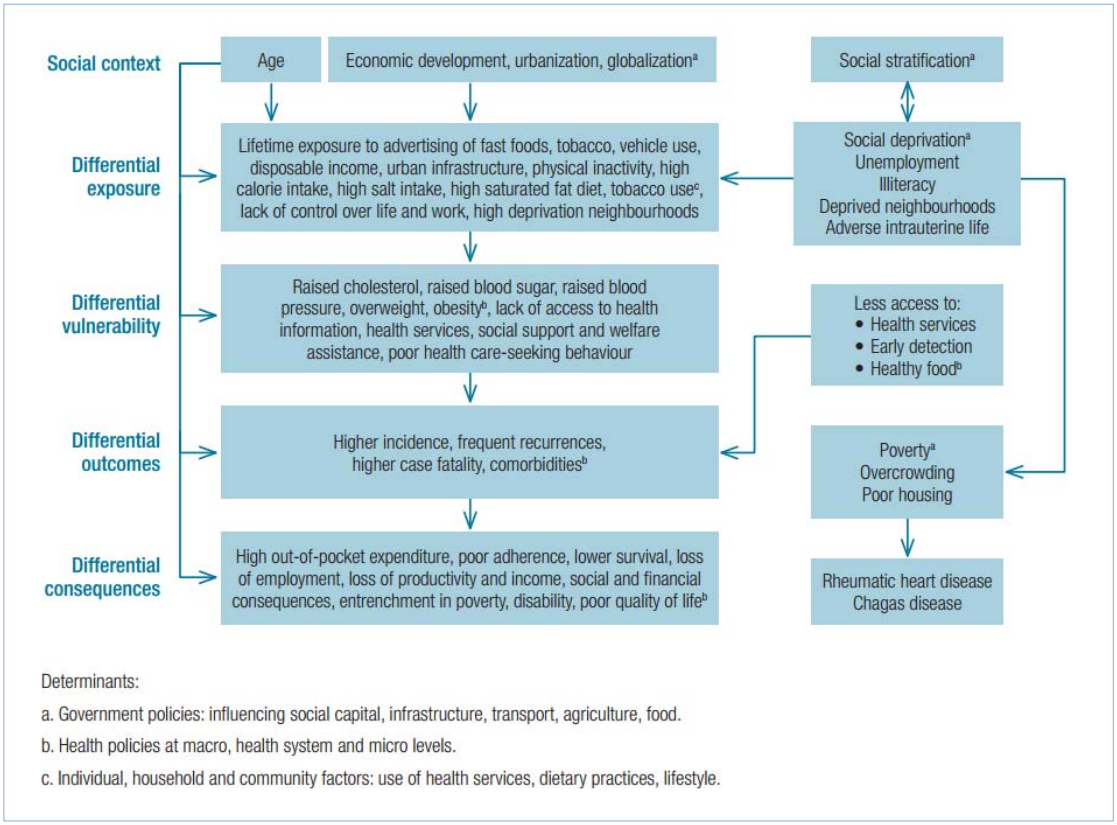
NCDs are at epidemic levels and rising. They account for 48% of healthy years of life lost (more than communicable diseases) and 63% of all deaths, chiefly from cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.[2]

NCDs cause substantial economic loss. Macroeconomic simulations predict that over the next 20 years, NCDs will cause a cumulative output loss worth US$47 trillion, representing 75% of the 2010 global GDP. Developing countries, especially those at or approaching middle-income level, absent effective interventions, are expected to assume a growing share of the losses.[2]

A feasible approach to prevent the onset of NCDs is to deal with the most important determinants of NCDs, the root causes: the structures and circumstances that stratify society. Policies that aim for equitable economic growth and prosperity, education, working environments, and access to health care and that intend to tackle poverty and unemployment are most likely to produce significant health gains in terms of NCDs.

Being poor, experiencing discrimination and marginalization because of gender, ethnicity or disability, and having relatively little economic power and social privilege determine ill health. People who have low socio-economic status and who live in poor or marginalized communities are more likely to die of NCDs than more advantaged people; hypertension and harmful use of alcohol are more common among people with lower educational achievement; lower education is associated with increased risk of diabetes.[iii,iv]

The conceptual framework below shows the pathways between socio-economic, political and cultural contexts and equity, health and wellbeing.[v]



The determinants along the pathways are also the key to how national policies with UN assistance can narrow the disparities in health outcomes between the least and most privileged within society. Below are perspectives and questions to prompt applying an NCD- and risk factor-

specific perspective to the country analyses and strategic planning steps in UNDAF preparation as they relate to various national development themes.

NCDs and inclusive economic development

NCDs hit the economy hard and impede the achievement of global development goals. They are intimately connected to both the health and poverty agenda of the Millennium Development Goals and the sustainable development cum universal health coverage agenda of the Post-2015 goals.

The rise in NCDs in developing countries is occurring on a compressed timeline compared to high-income countries, with the LMIC and their populations having a limited capacity to respond. Between 1990 and 2008, deaths due to NCDs in LMIC rose sharply, from just under 40% of all deaths to approximately 80%. Moreover, in LMIC, 29% of NCD-related deaths occur among people under the age of 60, this compared to 13% in high-income countries.[1, vi]

Influencing the most powerful determinants of how NCDs are distributed within populations requires macro level intervention – laws and policies that shape societal structures for power, resources and opportunity to distribute economic gains equitably. The challenge with NCDs is to make the broader social and economic policies and programmes, whose core business is not health, more NCD-responsive. [vii,viii]

As policy makers across sectors examine their respective development potentials, they can explicitly assess all policies and interventions being proposed by asking two questions: [4,8]

- Will daily living conditions be improved equitably?
- Are the inequities in the distribution of power, money and resources being tackled?

As UN country teams analyze a country's economic development status and potential, it is important to acknowledge that the most powerful determinants of NCDs are the same macro level interventions that with development assistance are shaping societal structures for power, resources and opportunity.ix,x Key among them are, for example, trade agreements and agricultural development.

With trade, caution must be applied in the consideration of new global, regional, or bilateral commitments. Before such commitments are made, the effects on health, the social determinants of health, and health equity must be fully understood. Assessing the beneficial and negative impacts on NCDs would include asking questions such as:[xi]

- Will reducing tariffs on food imports, making products more affordable, encourage consumption of highly processed products high in fats, sugars and salt?
- To what extent will the loss of tariff revenues affect public funding for education and healthcare?
- Will foreign investments in sectors such as education and healthcare increase or decrease access?
- Will protections for foreign investors ease the advertising, marketing and sale of tobacco and alcohol? Will the protections restrict government policies to reduce the harm from these products?

In the agriculture sector, questions can be:

- Will agricultural productivity increase the quantity and quality of food available to poor households?

- What is the impact of subsidies and other production incentives on fruit and vegetable growing for local consumption?
- Are the seeds, plants and fertilizers needed for fruits and vegetables priced such that they are affordable for small household or farm production?
- Will dietary diversity of rural households be promoted? Will it include fresh fruits and vegetables?

NCDs and human capital development

NCDs are barriers to sustainable development of human capital. People in LMIC experience NCDs at younger ages; have longer periods of illness; more premature deaths; and are increasingly obese.[xii]

The rise of NCDs among younger populations is jeopardizing the "demographic dividend" – the economic benefits expected when a relatively large part of the population, the case in LMIC, is of working age.[xiii]

Country productivity and competitiveness can suffer and opportunities are potentially lost because of NCDs. Economists are increasingly expressing concern that NCDs will result in long-term macroeconomic impacts on the labour force with the consequences most severe in developing countries. Globally, the labour units lost owing to NCD deaths and the direct medical costs of treating NCDs have reduced the quality and quantity of the labour supply and human capital .Business leaders, surveyed by the World Economic Forum, in particular those in countries where healthcare quality and access are perceived as poor, report a high degree of concern that their companies' performance will be hurt because of NCDs among employees. **NCDs contribute to absenteeism, poor performance on the job because of disability and loss of skilled workers.** [2,3]

While full, fair and decent work is integral to health, reduction of the health gap requires that governments also build systems of social protection **At the household level, among working poor, catastrophic illness and out-of-pocket expenditure for treatment drain income** that otherwise could be spent on e.g. education, representing a lost opportunity for economic advancement of children, particularly girls. Similarly, premature death of an income-earner or disability rendering people unable to work, can force a loss of savings and assets and tip households into overt poverty.

NCDs among women have far reaching impacts on development. This is particularly so in countries where women can experience economic, socio-cultural and geographic barriers to healthcare. **NCDs impede women's empowerment, undermining their roles in productive and reproductive life.** In cases where the mother in a household becomes chronically ill, mortality among children has been shown to rise and children withdraw from school in order to work to compensate for the mother's lost earnings. [xiv]

Universal coverage of essential health services to prevent and control NCDs and poverty reduction that includes protections from financial hardships due to illness help secure equitable human capital development.

In economic terms, the return on investments that promote and protect health and build healthy human capital can be many billions of dollars worth of additional outputs; in social terms individuals can have their abilities to lead full and productive lives restored or continued.

In designing development assistance that aims to build and protect human capital, questions related to NCDs could be:

- Do employment standards allow for sick time?

- Does poverty reduction include protection of households from poverty due to out-of-pocket health expenditures for longer-term treatment or catastrophic incidence of NCDs? [xv]
- Could taxes on tobacco and alcohol and licensing fees for retail outlets generate revenues for governments to direct to universal healthcare and health promotion?

NCDs, sustainable development and healthy environments

While expanding globalization and urbanization are hallmarks of development, social protections in the environments where people live and work are lacking. Add to this a low capacity and inaccessibility of healthcare and **the inequities and risk factor exposures they perpetuate reinforce a detrimental link between development and NCDs, and as NCDs increase, they undermine the progress in development.** [xvi]

Consumption-based growth is a key characteristic of the rapid development in LMIC as households gain purchasing power. With it comes increased exposure to modifiable risk factors: global food systems are changing local food environments by supplying and marketing highly processed affordable foods; emerging consumer markets are attracting the global alcohol industry; and people are becoming increasingly sedentary as motorized transportation becomes convenient and affordable and workplaces more mechanized. [xvii,xviii]

With accelerated development where environmental protection cannot keep pace, populations especially children can be exposed to risk factors for NCDs. Most cancers are caused by environmental exposures in genetically susceptible individuals and new information shows significant associations between cardiovascular diseases and diabetes and exposure to hazardous chemicals, heavy metals and radiation. [xix]

Rapid and large scale urbanization is resulting in slums and air pollution, unsafe and exploitative workplaces and environmental degradation, affecting determinants such as safe and secure housing, sanitation, clean drinking water supply and safe transportation. Also affected are the distribution, accessibility and affordability of healthy fresh foods. [xx,xxi]

An NCD perspective on sustainable development will focus on where people live and work. Social protections and health promotion in these settings may be lacking or need reinforcement. In addition, if there is low capacity and inaccessibility of healthcare, then **the inequities and risk factor exposures they perpetuate reinforce a detrimental link between sustainable development and NCDs, and as NCDs increase, they undermine the progress in development.**

Common settings are schools and workplaces where healthy behaviours can be taught and/or promoted e.g. school curriculum on nutrition, cooking practices, physical activity and work site health-related information and services e.g. availability of smoking cessation. The interventions can furthermore target the most vulnerable and marginalized groups in the settings.

A country analysis within the UNDAF preparation relating NCDs to sustainable and healthy environments can include the following questions:

- Do regulations on workplace safety include making workplaces smoke-free?
- Are there laws and regulations on drunk driving? Are they enforced?
- Are land-use, urban design and transportation policies coordinated to privilege walking and bicycling over car traffic; do plans include clean, safe and accessible public spaces?
- Are manufacturing processes being managed to avoid detrimental impacts on workplace air quality and exposure to hazardous substances? Are manufacturer and producer responsibilities clear and enforceable?
- Is transportation infrastructure such that local fresh fruits and vegetables can be delivered efficiently to urban settings? Is there infrastructure to support accessible urban markets for both farmers and consumers?

NCDs and democratic development, empowerment and governance

With population health being the product of diverse and complex factors outside the control of a single government sector, the governance of public institutions responsible for the environments where people live and work, from local to national levels, must be integrated, effectively a whole-of-government approach. **Democratic development leads to governance of health-in-all-policies that is inclusive** The governance mechanisms must reflect the multisectoral nature of factors that determine health and at the same time their processes need to include assessments of the impacts on health of the non-health sector policies and interventions.

To help ensure fair decision making to achieve health equity, reaching beyond government to involve civil society and the voluntary and private sectors is vital. All the stakeholders who shape and live in day-to-day environments can be empowered through fair representation in decisions by a socially inclusive framework for policy making – a whole-of-society approach – about how society operates.[9]

Engagement in democratic processes and involvement in governance mechanisms also manifests at the individual level. **People who are living with long term NCDs, if they become disenfranchised and disempowered through, for instance, impoverishment, cannot participate in democratic initiatives and institutions where their involvement in governance would serve their interests**. For example, community-based interventions that prioritize addressing exposure to modifiable risk factors in local environments require the active engagement of local residents. [xxii] Cumulatively, the social exclusion of those disabled by NCDs erodes the social cohesion essential for building effective and trustworthy public institutions that account for the interests of whole populations and especially the most vulnerable. [xxiii,xxiv]

Essential to effective governance is the understanding of the scale of NCD impacts on development, the effects of interventions and the ability to monitor progress with development assistance. For this, data on NCDs and their distribution and on the social determinants of health are required. Basic data systems need to be in place along with mechanisms to ensure that the data can be understood and applied to develop effective policies, systems, and programmes.

When building democratic institutions and processes with inclusive citizen representation and involvement to achieve inclusive governance structures that take into account NCDs and risk factors, questions to ask are:

- Are civil society organizations related to NCDs represented on key development decision making bodies eg associations for diabetes, cardiovascular diseases and cancers?
- Are community level organizations involved whose mandates include oversight of local environments e.g. food security, safe active transportation, community and neighborhood development?
- Can private organizations e.g. sports clubs, religious groups, social clubs be partners in national scale health promotion?
- Are public health institutions participating in e.g. development of trade agreements?
- Are workers involved in the creation of policy, legislation, and programmes relating to promoting and protecting health in the workplace?
- Are data on NCDs and risk factors routinely collected and synthesized to inform development assistance design and monitoring?

Supportive information and examples of entry points/synergies

- Table 1 lists a number of sources with supportive information prepared by UN Agencies in both health and non-health sectors which are relevant to multisectoral actions on NCDs. Some deal specifically with NCDs; others are addressing sectors that are determinants of health.
- Table 2 gives general examples of entry points for and possible synergies between selected best buys that address NCDs and risk factors and development assistance interventions in low- and middle-income countries.
- Table 2.1 and table 2.2 give specific applications related to alcohol and salt

Several UN agencies have documents relevant to multisectoral action on NCDs. Some deal specifically with NCDs; others are addressing sectors that are determinants of health. Below are examples.

ABSTRACT	SOURCE
The World Bank provides information on various types of domestic policy instruments – a systemic approach – that can build the resilience of individuals and households to multiple risks including illness and disability. Among the instruments are social insurance, facilitated savings and policies specific to poverty reduction.	World Bank. World Bank Development Report 2014. Risk and Opportunity: Managing risk for development. Link »
The empowerment of women is essential for equitable and sustainable economic development. Domestic policies need to address women's agency to make their own choices and promote what enables economic opportunities and women's access to endowments such as education, health, land and other assets.	United Nations Development Programme. The Future We Want: Rights and Empowerment: UNDP Gender Equality Strategy 2014-2017. At Link » World Bank. World Development Report 2012. Gender Equality and Development. At Link »
The movement towards universal health coverage is growing. A framework for tracking country and global progress towards UHC aims to inform and guide the discussions and assessment of both aggregate and equitable coverage of essential health services as well as protection from catastrophic financial impacts of ill health.	World Health Organization and the International Bank for Reconstruction and Development/The World Bank 2014. Monitoring progress towards universal health coverage at country and global levels: Framework, measures and targets. At Link »
The Priority Public Health Conditions Knowledge Network of the CSDH has analysed the impact of social determinants on specific conditions (including CVD, diabetes, alcohol and tobacco use), identified possible entry-points, and explored possible interventions to improve health equity by addressing social determinants of health.	World Health Organization 2010. Equity, social determinants and public health programmes. At Link »
UNDP provides a typology of multisectoral action on NCDs outside the health sector with three general categories: expanding delivery platforms; NCD-specific actions on social determinants; and NCD-sensitive actions on social determinants. It also outlines more specific areas and opportunities for the actors outside the health sector.	United Nations Development Programme 2014. Discussion Paper: Addressing the Social Determinants of Noncommunicable Diseases. Link »

ABSTRACT	SOURCE
The document supports policy makers in lower-and middle-income countries, as well as the development community. It elaborates on interventions to address priority risk factors: tobacco and alcohol use; excess dietary salt; unhealthy diets, physical inactivity and obesity; CVD; and environmental pollution.	World Bank. The Growing Danger of Non-communicable Diseases – Acting Now to Reverse Course. Conference Edition, September 2011. Link »

Integrated multisectoral actions to reduce NCDs and among people with low socio-economic status, highlighting entry points and synergies with best buys and specific examples for reducing the harmful use of alcohol and reducing the overconsumption of salt

Adapted from:

- Di Cesare M, Khang Y, Asaria P et al on behalf of The Lancet NCD Action Group.
- Inequalities in non-communicable diseases and effective responses. *The Lancet* 2013; 381:585-597;
- World Health Organization 2010. Equity, social determinants and public health programmes; World Health Organization 2012.
- Adelaide Statement on Health in All Policies; and World Health Organization 2013.
- Global NCD Action Plan 2013-2020.

Differential socio-economic context and position

DETERMINANTS AND PATHWAYS	SECTORS	EXAMPLE ENTRY-POINTS/SYNERGIES	EXAMPLE INTERVENTIONS (* BEST BUYS)
Social status Parents' social status Education Occupation Poor governance	Finance Employment Welfare Education and early life	Poverty reduction with social and financial protections Gender equity in education and employment Gender equity in governance of organizations whose mandates are education and employment	*Tax-financed universal healthcare with financial protection** *Tax-financed universal primary education with equitable early childhood education** *Removal of barriers to secure equitable employment**

Differential exposures in the environments where people live and work

Determinants and pathways		Sectors	Example entry-points/synergies	Example interventions (* best buys)
Rising purchasing power	Marketing of unhealthy products Psychosocial and work stress Lack of preventive health services Attitudes towards unhealthy behaviours	Finance Advertising and broadcasting Sports Trade Food manufacturing	Government revenue generation FCTC Workplace safety Nutrition and food security WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children	Tobacco and alcohol tax* Bans on tobacco and alcohol advertising, promotion and sponsorship* Restricted access to retail alcohol* Health information and warnings on tobacco* Smoke-free indoor workplaces and public places* Agreements with food industry to eliminate trans fats and limit salt* Health information on diet and physical activity* User-friendly food labeling
Rapid urbanization	Lack of social safety nets Poor community infrastructure, highly deprived neighborhoods Poor living conditions in childhood	Infrastructure planning and transport Housing Welfare and communities Land use Education and early life	Urban design Environment/air quality Poverty reduction WHO Healthy Cities	Health information on diet and physical activity* Policies on urban infrastructures to facilitate physical activity and active transport

Differential vulnerability of individuals

DETERMINANTS AND PATHWAYS		SECTORS	EXAMPLE ENTRY-POINTS/SYNERGIES	EXAMPLE INTERVENTIONS (* BEST BUYS)
Gender, disability, ethnicity Unemployment High personal/household expenditure on healthcare Limited or no healthcare Limited or no education Co-morbidity Lack of social support Limited or no welfare assistance Under-nutrition Physical inactivity	Poor health seeking behaviour; limited or no health literacy	Finance Healthcare and public health Education and early life Nutrition and food security	Tax-financed universal healthcare with emphasis on equitable access to preventive and primary care Poverty reduction with incentives to use preventive and primary care	*Tax-financed universal healthcare with financial protection** *Tax-financed universal primary education with equitable early childhood education** *For vulnerable groups primary care targeting early detection of elevated blood pressure and elevated blood glucose** *Hepatitis B immunization** *Screening and treatment of pre-cancerous lesions to prevent cervical cancer** *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

Differential healthcare outcomes of individuals

DETERMINANTS AND PATHWAYS		SECTORS	EXAMPLE ENTRY-POINTS/SYNERGIES	EXAMPLE INTERVENTIONS (* BEST BUYS)
Inappropriate drug prescribing Poor or no access to essential medicines Poor adherence to treatment protocols Discrimination in service delivery Comorbidity	Premature death Disability	Finance Healthcare	*Tax-financed universal healthcare with access to essential medicines* Payment/reimbursement mechanisms for health service providers to incentivize preventive care	*Counseling 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 aspirin** Awareness raising among healthcare practitioners of ethical norms and patient rights Healthcare providers incentivized to serve vulnerable groups Dedicated health services for vulnerable groups

Worked Example 1: Reducing the harmful use of alcohol [xxv]

Reducing the Harmful Use of Alcohol	Differential socio-economic 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 unlike in high-income countries, laws and interventions to protect against and discourage harmful use are weak or absent in LMIC. 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 can cause stress, which coupled with general cultural attitudes towards unhealthy behaviours, a lack of community level interventions to prevent harm and aggressive marketing and easy access to alcohol, can lead to harmful protracted drinking.	Individuals with poor health seeking behaviour, a co-morbidity 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 the third leading risk factor for poor health globally. It is a major avoidable risk factor for neuropsychiatric disorders and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. As an addiction, it can perpetuate poor adherence to treatment protocols. It can also lead to discrimination in service delivery.
Best buys xxvi	Tax-financed universal primary education with equitable early childhood education Removal of barriers to secure equitable employment	Enforcing bans on alcohol advertising Restricting access to retail alcohol	Alcohol tax	Tax-financed universal healthcare with financial protection E.g. screening for harmful use of alcohol; preventive treatment and care for alcohol use and alcohol-induced disorders

REDUCING THE HARMFUL USE OF ALCOHOL	DIFFERENTIAL SOCIO-ECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
OTHER INTERVENTIONS	Poverty reduction	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		Payment/reimbursement mechanisms for health service providers to incentivize preventive care Healthcare providers incentivized to serve vulnerable groups Dedicated health services for vulnerable groups
SECTORS AND STAKEHOLDERS	Social protection and welfare	Trade Industry Urban and retail planning Road safety	Finance Trade Industry	Finance Healthcare
ENTRY POINTS/ SYNERGIES	Effective poverty reduction can tackle the inequities due to poor personal social status and that of parents, lack of or little education, poor occupation and low income. Marginalized and minority populations, particularly indigenous peoples, are particularly vulnerable.	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 healthcare and education.		

Worked Example 2: Improving diet – reducing the overconsumption of salt

SALT REDUCTION	DIFFERENTIAL SOCIO-ECONOMIC 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 has been reported as the leading underlying cause of as many as 7.6 million premature global deaths in 2001. Globally, 51% of deaths due to stroke and 45% of deaths due to ischemic heart disease are attributable to high systolic blood pressure. Elevated blood pressure is a development issue because at any given age, the risk of dying from high blood pressure in LMIC 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%. Because cardiovascular diseases are predicted to rise with economic development, population-level and personal interventions to lower blood pressure are warranted. There is abundant evidence of a causal relation between high salt intake and elevated blood pressure. People of lower socio-economic status have nutrient poor diets of which one characteristic is high salt intake.	In LMIC, salt is used predominantly to preserve food and in seasonings or sauces added during cooking or at the table. As purchasing power increases with economic development, 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. Particularly vulnerable are children and youth. Whether fresh produce is available and affordable influences the extent to which highly processed food products are consumed. As adults in households gain employment, there is less time for home cooking; new purchasing power is directed to processed and pre-prepared food and meals.	Psychosocial stress and poor physical fitness correlate with lower socio economic status and also with elevated blood pressure. Limited or no healthcare is a barrier to preventive care and health promotion. Limited or no education is a barrier to health literacy. Low fruit and vegetable consumption causing low potassium intake that counteracts negative impacts of high salt diet	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.

SALT REDUCTION	DIFFERENTIAL SOCIO-ECONOMIC CONTEXT AND POSITION	DIFFERENTIAL EXPOSURES IN THE ENVIRONMENTS WHERE PEOPLE LIVE AND WORK	DIFFERENTIAL VULNERABILITY OF INDIVIDUALS	DIFFERENTIAL HEALTH OUTCOMES
INTERVENTIONS (INCLUDING *BEST BUYS)* [26]	Tax-financed universal primary education with equitable early childhood education Removal of barriers to secure equitable employment Poverty reduction	Voluntary or regulated reductions in the salt concentrations in processed and prepared foods including bread, condiments and sauces. Health promotion and social marketing to reduce use of salt in cooking and at the table, and to reduce the salt intake from preserved foods. Reducing the use of salt by informal food establishments and street food vendors. Restricting the advertising and marketing of non-alcoholic beverages and foods to children Taxes on unhealthy foods; subsidies on fresh produce; price incentives for fresh produce Healthy free or subsidized meals to school children 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 labeling	For vulnerable groups primary care targeting early detection of elevated blood pressure Health information on diet targeting vulnerable groups	Tax-financed universal healthcare Counseling 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 aspirin Healthcare providers incentivized to serve vulnerable groups Dedicated health services for vulnerable groups

SALT REDUCTION	DIFFERENTIAL SOCIO-ECONOMIC 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	Food manufacturing industries Nutrition, food security and agriculture Education Finance Trade Broadcasting and media		Finance Healthcare
ENTRY POINTS AND SYNERGIES	Effective poverty reduction can tackle the inequities due to poor personal social status and that of parents, lack of or little education, poor occupation and low income. Marginalized and minority populations, particularly indigenous peoples, are particularly vulnerable.	Agricultural interventions that promote availability, accessibility and affordability of fruits and vegetables		Payment/reimbursement mechanisms for health service providers to incentivize preventive care and health promotion

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