

# FROM IDEAS TO ACTION

Accelerating the NCD response  
through health equity



A CONCEPTUAL FRAMEWORK FOR COMMUNITY ADVOCATES

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**Dr Apoorva Gomer**, Associate Advocacy Director, Center for Integration Science, Brigham and Women's Hospital, lived experience advocate, Type 1 Diabetes Mellitus.

**Dr Grace Dubois**, Senior Policy and Advocacy Manager, NCD Alliance.

**Dr Ratna Devi**, CEO Dakshama Health, Board member Healthy India Alliance and Our Views, Our Voices Global Advisory Committee member.

**Einstein Rojas**, Board Member, Philippine Alliance of Patient Organizations, Healthy Philippines Alliance and Our Views, Our Voices Global Advisory Committee member.

**Maia Olsen**, Technical and Implementation Consultant, Global Coordination Mechanism on NCDs, World Health Organization.

**Emma Feeny**, Global Director Impact & Engagement, The George Institute for Global Health.

**Dr Ibtihal Fadhil**, Founder and Chairperson of Eastern Mediterranean NCD Alliance.

**Florence Riako Anam**, Programme Manager Love Alliance, GNP+.

**Camilla Williamson**, Global Healthy Ageing Advisor, HelpAge International.

**Prof Alafia Samuels**, Chair of NCD Child.

**Dr Salma Abdalla**, Lead Project Director, Boston University School of Public Health/3-D Commission.

**Sarah Thomsen**, Lead Policy Specialist, Sida.

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**Eliana Monteforte**, Director of Special Projects, Global Health Council

**Nupur Lalvani**, Founder Director, Blue Circle Foundation and lived experience advocate

**Dr Kate Armstrong**, Director/Founder Caring & Living as Neighbours (CLAN), Public Health Physician

**Tania Brown**, Principal Consultant, TWB Consulting, Aboriginal-owned business, Australia

**Dr Catherine Karekezi**, Executive Director, Kenya NCD Alliance

**Chris Agbega**, lived experience advocate, NCDs and disability

**Labram Musah**, National Coordinator, Ghana NCD Alliance

**Professor Kaushik Ramaiya**, Director, Tanzania NCD Alliance

**Charity Muturi**, lived experience advocate – NCDs and mental health, Kenya

**Lea Kilenga**, lived experience advocate – sickle cell, Kenya

**Darcy Allen De Gracia**, Policy and Advocacy Manager, Women Deliver

**Kwanele Asante**, Lawyer and Bioethicist, lived experience advocate, South Africa

**Felicity Porrit**, Equity and Health Unit, World Health Organization

**Theodore Swift Koller**, Gender, Equity and Human Rights, World Health Organization

**Dr Adelard Kakunze**, NCDs, Injuries and Mental Health Program Lead, African Union

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# Executive summary

**Noncommunicable diseases (NCDs) disproportionately affect the poorest and most vulnerable populations. Health equity for NCDs acknowledges the unjust, avoidable differences in the health status and access to resources of different groups, and targets policies and resources to those groups to meet their unmet needs. Health equity is achieved when everyone can attain their full potential for health and wellbeing.**

To narrow the gap in health outcomes, it is necessary to recognise that different determinants of health (such as social determinants, health system determinants and commercial determinants) intersect and overlap to shape and influence the individual experience of health and access across the continuum of care for a person living with NCDs. Designing equitable solutions for NCDs requires reaching those left furthest behind, adopting rights-based approaches, and applying principles of meaningful involvement of people living with NCDs to redress power imbalances. Putting people and communities at the centre allows to identify how different drivers and lived experiences interact and to identify solutions to the barriers faced in accessing care across the continuum and in achieving equity. This Conceptual Framework provides NCD community advocates with an introduction to what health equity means in the context of NCDs and adding an equity lens to advocacy on NCDs. It identifies eight priority areas for advancing health equity for NCDs addressing common barriers to equity.

These areas for action are (1) Ensure the meaningful involvement of people living with NCDs (2) Ensure access to people-centered NCD care (3) Create health enabling environments (4) Integrate people-centered care for NCDs (5) Mobilise financial and human resources (6) Prioritise health literacy (7) Identify and eliminate stigma and discrimination (8) Monitor, evaluate and use data for effective decision-making.



# NCD HEALTH EQUITY FRAMEWORK

Achieving health equity for NCDs requires reaching those left furthest behind, putting people and communities at the centre, and tailoring solutions to each context and unique needs and priorities.

## COMMERCIAL DETERMINANTS

include:

Obesogenic environments, exposure to marketing of health-harming products, industry influence in policies affecting health, exposure to pollution, etc.



## SOCIAL AND STRUCTURAL DETERMINANTS

include:

Demographics (e.g. gender, age, ethnicity, poverty, religion), socioeconomic factors (e.g. education, social status or class), political factors (e.g. instability), violence and racism, stigma and discrimination, culture/tradition, literacy, etc.



## HEALTH SYSTEM DETERMINANTS

include:

Accessibility of NCD information and care, availability of health system resources for NCDs – NCD workforce, medicines, equipment, affordability of NCD services etc.



## PEOPLE AND COMMUNITIES

Every person and community lives with a unique set of determinants and circumstances, which interact to shape their experience of health and NCDs across the care continuum.

Equitable solutions need to be available across the full continuum of care: health promotion, prevention, screening/diagnosis, treatment, management, rehabilitation, and long-term care and support, including palliative care.



Equitable solutions should be built together with people living with NCDs, with a human rights based approach that leaves no one behind by reaching the most marginalised and underserved.



## EIGHT PRIORITY AREAS TO ADVANCE HEALTH EQUITY FOR NCDs

- 1 ENSURE** the meaningful involvement of people living with NCDs.
- 2 ENSURE ACCESS** to people centred NCD care.
- 3 CREATE** health enabling environments.
- 4 PROVIDE** integrated care for NCDs.
- 5 MOBILISE** financial and human resources.
- 6 PRIORITISE** health literacy.
- 7 IDENTIFY** and eliminate stigma and discrimination.
- 8 MONITOR**, evaluate and use data for effective decision making.

# The purpose of this framework

This publication, the Health Equity Framework (thereafter 'Framework'), aims to provide community advocates with an introduction to what health equity means in the context of NCDs. It also aims to illustrate how a health equity lens can strengthen the NCD response providing advocacy recommendations to address common barriers to equity and meet the needs of underserved people impacted by NCDs.

The Framework is divided into three parts. Part 1 explores the concept of health equity in the context of NCDs and defines NCD health equity. This section shares key concepts and principles that are relevant to NCD health equity, including the meaningful involvement of people living with NCDs, a human rights-based approach, and the principle of leave no one behind. Part 2 focuses on the determinants of health as drivers of inequity and Part 3 of this Framework describes eight priority areas for action to advance NCD health equity.

The Framework can be used together with the accompanying [Practical Guide for NCD Community Advocates](#) to inform and guide community-based country level advocacy initiatives that apply a health equity lens to NCDs. Together, these resources are intended to support NCD civil society and people living with NCDs in their work towards an equitable NCD response across the full continuum of care. Other NCD stakeholders may find this publication a helpful resource, acknowledging that addressing health equity for NCDs requires both a whole-of-society and health-in-all policies approach to break down the entrenched inequities affecting the most vulnerable populations living with NCDs.

## METHODOLOGY

This Framework was developed through analysis and input provided during a consultative and co-creation process that included lived experiences on NCDs, perspectives from country level representatives of NCD civil society networks, bilateral and multilateral agencies, private sector, academia in the area of NCDs. Principles of meaningful involvement have been foundational to this Framework. In particular, the principle of people-centredness informed the development of guiding questions to learn from lived experiences. People living with NCDs' experience and understanding of health equity are at the heart of this Framework, sharing reflections on barriers to realising health equity and possible solutions that can inform advocacy at different levels.

A total of 62 contributors were engaged throughout the development of this Framework. The engagement took a co-creation approach, bringing together technical and lived experience experts. The contributors covered countries from the different world regions. To capture experiences and perspectives on the topic of health equity and NCDs it sought to engage those working with and/or representing the voices of indigenous populations, those working on gender and NCDs, poverty and NCDs, disability, mental health and neurological conditions, across the age spectrum (i.e., children and older people), those working with refugees and in humanitarian contexts, those with rarer NCDs, and those working on universal health coverage, social determinants of health and equity more broadly.

A Theory of Change (ToC) approach was used to organize inputs from contributors. The ToC analysis looked at the barriers or challenges to health equity, what solutions and opportunities would achieve greater health equity, and how to put proposed solutions into action. People living with NCDs and NCD civil society were engaged through 19 key informant interviews (KIIs) and focus group discussions (FGDs) to ground the Framework in the experiences of people living with NCDs who shared their knowledge, skills, and insights on equity. NCD Alliance members and supporters were also invited to complete an online survey which received 36 responses. An Advisory Group of 11 health equity experts was formed, contributing rich insights and technical expertise to inform the conceptualization of the Framework.

## PART 1

# Introduction

## Health equity in an NCD context

Noncommunicable diseases (NCDs) like cancer, diabetes, cardiovascular diseases, mental health and neurological disorders, and chronic respiratory diseases are the leading cause of death and disability worldwide, causing 74% of all deaths and three out of four years lived with a disability worldwide. Yet NCDs represent far more than a health issue. As a cause and a consequence of poverty, they are a major human rights and sustainable development issue and have been called the ‘social justice issue of our time’<sup>1</sup>.

Although the burden is universal, poor countries and communities everywhere are disproportionately affected, facing higher exposure to NCD risk factors; more barriers to NCD prevention, diagnosis, and treatment; and health systems that are less equipped to handle a growing NCD burden. Health and illness follow a social gradient – the lower a person’s socioeconomic position, the worse their chances for health.<sup>2</sup>

NCDs combine and interlink with other crisis, such as the COVID-19 pandemic, climate change, humanitarian crisis, and conflict, resulting in a polycrisis where single effects are compounded. These crises cause “systemic and cascading risks, where the impacts of one disruption flow into another, creating a spiral of worsening conditions for those who were already left behind”<sup>3</sup>. The COVID-19 pandemic brutally exposed and exacerbated health inequities in every country. People living with NCDs have been at the epicenter of the COVID-19 pandemic, experiencing more severe outcomes. COVID-19 and NCDs have clustered within specific populations highlighting social and economic disparities deeply embedded in our societies.<sup>4,5</sup>

The conditions in which people are born, grow, live, work, and age, and their access to power, resources and decision-making, determine to a large degree the ability to access quality health services, good nutrition, healthy environments and clean air. Along with the poor, other groups are also at a higher risk of being left behind by health systems, due to their gender, religion, ethnicity, education level, political system, culture, and a long list of other factors which are often met with discrimination.

This discrimination is present between individuals, but is also often embedded within institutions and systems, leading to whole populations being underrepresented, excluded, and having fewer life opportunities. The climate crisis and other humanitarian crises also disproportionately affect these groups, further preventing individuals from being able to fulfil their human right to enjoy the best possible health.

## PART 1

### Introduction. Health equity in an NCD context

Known collectively as the determinants of health, this complex mix of factors influence and often aggravate one another, widening health and other inequities and deepening poverty. NCDs are a marker of these inequities: they place a disproportionately heavy burden on poor and otherwise vulnerable people, within and between communities and countries everywhere. This is widely evidenced and quantified – the points below are just a few of many statistics to illustrate the effects of inequity on health.

- **Between countries:** Only one in two people living with diabetes globally has access to the insulin they need; in sub-Saharan Africa, only one in seven people does<sup>6</sup>. In high income countries (HICs) the survival rate for childhood cancer is over 80%. This drops to less than 30% in lower-middle-income and low-income countries (LICs)<sup>7</sup>.
- **Within countries:** Children from the poorest households are twice as likely to die before the age of 5 years than children from the richest households<sup>8</sup>, while children in the poorest 20% of households are over four times more likely to experience severe mental health problems than those in the highest 20%<sup>9</sup>.
- **Between neighbourhoods:** In Glasgow, male life expectancy is 15 years lower in the most deprived parts of the city compared to the least deprived areas<sup>10</sup>. In a poor suburb of Mumbai (Deonar) people barely make it 40 years, compared to an average urban life expectancy of 74 years in the State.<sup>11,12</sup>

Achieving health equity means putting in place policies and allocating resources to reach those who are most marginalised and furthest behind first, to narrow the gap in health and socioeconomic conditions. As a key driver of poverty and inequity, NCDs are inseparable from any discussion on health equity – equity cannot be achieved without addressing NCDs, and NCDs cannot be prevented, and their impact reduced, without closing inequities.



## Health equity

### Reversing the cycle of poor health and disparity

Health equity is the absence of unfair, avoidable, and remediable differences in health status among groups of people. Health equity is achieved when everyone can attain their full potential for health and well-being.<sup>13,14</sup>

All lived experience contributors to this publication were asked to provide their own definition of health equity. These are some of their responses:

“Health equity means equitable access across the continuum of care (prevention to palliative care) and across all levels of care (primary, secondary, tertiary). Assured provision of healthcare services (medicines and diagnostics), financial risk protection (less out-of-pocket expenditure), access to care irrespective of gender, age, rural/urban residency, education or occupation, and the meaningful involvement of people living with NCDs, youth, and older people in decision-making to ensure their priorities are reflected in programmatic and policy response”

“To me, health equity is a state in which everyone living with a noncommunicable disease has a fair and equal opportunity in accessing NCD services. This can only be achieved through focused and continuous societal efforts in addressing historical and contemporary injustices by trying to overcome economic, social, and other obstacles to NCD healthcare services and eliminate preventable NCD disparities”

“The just and fair distribution of health and social resources to all who need them without unjustified discrimination based on age, class, geography, gender identity, and sexual orientation. Health resources, services and treatments must be timeously accessible and affordable to all who need them. Equity should be undertaken from social justice and intersectional lenses to ensure that there are no health disparities in-country and between countries. Equity should prioritize black health justice and indigenous health justice in countries, regionally and globally because these vulnerable groups bear a disproportionate burden of mortalities and morbidities communicable and noncommunicable diseases”

NCDs are a marker of inequities, placing a disproportionately heavy burden on poor and otherwise vulnerable people, communities, and countries everywhere.

Over 31.4 million NCD deaths (more than three quarters) occur in low-and middle-income countries (LMICs)<sup>17</sup> where health resources are low, and health systems are poorly equipped to deal with the rising burden of NCDs. Over 85% of premature deaths (before the age of 70) occur in LMICs, ending lives during the most productive years. This, coupled with the cost of NCD care, perpetuates a cycle of poor health and poverty that continues across generations.

Over half the world’s population is currently without comprehensive coverage of essential health services, and millions are pushed into extreme poverty each year because of out-of-pocket (OOP) payments for healthcare. People living with NCDs are at increased risk of catastrophic health expenditure – health spending that exceeds 40% of income<sup>15</sup>. By some estimates, OOP spending for NCDs is twice as high per visit to a health facility than for infectious diseases (ibid). Similar disparities in OOP spending on health are seen between low-income countries (44%) and high-income countries (21%). The economic burden of NCDs is often heaviest for marginalised or vulnerable groups who are most at risk of being left behind by Universal Health Coverage (UHC)<sup>16</sup>. Many people in LMICs who are not able to make OOP payments for health and end up foregoing care altogether, often paying with their lives.

Health inequities in an NCD context are present across the full continuum of care, starting with prevention and continuing through palliative care. For instance, there is a higher exposure to NCD risk factors in LMICs, where over 80% of the world's 1.3 billion tobacco users live. Rates of overweight and obesity are also increasing in LMICs, particularly in urban areas and among women<sup>17,18,19</sup> with many countries experiencing a double burden of undernutrition and overweight<sup>20</sup>. The highest prevalence of obesity globally is in small island developing states (SIDS)<sup>21</sup>, where an NCD crisis is compounded by the disproportionate impact of the climate crisis. There is also clear link between poverty and increased health and social harms from alcohol consumption, with other structural factors (e.g., availability of alcohol, and implementation and enforcement of alcohol policies) being a strong predictor of outcomes.

For the poorest populations, hunger, polluted and toxic environments, infectious diseases, and a lack of healthcare are causing more severe and varied NCDs<sup>16</sup>. The high burden from infectious diseases experienced by the poorest billion is also contributing to driving the NCD burden. For example, Streptococcus (causing rheumatic heart disease), human papilloma virus (causing certain cancers, including cervical cancer) and tuberculosis (causing chronic respiratory diseases including chronic obstructive pulmonary disease), among others<sup>22</sup>, occur less in high-income countries thanks to the availability of antibiotics and vaccines, while they persist as major health concerns in LMICs. People living with NCDs in conflict and humanitarian settings also face unique inequities, including disruptions to the delivery of healthcare due to restricted access as a result of the damage or destruction of health facilities and infrastructure; limited availability of healthcare providers; or disrupted supply of medicines, diagnostics, and products<sup>23,24</sup>.

Geography can also create vast health inequities within a country, with some areas or populations being underserved by health facilities due to long travel times to access services. This can result in late diagnosis and lower adherence to treatment,<sup>25,26</sup>. Poor quality of care, particularly in underserved, rural areas in many LMICs, also drive inequities for people living with NCDs, with people receiving sub-optimal care or needing to travel further for higher quality care. The quality of care provided to the poor is demonstrated to be lower across a range of chronic conditions<sup>27</sup>.

## Same disease, different experience

The following testimony shared by Dr Kate Armstrong, President of Australian organization CLAN, illustrates the inequities that exist between a high- and lower-middle-income country (Australia and Vietnam) for children living with the same NCD. It also illustrates what can be achieved by applying an equity lens to the design of NCD interventions.

“Our first child was born in 1999 with a chronic health condition that no one had heard of. A condition called Congenital Adrenal Hyperplasia (CAH). At three weeks of age, he would have died if he hadn't been diagnosed...I read stories about children with the same condition in Vietnam, dying and becoming severely disabled, experiencing developmental delays, social isolation, stigma, and poverty...

We surveyed about 54 parents in Vietnam... families told us that for their child to have the best quality of life with CAH, they needed five things: affordable access to medicines and equipment; education, research and advocacy; optimal medical management; strong family support groups; and freedom from poverty. They needed to be helped to become financially independent so they could care for their child themselves.

When we listened to them and we did those five things in partnership with a whole range of stakeholders, mortality associated with CAH dropped in Vietnam. 16 years later, the mortality associated with CAH in Vietnam is almost zero. I would say children in Vietnam now have the potential to enjoy the same quality of life as children in Australia with CAH”

## Putting people first to advance health equity on NCDs

Placing an equity lens on all NCD interventions is the only way to close the gap across the NCD care continuum. Since every country and community experiences a unique set of circumstances, there is no 'silver bullet' solution to fit every context, and interventions must be informed by and co-created with people with lived experience. The principles of meaningful involvement are replicable across all contexts and are integral to progress towards health equity. In addition, States' obligations to fulfil human rights as well as their commitment to the SDGs and pledge to leave no-one behind and reach the furthest behind first, are universally applicable to any efforts to address health equity in the NCD response.

### Meaningful involvement: at the heart of health equity

To achieve health equity, the meaningful involvement of people living with NCDs is essential. It is the only way to truly identify the challenges and barriers that marginalized people and communities face, and to develop effective solutions to overcome them. Meaningful involvement requires placing people living with NCDs at the centre of all processes and efforts related to the NCD response, including governance, policies, programmes and services, from the very first stages of design and planning through to implementation, evaluation, and scale-up. This challenges one-sided and medicalised approaches to health by recognising that involving communities is essential to drive progress on NCDs. People living with NCDs should be seen as leaders in decision-making processes, providing unique, first-hand insights and expertise of the contextual challenges to NCD prevention and care, and overall quality of life.

The [Global Charter on Meaningful Involvement of people living with NCDs](#) outlines five principles as a basis for meaningful involvement. These are applicable to any effort furthering health equity for NCDs, to ensure that those left behind are central to efforts to improve health outcomes:

**Human rights-based:** People living with NCDs are fully aware of, and claim, their rights (including rights to health and participation) to realise their full potential as engaged members of society, free of stigma and discrimination, and duty bearers respect, protect, uphold, and fulfill their obligations.

**Respect & Dignity:** People living with NCDs are treated with respect and dignity, their privacy is respected, and they are treated as equals and supported to be autonomous and meaningfully involved in all decision-making processes concerning them.

**People-Centeredness:** People living with NCDs and their wellbeing, rather than their diseases, are placed at the centre of policies, programmes, and services, with their needs and priorities shaping the NCD response, rooting it in the community.

**Equity:** Ensuring that marginalised and underrepresented groups are considered central in processes to attain equitable and fair health and development outcomes, recognising that these groups are often at greatest risk of NCDs.

**Social Participation:** Having formal and transparent mechanisms for people living with NCDs and communities to be integrated into organisational processes and have a 'seat at the table' to inform and influence policy and decision making on an equal footing and hold institutions to account.

## Fulfilment of human rights: an obligation, not an option

A human rights-based approach is central to health equity. While the right to health includes entitlements to the right to a system of health protection that affords all an equal opportunity to the highest attainable level of health, achieving this means recognising the unique needs and circumstances of individuals and the inequities they face, based on contexts within which they live and the structural forces they are exposed to.

The realisation of multiple human rights is critical to an equitable NCD response. This includes the right to health; the right to access truthful, accurate, complete, and reliable information; the right to participation; the right to adequate food; and the right to equality and non-discrimination, among others. For more information, the Healthy Caribbean Coalition produced a [policy brief on essential considerations for equity-based and rights-based approaches](#). As mentioned elsewhere in this Framework, there are recommended cost-effective, evidence-based interventions to address NCDs (i.e., the NCD ‘best buys’ within Appendix 3 of the WHO Global Action Plan on NCDs). Countries can implement these to meet with their obligations to respect, protect, and fulfill the right to health and other human rights<sup>28</sup>.

## Leaving no one behind on the road to 2030

At the heart of the 2030 Agenda and the Sustainable Development Goals are the principles of equity and non-discrimination, with a commitment to ‘leave no one behind’ and ‘reach those furthest behind first’. Leave no one behind in the context of NCDs refers to reaching groups or communities that are not included in services or do not have equitable access to health information and services for the prevention and control of NCDs. It indicates addressing a gap in society where groups or communities are missing out on opportunities to prevent and control NCDs or to maintain, manage or improve their health, which leads to their poorer health status compared with other groups in society<sup>29,30</sup>. Reaching the furthest behind first means addressing the needs of groups that have been marginalised and/or underserved – those living in poverty or extreme poverty, indigenous peoples, ethnic minorities, older people, people with disabilities, and other marginalised groups – while also recognising their potential to contribute a wealth of knowledge, skills, and experience to advance the NCD and SDG response.



## PART 2

# Determinants of health

Determinants of health are factors that combine and interact to affect the health of individuals and communities. Whether people are healthy or not does not come down to a choice; it is determined by their circumstances and environment. Factors such as where we live, gender and ethnicity, income and education level, and our relationships with friends and family all have considerable impacts on health, along with more commonly considered factors such as access to and quality of health care services.<sup>31</sup>

There are countless determinants of health, and this Framework does not aim to provide a comprehensive analysis of them. Rather, it aims to give a broader overview of key determinants to consider in working towards an equitable NCD response across the full continuum of care. However, every community is unique, as is the experience of each individual within a community. Therefore, in order to address the determinants of health to advance an equitable NCD response within a community, region or country, it is crucial to consult people living with NCDs to identify and understand the barriers they face.

The determinants of health are numerous and diverse, and they can be categorized in many different ways. In this Framework, we have grouped a sample of determinants into three categories – the social determinants of health, the commercial determinants of health, and the health system determinants of health. This categorization is not rigid – some determinants may fall under two or all three of these categories, and most determinants intersect and overlap to shape and influence the individual experience of health for a person living with NCDs. An equitable NCD response will consider how a person's unique lived experiences of NCDs interact with determinants of health across the entire continuum of NCD care.

## Social and structural determinants of health

The determinants of health, as described above, have significant impact on the realisation of health equity. Many of the most influential determinants are non-medical, and can be considered as social determinants of health, or the wider set of social factors that determine the conditions in which people are born, grow, live, work, and age, and access to power, money, and resources.

WHO has recently published the [Operational framework for monitoring social determinants of health equity](#) for national governments and their partners which provides countries with critical guidance for monitoring the social determinants of health, using data for action across sectors to improve health equity<sup>32</sup>. The Operational Framework is a critical resource to drive action to improve health equity alongside the forthcoming WHO World report on social determinants of health equity.

In addition to economic status, these include gender, ethnicity, and education level, amongst many others. These are compounded by discriminatory practices that are often deeply embedded at institutional and systems levels. For instance, certain groups may be under-represented, underserved, or excluded in decision-making processes due to social determinants like ethnicity, gender or sexual orientation. These discriminatory practices are often referred to as 'structural determinants' of health.

More specifically, structural determinants of health represent the socioeconomic-political mechanisms, structures, systems, and forces that generate the social stratification of populations according to income, education, occupation, sex, gender, race and ethnicity, place of residence, and other factors. The resulting socioeconomic positions produce unequal allocation of power, money, and resources.<sup>33</sup>

Many social determinants of health affect broader population groups, rather than individuals or contained communities. These can include climate change and climate-related crisis<sup>34</sup>, exposure to violence and conflict,<sup>35, 36</sup> unsafe working environments<sup>37</sup>, political instability, and poor sanitation<sup>38</sup> among others.

**“Our movements and efforts around Health Equity in NCDs need to be intersectional. It’s not possible to address health equity without considering discrimination, asymmetrical power, oppressive structures, and stigmatization well beyond health, including racism, histories of colonialism, gender inequity, and inequities faced by other marginalized communities.”**

**Maia Olsen**, Technical and Implementation Consultant, WHO Global Coordination Mechanism on NCDs.

**“It is much easier to talk about healthcare and treatment gaps ... [than it is] to talk about social determinants of health and what type of policies and interventions are needed to prevent NCDs. It’s much easier for a donor to say, I’m going to give this [much to medical supplies] but harder to say we contributed to building a park in a city... [since] it will take years and years to say because of this park, we reduce obesity by this much in this city.”**

**Salma Abdalla**, Lead Project Director, Boston University School of Public Health/3-D Commission.



## Commercial determinants of health

The commercial determinants of health (CDOH) are based on the commercial practices and undue influence in policymaking by health-harming industries – including industries involved in tobacco, alcohol, unhealthy foods and beverages, formula milk, and fossil fuels, amongst others – and shape our environments, exploit people’s vulnerabilities, and weaken public policy. These commercial actors are driving the global burden of preventable NCD morbidity and mortality, and have framed NCDs as “lifestyle diseases”, putting the blame on individual behaviors while neglecting their own destructive role in shaping environments.

This industry-led, individualistic framing drives narratives that stigmatize people living with NCDs and ignores the impact of non-medical contextual factors on health outcomes. They place the responsibility of prevention, care, and access on individuals. The NCD burden may be driven by the consumption of unhealthy products, but it is our environments that fuel such consumption via their marketing and by making the unhealthy option the “default choice”. Access to healthy options and quality care is not only a matter of choice but also of social and structural determinants, with marginalised groups often being disproportionately exposed to those determinants which influence health negatively. This highlights the fact that the choices we make are limited by the choices we have.

For instance, poor neighborhoods are often exposed to highly obesogenic environments, where people cannot afford healthy foods which are often priced higher than junk food or healthy food is simply not available (i.e., food deserts). Often there is also no or very limited safe spaces that encourages physical activity. Air pollution is another critical driver of health inequities, with certain populations especially vulnerable to the impacts – people in Africa, Asia and the Middle East breathe higher levels of pollutants on average than people in other parts of the world, resulting in greater health risks<sup>39</sup>.

Commercial actors also take advantage of less regulated environments (most often LMICs and SIDs) to advertise, promote, and sell health-harming products, while not being held accountable for the adverse impacts of their activities on population health and human rights. Further, within all countries, children and adults who are living in poverty are disproportionately the targets of harmful marketing.

Health-harming industries and their products and practices are driving the unequitable distribution of NCDs that disproportionately burdens the poor. Achieving health equity in an NCDs context requires getting commercial practices like these under control and limiting their unhealthy influence in communities and environments.



## Health system determinants

Health system determinants are related to how well a health system is able to answer the needs of the population it serves, including factors such as availability, affordability, accessibility, acceptability, and appropriateness of health systems and NCD services in their context. They also include factors relating to how well-equipped a health system is, such as technology, a skilled health workforce, availability and accessibility of medicines, and the quality of care. These factors depend to a large degree on each country's income level, and the public funds which are allocated to health. Even families who are high on the social gradient in a low-income country may struggle to access the NCD treatment they need if the technologies and medicines are simply not available in the country. The situation is even more serious for marginalized families and communities. For instance:

- In Africa, the presence of trained neurologists is far below the global average, with a ratio of 0.03 neurologists per 100,000 people, in stark contrast to Europe's 8.45 neurologists per 100,000 individuals.<sup>40</sup>
- Comprehensive cancer treatment is reportedly available in more than 90% of HICs, but less than 15% of LICs.<sup>41</sup>
- LMICs account for 90% of the global burden of disease but for only 12% of global spending on health. High-income countries spend about 100 times more on health per capita than low-income countries (US\$3039 versus US\$30).<sup>42</sup>
- Highly specialized professionals, required for managing complicated NCDs, make up less than 10 per cent of the available workforce in LMICs<sup>43</sup>.

There are also huge disparities in access to medicines and quality standards between countries, and almost half of the global population has little to no access to diagnostics<sup>44</sup>. The 2021 Lancet Commission on diagnostics found access to diagnostic testing inequitable in many parts of the world. Availability of diagnostics is more severe at the primary health care level where in LMICs only 19% of populations have access to basic diagnostic tests (other than for HIV/AIDS and malaria). The poor, marginalised, young, and less educated have the least access<sup>45</sup>. Health commodities, such as test kits and medicines, remain unaffordable for many people living with NCDs, given their absence from Essential Drugs Lists (EDLs).

Few LMICs are currently providing services for NCDs in their national UHC health benefit packages and due to the long-term or life-long treatment and care required, people living with NCDs often face a significant financial burden to access care. This is the case for more than 60% of people living with NCDs in some LMICs, where many experience catastrophic health expenditure related to NCD care<sup>46</sup>.

Health system determinants interact with the broader social determinants, and this plays a key role in how people use and experience their health system and how equitable that health system is. Health systems themselves should consider the barriers to health equity in their specific context and design service provision to overcome these. Community healthcare workers, digital health solutions, and integrated care models are all approaches being used successfully by health systems to overcome barriers to equity.

However, health systems alone cannot tackle health inequity. This requires investment, as well as a whole-of-society approach that prioritizes prevention and strong primary healthcare. All countries have committed to achieve universal health coverage (UHC) by 2030, but this will only be possible with adequate investment and an equity lens applied at all stages of policy design, implementation, and monitoring and evaluation.



## There is no Universal Health Coverage without equity

Achieving Universal Health Coverage (UHC), including for people living with NCDs, is a critical means of addressing unjust economic burdens. This has been recognized as part of the UN 2030 Agenda for Sustainable Development and is set forth in Target 3.8<sup>47</sup>. UHC is about ensuring that people have access to services of reasonable quality without suffering financial hardship. It is linked to numerous Sustainable Development Goals (SDGs), including the goals on poverty (SDG 1), gender equality (SDG 5), inequality (SDG 10) and more.

However, simply making health services available for those who wish to use them will not fulfil the potential of UHC. For this, services need to be made available in an equitable manner, in which all people are equally aware they are available and have the same ease in accessing them.

For instance, an annual check-up that is included in a country's health benefits package is not the same for a person who can walk to their primary health center in ten minutes, as for a person who is living in a remote area and has to spend time and money taking public transportation, as well as finding childcare or losing a day of work.

The money and time required for many people to visit a medical clinic – especially those living in rural or remote communities in LMICs – results in fewer visits to primary care centers, which are important opportunities to identify and screen for conditions like overweight and obesity, hypertension, and abnormal blood sugar. As a consequence, early diagnoses are less common; NCDs tend to be diagnosed at a later stage when treatment is more complicated and expensive.

Therefore, it is crucial that UHC interventions consider communities that are at risk of being left behind to ensure that services reach them in an equitable manner. This may involve finding ways to bring health and NCD care to these communities, rather than requiring people to come to them. This is the difference between 'equality' and 'equity'. Equality means the same services are available to all people. Equity means all people have the same ease and opportunity in using them. This requires the allocation of resources and opportunities according to the different circumstances of specific communities, to reach an equal health outcome.



This graphic created by the Robert Wood Johnson Foundation (@RWJF) does a great job of illustrating what it looks like when equality is deemed the solution. <https://betterbikeshare.org/2019/10/24/equity-vs-equality/>

## PART 3

# Priority areas to advance health equity for NCDs

This section presents eight priority areas to advance health equity for NCDs which were identified through consultative workshops, key informant interviews, focus group discussions and an online survey which included people living with NCDs. These priority areas for action make up the NCD Health Equity Framework. Under each area, some of the common barriers to achieving health equity for people living with NCDs are described, followed by recommendations to address these barriers. This is not an exhaustive list; NCD advocates are encouraged to use the accompanying Practical Guidance to identify others, or expand on these and add detail based on their respective contextual needs and priorities<sup>48</sup>.

To identify recommendations to achieving health equity for NCDs, it is important to focus on the experiences of people living with NCDs. This requires understanding the contexts within which people live, how they access and make sense of health information, and how and whether they access services for NCD prevention and care. For this reason, the first priority area for action – ensuring the meaningful involvement of people living with NCDs – can be considered an enabler and essential component to advancing health equity for NCDs in all other priority areas.

### EIGHT PRIORITY AREAS TO ADVANCE HEALTH EQUITY FOR NCDs

**1 ENSURE** the meaningful involvement of people living with NCDs.

**2 ENSURE ACCESS** to people centred NCD care.

**3 CREATE** health enabling environments.

**4 PROVIDE** integrated care for NCDs.

**5 MOBILISE** financial and human resources.

**6 PRIORITISE** health literacy.

**7 IDENTIFY** and eliminate stigma and discrimination.

**8 MONITOR**, evaluate and use data for effective decision making.

## 1. Ensure the meaningful involvement of people living with NCDs

### BARRIERS

Peoples' lived experience is often not considered or factored into NCD policy development and solutions. A diversity of views and lived experiences have been missing from decision-making processes, which have typically taken a top-down approach<sup>49</sup>.

The right to participate in decision-making processes that affect one's life and health is a human right, but people living with NCDs have not been prioritised in decision-making processes. In applying a health equity lens, it is critical to acknowledge existing power imbalances. Underserved and marginalised populations may have fewer opportunities to have their views and voices heard, and it is key to ensure specific strategies to reach those furthest behind. The meaningful involvement of these communities is important for understanding barriers, identifying solutions, and effective planning of policies, programmes, and services, while strengthening transparency, accountability, and governance at national level and beyond.<sup>50</sup> The involvement of people living with NCDs is central to an effective, person-centred NCD response.

**"...as long as people living with NCDs are not involved as key partners in the drafting, implementation and measuring and evaluation of interventions aimed at NCD prevention and control, we are not going to make substantive progress"**

**Tania Brown**, Consultant at TWB Consulting, Aboriginal-owned business.

### RECOMMENDATIONS

The voices of those left behind and the furthest behind are rarely heard - resources are available to support finding ways to reach these communities and individuals. The [Global Charter on Meaningful Involvement of People Living with NCDs](#)<sup>51</sup> provides a framework to enable the meaningful involvement of people living with NCDs in decision-making at all levels. The aim of the Global Charter is to have meaningful involvement, via its principles and ten core strategies, embedded into organizational practices, mobilizing all actors such as governments, international partners, private sector, and civil society organizations. WHO has recently produced a [Framework for Meaningful Engagement of People Living with NCDs and Mental Health and Neurological Conditions](#). This WHO framework also includes principles and enablers for meaningful engagement, which align with those in the Global Charter. It is a technical resource outlining practical actions for Member States and WHO offices to operationalize the meaningful involvement of people with lived experience.

NCD civil society have powerfully advocated for increased action on meaningful involvement. Civil society, with its close connections to communities and people with lived experience, can play a key role in supporting more equitable opportunities for participation. For instance, by facilitating connections between governments, healthcare providers, researchers, and other key stakeholders, with marginalised people and communities, to remove barriers to meaningful involvement and by involving communities and people with lived experience in priority-setting around the use of resources for health.



## 2. Ensure access to people-centered NCD care

### **BARRIERS**

Health inequities for people living with NCDs are often most pervasive in terms of access to care. Barriers to equitable access to NCD care are present across the continuum of care, including screening, diagnosis, treatment and control, rehabilitation, and palliative care, across different levels of the health system and dimensions of access<sup>52</sup>. Access inequities in LMICs are visible in inadequate health system infrastructure, poor continuity of care, unequal geographical access to health services, a shortage of human resources for health and workforce capacity, weak supply chains, insufficient procurement practices, low availability and affordability of diagnostics and medicines, and a lack of public health information and appropriate training in self-management and education for people living with NCDs and high-risk populations.

Furthermore, the current predominant focus on hospital-based, disease-based models of care undermines a people-centred approach to NCD care, reduces access to care for the vast majority and fails to meet the needs of the most marginalised. A recent systematic review found that supply-side components at the primary healthcare level are insufficient for NCD care, especially for cardiovascular diseases, chronic respiratory disease, and cancer<sup>53</sup>. Evidence is critically lacking for demand-side perspectives related to access to NCD care at the primary healthcare level.

### **RECOMMENDATIONS**

To advance a people-centered approach to access and more adequately address the needs of people living with NCDs, particularly those left furthest behind, NCDA has [developed indicators](#)<sup>54</sup> that can be factored into NCD access initiatives and programming. These build on the Strategic Approaches provided in the [WHO Framework on Integrated, People-Centred Health Services](#) to consider dimensions of access from the perspective of those with lived experience.

By accelerating UHC implementation by including quality NCD services in national UHC health benefit packages, countries can improve the affordability of medicines and products, and access to health services and treatment. Civil society and communities can play a key role in advocating for the inclusion of essential NCD services across the continuum of care, as contained in Appendix 3 of the WHO Global NCD Action Plan, into UHC benefits packages<sup>23</sup>. Additionally, a new compendium on NCDs describes steps to ensure that NCDs are integrated into a country's UHC priority health benefits package<sup>55</sup>. Civil society can also play a role in advocating for essential and quality NCD medicines, diagnostics, and products in national essential medicines and diagnostics lists and in national drug procurement systems.

To advance equitable access strategies, the forthcoming WHO World Report on Social Determinants of Health Equity, as put to the WHO Executive Board, includes a recommendation to *Build a health and care sector that ensures equitable access and is based on genuine participation*<sup>56</sup>. Building and retaining a health workforce capable of delivering equity is key to meeting the needs of people living with NCDs and improving access. The expected World Report recommends WHO Member States should recognize and reward work in the care economy, including informal care, and demonstrate the role of the health and care sector as a driver of health equity and social inclusion, by ensuring decent and safe working conditions and addressing pay and representation gaps. The forthcoming World Report also recommends to achieve UHC through progressive health financing and primary health care approaches. This includes facilitating equitable access to health technologies from research and development through to manufacturing and equitable delivery, as well as increasing the share of health and care sector funding dedicated to populations experiencing marginalization.

### 3. Create health enabling environments

#### BARRIERS

Creating an enabling environment for health equity means addressing not only the health but the non-health determinants which influence people's health outcomes. It is not possible to achieve health equity for people living with or at risk of NCDs without addressing the broader determinants of health – such as social, structural, and commercial – in relation to NCD prevention. For instance, the commercial determinants of health have led to the exposure of marginalised populations to health-harming industries (tobacco, alcohol, ultra-processed foods, pollutants), and public health policies, laws, and regulations to reduce such exposure are often non-existent and weak by not reducing exposure equitably<sup>57</sup>.

#### RECOMMENDATIONS

Equitable public policy design is needed to ensure that population-wide policies reach the hardest to reach, and most vulnerable populations first. Examples include ensuring public health labels reach the widest audience possible. For instance, the Framework Convention for Tobacco Control (FCTC) guidelines<sup>58</sup> recommend large pictorials for tobacco health warnings to reach people with lower literacy. Ensuring that children and other vulnerable populations are protected from being a target audience of the harmful marketing of health-harming industries and practices<sup>59</sup>. Regarding fiscal policies, ensuring that health tax reform is designed in a way that advances health equity across populations. For example, while taxing sugar-sweetened beverages (SSB) has gained popularity, the number of countries using taxes to incentivize healthy eating, by increasing the affordability of healthy food, is relatively small and underutilized<sup>60</sup>. Importantly, evidence suggests that higher (excise) taxes on tobacco, alcohol, and sugar-sweetened beverages are progressive measures which benefit low-income populations.<sup>61, 62</sup> Equitable opportunities and access to environments that support regular and safe physical activity, particularly for disadvantaged and vulnerable communities, is another example.<sup>63</sup>

The Appendix 3 of WHO's Global Action Plan for the Prevention and Control of NCDs 2013-2030, also known as the [WHO's 'best buys' and other recommended interventions on NCD prevention and control](#), are essential for realizing health equity for NCDs. A [civil society guide by NCDA](#) unpacks WHO's Best Buys and other recommended interventions<sup>64</sup> to advance NCD prevention, providing information on WHO technical packages on specific risk factors such as REPLACE (trans fats), SHAKE (salt), SAFER (alcohol) and MPOWER (tobacco). The WHO has also developed taxation manuals for tobacco<sup>65</sup>, SSB<sup>66</sup>, with a manual on alcohol taxation currently under development. These technical packages and practical guides can ensure these public policies are designed with a health equity lens.

Engaging multiple sectors and stakeholders is also critical for designing equitable NCD policies and creating enabling environments that promote health equity. A useful resource is the recently published WHO [global mapping report on multisectoral actions](#), which assesses progress<sup>67</sup> [against four pillars in 46 countries, across all WHO regions](#)<sup>68</sup>. It shares specific actions used in the WHO regions, such as the inclusion of diverse stakeholders from different government sectors in activities that promote the adoption of co-design and co-benefit approaches.



## 4. Integrate people-centered care for NCDs

### BARRIERS

The lack of integrated, person-centred care is a key barrier to achieving health equity for people living with NCDs, particularly in LMICs. People living with NCDs often live with multiple conditions, including more than one NCD, or a combination of noncommunicable and communicable diseases or conditions. This impacts on the uptake and adherence to treatment due to testing and treatment fatigue and cost of care. Repeat tests, travel costs and multiple consultations for persons living with more than one NCD are some of the concerns raised by contributors to this Framework. This is especially the case in private health care and when accessing more specialized NCD care.

Therefore, “health systems need to adapt to a clearer focus on the person and their state of health through the life course, not only the single health crisis or condition that leads them to seek care at a particular moment”<sup>69</sup>. There is a lack of people-centered approaches and services to prevent, treat and care for people living with NCDs and other conditions, in a holistic and integrated manner.

**“When you look at the community health level, this is where we need to see this integration. We need to have the adequate human resources that are not dealing just with HIV, but with other high-burden diseases”**

**Dr Adelard Kakunze**, Lead, Non-communicable diseases (NCDs), Injuries and Mental health Program  
Disease Control and Prevention Division, Africa CDC.

### RECOMMENDATIONS

Putting people and their families at the centre of their care is essential to address the needs of people living with multiple chronic conditions. For example, there have been several policy frameworks that call for the integration of HIV services in NCDs screening and treatment<sup>70</sup>, including the Political Declaration on HIV/AIDS adopted at the UN General Assembly in June 2021. The political declaration includes the target committing governments to provide coverage of NCD services for 90 per cent of people living with HIV by 2025<sup>71</sup>.

By expanding the delivery of primary healthcare for a sustained, people-centered, and integrated health system, governments can support progress towards UHC and ensure an equitable and inclusive NCD response. Solutions include integrating NCD prevention and care services into primary healthcare and existing health service structures, including in humanitarian responses, and adopting people-centered approaches to UHC that ensures people are treated holistically throughout their life course. Integrated care via the implementation of the WHO PEN-Plus model of care for severe chronic NCDs may be helpful to deliver clusters of related health-sector interventions based on shared provider competencies and common patient characteristics<sup>72</sup>.



## 5. Mobilise financial and human resources

### BARRIERS

There is currently too little emphasis on social justice and health equity in decision-making processes for resource generation and allocation at all levels in the response to NCDs. NCDs are amongst the least funded disease areas in global programmes toward achieving UHC and SDGs, which is highly disproportionate to the disease burden, particularly in LMICs. The fiscal space for health is shrinking in many countries due to a range of competing national priorities in the post-COVID era<sup>73</sup> – including an increase in humanitarian crises due to climate change and conflict, and the rise of infectious diseases and pandemic preparedness – all of which are sources of diversion from NCD priorities.

To compound this, the WHO has predicted a shortfall of 18 million health workers by 2030, particularly in LMICs<sup>40</sup>. Further, NCD-specific knowledge among health workers is often insufficient and the health workforce is often not equipped with the required skills to work across specialties, and along a continuum of care, for the provision of integrated care<sup>74</sup>.

**“You hardly find specialized doctors or clinicians in these parts of our communities because of lack of motivations, the fact that everybody wants to be in a city center or in a bigger hospital, leaving communities to suffer.”**

**Labram Musah**, National Coordinator, Ghana NCD Alliance.

**“[There are] ...inadequately qualified specialists to treat noncommunicable diseases. There hasn’t been the level of investment and commitment to training a health workforce that can address and service especially patients with comorbidities”**

**Kwanele Asante**, Lawyer and Bioethicist, lived experience advocate, South Africa.

### RECOMMENDATIONS

International development agencies have been reluctant to support LMICs with financial investments for NCDs and despite commitments by high-income countries, attention needs to shift towards innovative financing models for NCDs and a greater reliance on domestic financing for NCD prevention and care that benefits those left furthest behind. For greater health equity in the area of resources for NCD prevention and care, decisions need to be based on an analysis of who has greater needs – in terms of risk, mortality, morbidity, and financial burdens. This analysis should inform policies and programmes in service, population, and financial coverage of NCD prevention and care, as part of the drive towards UHC.

By integrating NCD prevention and care in UHC benefits packages, governments can improve the efficiency in health spending overall, particularly if supported by routine disaggregated data collection and analysis. Further, calls for disaggregation of data on poverty and disability under SDG 1 (end poverty in all its forms, target 1.3)<sup>75</sup> is an important way to strengthen social protection mechanisms and generate financial resources for those left furthest behind. While the government is responsible for increasing domestic financing for NCDs and reducing OOP spending, advocacy can prioritize calls for NCDs to be included in national UHC responses and social protection schemes, including measures to minimize catastrophic and OOP for the poorest and most vulnerable<sup>15, 76</sup>.

People’s health cannot be addressed in isolation from economic security, equity and well-being – they are inextricably linked. Universal health coverage is a part of broader social protection. LMICs are far from achieving universal social protection: between 42-82% of their populations are not covered by any social protection scheme.<sup>77</sup> Civil society can play a key role in calling for the expansion of schemes to ensure that more people with NCDs get the long-term care they need and to protect against catastrophic health expenditures for NCDs.

Advocates can also play a key role in advocating for taxation and fiscal measures to generate domestic resources for health, as outlined in Appendix 3. With more sustainable domestic resourcing, countries can ensure increased access to quality and affordable essential medicines for people living with NCDs, particularly poor and vulnerable populations, by placing them on the list of essential drug and diagnostic lists. Aligning these policies and financing initiatives will also ensure that prevention and care interventions are holistic, and people centered. These measures will help mitigate significant financial costs to individuals and their households by prioritizing a more just and equitable approach to resource allocation and distribution.

## 6. Prioritize health literacy

### BARRIERS

Health literacy is an important resource for knowledge and action. It is the basis for good health-seeking behavior. Lack of information and poor health literacy on the other hand impacts negatively on health seeking behavior, and results in poorer health outcomes and poorer use of health care services. While health promotion is integral to primary health care and UHC, the extent to which it is facilitated does not always translate to improved health literacy.

**“My life experience living with hypertension made me understand the importance of earlier information and the ability to access healthcare on time no matter where you are or what level you may be at within society”**

Survey respondent, community advocate with lived experience of NCDs, Nigeria.

An integrated conceptual framework for health literacy development for NCDs has been developed by the WHO and identifies barriers to putting health literacy into action. It recognises that different people have different ways of learning about health. For example, through community conversations, printed materials, communication and interaction with health workers, or via conventional and digital media. The WHO framework identifies barriers to people accessing information about health and health care, including availability or physical access to information, service quality, service responsiveness, cultural safety and stigma, gender inequality, language, cost or availability of UHC, racism and other discriminatory practices, information and communications technology (ICT), and complexity and comorbidity<sup>78, 79</sup>. Others include language and literacy barriers, a lack of age sensitive information, and the use of medical jargon.

Commercial entities or actors can present a barrier to NCD health literacy (see Priority 3 Create Health Enabling Environments) by investing significant resources in tactics to undermine science and public health campaigns<sup>80</sup>, including through marketing and interference in policy making. This is true of health-harming industries such as the tobacco, alcohol and food and beverage industries and can be detrimental to health promotion and literacy in contexts where laws and regulations to counter such tactics are weak<sup>81</sup>.

### RECOMMENDATIONS

**A new approach to health literacy is needed to improve equity in diverse settings.**

The WHO has spearheaded an approach defined as the ‘health literacy development approach’<sup>82</sup> that involves a range of stakeholders – from health workers, health systems, organisations, and policy makers meaningfully engaging communities<sup>62</sup>. This approach recognizes that for many, people health decisions and actions occur within family, community and cultural practices and beliefs, which can mean that health choices are restricted by social and environmental factors beyond the control of individuals. There are **five action areas**<sup>83</sup>, based on case studies to promote sustainable improvements in health and equity.<sup>78</sup>

One action in particular is crucial for advancing equity for those who tend to miss out or are left behind. Action area 4 is to ‘target priority groups’ that are not easily accessing health information or health care relevant to the prevention and control of NCDs of whose needs are not met by current approaches to health service delivery. These are priority groups who are typically underserved or marginalised, including language and cultural minority groups, people with disabilities and mental health conditions, people with low education and socioeconomic status, older people, and people with limited digital skills and access among others. Activities to target priority groups include identifying and prioritizing groups that are being left behind, implementing WHO National Health Literacy Demonstration Projects<sup>84</sup> to allow for meaningful engagement with priority groups, and applying health literacy and co-design principles when implementing digital services. For a detailed overview of actions for each action area refer to Volume 3 in the [WHO NCD health literacy development series](#).

## 7. Identify and eliminate stigma and discrimination

### BARRIERS

Discrimination and stigma are a common experience for people living with NCDs and can present in various ways, including self-stigma, stigma by association (involves public disapproval due to associating with people who have been stigmatized),<sup>85</sup> public stigmatization and structural discrimination<sup>86</sup>. The Global Advocacy Agenda of People Living with NCDs found that two-thirds of people living with NCDs consulted had experienced stigma and discrimination<sup>87</sup>. Causes of stigma take many forms and can be due to visibility of symptoms or outward appearance, fear and blame from others for poor lifestyle resulting in disease or driven by negative stereotypes in society<sup>88</sup>. NCD-related stigma and discrimination is considered most common for mental health conditions. Stigmatization can lead to poorer health outcomes due to fears people have about disclosing health conditions, accessing healthcare services, and adhering to treatment. A survey respondent in India issued a call to action that stigma is a barrier to equity and results in underreporting of illness.

**“We must work on issues related to stigmatization and discrimination against our people living with NCDs. Factors such as race, ethnicity, gender, and sexual orientation should not be issues that prevent anyone from accessing the best medical care”**

Online survey respondent.

**“If it wasn’t for Aboriginal Community Controlled Health Services, which is a free service for Aboriginal and Torres Strait Islander people, our people wouldn’t receive the health care that they need because our mainstream health system in many states and territories have challenges in and around racism and discrimination”**

**Tania Brown**, Consultant at TWB Consulting, Aboriginal-owned business, Australia.

The social positioning of people living with NCDs plays a role in how people with lived experience engage with health systems and services. Where discrimination and exclusion of persons based on health status, gender, sexual orientation, race, and ethnicity are common, equitable access to health services is threatened. Poor knowledge about NCDs also fuels misinformation and perceptions that stigmatize people living with NCDs. This influences the quality of care from healthcare providers whose personal beliefs may be misinformed by discriminatory views of people living with NCDs. Consequently, this drives people living with NCDs away from seeking healthcare.

**“...There is a lot of discrimination or stigma related to NCD status, which can further exacerbate health disparities. For example, individuals with mental health conditions may face discrimination and social exclusion, making it more challenging to access appropriate care in this setup**

Online survey respondent.

### RECOMMENDATIONS

To reduce and ultimately remove health inequities for people living with NCDs, stigma and discrimination must be acknowledged and addressed by improving and strengthening policies, education and health literacy, healthcare capacity and access. The [WHO Comprehensive Mental Health Action Plan 2013-2030](#) sets out proposed actions for government, international and national partners, and the WHO Secretariat. The [Global Advocacy Agenda](#) of People Living with NCDs, based on a consultation with 1,893 people from 76 countries with lived experience, sets out calls to action under the ‘human rights and social justice’ pillar that address stigma and discrimination in workplaces, schools, healthcare settings. [The WHO Framework on Meaningful Engagement for People Living with NCDs](#) also sets out actions related to the elimination of stigmatization for WHO and Member States.

## 8. Monitor, evaluate and use data for effective decision-making

### BARRIERS

Lack of quality and reliable data on NCDs is a major barrier to achieving NCD targets and an effective, inclusive approach that leaves no one behind. Globally, NCD commitments and targets do not capture inclusive information and data across populations and disease areas. There is limited knowledge and understanding of NCDs in all their diversity, which deepens inequities.

Currently, major NCD data gaps relate to people living with multiple NCDs and/or NCDs other than the major conditions (beyond the 5x5 approach), a focus on morbidity – defined as the state of living with a disease or condition that has a negative impact on wellbeing – and for people younger than 30 or older than 70 years. Quality of care metrics for both prevention and treatment, including in hospital treatment, need to be developed, implemented and monitored for continuous quality improvement. On UHC commitments specifically, the UHC service coverage index NCD tracer indicators do not include any reference to NCD care provision. There are also data gaps on out-of-pocket payments for people living with NCDs in LMICs.<sup>14,89</sup>

There is also a need for disaggregated data – which show how NCDs are experienced by people of different ages, socioeconomic status, education levels, place of residence, sex and gender, race, ethnicity, and indigeneity and other characteristics – to advance equity. Disaggregated data is critical for the design of equity-oriented policies, programmes, and services<sup>90, 91</sup>.

**“If you don’t have the data to show there are inequities... it’s very difficult to argue at the policy level if you’re not backed with existing data. [It becomes difficult] to convince people that you can address inequities in a substantial way”**

**Salma Abdalla**, Lead Project Director, Boston University School of Public Health/3-D Commission.

### RECOMMENDATIONS

High-quality, disaggregated and reliable data informs the quality of health policies and programmes and plays a role in ensuring accountability at all levels. For a more inclusive, equity-driven NCD agenda, progress towards existing national and global targets, including those linked to the Sustainable Development Goals, Universal Health Coverage, and the Global NCD Action Plan, should be regularly reported against and disaggregated according to age, disease, gender, geographical region, and socioeconomic groupings where possible. In addition, data needs to strengthen the focus on younger and older people living with NCDs (those under 30 and over 70), recognize a broader set of conditions and diseases, and widen the focus from mortality to morbidity and multimorbidity, including the quality of NCD care provided at all levels of a health system. This requires investment in NCD surveillance systems to include monitoring of data on NCD morbidity and mortality across all age and disease groups in order to improve NCD prevention and management<sup>67</sup>.

Governments have the responsibility to provide adequate health services<sup>92</sup> for people living with NCDs, by integrating essential NCD services across the continuum of care into UHC benefit packages, including as specified in Appendix 3 of the WHO Global NCD Action Plan for the Prevention and Control of NCDs. NCD Alliance are calling for the disaggregation of reporting on UHC Target (a) “To progressively cover 1 billion additional people by 2023 with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to covering all people by 2030” by age, disease, gender, geographical region, and socioeconomic groupings.

WHO has developed the [Noncommunicable disease facility-based monitoring guidance](#) for NCD patient and programme monitoring. The guidance includes a monitoring framework and set of core and optional standardized indicators to guide recording and reporting of health services data at the primary care level. This guidance can be leveraged by civil society to advocate for the inclusion of NCD monitoring in routine health information systems and health facility surveys, where it is currently lacking. To date there are no standardized indicators for monitoring NCD services at secondary care level.

Community-led monitoring (CLM) is an underutilized accountability mechanism for the improvement of NCD service quality and access. CLM practices are a key pathway to more equitable access to NCD services and a rights-based approach. CLM has been used extensively in TB and HIV services and experiences show that communities can play a vital role in addressing data gaps by compiling evidence on what works well, what is not working, and what needs to be improved, and provide suggestions for targeted action to improve health service delivery and health outcomes. CLM can also be used to identify and address systemic barriers (e.g., including but not limited to racial, gender and age inequities), as well as identify policy and legal gaps that impact on people's access to and uptake of health and other services. An [introductory guide on CLM for NCD services](#) has recently been published to guide efforts<sup>93</sup>.

## Conclusion

Enhancing health equity is an overarching goal of Universal Health Coverage and an essential component to an effective NCD response. Viewing NCDs through an equity lens reveals the myriad ways the determinants of health disproportionately impact LMICs and the most marginalised and underserved populations in all societies.

This Framework illustrates how the different determinants of health intersect to influence different individual experiences of equity for a person living with NCDs (see Figure 1). Achieving health equity for NCDs requires putting people at the centre, recognising that personal characteristics, lived experience of NCDs, and different determinants of health, interact and combine to shape quality of life and health outcomes. Advancing equitable solutions requires reaching those left furthest behind, meaningfully involving people living with NCDs and communities and adopting a rights-based approach to NCDs. Areas for action and specific policy recommendations should be tailored to each context and unique populations left behind. The Framework offers areas for action to address common barriers to equity for people living with NCDs. Civil society and community advocates should conduct context-specific analysis of NCD inequities in a country or local setting to develop their own tailored calls to action.

To support civil society and community advocates operationalize a health equity lens for NCD advocacy, NCDA has developed an accompanying **Practical Guide for NCD Community Advocates**. This guides advocates to develop an NCD Equity Report using an NCD Health Equity Assessment Tool to establish a foundation for advocacy efforts in this area.



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- 92 Essential health services including preventive, promotive, curative, rehabilitative and palliative health services are typically delivered through different levels of health care – community level, primary health care facilities, first level hospitals, tertiary level hospitals and at the population level. Collecting and analysing data is a crucial part of the process in determining the criteria for identifying health and intervention priorities at different levels.
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NCD Alliance

31-33 Avenue Giuseppe Motta

1202 Geneva, Switzerland

[www.ncdalliance.org](http://www.ncdalliance.org)



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