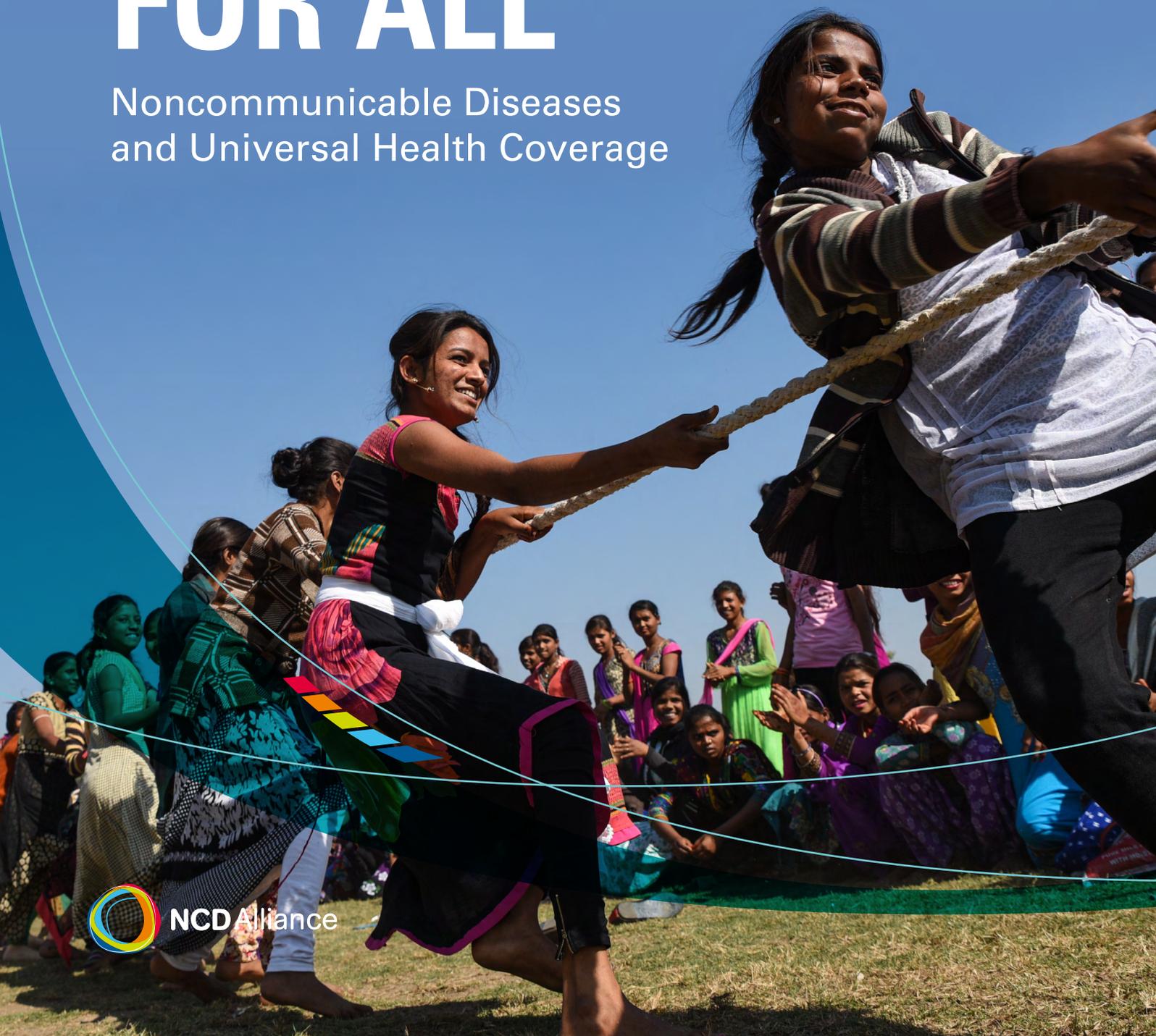


# ENSURING HEALTHY LIVES FOR ALL

Noncommunicable Diseases  
and Universal Health Coverage



NCD Alliance



# ENSURING HEALTHY LIVES FOR ALL

## Noncommunicable Diseases and Universal Health Coverage

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Edited by NCD Alliance, December 2018

Cover: Adolescent girls play a game of tug-of-war during an annual meeting of girls' clubs in Udaipur, India. © 2016 Arvind Jodha/UNFPA, Courtesy of Photoshare.jpg

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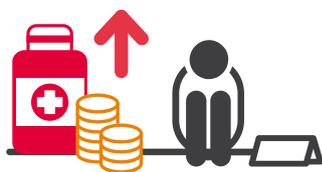
- ◀ Since 2007, the National Cancer Institute (INCAN) of Mexico has offered free treatment and care to all women against breast cancer. Since then thousands of Mexicans have detected and treated it in time, surviving the disease.

Noncommunicable diseases (NCDs) – including cancer, cardiovascular disease, chronic respiratory diseases, diabetes, and mental and neurological conditions – are the leading causes of global death and disease worldwide, and a major contributor to health expenditure due to their chronic nature. NCDs are responsible for over half of the global burden of disease and for over 70% of all global deaths, and more than three quarters of global NCD deaths occur in low- and middle-income countries<sup>1</sup>. A new approach to prevention and treatment of NCDs is essential to deliver on the Sustainable Development Goal to improve health and well-being for all.

## Key Statistics<sup>2</sup>



At **LEAST HALF OF THE WORLD'S POPULATION** STILL DO NOT HAVE FULL COVERAGE OF ESSENTIAL HEALTH SERVICES



ABOUT **100 MILLION PEOPLE** are still being pushed into **EXTREME POVERTY** due to **HEALTH CARE COSTS**

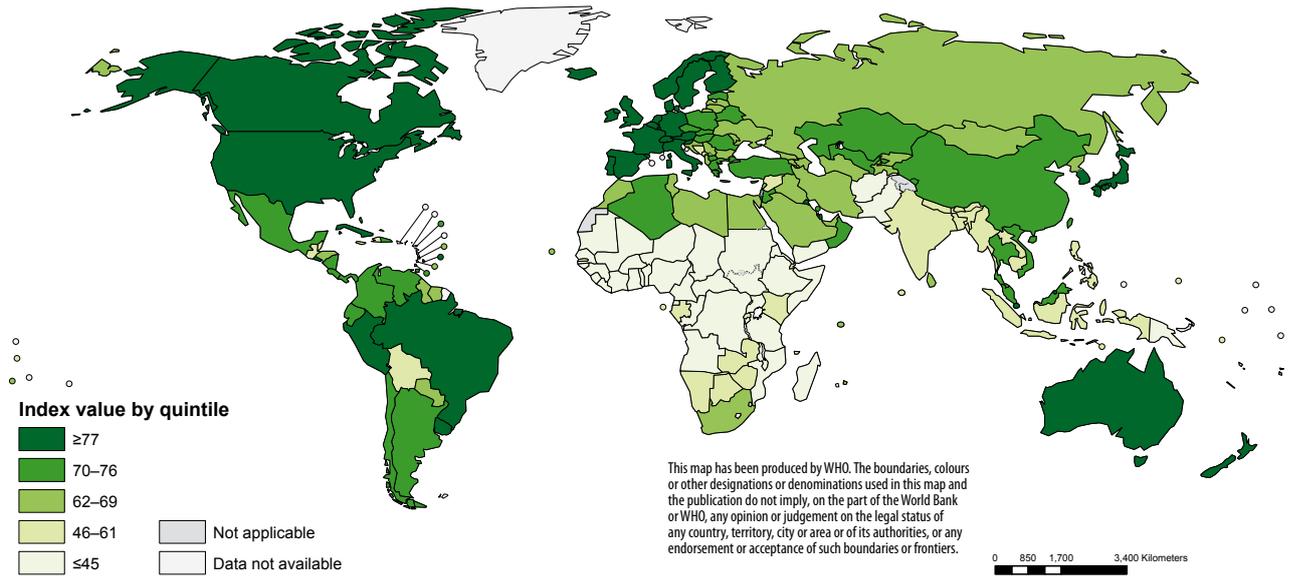


OVER **800 MILLION PEOPLE** spend at least **10%** of **THEIR HOUSEHOLD BUDGETS** on **HEALTH-RELATED COSTS** in 2010

<sup>1</sup> <http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>

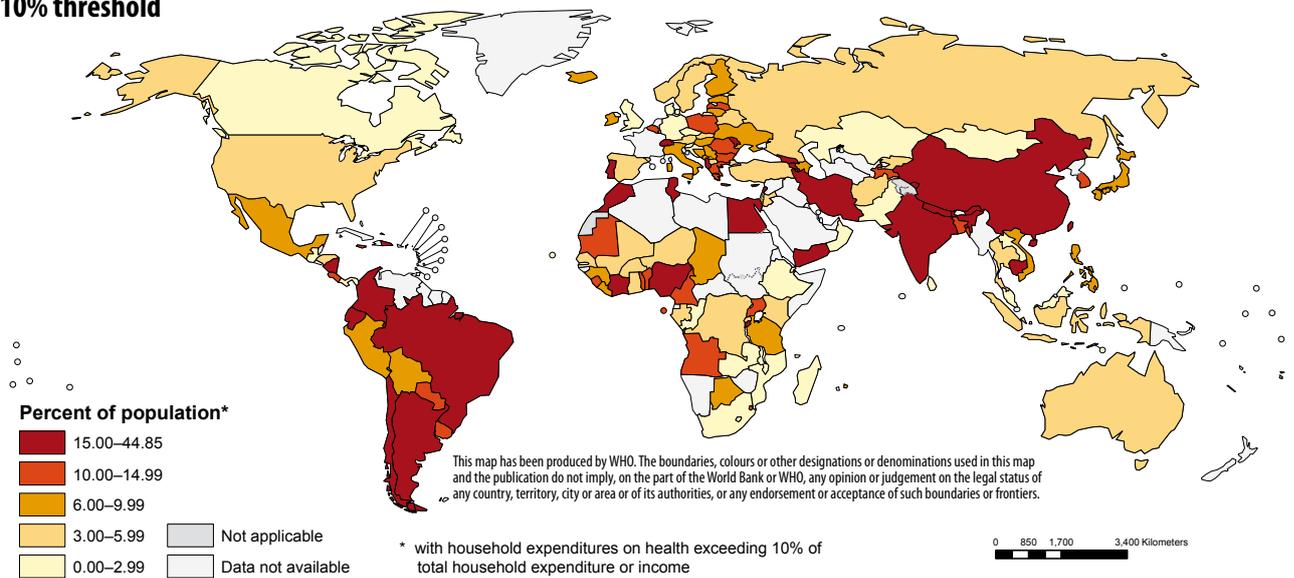
<sup>2</sup> [http://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](http://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

### UHC service coverage index by country, 2015: SDG indicator 3.8.1



### Incidence of catastrophic health spending: SDG indicator 3.8.2, latest year

#### 10% threshold



Source: Tracking Universal Health Coverage: 2017 Global Monitoring Report.  
<http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf>

# Introduction

In May 2018, the World Health Organization (WHO) Director-General, Dr Tedros Adhanom Ghebreyesus, unveiled the new five-year strategic vision for WHO: one billion more people benefit from UHC; one billion more people have better protection from health emergencies; and one billion more people enjoy better health and well-being<sup>3</sup>. These targets are to be achieved by 2023, and help strengthen countries health systems on their path to achieving the Sustainable Development Goal (SDG) target 3.8 on universal health coverage (UHC).

These “triple billion” targets for WHO set out a strategic framework for UHC and for global health and development work, encouraging all initiatives to help deliver on these targets. Over 60 per cent of people living with NCDs have experienced catastrophic health expenditure, and being uninsured increases the risk of high out-of-pocket costs<sup>4</sup>. Health systems that protect individuals and communities from the economic burden of NCDs are essential if the world is to achieve the Sustainable Development Goal of poverty reduction – the links between NCDs, health and economic development are deep and intertwined. Strong health systems can help expand financial risk protection for people living with NCDs.

Out-of-pocket (OOP) payments for NCD treatment and care often trap poor households in cycles of catastrophic expenditure, impoverishment, and illness, and in many countries, coverage and access to NCD services, including early diagnosis, treatment and palliative care, is inadequate. Too often, health systems are fragmented and oriented towards single-disease treatments, instead of adopting a lifecourse approach to health that provides people with the services and care they require for multiple conditions.

In September 2015, world leaders adopted the 2030 Agenda for Sustainable Development and the SDGs, of which Goal 3 focuses on achieving health and well-being for all. SDG3 includes target 3.4 to reduce premature mortality due to NCDs by one-third by 2030 and promote mental health and well-being, and target 3.8 to achieve universal health coverage for all.

World leaders again met in September 2018 at the third United Nations High-Level Meeting on NCDs, where they adopted a Political Declaration to accelerate the NCD response, building upon commitments made at previous UN High-Level Meetings on NCDs in 2011 and 2014.

The body of epidemiological and economic evidence on the urgency, necessity and feasibility of meeting these commitments is robust and growing.

This policy brief is an update to the NCD Alliance’s 2014 brief **UHC and NCDs: A mutually reinforcing agenda**, and reflects the developments in both the NCD response and UHC agenda since the adoption of the 2030 Agenda for Sustainable Development and the SDGs<sup>5</sup>. It makes the case for including NCDs in national UHC benefit packages in order to fully achieve the 2030 Agenda target of healthy lives and well-being for all at all ages.

Community health workers check the blood pressure of a woman with breathing difficulties, Achham district, Nepal, February 2018



<sup>3</sup> <http://www.who.int/news-room/detail/18-05-2018-director-general-brings-ambitious-agenda-for-change-to-world-health-assembly>

<sup>4</sup> [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(18\)30323-4.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30323-4.pdf)

<sup>5</sup> <https://sustainabledevelopment.un.org/post2015/transformingourworld>

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The imperative for governments to take action is clear. The response requires implementation of tried-and-tested priority policies to prevent and treat NCDs in all countries and in all resource settings, leaving no one behind. It is now time for governments to deliver and put the health and well-being of their people first.

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# The unique features of the NCD epidemic

## Chronic

NCDs are chronic in nature and often lifelong. People living with NCDs (PLWNCDs) often have multiple interactions with the health system over their lives, and may require disability management and long-term care, including rehabilitation and palliative care.

## Co-morbidities

Many PLWNCDs often suffer from two or more NCDs, or other diseases such as tuberculosis and HIV/AIDS. As people live longer due to improvements in healthcare, co-morbidities are increasingly becoming the norm. There is increased recognition of the global prevalence of mental ill health, also affecting PLWNCDs, and unmet need for mental health services worldwide. This creates significant challenges for health systems that, to date, have been configured to treat individual diseases.

## Lifecourse

Exposure to risk factors for NCDs begins as early as in-utero (e.g. tobacco use, harmful use of alcohol, lack of physical activity, poor diet) and patterns of consumption of unhealthy products may start in childhood and adolescence. Exposure to both indoor and outdoor air pollution throughout the lifecourse is increasing due to rapid urbanisation. Ageing populations are at increased risk of developing NCDs and NCD-related disabilities.

## Comprehensive

Progress on NCDs relies on a balanced, lifecourse approach that spans the continuum of care, from health promotion and prevention to screening, diagnosis, treatment, rehabilitation and palliative care. Comprehensive UHC must ensure these essential services are included in national benefit packages in order to improve the health and well-being of populations.

## Multisectoral

The health sector and health policies alone cannot alleviate the health and economic burden due to NCDs. The majority of NCD risk factors – tobacco, alcohol, unhealthy diet, physical inactivity, and air pollution – are driven by other sectors including industry, agriculture, trade, education, employment, and transport. Social determinants and the environments in which people live play a crucial role in exposure and vulnerability to the risk factors and consequences of NCDs. A whole-of-government and whole-of-society approach is necessary in order to deliver a comprehensive approach to NCDs.

# What is universal health coverage?

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, has said that “all roads lead to universal health coverage,” and, under his leadership, has oriented the World Health Organization to focus on the achievement of UHC as a priority. Comprehensive UHC spans the continuum of care, from health promotion and prevention to treatment, rehabilitation, and palliative care.

The concept of UHC is firmly rooted in the belief that the highest attainable standard of physical and mental health is a fundamental human right, and that all people should have access to quality essential health services without incurring financial hardship.

## The World Health Organization defines UHC as\*:

1

**Good-quality** essential health services across the continuum of care are available, according to need.

2

There is **equity** in access to health services, whereby the entire population is covered, not only those who can afford services.

3

**Financial-risk protection** mechanisms are in place to ensure the cost of using care does not put people at risk of financial hardship.

\*[https://www.who.int/health\\_financing/universal\\_coverage\\_definition/en](https://www.who.int/health_financing/universal_coverage_definition/en)

“

**Universal health coverage is ultimately a political choice. It is the responsibility of every country and national government to pursue it.”**

**Dr Tedros Adhanom Ghebreyesus,**  
WHO Director-General

UHC must be - by definition - truly universal. It covers all populations – from refugees and marginalised groups such as indigenous peoples and people living with disabilities or mental health conditions, to the poorest and those living in rural or remote areas. By this definition, even some of the world’s richest countries have major gaps in their provision of UHC. UHC provides governments with an opportunity to develop gender-sensitive responses – taking into account differences in risk factors, prevalence of different conditions and treatment options - that result in long-lasting health benefits.

Achieving UHC is possible for all countries, regardless of income level. It requires strengthening health systems in a comprehensive manner, robust and sustainable financing mechanisms, a well-trained and resourced health workforce, and good governance as core critical elements of successful UHC mechanisms. Governments should ensure that national UHC programmes include the WHO package of essential NCD interventions (PEN Package)<sup>6</sup> and are structured to deliver integrated care.

UHC requires a whole-of-government and whole-of-society approach, breaking down existing health and development siloes to deliver strong health systems that are responsive to the needs of people.

“

**Health insurance should include everyone, especially the poor.”**

A person living with an NCD in Cairo, Egypt, part of the NCD Alliance’s Our Views, Our Voices consultation

<sup>6</sup> [https://www.who.int/ncds/management/pen\\_tools/en/](https://www.who.int/ncds/management/pen_tools/en/)

# Poverty and NCDs

The recent *Lancet* Taskforce on NCDs and economics discussed the complex, reinforcing interaction between inequalities and health, highlighting that better household economic and educational outcomes enhance health, whereas low socioeconomic status and poverty increases the risk of chronic ill health, and NCDs reduce a household's economic status<sup>7</sup>. People living in poverty are often more exposed to common risk factors for NCDs and limited in their ability to practice behaviours that promote health due to the environments in which they live, thereby increasing the chance they will develop an NCD later in life and be diagnosed at a later period<sup>8</sup>.

“

**Transport, consultation, medicines cost money, kids in school need fees, and life must generally go on. It is very expensive. This illness can make one sell a piece of land.”**

A person living with an NCD in Machos, Kenya, part of the NCD Alliance's Our Views, Our Voices consultation

Poorer and marginalised people may face significant barriers to access preventative, primary or acute care, including out-of-pocket or informal payments, discrimination or stigma, or practical issues such as language barriers or distance to healthcare facilities. Late diagnosis severely decreases the chance of successfully managing a chronic condition, and often results in premature mortality.

The chronic nature of NCDs often requires long-term care and treatment, diverting much-needed resources in low-income households. Catastrophic out-of-pocket expenditure due to NCDs heightens the devastating effects of NCDs, limiting spending potential of people in low-resource settings. People living with NCDs sometimes suffer from loss of productivity and absenteeism in the work force and in schools, further limiting their earning potential. Ensuring that essential NCD prevention and treatment is a core component of national UHC packages can help provide affordable, quality care to the people who need it most.

UHC that addresses NCDs and reduces catastrophic out-of-pocket expenditure for all people will help to break the cycle of poverty and poor health due to NCDs and help promote sustainable economic growth.



Centre Valbio traveling health clinic staff provide examinations and medications to local people in Antalarava village, Madagascar.

<sup>7</sup> Niessen Louis, Mohan D, et al. Tackling socioeconomic inequalities and non-communicable diseases in low-income and middle-income countries under the Sustainable Development agenda. *The Lancet Taskforce on NCDs and economics*, April 2018.

<sup>8</sup> *Ibid.*

# The power of primary health care to close the health gap

## Person-centred and responsive to needs

Quality primary health care (PHC) is a foundation of UHC and is required to achieve sustainable, equitable UHC mechanisms. PHC is comprised of three main areas: empowered people and communities; multisectoral policy and action; and primary care and essential public health function, which includes services across the continuum of care<sup>9</sup>. Health systems oriented towards delivering strong PHC help deliver the shared goal of health and well-being for all and achieve the health-related SDGs. PHC meets people where they are with the services they need, and is a natural entry point for delivering integrated care and services.

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“  
Low income group communities surely face challenges in accessing quality health care; they often tend to delay treatment, which leads to complications.”

A person living with an NCD in Chennai, India, part of the NCD Alliance's Our Views, Our Voices consultation

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<sup>9</sup> <http://www.who.int/primary-health/en/>

Forty years since the adoption of the Alma Ata Declaration on Primary Health Care, the evidence for delivering strong PHC systems and integrated care has only grown. Earlier this year, the NCD Alliance produced [Shaping the Health Systems of the Future: Case Studies and Recommendations for Integrated NCD Care](#), a practical guide setting out how health stakeholders are pursuing integration in PHC settings. The case studies presented in this report provide examples of how governments can scale up PHC and integrated care in order to achieve UHC – from including diabetes education and screening with TB services to providing cervical cancer screening at HIV testing facilities<sup>10</sup>.

Integrated primary health care, particularly in low-resource settings, can be an instrumental tool in reducing health inequalities by implementing policies and programmes that reach vulnerable populations, including those who often cannot afford health services.

Person-centred care means that all people are treated with dignity and respect, and that the care they receive is personalised, coordinated, and enabling – this approach to health sees people as partners in their own health, together with the health care worker. This type of care can have better outcomes, equipping individuals with the knowledge and tools to understand, participate, and actively manage their own health.

In order to deliver person-centred care, a well trained and resourced health workforce is essential, as sustainable UHC mechanisms will only be possible with a health workforce that is empowered and enabled to deliver integrated care.

This means that comprehensive UHC must span the continuum of care – from health promotion, prevention, screening and diagnosis, to treatment, rehabilitation and palliative care – with a strong lifecourse approach to health. Included in this is the need to ensure access to affordable, quality vaccinations and other essential medicines and technologies. In order for health systems to be resilient and responsive, they must be well resourced and prepared to meet the needs of the population given both the current and projected burden of disease, with a focus on reaching the most marginalised first in order to leave no one behind.

◀ Mexican nurse from Instituto Nacional de Ciencias y Nutrición Salvador Zubirán, Mexico DF, September 2017

“

**A cancer survivor is always a patient that needs constant monitoring. It can always come back, that’s why I label myself as a perennial patient. Cancer is a life-changing event.”**

A person living with cancer in Quezon City, the Philippines, part of the NCD Alliance’s Our Views, Our Voices consultation

An example of the importance of a lifecourse approach to health and strong primary health care within a UHC system, is addressing childhood cancer. In 2018, WHO launched the Global Initiative for Childhood Cancer, with a goal target of achieving at least 60 per cent survival rate for children with cancer by 2030, and to increase country capacity to deliver childhood cancer care. Increasing the childhood cancer survival rate requires early screening and diagnosis, followed by effective and timely treatment. Most childhood cancers can be cured with generic medicines, which should be part of a country’s essential UHC benefits package, and childhood cancer treatment can be cost-effective in all income settings<sup>11</sup>.



<sup>10</sup> [https://ncdalliance.org/sites/default/files/resource\\_files/ShapingTheHealthSystemsOfTheFuture\\_FINAL\\_WEB\\_0.pdf](https://ncdalliance.org/sites/default/files/resource_files/ShapingTheHealthSystemsOfTheFuture_FINAL_WEB_0.pdf)

<sup>11</sup> Gupta S, Howard SC, Hunger SP, et al. Treating Childhood Cancer in Low- and Middle-Income Countries. In: Disease Control Priorities, volume 3. <http://dcp-3.org/chapter/900/treating-childhood-cancers-low-and-middle-income-countries>

# Co-morbidities: A challenge for 21<sup>st</sup> century healthcare

Many health conditions do not occur in isolation, especially in ageing populations<sup>12</sup>, and today's health systems need to adapt to address people living with multiple conditions. Often, two or more chronic conditions manifest in the same individual. Globally, one in three adults live with multiple chronic conditions, a figure that is predicted to dramatically rise between now and 2030<sup>13</sup>. People living with some infectious diseases can have an increased risk of developing NCDs – such as people living with HIV having an increased risk of cardiovascular disease<sup>14</sup> and some cancers<sup>15</sup>, and diabetes being a known risk factor for active tuberculosis (TB) and reactivation of latent TB<sup>16</sup>. Living with a chronic, life-changing condition may often impact a person's mental health and well-being. These are known as co-morbidities, and often elevate the financial and mental hardship due to poor health. Reproductive and sexual health conditions can be particularly sensitive, and social norms and traditions can further compound the burden due to lack of autonomy and mobility, particularly for women and girls.

PHC that addresses NCDs and co-morbidities can also help improve global security, delivering stronger health systems that are better placed to respond to public health emergencies. For example, hepatitis C is a major preventable and treatable cause of liver cancer, while diabetes complications can require expensive treatment, such as dialysis and amputations, increase the risk of infectious diseases like malaria, and makes tuberculosis harder to treat<sup>17</sup>. Similarly, tobacco use is not only a risk factor for NCDs but also increases the risk and severity of influenza and tuberculosis<sup>18</sup>.

Integrated primary health care is a powerful tool to help deliver strong UHC systems that meets the needs of people and treats them as a whole, instead of as a disease, and helps strengthen global security. Delivering UHC will require going beyond the traditional health and development siloes of the Millennium Development Goals (MDGs) and working in a new development paradigm that is based on integration and co-benefit solutions.

Primary health care systems must be reoriented in order to build capacity to address emerging disease patterns and interlinkages, with the delivery of more integrated care being key to improving efficiency. There is a heightened need to leverage existing platforms for infectious diseases and maternal and child health, together with social support mechanisms and coordination across disciplines, and to address shared risk factors across diseases.

There is no one size fits all formula for UHC or primary health care. Each country must mould its own universal health coverage package that fits the needs of its people, taking into account the views and experiences of people living with health conditions, such as NCDs, as well as of their carers.

“

**It is important that medical insurance schemes are accessible and available to every citizen of the country. The mental stress and trauma that a patient and his or her family go through, in India, when there is a financial challenge is frightening.”**

A person living with an NCD in Chennai, India, part of the NCD Alliance's Our Views, Our Voices consultation

<sup>12</sup> Divo, Miguel J et al. "Ageing and the epidemiology of multimorbidity" European respiratory journal vol. 44,4 (2014): 1055-68.

<sup>13</sup> Hajat, Cother and Sandeep P Kishore. "The case for a global focus on multiple chronic conditions" BMJ global health vol. 3,3 e000874. 22 Jun. 2018, doi:10.1136/bmjgh-2018-000874

<sup>14</sup> Triant VA. Cardiovascular Disease and HIV Infection. Current HIV/AIDS Reports 2013; 10(3), 199–206.

<sup>15</sup> Silverberg MJ et al. Cumulative incidence of cancer among persons with HIV in North America: a cohort study. Annals of Internal Medicine 2015; 163, 215

<sup>16</sup> Ai J-W et al. Updates on the risk factors for latent tuberculosis reactivation and their managements. Emerg Microbes Infect. 2016; 5(2): e10.

<sup>17</sup> <https://www.cdc.gov/globalhealth/healthprotection/fieldupdates/winter-2017/ncds-impact-ghs.html>

<sup>18</sup> *ibid.*

# Delivering UHC

## Financing

Adequate and sustained resources are essential for achieving UHC. Increasing domestic resources for health will be required in all settings.

For example, in Global Financing Facility (GFF) eligible countries, 79% of health expenditure is covered by domestic resources, with international aid accounting for the rest<sup>19</sup>. Close to half of domestic expenditure in GFF eligible countries currently comes from OOP payments, which is the most regressive form of health spending and further impoverishes those least able to afford care. The achievement of UHC may require domestic fiscal reform to increase the total resources available and to reduce the share from OOP expenditures, which should be supported and required by international donors to make sure the transition is transformational and sustainable. Revenues from interventions implementing fiscal measures on unhealthy commodities – such as tobacco, alcohol, sugar-sweetened beverages, and fossil fuels – can provide a double-dividend if reinvested in health systems strengthening. However, these revenues will diminish over time as the taxes are effective in their primary goal to reduce consumption of unhealthy products and saving costs to health systems.

WHO has shown that by investing an additional US\$ 1.27 per person per year and implementing just some of the recommended WHO Best Buy cost-effective interventions in low- and lower-middle-income countries between now and 2030, 8.2 million lives could be saved and US\$ 350 billion could be generated in economic output as a result of reduced expenditure on health care, increased workforce participation resulting in boosted GDP, and more resources to invest in health<sup>20</sup>. If countries were to implement the full set of WHO cost-effective interventions in all countries, the returns on investment would far outweigh any perceived initial costs. The economic imperative for investing in NCDs as a means to finance UHC are clear – governments must make the political choice to invest in health.

## Partnerships

At the heart of the 2030 Agenda for Sustainable Development and the SDGs is delivering sustainable development in an integrated and indivisible manner. This is why SDG 17 on partnerships spans all goals and targets. Given that the health sector is the recipient of the outputs of other sectors, partnerships and a 'Health in all Policies' approach between health and sectors such as transportation, education, urban planning, and agriculture are essential for achieving the 2030 targets.

However, governments and stakeholders cannot view SDG 17 as a spur to enter into partnerships without giving due attention to real and perceived conflicts of interest. For health, and for NCDs in particular, these conflicts are especially pertinent, as some private sector actors position themselves as compatible partners in sustainable development when, in fact, their core business contributes to the burden of NCDs and poor health. For example, the actions of alcohol and sugar-sweetened beverage industries were particularly noteworthy in the lead up to the 2018 UN High-Level Meeting on NCDs.

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**The public and private health care services differ significantly. If the government hospitals are equipped to cater to the needs of people living with these conditions, the financial burden can certainly be off loaded.”**

A person living with an NCD in Tamil Nadu, India, part of the NCD Alliance's Our Views, Our Voices consultation

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<sup>19</sup> Save the Children, Tick Tax : Why taxation is so critical to the GFF's success, October 2018

<sup>20</sup> Saving lives, spending less-: a strategic response to noncommunicable diseases. Geneva, Switzerland. World Health Organization; 2018 (WHO/NMH/NVI/18.8).

# How can UHC strengthen the NCD response?

## 1

### Providing health services

Increasing health systems' capacity to respond to NCDs

Establish a comprehensive package of NCD services including public health and prevention

Strengthen quality assurance

Maximise opportunities to integrate health services

Reorient health systems for chronic care

Complement UHC with action to address social determinants

## 2

### Covering populations

Addressing inequalities in the NCD burden

Embrace progressive universalism, ensuring that those farthest behind are reached from the beginning

Ensure coverage reaches vulnerable and marginalised populations

Empower communities, civil society, and people living with NCDs

Enabling policies, regulations, and laws to deliver quality, sustainable services

Strengthen surveillance and information systems

## 3

### Covering costs

Alleviating the economic burden of NCDs

Implement the WHO Best Buys and other recommended cost-effective interventions to reduce the prevalence of NCDs

Leverage domestic and innovative financing mechanisms

Enhance international, regional, and national cooperation

Improve financial risk protection to eliminate out-of-pocket expenses at the point of service delivery

Expand social protection schemes, such as conditional cash transfers

Explore mixed models given the multisectoral nature of NCDs and co-morbidities, such as through public-private partnerships while excluding real and perceived conflicts of interest

# UHC and NCDs

## A mutually reinforcing agenda

# 2019

2019 will be a pivotal year for the UHC agenda, with Heads of State and Government convening at the United Nations for the first High-Level Meeting on Universal Health Coverage.



There is no one size fits all formula for UHC or primary health care. Each country must mould its own universal health coverage package that fits the needs of its people, taking into account the views and experiences of people living with health conditions, such as NCDs, as well as of their carers.



With its intrinsic focus on equity and human rights, UHC provides a powerful vehicle to accelerate progress on reducing inequalities in health and NCDs. The first UN High-Level Meeting on UHC taking place in September 2019 must ensure a comprehensive, lifecourse approach that spans the continuum of care.

NCD prevention via reducing exposure to risk factors must be a core component of UHC, and integrated primary health care is a means to achieve this shared vision of health and well-being for all.



Cardiovascular Disease



Chronic Respiratory Diseases



Cancer



Diabetes



Mental and Neurological Conditions



NCDs must not and do not have to push people further into poverty; governments must make the political decision to put people first.



The UHC target in the Sustainable Development Goals will not be achieved unless governments and stakeholders integrate NCDs across the continuum of care, expanding financial risk protection for all people. Healthy lives for all is an achievable goal, but one that requires multisectoral collaboration and a commitment to develop long-lasting, strong health systems that deliver for people.



**MAKING NCD PREVENTION AND CONTROL A PRIORITY, EVERYWHERE**

Website: [www.ncdalliance.org](http://www.ncdalliance.org) Twitter: [@ncdalliance](https://twitter.com/ncdalliance) E-mail: [info@ncdalliance.org](mailto:info@ncdalliance.org)