Governing Board document 1/2018

Annotated agenda and decision sheet (draft)

Time: 1400-1530 hours (Central European Time)
Venue: Geneva connect-in by WebEx

Chair: Dr James Hospedales

1. (1400-1410) Welcome by the chair, Check-in and introductions of Steering Committee members, and adoption of agenda.

See document 2/2018 on current membership of the Steering Committee.

2. (1410-1420) Constitutive act

See document 3/2018 on the terms of reference of the Governing Board.

Draft decision 1: *Noting with appreciation the work done by the Steering Committee to initiate the Defeat-NCD Partnership, its members decide to constitute themselves as its Governing Board to serve with immediate effect and for the initial period till 31 December 2018.*

Draft decision 2: *The Governing Board adopts its terms of reference and operating procedures, as outlined in document 3/2018.*

Draft decision 3: *The Governing Board decides to appoint Dr James Hospedales as its Chair, to serve for an initial period till 31 December 2018.*

Draft decision 4: *Noting with warm appreciation the encouragement provided by Michael Moller, Director General of the United Nations Office in Geneva, the Governing Board appoints Mr Moller as Hon President noting that this role does not have any fiduciary or legal obligations.*

3. (1420-1430) Progress update

See document 4/2018 for the founding concept note and document 5/2018 for a summary report on progress so far with establishing the Defeat-NCD Partnership,

Draft decision 5: *The Governing Board appreciates the favourable reactions to the concept note dated 26 November 2017 in key stakeholder consultations, and adopts this as the founding framework for the Defeat-NCD Partnership, noting that this will be revised and updated with experience.*

Draft decision 6: *The Governing Board thanks the initial supporters of the Defeat-NCD Partnership, appreciates the United Nations Institute for Training and Research (UNITAR) for its practical assistance, and welcomes the progress that has been made so far.*

4. (1430-1440) Appointment of the Chief Executive

See document 6/2018 on the terms of reference for the chief executive, and document 7/2018 on the curriculum vitae of the CEO-designate Dr Mukesh Kapila.

Draft decision 7: *The Governing Board recognises the conceptual and foundational work done on the Defeat-NCD Partnership by Dr Mukesh Kapila, approves the terms of reference of the chief executive and decides to appoint Dr Kapila to this role for the period till 31 December 2018 or earlier if the longer-term chief executive of the Partnership has been selected and appointed.*

Draft decision 8: *The Governing Board decides to initiate a competitive process for the selection of the longer-term chief executive, including through public advertising for potentially interested candidates, as soon as feasible.*

Draft decision 9: *The Governing Board authorises the chief executive to make financial and programmatic decisions required for the effective and efficient day-to-day functioning of the Defeat-NCD Partnership, reporting to the Board on a regular and periodic basis.*

5. (1440- 1520) Next steps

Oral discussion. Issues covered include the role of the Governing Board and its members, financing matters, institutional issues, future programming priorities.

Draft decision 10: *The Governing Board requests the chief executive to examine the best arrangements for the longer-term hosting of the Defeat-NCD Partnership, and to make recommendations to the Board accordingly. In making its selection, the Board will give particular focus on the potential hosting organisation's demonstrated capacities to provide country programming support through the full range of services necessary for rolling out the four tracks of the Partnership in a cost effective and efficient manner.*

6. (1520-1530) Any other business and closure.

Governing Board document: 2/2018

31 January 2018; rev 7* Feb 2018

Membership of the Governing Board of the Defeat-NCD Partnership

The following are appointed members of the Governing Board for an initial period till 31 December 2018.

1. **Dr James Hospedales (Chair)**. Executive Director of the Caribbean Public Health Agency.

2. **Dr Abbas Gullet**. Secretary General of the Kenya Red Cross Society.

3. **Ms Celina Gorre**. Executive Director of the Global Alliance for Chronic Diseases.

4. **Mr Peter McDermott**. Director of Fajara Associates

5. **Dr Harald Nusser**. Head of Novartis Social Business.

6. **Ms Soraya Ramoul**. Director of Global Access to Care at Novo Nordisk.

7. **Mr Dinuke Ranasinghe**. Chief Executive Officer of Arcadier.

8. **Professor Alafia Samuels**. Director of the Sir George Alleyne Chronic Disease Research Centre (CDRC) at the University of the West Indies.

9. **Mr Subhanu Saxena**. Regional Director at the Bill & Melinda Gates Foundation.

Ex officio members from Partnership programme countries:

10. Representing the **Government of Haiti**: TBC **Dr. Lauré Adrien, Director General,** Ministry of Public Health and Population.

11. Representing the **Government of Kenya**: TBA

12. Representing the **Government of Tajikistan**: **H.E. Mr Jamshed Khamidov**. Ambassador Extraordinary and Plenipotentiary and Permanent Representative of the Republic of Tajikistan to the United Nations in Geneva.

Ex officio observers

13. Representing the **World Health Organization**: **Dr Cherian Verghese**. Coordinator at the Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention of WHO.

14. **Dr Nikhil Seth**. Executive Director of the United Nations Institute for Training and Research. [Host agency].

15. **Professor Mukesh Kapila**. Chief Executive of the Defeat-NCD Partnership and Secretary to the Governing Board. Professor of Global Health and Humanitarian Affairs, University of Manchester.

Governing Board document: 3/2018

31 January 2018 rev 7 Feb 2018

Terms of Reference and rules of procedure for the Governing Board

These TORs and rules of procedure adopted at the establishment of the Defeat-NCD Partnership may be modified with further experience.

1. The Defeat-NCD Partnership will be overseen by its Governing Board (GB) with the following terms of reference:

- to decide on policies and strategies.
- to review and endorse the periodic work plans and budgets of the Partnership including the secretariat, and to monitor performance and progress on the delivery of the Partnership's strategies and objectives.
- To communicate, advocate and make other appropriate representations to promote and advance the Partnership
- to make best possible efforts to mobilise resources and to ensure the financial viability of the Partnership and its secretariat.
- to establish "rules of engagement" with the private business sector based on the principles of the United Nations Global Compact.
- to identify and manage any risks – strategic, operational, and reputational.
- to appoint the Governing Board chair, vice chair, and treasurer, for renewable three-year terms.
- to set rules for its own meetings and manage governance processes.
- to provide accountability to donors and other stakeholders in the Partnership.
- to play an active lead role in identifying the chief executive, advise and support him/her and, through the chair, provide appraisal and functional supervision of the chief executive.

2. The GB composition is intended to provide a broad reflection of stakeholders and constituencies that are relevant to NCDs and that are also providing financial, technical and other practical support to the Partnership. These will include donor governments/public sector, groups representing people with NCDs, international agencies, philanthropies, research and academia, private business sector, and those with other specialist expertise deemed to be relevant and useful.

3. The World Health Organization, as the lead global health agency for the United Nations system, has ex- officio presence on the GB, with the right to vote. Other ex-officio members with full voting rights include the representative of the governments of countries where the Partnership has programmes.

4. Other ex officio members include (a) a representative of the agency hosting the Partnership and (b) the chief executive. They participate fully in meetings but do not have voting rights.

5. The minimum size of the GB shall be 7 members and the maximum 28 members. The optimal size of the GB is seen as approx. 17 members. As the Partnership develops with more and more partners coming on board, a constituency-based system may be introduced to ensure that the GB remains optimally-sized but representative of its stakeholders. Initial thresholds for financial contributors who would like a seat on the GB may also be instituted.

6. The quorum for decision making shall be at least 7 members present with decision made by majority of them when a formal vote is required.

7. The GB is committed to the principle of gender equality and will strive strongly to ensure a gender-nuanced approach in all Partnership programming, as well as equal representation by women and men in our own internal processes.

8. All members, while discharging their commitments as GB members, recognise their personal and professional duty to serve the best interests of the Partnership with due objectivity and integrity. Based on best governance practices in the international agency arena, a code of conduct will be developed that GB members are expected to sign, as well as a register of relevant interests, to provide for transparency and the full disclosure of any actual or perceived conflicts of interest. A system for managing any possible conflicts of interest will be developed, for example, by relevant members being recused from decision-making on particular issues if that would be appropriate.

9. The GB will meet by teleconference approx. every four months or as frequently as its members decide. All such meetings will be deemed to have occurred in Geneva even as members attend digitally from elsewhere. At least one GB meeting annually will be held face-to-face, in Geneva or elsewhere, subject to the availability of resources.

10. The normal period of notice for a GB meeting shall be 14 days and the agenda and supporting documents should be made available to members at least 7 days in advance. The record of decisions made at a GB meeting shall normally be circulated within 7 days.

11. Decisions would normally be made at a regularly-convened Board meeting. However, for the efficient discharge of the Partnership's business, necessary decisions may also be made by email. Such electronic decision-making will normally be made by giving members 14 days to respond to draft decisions. As long as a quorum of 7 responses have been received electronically, the decisions will be deemed to have been taken if so approved by the majority of them.

12. An extraordinary meeting of the GB may be convened by the chair at any time at his or her own initiative, or at the request of at least 3 members, or at request from the chief executive. If the chair refuses such a request, an extraordinary meeting may still be convened if at least 5 members so demand. Extraordinary meetings shall be required to give 5 working days' notice.

13. In the case of an emergency where an immediate response or measure is required to protect the interests or activities of the Partnership, the chair (or vice chair in his/her absence) and the chief executive acting together may jointly take necessary decisions. Such decisions should be communicated as soon as feasible electronically to the full Board membership for endorsement.

14. All GB members serve voluntarily and may not be remunerated for their time or effort while performing their duties as GB members. They may reclaim travel expenses incurred on behalf of the Partnership unless they decide to waive this or if these cannot be covered from their own agencies.

Governing Board document 4/2018

26 November 2017

CONCEPT NOTE: DEFEAT-NCD PARTNERSHIP

The **Defeat-NCD Partnership**[1] addresses the most significant global health problem of the age: premature death, sickness, and disability from selected no-communicable diseases. It aims to reduce this burden in resource-poor countries by making it easier and more cost-effective for them to access a range of inter-connected, essential services and resources, through:

1. A Defeat-NCD Knowledge Forum to help participating countries and stakeholders to share knowledge and expertise, advocate for effective public policies, and mobilise adequate resources to tackle non-communicable conditions of public health importance.

2. A Defeat-NCD Technical Assistance Facility to help least developed and low income, and lower middle income countries to build-up their capacities to reduce NCD risks and improve treatment among vulnerable populations.

3. A Defeat-NCD Supplies Procurement and Distribution Facility and related capacity building support for least developed and low income countries, to expand the in-country availability and provision of NCD-related diagnostics, equipment, and medicines.

4. A Defeat-NCD Supplies Fund to enable least developed and low income countries to access additional and other innovatively-generated finance for obtaining essential NCD-related diagnostics, equipment, medicines, and services.

The Partnership is open to all as a joint endeavour of governments, multilateral agencies, civil society, philanthropic foundations, and the private sector. It will focus initially on **diabetes and hypertension**, and expand to other NCDs when feasible. It will follow WHO's policies and expert guidance on "best buys", and technical standards for NCD management, with impact tracked through its periodic NCD Progress Monitor reports.

The Partnership works by mobilizing global knowledge, tools, capacities, and finances to benefit resource-poor countries according to their specific needs and defined NCD action plans. This includes the populations of humanitarian concern that are hosted by them.

The priority focus is on 49 least developed and low income countries with technical capacity building support also available to a further 43 lower middle income countries.

The Defeat-NCD Partnership advances and sustains the achievement of Universal Health Coverage through enabling poorer populations at risk of NCDs to receive the prevention, screening, and treatment services they need through nationally-led health systems and health-care provision arrangements. This is a direct contribution to Sustainable Development Goal (SDG) 3 on ensuring healthy lives and promoting well-being for all at all ages, and specifically target 3.4 to reduce by one-third premature mortality from NCDs by 2030.

[1] Website www.defeat-NCD.org is under development. Email: secretariat@defeat-ncd.org. For further information on the Partnership contact Mukesh@mukeshkapila.org

What are NCDs?

1. Non-communicable diseases (NCDs)[2] are ailments of long-term, often lifelong, duration. The main types (about 80%) of NCDs are cardiovascular diseases, diabetes, cancers, and chronic respiratory conditions. The other 20% of NCDs include a very wide range of mental and bodily disorders that may affect individuals either alone or as co-morbidities.

2. NCDs are the result of a combination of genetic, physiological, environmental and behavioural factors. The latter include tobacco use, excess alcohol intake, unhealthy diet with high sugar and salt intake, physical inactivity, and ambient pollution. These are increasingly augmented by the secondary consequences of worldwide trends such as rapid unplanned urbanization, globalization of unhealthy lifestyles, and ageing.

Why are NCDs important?

3. NCDs are now the major contributor to the global burden of disease. They kill 40 million people each year, equivalent to 70% of all deaths globally. Each year, there are 15 million "premature" deaths (i.e. below the age of 70 years) from NCDs. With insufficient progress being made, a business-as usual scenario projects this to increase by approx. 30% by 2030.

4. NCDs are not just medical problems. They have huge personal, social and economic impacts as the people affected are often at the peak of their productive careers and precious investment has already been made in their education and training. Their premature demise or impaired productivity due to long-term sickness or chronic disabilities can impoverish them and their families and dependents. NCDs have already become a major burden on health and social support systems, and a brake to national development.

What are diabetes and hypertension?

Diabetes

5. Diabetes mellitus is both an acutely life-threatening as well as a chronic condition in which high blood sugar over a long period of time causes many complications such as heart disease, stroke, kidney failure, eye damage leading to blindness, and difficult-to-treat ulcers that can require limb amputation.

6. Diabetes is due to specialised cells in the pancreas not producing enough insulin (Type I) or body cells not responding properly to them (Type 2). Type I (10% of all people with diabetes) is not preventable with current knowledge and requires insulin injections without which death within a few days is inevitable. Type 2 (90%) is treated with oral medication but may also need insulin. Diabetes is partly inherited genetically but lifestyle factors such as obesity, high sugar consumption, and low exercise levels are strongly contributory.

7. In addition, a gestational type of diabetes can occur during pregnancy where there is hyperglycaemia i.e. blood glucose values above normal but below that diagnostic of diabetes. Women with gestational diabetes are at increased risk of complications during

[2] All data quoted in this paper are taken or extrapolated from WHO, UN, World Bank, and the Global Burden of Disease project at the Institute for Health Metrics and Evaluation.

pregnancy and at delivery. They and their children are also at greater future risk of type 2 diabetes. Gestational diabetes is diagnosed through prenatal screening and insulin may be required to manage it, if dietary measures don't work.

Hypertension

8. Hypertension is a long-term condition that occurs when the pressure of the blood pushing against the walls of blood vessels (arteries), is consistently too high. Also known as a 'silent killer" because it does not usually cause symptoms, the untreated complications include coronary heart disease, heart failure, stroke, and peripheral vascular disease, as well as renal and visual impairment that can lead, in extreme cases, to kidney failure and blindness. Hypertension is also a risk factor for cognitive impairment such as in dementia, itself a major problem of ageing populations.

9. 90-95% of hypertension is classified as primary high blood pressure due to lifestyle and genetic factors. The remaining cases are secondary to specific identifiable causes. One of these is a particularly dangerous form of high blood pressure that occurs in pregnancy: pre-eclampsia and eclampsia. This can arise as an emergency and kill both mother and baby. Women who suffer from this may have gestational diabetes too, and tend to develop chronic hypertension and diabetes later on in life.

10. If hypertension is picked up through screening programmes or discovered incidentally while investigating other conditions, it can be easily controlled through lifestyle changes (obesity and dietary salt reduction, exercise, not smoking and managing stress) and oral anti-hypertension medication. Some form of medication usually become necessary to prevent progression and complications. Depending on the stage of the hypertension, there are several drug types and combinations available to optimise treatment on an individual basis.

Why are hypertension and diabetes important?

11. While little can be done yet about the genetic factors, type 2 diabetes and hypertension risks can be reduced (primary prevention) through healthy diet and regular physical exercise. People with diabetes and hypertension can reduce complications (secondary prevention) through carefully managed therapy. Once complications have set in, their prompt treatment (tertiary prevention) is essential to preserve life quality and reduce disability and handicap.

12. The focus on diabetes and hypertension is justified by their huge public health significance. Each on its own and in combination, cause most of the NCD global deaths: some 1.6 million deaths are attributed to diabetes and 5.7 million deaths to hypertension (out of some 17.7 million from cardiovascular conditions more broadly).

13. These conditions are directly and indirectly associated with three of the most common underlying public health risk factors: raised blood pressure, increased blood glucose, and elevated blood lipids. The interconnections between hypertension/cardiovascular disease and diabetes mean that the prevention, screening, and treatment for raised sugar, blood pressure, and lipids are best done together.

Diabetes

14. Worldwide, diabetes is the 8th overall leading cause of death (5th in women) with 3.7 million deaths related to blood glucose levels, in 2012. It is projected to become the 7th

biggest cause of death by 2030. In 2014, 422 million people had diabetes equating to an adult prevalence of 8.5%. This is expected to increase to 10% by 2035.

15. Diabetes is highly correlated with obesity, the global prevalence of which has nearly doubled since 1980. In 2014, 11% of men and 15% of women age 18 and older were obese, while more than 42 million children under five years were also overweight in 2013. NCDs may be moving towards striking at younger ages. Meanwhile, many children with type I diabetes already struggle in school and their learning gaps are difficult to remedy later on.

16. Apart from its own direct consequences, diabetes is a major potentiator of another NCD: about 11% of cardiovascular deaths are attributed to high blood glucose levels. Diabetes complications are also responsible for a significant proportion of the population disability burden. As hypertension frequently co-exists alongside diabetes, their combined complications potentiate each other.

Hypertension

17. More than a billion people around the world suffer from raised blood pressure and account for 57 million disability-adjusted life years lost. In Africa, for example, the adult prevalence of raised blood pressure is highest at over 40%.

18. The hypertensive disorders of pregnancy are significant contributors to maternal and perinatal mortality: affecting some 5-10% of all deliveries, rising to as high as 18% in parts of Africa.

Why focus on resource poor countries?

19. Poorer nations bear the brunt of the enormous impacts of NCDs with some 86% of premature deaths in 2015 occurring in low and middle-income countries (47% in low and lower middle-income countries). This is reflected in the NCD age-standardised death rate of 625 per 100,000 in low-income countries compared to 397 per 100,000 in high-income countries, in 2012. Put another way, the resident of a low- income country faces a lifetime chance of 20-30% of dying from an NCD under the age of 70; this is two to four-fold that of a high-income country resident.

20. Some richer countries are beginning to show some declines in NCD levels as they invest in prevention and control measures, and no doubt they will make more progress. Meanwhile, when poor countries start getting a little more prosperous, the prevalence of NCD risk factors tend to increase.

21. During 2011–2025, the cumulative economic losses due to NCDs in low- and middle-income countries were estimated at US$ 7 trillion. This sum far outweighs the estimated annual US$ 11.2 billion cost of interventions to reduce the burden. Meanwhile, less than 2% of global development assistance for health goes to NCDs of which only a miniscule share is for diabetes and hypertension.

22. Resource poor countries are constrained in their response by a number of factors. To start with, poorer people are more vulnerable because they are more likely to have to endure unhealthy living and working conditions, and to be less able to afford healthier lifestyle options. They are also often less educated on risks and the knowledge to manage them.

23. These countries also have weak institutional capacities and invest less in prevention, public health protection, and curative care. Prevalent inequalities mean that the poorest groups can least afford the remedies on offer that include lifetime medication.

Populations of humanitarian concern

24. The special circumstances of people in crisis circumstances, due to so-called natural disasters and violent conflicts, deserves particular attention. At any moment, about a billion people worldwide are marooned in chronic crises, or going-into or recovering-from them. These include some 90 million people who are forcibly displaced within national boundaries, and as refugees, or are stateless. Climate change and other environmental factors, as well as changing patterns of violence mean that crisis risk factors are on the increase. As various types of risk factors collide, they potentiate each other and the impacts are disproportionately greater for poorer populations.

25. Crises from any cause inevitably result in the disruption of health and social protection systems. This is particularly serious for those with NCDs that require long-term therapy in a predictable and reliable manner. Meanwhile, although traditional humanitarian relief providers prioritise immediately life-threatening conditions, they do not recognise NCDs as part of them, and do not generally provide NCD supplies and services. In addition, as the vast majority of forcibly displaced populations are hosted by resource-poor countries, the usual humanitarian relief models can create inequities and tensions between the equally poor host and hosted groups.

What is the global policy response to NCDs?

26. Diabetes and hypertension are both treat-able and their complications largely avoidable, thereby enabling those affected to live normal and productive lives. They are also largely preventable conditions (except type 1 diabetes and some aspects of hypertension). There is sound scientific evidence and consensus on how to manage them effectively through bringing about behavioural changes in modifiable risk factors, screening, testing, and medicines.

27. Initially slow to react to this growing public health challenge, countries finally adopted a *Political Declaration on NCDs*[3] at the UN in 2011. In 2013, the World Health Assembly endorsed the *WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020*[4]. The centrepiece of this are nine voluntary targets for 2025 against a baseline in 2010:

- *Target 1: A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases*
- *Target 2: At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context*
- *Target 3: A 10% relative reduction in prevalence of insufficient physical activity*
- *Target 4: A 30% relative reduction in mean population intake of salt/sodium*
- *Target 5: A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years*
- *Target 6: A 25% relative reduction in the prevalence of raised blood pressure or containing the prevalence of raised blood pressure, according to national circumstances*

[3] UN (2011). Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases. [Online]

[4] WHO (2013) Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. [Online]

- *Target 7:* *Halt the rise in diabetes and obesity*
- *Target 8:* *At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes*
- *Target 9:* *An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities*

28. Recently, the control and management of NCDs have been brought into the centre of the world's development *Agenda 2030* and its *Sustainable Development Goals (SDGs)*[5]. These reinforce the right to health as a basic human right that was originally enshrined in the *1948 Universal Declaration on Human Rights*[6].

29. SDG 3 seeks to "*ensure healthy lives and promote well-being for all at all ages".* Specifically, target 3.4 commits *to reduce by one third premature mortality from non-communicable diseases through prevention and treatment, by 2030.* Target 3.8 aims for *universal health coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.* This has immense implications for NCD-related promotion, prevention and treatment interventions.

30. *Agenda 2030* asks for "no one to be left behind" and calls for "those furthest behind now" i.e. the poorer and more vulnerable populations, to be given priority attention. This is both a moral issue and a necessary response to the mood of the turbulent age we live in, where we have growing discontent over widening inequalities at a time of unprecedented accumulation of wealth, knowledge, and capabilities, that should benefit everyone.

What is the scope of our Partnership?

31. The Defeat-NCD Partnership will prioritise countries according to their development and income status. Top priority will be given to the least developed countries (LDCs) as defined by the UN and low income countries (LICs) as defined by the World Bank. By and large, these lists overlap. Accordingly, 49 countries are designated **Priority I countries** for the purposes of this Partnership. Middle income countries (MICs) are classed by the World Bank into upper and lower middle income countries. 43 lower middle income countries (LMICs) are designated **Priority II countries** for our purpose.

32. The criteria for the classification of countries and the consequent list of countries within our scope are at **annex 1**. This list would be periodically reviewed as the status of countries changes. The intention is to cover all these countries so that "no one is left behind". However, practical considerations require further prioritisation within the list. This will depend not just on relative needs but also market analyses to determine where there is an optimal mix of official policies and commitments, a minimum level of capacities with whom one could collaborate, and a core of interested partners with whom to engage.

What will our Partnership do?

33. The Defeat-NCD Partnership is guided by the principles and strategies set out by WHO's *NCD Global Action Plan 2013–2020*. Its 2014 *Global Status Report on NCDs*[7]

[5] UN (2015). Transforming our world: the 2030 Agenda for Sustainable Development. [Online]

[6] UN (1948). Universal Declaration of Human Rights. [Online]

[7] WHO (2014). Global status report on noncommunicable diseases 2014. [Online]

describes the constraints and challenges for lesser developed countries including the lack of national policies, health system capacities, availability and affordability of medicines, and financing. The WHO Director General Dr Tedros has called for[8] *"changing the NCD paradigm"* through choosing healthy policies right across the national policy spectrum, recognising that *"all roads lead to Universal Health Coverage"*[9].

34. Accordingly, the Partnership strives to advance UHC in resource-poor countries through tackling NCDs in a systematic and sustained manner through nationally-led health policies, and systems, and driven by their own National NCD Action Plans. The WHO-recommended "best-buys"[10] for NCD management will be pursued, and impact tracked through the WHO *NCD Progress Monitor*[11]

Partnership Objectives

35. The overarching **purpose** of the Defeat-NCD Partnership is to help reduce the burden of diabetes and hypertension in resource- poor countries through four tracks:

- A Defeat-NCD Knowledge Forum to share knowledge and expertise, advocate for effective public policies, and mobilise adequate resources to tackle non-communicable conditions of public health importance.

- A Defeat-NCD Technical Assistance Facility to help least developed and low income, and lower middle income countries to build-up their capacities to reduce NCD risks and improve treatment among vulnerable populations.

- A Defeat-NCD Supplies Procurement and Distribution Facility and related capacity building support for least developed and low income countries, to expand the in-country availability and provision of NCD-related diagnostics, equipment, and medicines.

- 4. A Defeat-NCD Supplies Fund to enable least developed and low income countries to access additional and innovatively-generated finance, to obtain essential NCD-related diagnostics, equipment, medicines, and services.

36. Where populations of humanitarian concern (refugees, displaced and others affected by disasters and conflict emergencies) need provision for NCDs, this would normally be made available through the same mechanisms as established under the four tracks of this initiative. This intention here is to provide an equitable service for all populations, guided by their specific needs and vulnerabilities. However, it is recognised that provision during emergency humanitarian crises will need special rapid-response operational modalities in partnership with specialised humanitarian agencies.

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[8] Tabaré RV, Tedros A.G. (2017). Lancet. Beating NCDs can deliver universal health coverage. [Online]

[9] Tedros A.G. (2017). Lancet. All roads lead to universal health coverage. [Online]

[10] WHO/WEF (2011). From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries. [Online]

[11] WHO (2017) Noncommunicable Diseases Monitor [Online]

Objective 1: Defeat-NCD Knowledge Forum

37. A multi-stakeholder public-private forum will facilitate co-operation among all who have a stake in the Partnership through financial or/and technical co-investment. Its principal business would be to discuss and review latest knowledge and insights from experience, stimulate innovation, and advise accordingly. It would also conduct advocacy for effective national and international polices within and beyond the health sector (e.g. trade and unhealthy food taxation policies), mobilise resources, and share expertise to help priority countries in practical ways.

38. Forum members include governments and public sector bodies, multilateral agencies, civil society, philanthropies, and academia, as well as the private business sector including, in particular the pharmaceutical and healthcare industry. The latter would be expected to subscribe to the ten principles of the *UN Global Compact*[12] concerning respect for human rights, labour, environment, and anti-corruption.

Objective 2: Defeat-NCD Technical Assistance Facility

39. To reduce diabetes and hypertension risks among vulnerable populations and expand their access to effective treatment requires action at country level. The Partnership will help targeted countries (both Priority I and Priority II), to do just that.

40. Working with key national stakeholders, the Partnership will analyse and help tackle constraints to the quality of care. We would start with a strategic partnership with the government ministry of health to establish or update national policies and costed plans, conduct the necessary operational research to establish the specific national epidemiological patterns for diabetes and hypertension (incidence, prevalence and distribution by type), and to set-up diabetes registers.

41. Diabetes registers are useful tools for ensuring universal coverage and for tracking quality of care. Specific intermediary process and outcome Indicators would be agreed in line with WHO standards e.g. monitoring HbA1c, retinopathy checks and blindness rates, renal function, amputation rates, and body mass index. Optimal diabetes management also requires the control of cholesterol and blood pressure with appropriate medication provided at the same time.

42. National protocols for treatment would be reviewed and updated where necessary along with the training of healthcare providers (doctors and nurses) for the early detection and treatment of hypertension and hyperglycaemia, including ante-natally. This would be done in conjunction with medical and health training institutions and professional associations. As private health practitioners and pharmacies are a major provider of services, they will be targeted as key audiences.

43. The prevention, screening, and treatment of raised blood pressure and blood sugar is most cost-effective at the community and primary healthcare level, and only complicated cases should go to hospitals for specialist attention. Thus, a crucial strategy will be to work with community service providers such as clinics, pharmacies, and school health services.

44. Ultimately, self and family care are central to effective management. Thus, outreach would be promoted through community-based voluntary organisations such as the Red

[12] UN. The Ten Principles of the UN Global Compact. [Online]

Cross and Red Crescent which are present in all countries and whose unpaid volunteers operate from branches in towns and villages everywhere. They specialise in "walking the last mile" and can do much to magnify risk reduction and prevention messaging, and to boost the day-to-day quality of care.

45. Elements from this menu of strategies would be selected according to specific country contexts. This would be done through country needs assessments including understanding the local epidemiology, reaching agreements with national health authorities, mapping key actors and making local partnerships. The networks that are established in this way for diabetes and hypertension can then be easily used and extended for other NCDs.

Objective 3: Defeat-NCD Supplies Procurement and Distribution Facility

46. A most serious constraint to managing diabetes and hypertension effectively is the reliable availability and affordability of diagnostics and medicines. In the case of diabetes, this means insulin and oral hypoglycaemic agents, and the associated technology for self-monitoring of glucose levels: handheld meters and test strips (for both blood and urine). For example, some estimates suggest that for those on insulin, 50% don't receive it on a reliable basis – with obviously grave consequences for them. In addition, the optimal care of diabetes requires blood pressure lowering and cholesterol reducing drugs, when indicated. Laboratories need the equipment and supplies to test for HbA1C as well as lipid (cholesterol) levels. Various types of anti-hypertensives and easy-to-use blood pressure monitors are needed for managing hypertension.

47. An Essential Supplies Procurement and Distribution Facility will be established to serve Priority I countries. This would manage the procurement of diabetes and hypertension relevant items on the WHO Model List of Essential Medicines[13], in sufficiently large quantities to ensure quality of drugs alongside economies of scale and continuity of supplies. Pharmaceutical companies have expressed interest including, for example, to a low maximum cost of insulin for the world's poorest countries, and scales of production could bring this cost further down. An important aspect of the arrangement would ensure that current antitrust and anti-dumping legislation is followed while allowing participating companies to engage in a bundled fashion with volumes and prices that are competitive.

48. The Facility would utilise specialised procurement expertise of the hosting entity (see annex 2). In doing so, good public service procurement principles will be followed that are benchmarked to standards established by the United Nations that are, inter alia, accepted by all countries. These seek to achieve best value for money through an open, competitive, fair, transparent, and accountable process with established rules and regulations that are applicable to all who wish to offer products or services through the Facility.

49. Thus, the Facility will tackle the main barriers to reliable supplies provision through lower prices, quality control, standardisation, speed and reliability of distribution to prevent stockouts, while ensuring transparency. An important added-value of the Facility would be to provide technical assistance to build national capacities in supply chain management including skills in procurement, customs clearance and exemptions, warehousing and stock control and rotation, and secondary distribution to delivery points. Experience suggests that these are frequently-encountered choke points, even when supplies are available.

50. In summary, the Facility would help countries to ensure that NCD-related diagnostics and medicines are widely available close to where people live, and accessible by them.

[13] WHO (2015). 19th WHO Model List of Essential Medicines. [Online]

Objective 4: Defeat-NCD Supplies Fund

51. Universal health coverage means that no one should suffer financial hardship when getting the promotive, preventive, curative, rehabilitative and palliative healthcare they need. UHC is not possible to achieve without meeting the needs of the hundreds of millions of people with hypertension and diabetes. This is not just about medicine supplies. For example, the cost of insulin is only about a quarter of the total cost of the entire essential care package for people with diabetes. Many hypertension medicines are relatively inexpensive.

52. However, no country – rich or poor - has advanced UHC without public (i.e. government budgeted) financing. Estimates vary but for minimum essential UHC, a country needs to spend at least 5% of its GDP on health with a minimum of roughly US$80-90 per capita, That would achieve sufficient coverage and also reduce out-of-own-pocket expenditure to less than 20%. Hardly any low-income country has reached these benchmarks. Based on the historical experience of richer countries they would have to reach upper middle income status to do so.

53. However, with the injection of new leadership from the WHO Director General Dr Tedros, more countries are embarking on the path to UHC. They are reforming their health financing policies. But as they increase coverage, there are inevitable gaps that will need external financing.

54. The Defeat-NCD Supplies Fund is intended for least developed and low income countries to expand coverage of services for people with diabetes and hypertension. To be eligible for the Fund's support, countries would have established diabetes and hypertension management policies as recommended by WHO, and planned progressive multi-year provision for -related services and supplies in their forward national health plans and budgets. Where they need assistance to do so, technical advice could be provided from the Partnership (under Objective 2).

55. The Fund would be initially set-up and resourced from donor government, private sector, and philanthropic contributions. Replenishment would also come from them. It is envisaged that donor government funds will help to leverage some four times greater funding from private sector and other sources. Alternative and innovative sources will also be examined, learning from examples such as the Global Vaccines Fund (GAVI), Global Fund against AIDS, TB and Malaria, and UNITAID These include social impact bonds, and earmarked national or international taxes, for example, from sugary beverage sales. Blended financing (a mix of grants and loan/equity investments from international financial institutions including the World Bank Group and perhaps Regional Development Banks) would be explored as part of public-private partnerships.

Who will the Partnership benefit?

56. The most important benefit would be to people with diabetes and hypertension, and their families and communities by saving their lives, maintaining their healthy functioning, and securing their livelihoods. A critical benefit would be the reduction of the out-of-own-pocket expenditure of people who need life-long treatment and may get catastrophically impoverished as a consequence. 100 million people around the world fall below the poverty line every year as a result of crippling medical bills.

57. For health services, the capacity building component concerned with enhancing the quality of prevention and care brings greater effectiveness and efficiency for the scarce

resources that they have at their disposal, through reducing wastage from misused medication and diagnostics, and achieving better clinical outcomes.

58. For the governments of low income countries faced with the escalating burden of NCDs, this initiative would reduce the overall burden of conditions that generate major social and economic costs, while enhancing the productivity of the NCD-affected labour force and getting better returns from the 'sunk costs' of their education and training.

How will the benefits from the Partnership be sustained?

59. Trends in the underlying risk factors and behaviours that influence health outcomes take a long time – perhaps a generation or more - to manifest themselves. Furthermore, diabetes and hypertension management requires the permanent provision of medicines and risk factor modification inputs. Thus, long-term programming is essential to achieve sustained and sustainable impacts. Therefore, this Partnership is envisioned up to at least 2030, coinciding with the remaining period of the SDGs. There would, of course, be regular reviews as NCD epidemiology evolves, and adaptations will be necessitated by advances in scientific knowledge and new medicines and technologies.

60. This Partnership is targeted at poorer countries. It is not possible to meet the essential health needs of poor people/countries without external subsidisation until the point that they can afford to pay for themselves, either individually (out-of-own-pocket expenditures) or through pooled cost-sharing arrangements e.g. health insurance schemes, taxpayer-funded government national health systems. Additionally, NCD programming for populations of humanitarian concern are likely to need external financing until a crisis moves into rehabilitation and recovery.

61. In general, the sustainability for diabetes and hypertension programming depends on increasing the affordability of essential products and services. With this in mind, this initiative contributes to fostering longer-term sustainability by:

- First, through the Essential Supplies Procurement and Distribution Facility (objective 3), pursuing affordability through seeking maximum reductions in the costs of providing medicines and diagnostics through economies of scale that are negotiated centrally with suppliers. Pharma should have some incentive to do so, not just as part of their CSR commitment but also because of the expanded market that would be created for their products as greater treatment coverage is achieved. Over time, this would more than make up for initial discounts or subsidies, especially when the country graduates to higher income status. Meanwhile, the market for pharmaceuticals in less developed countries is already growing at about 50% faster than the market in mature economies.

- Second, the initiative seeks to engage with developing country governments and assist them through technical assistance and capacity building (objective 2) so that their health policies incorporate NCD costs into national health budgets, in a progressive manner. The initiative will also engage actively with national health financing debates, for example, with the World Bank in finding context-specific options for sustainable financing e.g. employment based and social security based health insurance schemes.

- Third, with the gap between total health needs and availability of resources (of magnitude of at least $40 per capita), the Partnership's Supplies Fund (objective 4) aims to leverage a transfer of resources from richer countries (e.g. OECD donor

nations), and rich entities (e.g. CSR contributions from private sector companies, philanthropies) to poorer ones as part of the shared commitment to universal health coverage.

62. In short, while corporate social responsibility, philanthropic, and government donor contributions would provide the essential stimulus to start, this is not conceived as a 'charitable' project. It's business model will seek financing diversity and long-term sustainability. This is defined as the ability of programme countries to finance their own long-term NCD-handling requirements.

How will the Partnership be organised?

The Partnership will be guided and governed by a Steering Committee. Its day-to-day work will be the responsibility of an Executive Director supported by a small secretariat based in Geneva. Organisational arrangements are outlined in greater detail at **annex 2**.

Annex 1

Listing of countries by development and income status

Development status

The criteria for being considered a Least developed Country (LDC) is defined by the United Nations Committee for Development Policy, based on the following:

- *Income* based on a three-year average estimate of GNI per capita for the period 2011-2013, based on the World Bank Atlas method (under $1,035 for inclusion, above $ 1,242 for graduation as applied in the 2015 triennial review).
- *Human Assets Index (HAI)* based on indicators of: (a) nutrition: percentage of population undernourished; (b) health: mortality rate for children aged five years or under; (c) education: the gross secondary school enrolment ratio; and (d) adult literacy rate.
- *Economic Vulnerability Index (EVI)* based on indicators of: (a) population size; (b) remoteness; (c) merchandise export concentration; (d) share of agriculture, forestry and fisheries; (e) share of population in low elevated coastal zones; (f) instability of exports of goods and services; (g) victims of natural disasters; and (h) instability of agricultural production.

Income status

As defined by the World Bank for fiscal year 2018 based on income status in 2016**:**
Lower middle income countries (LMIC) had GNI per capita US$1006- US$3955
Low-income countries (LIC) had GNI per capita US$1005 or less.

NB: this list is subject to change following periodic reviews done by the UN and World Bank.

Country	**Least Developed Countries (LDC)** as in 2017	**Low-income countries (LIC)** as for 2018	**Lower middle income countries (LMIC)**
Afghanistan	✓	✓	
Albania			✓
Angola	✓		✓
Armenia			✓
Bangladesh	✓		✓
Belize			✓
Benin	✓	✓	
Bhutan	✓		✓
Bolivia			✓
Burkina Faso	✓	✓	
Burundi	✓	✓	
Cambodia	✓		✓
Cameroon			✓
Cape Verde			✓
Central African	✓	✓	

Republic			
Chad	✓	✓	
Comoros	✓	✓	
Congo, Dem Republic of	✓	✓	
Congo, Rep			✓
Cote d'Ivoire			✓
Djibouti	✓		✓
Egypt	✓		✓
El Salvador			✓
Eritrea	✓	✓	
Ethiopia	✓	✓	
Fiji			✓
Gambia	✓	✓	
Georgia			✓
Ghana			✓
Guatemala			✓
Guinea	✓	✓	
Guinea-Bissau	✓	✓	
Guyana			✓
Haiti	✓	✓	
Honduras			✓
Indonesia			✓
India			✓
Iraq			✓
Jordan			✓
Kenya			✓
Kiribati	✓		✓
Korea DPR	✓	✓	
Kosovo			✓
Kyrgyz Republic			✓
Laos	✓		✓
Lesotho	✓		✓
Liberia	✓	✓	
Madagascar	✓	✓	
Malawi	✓	✓	
Mali	✓	✓	
Marshall Islands			✓
Micronesia, Fed States of			✓
Mauritania	✓		✓
Moldova			✓
Mongolia			✓
Morocco			✓
Mozambique	✓	✓	
Myanmar	✓		✓
Nepal	✓	✓	
Nicaragua			✓
Niger	✓	✓	
Nigeria			✓
Pakistan			✓
Papua New Guinea			✓
Paraguay			✓

Philippines			✓
Rwanda	✓	✓	
Samoa			✓
Sao Tome and Principle	✓		✓
Senegal	✓	✓	
Sierra Leone	✓	✓	
Solomon Islands	✓		✓
Somalia	✓	✓	
South Sudan	✓	✓	
Sri Lanka			✓
Sudan	✓		✓
Swaziland			✓
Syria			✓
Tajikistan			✓
Timor-Leste	✓		✓
Tanzania	✓		✓
Togo	✓	✓	
Tonga			✓
Tunisia			✓
Tuvalu	✓		(is actually Upper Middle Income)
Uganda	✓	✓	
Ukraine			✓
Uzbekistan			✓
Vanuatu	✓		✓
Vietnam			✓
Yemen	✓		✓
Zambia	✓		✓
Zimbabwe		✓	
93 LICs and MICs	**49 LDCs** *of which 30 are also low income countries*	**30 LICs**	**63 LMICs** *of which 43 are also LDCs*

Annex 2

Organisational arrangements

1. The Defeat-NCD Partnership will have strong but streamlined organisational arrangements. A Steering Committee will provide governance and accountability. The Steering Committee would oversee an Executive Director supported by a secretariat, to progress the day-to-day work of the Partnership. The secretariat would be housed by a competitively--selected 'hosting agency'. A Consultative Group of contributing stakeholders and invited experts would enable wider knowledge and experience to be drawn upon to benefit the initiative and expand its outreach and ultimate impact.

The Steering Committee

2. The Defeat-NCD Partnership will be governed by its Steering Committee. Its terms of reference would be as follows:

- to decide on policies and strategies.
- to review and endorse the periodic work plans and budgets of the initiative including the secretariat, and to monitor performance and progress on the delivery of the Partnership's strategies and objectives.
- to mobilise resources and to ensure the financial viability of the initiative and its secretariat.
- to establish "rules of engagement" with the private sector based on the principles of openness, fairness, transparency, and accountability to obtain best value for money.
- to identify and manage any risks – strategic, operational, and reputational.
- to appoint the Steering Committee chair and vice chair for renewable three-year terms.
- to set rules for its own meetings and manage governance processes.
- to represent the interests of initiative stakeholders.
- to provide accountability to donors.
- to play an active lead role in identifying the Executive Director, advise and support him/her and, through the chair, provide appraisal and functional supervision of the Executive Director.

3. The Steering Committee members would serve in their personal capacity while reflecting different multi-sectoral and agency perspectives. They would include government/public sector, philanthropic, and private sector donors, and governments of programme countries. Some independent experts, representatives of groups representing people with NCDs, and the World Health Organization as the lead global health agency for the United Nations system, would also be invited to join the Steering Committee. Additional non-voting ex-officio members would include the Executive Director of the Defeat-NCD Partnership, and a representative of the agency hosting the Partnership.

4. The Steering Committee would meet every four months or as frequently as its members decide. At least one Steering Committee meeting annually would be held face-to-face and others may be convened virtually if so desired. All Steering Committee members serve voluntarily but may reclaim travel expenses incurred on behalf of the initiative if these are not already covered from their own agencies.

5. The optimal size of the Steering Committee is seen as up to 21 members. As the initiative develops with more and more partners coming on board, a constituency-based system may be introduced to ensure that the Steering Committee remains optimally sized

but representative of its stakeholders. Initial thresholds for financial contributors who would like a seat on the Steering Committee would be an annual contribution of at least US$1 million for governments and US$ 250,000 for non-governmental groups.

The Consultative Group

6. Smaller and occasional financial and technical contributors would be able, alongside other invited experts of distinction, to join a Consultative Group and to participate in an Annual Forum of Stakeholders. This would be a face-to-face gathering with an emphasis on sharing knowledge and experience, stimulating innovation, and discussing forward strategies. The Annual Forum could be held alongside the annual face-to-face meeting of the Steering Committee.

The secretariat

7. The secretariat's primary role is to facilitate the work of the initiative through the implementation of the SC-endorsed implementation plan and other decisions. Additionally, the secretariat would support the Defeat-NCD Consultative Group and Steering Committee with the planning and organisation of their meeting logistics, agendas, and procedures.

8. As the initiative requires close liaison with the World Health Organization and other development and humanitarian organisations and donors, the secretariat would be located in Geneva. An out-posted hub of the secretariat to support more cost-effective back office operations as they increase may be located elsewhere, if justified.

9. A lean secretariat is envisaged that would be gradually built up as the work progresses and volume builds up:

- The initial "start-up phase" would need the appointment of the Executive Director and key support staff.
- The following "build-up phase" would see this expanded further including with dedicated capacity for partnerships development; communications and advocacy; procurement and supply chain management; and public health/NCD technical expertise).
- the subsequent "established phase" would see further expansion as activities supported by the Partnership expand in a greater number of countries.

10. Appointments would be made through a competitive process. Secondees may be considered but would also have to go through competitive appraisal. Secretariat personnel would have contracts administered by the hosting agency. The Executive Director would have an initial two-year fixed-term contract.

11. The terms of reference of the **Executive Director** would be to:

- Make high level representation and advocacy to promote the initiative.
- Prepare, under Steering Committee guidance, future policies, strategies, and plans for SC approval.
- Be an ex-officio member of the Steering Committee, and serve as its Secretary.
- Help mobilise financial resources.
- Manage the human and financial resources of the secretariat in compliance with the rules and regulations of the hosting agency.
- Progress and report periodically on the implementation of approved plans.

- Manage the relationship with the hosting agency including the receipt of effective and efficient agreed hosting services.
- Represent and advocate for the interests of the initiative in relevant fora.
- Monitor and review delivery of planned objectives, and arrange for independent evaluations as required.

Hosting Agency

12. The Steering Committee will initiate a competitive process to select a hosting agency to house the secretariat. The terms of reference for the selected hosting agency would be to:

- Establish standard operating procedures (SOPs) covering all key aspects of support for the Secretariat.
- Act as administrative agent, responsible for entering into agreement with donors.
- Discharge full fiduciary responsibility, reporting and accountability for the receipt, custody and disbursement of all donor contributions and secretariat expenditures. This includes periodic audits in accord with UN norms and regulations.
- Recruit, contract, and administer the staff of the Partnership.
- Advise on technical requirements and handle any procurement of goods and services that may be required.
- Provide general administration services including IT and communications, website hosting and branded email, travel organisation, and other back office support as required.

13. The Essential Supplies Procurement and Distribution Facility (Objective 3 of the Partnership) would utilise the specialised procurement and distribution expertise of the hosting agency to facilitate the shipment of agreed essential materials in the right quantities to the right places including facilitating customs clearance and exemptions and bring down related costs. The hosting agency can also help to negotiate deals (through its LongTerm Agreement modalities) with local distributors to ensure "last mile distribution" so that there is reliable drug availability at the local dispensary/pharmacy level. Once the Facility is functioning for diabetes and hypertension related diagnostics, equipment, and medicines, the procurement and supply of essential medicines for other NCDs can also be considered.

14. The best-suited hosting agency that can meet the above requirements will demonstrate that it has a proven track record in a number of dimensions:

- A strong presence in low and lower-middle income countries along with good global access – through a worldwide network of its own offices and, beyond that, access to all UN offices in all developing countries – vital for facilitating global interactions and in-country operations.
- Systems to provide a full suite of fund management services, procurement, distribution, and project management.
- A reputation for stringent quality assurance and risk management systems and procedures in place.
- As a non-sectoral agency, it should be 'neutral' with no technical stake of its own that could confound its trusted good offices function.
- It should have previous experience as a hosting agency for other global projects and initiatives
- It should have the status to be able to provide appropriate privileges and immunities extended to the UN.
- It should have particular capabilities to operate in fragile contexts.
- It should be capable of starting up very quickly with immediate office space and accelerated contracting modalities.

15. It is understood that the Defeat-NCD Partnership will retain its own clear mandate, brand and identity that is recognisable to all stakeholders.

Initial Steps

16. An interim Steering Committee will be established, along with the appointment of an interim Executive Director to start rolling out the Partnership, including continuing to refine its design and bring key stakeholders on board as quickly as possible.

17. In parallel, pledges would be sought from donors to make the initial start-up investments. The selection of the hosting agency will then be made and negotiations on the terms and conditions of the hosting arrangements finalised.

18. Once the minimum core capacities of the Partnership have been set up, country level needs and capacities assessments will be conducted – to operationalise the initiative and progress its specific objectives. The intention, subject to resources, would be to conduct 2-4 such assessments in the first full year, and then 4-6 or more annually.

Governing Board document 5/2018

31 January 2018

Progress report

This report covers the period from the earliest conceptualisation (May 2017) till the first meeting of the Governing Board (January 2018). The minimum necessary start-up funds were received around mid-Jan 2018; that may thus be taken as the birth day of the Defeat-NCD Partnership.

- We have developed, consulted upon, and received broad endorsement from key stakeholders for the concept for the Partnership (GB document 4).
- An initial Steering Committee was established, to be transformed into the Governing Board at the meeting on 31 January 2018
- Domain names have been registered. a logo is under design and a website is under construction (www.defeat-ncd.org)
- The first distinguished members of the wider Consultative Group are coming on board.
- Michael Moller, Director General of the UN Office at Geneva has kindly agreed to be our Hon. President.
- We have found a home for our start-up phase with UNITAR (the United Nations Institute for Training and Research) who is hosting us.
- We have started appraisals for the most optimal longer-term hosting arrangement.
- We have received start-up funds, with expectations for more to come.
- Our office in Geneva is now open, and minimum essential furniture and equipment are under procurement.
- We have defined our immediate core personnel needs with their terms of reference, and begun the recruitment process. 4 of 6 core personnel had been recruited or identified by 31 Jan, with the rest expected to be selected by early February. The core team is envisaged as a chief executive, two public health programme specialists, an innovative financing adviser, a communications and outreach adviser, and a programme assistant/administrator. Some of the incumbents will be part-time until the business builds up.
- We have started to design the individual tracks indicated in the concept note
- To develop our country-level work, where it all matters, we have confirmed missions to Tajikistan (w/b 12 Feb). Haiti (w/b 19 Mar), Tanzania (Tbc April), Myanmar (w/b 7 May tbc). We are open to other suggestions; criteria are outlined in the concept note.
- We have reached out to several potential governmental and non-governmental partners to lay the foundations for significant longer-term support for the Partnership.

Governing Board document 6/2018

31 January 2018

Outline terms of reference for the chief executive

These outline TORs will be fleshed out before advertising for the longer-term appointment.

The chief executive is responsible for managing and progressing the Defeat-NCD Partnership, inter alia, through:

- Managing, on a day-today basis, the human and financial resources of the Partnership in compliance with the rules and regulations of the hosting agency.
- Making high level representation and advocacy to promote the Partnership.
- Preparing, under Governing Board guidance, the policies, strategies, plans and budgets for GB approval.
- Participating as an ex-officio member of the Governing Board, and serving as its Secretary.
- Helping to mobilise financial resources for the Partnership.
- Progressing and reporting periodically on the implementation of approved plans.
- Managing the relationships of the Partnership with the hosting agency including the receipt of effective and efficient agreed services.
- Representing and advocating for the interests of the Partnership in relevant fora.
- Monitoring and reviewing the delivery of planned objectives.

Key outputs/deliverables:

Subject to the full and timely availability of resources, the key deliverables for the to be progressed are as outlined under the four tracks of the Defeat-NCD Partnership Concept Note:

- Establishing the Governing Board and the Consultative Group as dimensions of the Knowledge Forum (Track 1)
- Establishing the key functions of the Secretariat (Track 1)
- Conducting country level assessments and research including appropriate capacity building modalities for targeted countries. (Track II)
- Designing the operational modalities for the procurement track (Track III)
- Mapping and advancing innovative financing modalities in the development and humanitarian field, and proposing options for NCD innovative financing (Track IV)

Essential Competencies:

- Specific expertise. Proven expertise in healthcare and public health, and strong understanding of non-communicable diseases epidemiology, prevention and management, and country programming. Substantial international and national experience in the global health, development, and humanitarian fields. Strong working knowledge of international institutions within and outside the UN, including governments, academia, private sector and civil society. Track record in both mobilising and allocating substantial financial resources.

- Strategic orientation. Able to think and develop forward strategies and conceptualise innovative approaches in the context of moving forward in a fast-changing and challenging world.

- Leadership. Mature judgement with the ability to inspire confidence and respect internally and with external partners, with a track record of developing and leading multi-agency partnerships.

- Communications. Excellent written and verbal communication skills, and ability to articulate ideas in a clear, concise style including both for professional and management reports, and public, media and policy-maker messaging. Fluency in English is essential.

- Effectiveness oriented. Able to deliver agreed results and outcomes while ensuring efficient use of resources.

- Organisational management. Sound organizational skills including the ability to formulate and prioritize work programmes, design, monitor and evaluate projects, manage significant human and financial resources, oversee administrative aspects and provide financial supervision and accountability.

- Teamwork. Able to create an empowering work environment and to mentor and motivates staff. Good interpersonal skills and ability to establish and maintain effective working relations in a multi-cultural, multi-ethnic environment with sensitivity and respect for diversity, including gender balance.

Essential Qualifications:

- Education. A medical degree along with an advanced University Degree (Masters) in public health.

- Experience. A minimum of 25 years of international and national experience in the policy and practice of programmes in the health, development, and humanitarian fields. That would include at least 10 years in leadership roles.

Reporting structure: The incumbent reports to the Governing Board, with an administrative line to the hosting agency.

Level of post: The incumbent is at the level of D2 in the United Nations system.

Governing Board document 7/2018

31 January 2018

Curriculum vitae of Professor MUKESH KAPILA

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Summary of experience

Over 30 years of experience in global and public health, international humanitarianism, development, human rights, conflict management and diplomacy with substantive leadership roles handling large teams and budgets. Senior positions in the UK Government, UN multilateral agencies, International Red Cross and Red Crescent, at both headquarters and in the field, and in academia. Active involvement through founding and leadership positions in NGOs and civil society groups. Innovative "start-ups" – of programmes and institutions – a particular strength.

Functions and expertise have included policy, strategy, knowledge development and sharing, training, capacity building, and lesson learning, representation and communications, overseeing substantial and sustained organisational growth, partnership and network development on a global scale, programme planning and delivery, fostering innovation; mentoring and teaching, accountability and performance evaluation, communications, diplomacy and representation, resource mobilisation, capacity building, advocacy, negotiation and mediation, and organisational change management.

CURRENT WORK

From April 2012: **Professor of Global Health and Humanitarian Affairs, University of Manchester, UK** (part time)

From May 2017: Design and start-up of **The Defeat-NCD Partnership**

Other current roles:

- Strategy Adviser, Indian Red Cross Society
- Chair, Board of Directors, Nonviolent Peace Force
- Chair, Board of Trustees, Manchester Global Foundation
- Associate Fellow, Geneva Centre for Security Policy (GCSP)
- Adjunct Professor, International Centre for Humanitarian Affairs, Nairobi
- Member, International Certification Commission, Professional for Humanitarian Assistance and Protection (PHAP)

- Special Representative, Aegis Trust for the Prevention of Crimes against Humanity
- Special Adviser, Syria Relief
- Member, Global Genocide Prevention Advisory Network

PREVIOUS POSITIONS

From June 2015- Aug 2016 **Special Adviser to the United Nations for the World Humanitarian Summit, May 2016 Istanbul**

Policy and strategy advice on wide ranging Summit agenda, facilitation of global consultations, and contribution to drafting of key documents. Focal point and organiser of the special high-level session on global health.

From Sept 2006 – Jan 2012 **International Federation of Red Cross and Red Crescent Societies, Geneva, finishing as *Under Secretary General for National Society and Knowledge Development (2010-2012).***

Previously various full and part-time roles over time including as **Special Adviser to the Secretary General, Special Representative of the Secretary General,** and **Director Policy and Planning Division.**

Handled a wide range of policy and strategy matters, including in relation to the Governing Board. Contributed to the formulation and successful adoption of the corporate Strategy 2020, and new thinking in areas such as climate change, and conflict and peace. International representation and partnership-building. Development of new initiatives in planning, reporting and performance rating, global accredited learning, and use of information technology to connect, collaborate, and share knowledge. Familiarity at leadership and senior management level across the 187-strong global Red Cross Red Crescent network of National Societies with experience of programming, services and capacity building needs in all regions. Conceptualisation of approaches to organisational development and the management of change.

Previous functions in the IFRC have included membership of the senior management team, and leadership and direction of worldwide "global alliances" of the Red Cross Red Crescent such as HIV and disaster risk reduction where successful scale-up has been achieved. As Director of Policy and Planning Division oversight and line management of 5 departments in Geneva: Departments of Health and Care; Disaster Policy and Preparedness; Principles and Values; Organisational Development; Planning, Monitoring, Evaluation, and Reporting and their out-posted staff in ten regional offices worldwide.

From Sept 2009- Aug 2010 (part-time) **Chief Executive, Foundation for Genomics and Population Health, Cambridge, UK**

The mission of the PHG Foundation is to help "create a blueprint for public health in the 21st century" by knowledge-sharing and translating the latest scientific advances into better health care worldwide. My role, as CEO, reporting to the Board of Trustees has been to manage the staff and budget, lead the future strategic development of the Foundation, initiate key international partnerships for example, with Cambridge University, World Health Organisation, and the Clinton Global Initiative, with an emphasis on building developing country capacities in science for evidence-based public policy development. Pioneered a novel concept in resource mobilisation through a "corporate social bond" investment product for philanthropic and general public contributors.

Jan 2008 – July 2009 (part-time): **Policy Adviser, *Global Facility for Disaster Reduction & Recovery*, World Bank, Washington DC**

Providing advice on policy and strategy in relation to disaster reduction and recovery. Designed new global programme on South South Co-operation, a new corporate "Global Strategy 2015+"; and a new global facility for accelerated post disaster recovery.

May 2004 – Sept 2006: **Director (UN senior director level D2) at World Health Organization, Geneva** in the Department of Health Action in Crises, and subsequently as Adviser to the Director General, Internal Oversight Services.

Responsible for emergency response and operations and policies, strategies, and partnerships for health action in crises for WHO. Chair of the IASC Health Cluster. Also, oversight of thematic programmes such as on women's' health and sexual and gender violence in humanitarian situations, and natural disaster preparedness and reduction. Field experience of dealing with major emergencies include the Indian Ocean Tsunami Responsible *for pulling together an inter-agency consortium for a major new work programme on scaling-up HIV services for populations of humanitarian concern. From May – Sept 2006, adviser to the Director General on programme performance, evaluation and accountability issues.*

Feb 2003 – April 2004: **SUDAN: UN Resident and Humanitarian Coordinator (senior director level D2)**, *and* Designated Official for Security, UNDP Resident Representative, OCHA Representative, & Director of UN Information Centre.

Overall head of the United Nations system in the Sudan, with oversight of the largest (at the time) UN programme in the world: about US$380 million and approx.1000 staff, with offices in Khartoum, Nairobi, and several in-country locations. UN programmes included major humanitarian assistance, conflict and disaster prevention and mitigation, recovery, rehabilitation, human rights, and capacity building. In-country representation on behalf of the UN Secretary General, Kofi Annan.

Dec 2002 – Feb 2003: **Special Adviser to the UN High Commissioner for Human Rights**, *the late* Mr Sergio Vieira De Mello, in Geneva.

Dealing with country-based operations of the Office of the High Commissioner for Human Rights. Review of human rights protection and promotion programmes in Burundi, Cambodia, and several other countries. My recommendations for reform were accepted ultimately by the UN General Assembly and largely implemented.

May – November 2002: **Special Adviser to the Special Representative of the Secretary General, United Nations Assistance Mission in Afghanistan**, Mr Lakhdar Brahimi

Dealing with the resourcing of UNAMA's mission in peace-support, humanitarian relief, rehabilitation, and reconstruction. Facilitation of links with donor governments. Successfully helped to mobilise some US$1.5 BILLION for the initial phase of Afghan recovery after the removal of the Taliban and following the Bonn Agreement. Special assistance on security sector reform, drugs action and related issues.

Jan 1998 – April 2002 **Head *of* Conflict & Humanitarian Affairs Department**, UK Govt. Department for International Development

Direct management of some US$500 million annual expenditure and 100-strong team. Policy support to Ministers and high-level representation of British Government in international fora including boards of multilateral agencies. Handling policy and programmes on crisis management, humanitarian assistance and post-crisis recovery/reconstruction, conflict prevention, peacekeeping, and peace building. Field and management experience dealing with a range of complex situations e.g. Afghanistan, Bosnia, Kosovo, and other parts of the former Yugoslavia, Rwanda and Great Lakes, Indonesia and East Timor, Iraq, Angola, Sudan, Sierra Leone, Liberia, Sri Lanka, North Korea, Central Asian republics, Latin America. Official travel to more than 70 countries.

1994-97*:* ***Head of Conflict Prevention & Humanitarian Policy Section and Senior Humanitarian Adviser*** *in Emergency Aid Department of DFID (previously Overseas Development Administration - ODA)*

1990 - 1994: **Senior Health and Population Adviser** to the UK Foreign & Commonwealth Office's Overseas Development Administration *designing and supervising the delivery of health and development assistance programmes in South Asia, Caribbean, Southern Africa, Central and South America; resident (1993-94) in Central/Southern Africa in ODA's Regional Office.* This included developing major new programmes in Malawi, Zambia, and Zimbabwe.

1987 - 1990: **Deputy Director, National UK AIDS Programme** at the Department of Health's Health Education Authority. *Responsible for design, start-up, and management of the first HIV nationwide programme in the UK. Concurrently* ***Adviser to the World Health Organisation's Global Programme on AIDS****, directly contributing to the planning of the first generation of HIV Prevention and Control Programmes in India, Indonesia and China, and advising on programmes in Africa and Eastern Europe. Member of the International Working Group that reviewed the future of GPA - leading to the formation of UNAIDS.*

1984 – 1987: **Public Health Specialist** (training grades) at Cambridge Health Authority, UK *covering district health planning, management, and reorganisation of services, monitoring quality of health service delivery in hospitals and primary care, public health surveillance, communicable disease control and epidemiological investigations*.

1980 – 1984: **Physician** (training grades) in UK National Health Service (in High Wycombe and Cambridge, UK) with posts in hospitals (medicine, surgery, paediatrics, obstetrics and gynaecology) and in primary health care.

OTHER ROLES

High Level Independent Panel (2016-17)	Evaluation of the Parliamentary Assembly of Mediterranean (PAM)
Co-director (2010-13)	Project on Post-2015 Development (SDGs replacing MDGs)
Senior Member (2009 -)	Hughes Hall College, Cambridge University
Chair of Council (2011 - 2014)	Minority Rights Group International
Member (2010-):	Scientific Advisory Board, DIHAD
Member Editorial Board (2005 -)	Global Governance
Adviser (2009 -)	Solutions International
Adviser (2005)	To the UN Undersecretary General for Humanitarian Affairs on the International Strategy for Disaster Reduction
Board Member (2001-04)	The International Peace Academy (IPA), New York

Board UNITAR (2002-04)	Personal appointment of the UN Secretary General at the *United Nations Institute for Training and Research* (UNITAR).
Member	United Nations Disaster Assessment and Co-ordination Team (UNDAC)
Adviser (2009 - 11)	Mid Term Review of the Hyogo Framework for Action, UNISDR
Professor (2006)	Geneva School of Diplomacy and International Relations
Technical Director (2006-07)	HIV Humanitarian Programme UNAIDS.
Adviser (2008)	Geneva Humanitarian Forum
Adviser, then President (2006-11)	Alliance for Direct Action against Rape in Conflicts and Crises (co-founder)
Advisory Board (2006-8)	Geneva Centre for the Democratic Control of Armed Forces
Adviser (2008-09)	International Labour Organisation, Geneva

HONOURS, PRIZES & AWARDS

2014	**California Legislature Assembly Resolution 395** – as stated "for a lifetime of achievements and meritorious service to humanity"
2013	**"I Witness!" Award** – for human rights
2007	**Dr Jean Mayer Global Citizenship Award –** as stated "…for moral courage, personal integrity, and passion…dedicated to solving the most pressing problems facing the world…" Institute of Global Leadership, Tufts University, USA
2002	**Bestowed Commander of the Order of the British Empire (CBE) by Her Majesty Queen Elizabeth II -** for international services
1993	Sarajevo-Operation Phoenix (emergency relief)
1984	Syntex prize - Cambridge
1976	Christian Deelman Award - for development work in India
1974	Muir Bursary - for cyclone relief work in Bangladesh
1971 - 73	(**Commonwealth) Scholarship to United Kingdom**
1971 - 73	Scholarship & various prizes at Wellington College, England
1970	**Government of India National Merit Award**

EDUCATION AND QUALIFICATIONS

Schools:	1961-70	St John's School, Chandigarh, India
	1971-73	Wellington College, Berkshire, UK
Universities:	**1974-80**	**Oxford University (St Peter's College)**
	1984-85	**London University (London School of Hygiene & Tropical Medicine)**

Graduate qualifications	**BA Honours**	**(Oxford, 1977)**
	BM BCh	**(Oxford, 1980)**
Advanced (masters) quals.	**MA**	**(Oxford, 1981)**
	MSc	**(London, 1985)**
Other postgraduate quals.	DRCOG 1982, MRCGP1984, MFPHM 1988, elected FFPHM 1997: all UK professional qualifications	

PUBLIC ENGAGEMENT EXPERIENCE

See list of papers and blogs as well short films and media appearances at www.mukeshkapila.org

Author of "Against a Tide of Evil" *www.againstatideofevil.org nominated for the Best Nonfiction Book Award for 2013*

*Blog site: "**Flesh and Blood"** http://www.e-ir.info/category/blogs/kapila/*

Media: Extensive continuing experience of dealing with radio, TV and print media globally and nationally in many countries in all continents. Appearances in major flagship programmes of BBC (including *Hard Talk, Panorama*), CNN, ABC, CBC, VOA, PBS, France24, Al Jazeera, SABC, Kenya TV and many others. Published several OpEds.

Public and motivational speaker: Numerous public speaking engagements in Universities (including Oxford, Cambridge, London, Manchester, Edinburgh, York, Harvard, Columbia, Stanford, Cornell, Rome, Geneva, St Petersburg, and many others. Keynote speaker at numerous conferences, book festivals and public events.

Delivered the 2nd memorial lecture in honour of Nobel Prize winning human rights activist Wangari Maathai in 2013.

TedX speaker.

OTHER INTERNATIONAL EXPERIENCE

1. **Varied international work experience since 1974** with numerous assignments with government, inter-governmental and non-government institutions in many countries in Africa, Asia, Europe, Middle East, Latin America & Caribbean. Travelled for professional reasons to some 130 countries. Apart from country of birth (India) and country of residence (UK, France), lived and worked for prolonged periods in Bangladesh, Malawi, Sudan, and Switzerland.

2. **Experience with NGOs & private sector**. Founder (and Secretary 1975 - 79, Director 1979 - 83, Vice President 1983 - 86) of *World Community Development Service*, an international development agency. Founder (and Director 1983 - 1990) of *Action Health*, an international NGO with programmes in Asia and Africa. Vice President (1982 - 83) of *Indian Volunteers for Community Service*, a voluntary agency specialising in community development programmes in India and amongst the Indian ethnic community in Britain. Co-opted member of the Governing Council (1985 - 1988) of *Christa Grama Seva Sangha*, India. Co-founder (and Company Secretary 1988, Chairman of Board of Directors 1988 - 90)

of *North South Travel Limited* (a travel company in London, the profits of which were channelled to the *North South Charitable Trust* and used to fund programmes in developing countries). Co-founder (2006) of the *Alliance for Direct Action against Rape in conflicts and Crises.* Co- Founder (2014) of *People4Sudan.*

3. **Previous academic experience and publications.** Member (1975 - 80) of Queen Elizabeth House, the Commonwealth Institute of Development Studies, University of Oxford. External examiner (1986) for Banaras University, Varanasi, India. Varied experience of lecturing and teaching postgraduates and others in UK, Geneva, and internationally. Various papers published in journals; occasional book reviews; previously editor of, or on editorial board of various publications; numerous major reports and papers. See list at http://www.mukeshkapila.org ***Author of "Against a Tide of Evil" published by Mainstream (Random House Group). Released March 2013.***

4 Adviser/ Consultant on HIV. Initially (1988 - 1990) to *World Health Organisation* for its Global Programme on AIDS including participation in various country planning and review missions and as Chair or Rapporteur in expert groups and consultations in WHO HQ Geneva, and WHO Regional Offices in Copenhagen, Delhi and Manila. Organisation of numerous expert meetings, including the World Summit of Ministers of Health in London, 1988. Member of Steering Group (1988 - 1992) of AIDS and Reproductive Health Network - supporting collaborative research in developing countries, co-ordinated from the Department of Population Sciences, Harvard School of Public Health, Boston, USA. Numerous publications on HIV/AIDS including co-editor of an HIV/AIDS series of monographs. Advisor to UNAIDS.

PERSONAL: Born 4 April 1955, India**.**
Nationality: British citizen; Overseas Citizen of India (OCI)

(CV/ Jan 2018.mk)

Governing Board document 8/2018

7 February 2018

Decision sheet from the 1st Board meeting held on 31 Jan 2018

The first meeting of the Steering Committee/Governing Board took place on 31 January 2018 at 1400 hours CET in Geneva.

Present: James Hospedales (chair); Abbas Gullet; Celina Gorre, Jamshed Khamidov, Peter McDermott, Harald Nusser, Soraya Ramoul, Dinuke Ranasinghe, Alafia Samuels, Cherian Verghese. *In attendance:* Mukesh Kapila, Nikhil Seth (represented by Emily Fraser).

Apologies: Subhanu Saxena

The Steering Committee/Governing Board considered the documents prepared for the meeting (listed below) discussed improvements and, subject to those revisions being incorporated (see revised documents as indicated below), resolved as follows:

Constitutive act

See document 2/2018 (revised) on current membership of the Steering Committee and its successor Governing Board.

Decision 1 (31Jan2018): *Noting with appreciation the work done by the Steering Committee to initiate the Defeat-NCD Partnership, its members decide to constitute themselves as its Governing Board to serve with immediate effect and for the initial period till 31 December 2018.*

Decision 2 (31Jan2018): *The Governing Board adopts its terms of reference and operating procedures, as outlined in revised document 3/2018.*

Decision 3 (31Jan2018): *The Governing Board decides to appoint Dr James Hospedales as its Chair, to serve for an initial period till 31 December 2018.*

Decision 4 (31Jan2018): *Noting with warm appreciation the encouragement provided by Michael Moller, Director General of the United Nations Office in Geneva, the Governing Board appoints Mr Moller as Hon President noting that this role does not have any fiduciary or legal obligations.*

Progress update

See document 4/2018 for the founding concept note and document 5/2018 for a summary report on progress so far with establishing the Defeat-NCD Partnership.

Decision 5 (31Jan2018): *The Governing Board appreciates the favourable reactions to the concept note dated 26 November 2017 in key stakeholder consultations, and adopts this as the founding framework for the Defeat-NCD Partnership, noting that this will be revised and updated with experience.*

Decision 6 (31Jan2018): *The Governing Board thanks the initial supporters of the Defeat-NCD Partnership, appreciates the United Nations Institute for Training and Research (UNITAR) for its practical assistance in incubating the Partnership, and welcomes the progress that has been made so far.*

Appointment of the Chief Executive

See document 6/2018 on the terms of reference for the chief executive, and document 7/2018 on the curriculum vitae of the CEO-designate Dr Mukesh Kapila.

Decision 7 (31 Jan2018): *The Governing Board recognises the conceptual and foundational work done on the Defeat-NCD Partnership by Dr Mukesh Kapila, approves the terms of reference of the chief executive and decides to appoint Dr Kapila to this role for the period till 31 December 2018 or earlier if the longer-term chief executive of the Partnership has been selected and appointed.*

Decision 8 (31 Jan2018): *The Governing Board decides to initiate a competitive process for the selection of the longer-term chief executive, including through public advertising for potentially interested candidates, as soon as feasible.*

Decision 9 (31Jan2018): *The Governing Board authorises the chief executive to make financial and programmatic decisions required for the effective and efficient day-to-day functioning of the Defeat-NCD Partnership, reporting to the Board on a regular and periodic basis.*

Longer-term hosting arrangements

Decision 10 (31Jan2018): *The Governing Board requests the chief executive to examine the best arrangements for the longer-term hosting of the Defeat-NCD Partnership, and to make recommendations to the Board accordingly. In making its selection, the Board will place particular emphasis on the potential hosting organisation's demonstrated capacities to (i) host the Defeat-NCD Partnership's secretariat in Geneva where it will remain headquartered and (ii) provide country programming support through the full range of services necessary for rolling out the four tracks of the Partnership in a cost effective and efficient manner.*

List of Board documents:

Doc 1/2018 (31 Jan 2018):	Annotated agenda and draft decision sheet
Doc 2/2018 (Rev 7 Feb 2018):	Membership of the Governing Board.
Doc 3/2018 (Rev 7 Feb 2018):	TORs and rules of procedure for the Governing Board
Doc 4/2018 (26 Nov 2017):	Concept Note: Defeat-NCD Partnership
Doc 5/2018 (31 Jan 2018):	Progress report
Doc 6/2018 (31 Jan 2018):	Outline terms of reference for the chief executive
Doc 7/2018 (31 Jan 2018):	Curriculum vitae of Professor Mukesh Kapila

Governing Board document 9/2018

15 February 2018

Appointment of Treasurer

***Draft decision 11**. The Governing Board thanks Mr Dinuke Ranasinghe for offering to act as Treasurer, and decides to appoint him to this role for the initial period till 31 December 2018. The Treasurer's terms of reference are to advise the Board and CEO on (i) the budgetary and financial aspects of the programme of work of the Partnership; (ii) obtaining best value for money on the activities and arrangements entered-into by the Partnership; (iii) financial sustainability aspects of the Partnership.*

Subject to any modifications proposed, and a quorum of 7 responses having been received electronically, this draft decision or an amended decision will be deemed to have been taken **on 1 March 2018** if so approved by the majority of them.

Bio of Mr Dinuke Ranasinghe:

Dinuke is Chief Executive Officer of Arcadier, the world's leading provider of marketplace software. He is a technologist with 20 years of experience spanning conceptualisation to delivery and building organisations to sustainable positions. Prior to Arcadier, Dinuke held senior positions in PayPal Private Limited and Visa International (Australia), deploying innovative technology across multiple countries. Dinuke is a citizen of Australia and holds degrees from the University of Oxford, University of Sydney and the Australian Graduate School of Management.