PROGRAMME NOTE

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OVERVIEW

The Defeat-NCD Partnership was established in January 2018 to help tackle the most significant global health problem of the age: premature death, sickness, disability, and the associated social and economic impacts of selected non-communicable diseases (NCDs). The initial focus is on diabetes and hypertension. However, there will likely be expansion to other NCDs, in due course, probably starting with the early detection and treatment of breast cancer.

Our vision is that of a world in which there is universal health coverage (UHC) for NCDs. This is a direct contribution to the transformational *2030 Agenda for Sustainable Development* to which all nations have subscribed.

Our specific mission is to enable and assist lower-income and lesser developed countries to scale-up sustained action against NCDs so that they can progress *Sustainable Development Goal (SDG) 3 on ensuring healthy lives and promoting well-being for all at all ages* and, more specifically, to achieve target 3.4 to reduce, by one-third, premature mortality from NCDs by 2030. Accordingly, **the priority focus of The Defeat-NCD Partnership is on the 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 is a people-public-private Partnership that is anchored in the United Nations system but extends beyond. It is an open, joint endeavour that includes governments, multilateral agencies, civil society, academia, philanthropic foundations, and the business sector. It follows the expert guidance and the technical norms and standards issued by the World Health Organization (WHO) for the best way to manage NCDs. Impact is tracked through the WHO's periodic NCD Progress Monitor reports.

The Partnership works by mobilising global and national knowledge, tools, capacities, and financing to benefit resource-poor countries according to their specific needs and defined NCD action plans. This includes vulnerable populations in humanitarian crisis and the countries hosting them, such as people living in conflict and disaster contexts including refugees and the internally displaced.

In practical terms, **the Partnership is focused on the country level**. This work enables the country's populations to access a range of inter-connected essential services and resources, through four tracks: a Capacity Development and Community Mobilisation Facility, an Essential Supplies Procurement and Distribution Facility, a Financing Facility, and a Humanitarian Crises Support.

THE NCDs CHALLENGE

The Partnership was born from the recognition that NCDs are now the major contributor to the global burden of disease. They kill at least 40 million people each year, the equivalent to 70% of all deaths globally[1]. Each year, there are 15 million "premature" deaths (i.e., below the age of 70 years) from NCDs. Continuing with business as usual will increase this by a third by 2030. NCDs are not just medical problems. They have huge personal, social and economic impacts and their rising prevalence is a serious setback for human and national development.

Our focus on diabetes and hypertension is justified by the public health burden. Each, on its own and in combination, cause most of the global NCD deaths. At the same time, the risk factors that lead to raised blood sugar and blood pressure are reducible. Both diabetes and hypertension are easily treatable and their complications largely avoidable. See **Annex 1** for more information on the technical aspects of diabetes and hypertension.

The Defeat-NCD Partnership prioritises poorer countries because they bear the brunt of the enormous impact of NCDs with some 48% of premature deaths occurring in low and lower-middle income countries[2]. 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 higher than the equivalent risk for a high-income country resident.[3] Meanwhile, when poor countries start getting a little more prosperous, the prevalence of NCD risk factors tend to initially increase.

The cumulative economic losses due to NCDs in low- and middle-income countries are estimated at US$ 7 trillion for 2011-2025[4]. This sum far outweighs the estimated annual US$ 11.4 billion cost of interventions to reduce the burden[5]. Meanwhile, less than 2% of global development assistance for health goes to NCDs of which only a miniscule share is for diabetes and hypertension[6].

Resource poor countries are constrained by several factors in their response to NCDs. To start with, poorer people are more vulnerable because they are more likely to have to endure unhealthy living and working conditions. They are less able to afford the healthier lifestyle options. They are also often less educated on the risks without having the knowledge to manage them. These countries can have weak institutional capacities and invest less in prevention, public health protection, and curative care. Furthermore, prevalent inequalities mean that the poorest groups can least afford the remedies on offer that include a lifetime of medication.

Special attention is needed for the hundreds of millions of people suffering humanitarian concerns. These are the people seriously affected or displaced by

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[1] WHO (2016). NCD mortality and morbidity. [Online]

[2] ibid.

[3] Global status report on noncommunicable diseases 2010 (2011). [Online]

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

[5] ibid.

[6] WHO global coordination mechanism on the prevention and control of noncommunicable diseases (2015). [Online]

disasters and conflicts. Their life chances if they suffer from NCDs are known to be severely compromised by the discontinuities in provision that happen in crisis contexts.

FRAMING THE DEFEAT-NCD PARTNERSHIP APPROACH

Initially slow to react to this growing public health challenge, countries finally adopted a *Political Declaration on NCDs*[7] at the United Nations (UN) in 2011. In 2013, the World Health Assembly endorsed the *WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020*[8]*.* The nine voluntary targets for 2025 against a baseline from 2010 is the centrepiece:

- *Target 1: A 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or 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 contain the prevalence of raised blood pressure, according to national circumstances.*
- *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 non-communicable diseases in both public and private facilities.*[9]

Subsequently, the control and management of NCDs was brought into the centre of the *2030 Agenda for Sustainable Development* [10]. SDG 3 seeks to "*ensure healthy lives and promote well-being for all at all ages*[11]*".* Specifically, target 3.4 commits to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment by 2030[12]. Target 3.8 aims for *universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all*[13]. This has immense implications for NCD-related promotion, prevention and treatment interventions.

The *2030 Agenda* affirms that there will be "no one left behind" and calls for "those furthest behind now" i.e., the poorer and more vulnerable populations, 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

[7] UN (2011). Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases. [Online]
[8] WHO (2013) Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. [Online]
[9] Ibid.
[10] UN (2015). Transforming our world: the 2030 Agenda for Sustainable Development. [Online]
[11] Sustainable Development Goals (2016). [Online]
[12] Sustainable Development Goal 3 Targets and Indicators (2016). [Online]
[13] ibid.

inequalities at a time of unprecedented accumulation of wealth, knowledge, and capabilities that should benefit everyone.

WHO's 2014 *Global Status Report on NCDs*[14] 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 Adhanom Ghebreyesus has called for[15] *"changing the NCD paradigm"* through choosing healthy policies right across the national policy spectrum, recognising that *"all roads lead to Universal Health Coverage"*[16].

Accordingly, the Partnership strives to advance UHC in resource-poor countries by 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"[17] for NCD management are pursued, and the impact will be tracked through the WHO *NCD Progress Monitor*[18].

THE SCOPE OF THE DEFEAT-NCD PARTNERSHIP

The Defeat-NCD Partnership prioritises countries according to their development and income status. Top priority is 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. Forty-three lower-middle income countries (LMICs) are designated **Priority II countries** for the purposes of the Partnership.

The criteria for the classification of countries and the consequent list of countries within the Partnership's scope are found in **Annex 2**. This list is periodically reviewed as the status of countries changes. The intention is to cover all of these countries so that "no one is left behind". However, practical considerations require further prioritisation within that list. This will depend not only on relative needs but also market analyses to determine where there is an optimal mix of official policies and commitments, a minimum level of capacity that can be utilised, and a core of interested partners with whom to engage.

PROGRAMMING STRATEGY

The **values that inspire our programming principles** are those of health as a basic human right, enshrined originally in the *1948 Universal Declaration on Human*

[14] WHO (2014). Global status report on non-communicable diseases 2014. [Online]

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

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

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

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

Rights[19]. A challenge as extensive as the NCDs needs an equally far-reaching strategy: nothing less than the creation of a **people-centered "NCD Movement" to bring about the wide-scale changes that are needed**. Gender, age, social and geographical considerations are vital to ensure that practical approaches are relevant to specific contexts.

While we support all efforts that enable the making of healthy public policy and lifestyle choices such as WHO's "best buys" in NCDs, **our own attention is centered on people who are currently suffering from NCDs.** They are in two categories: firstly, those who are diagnosed with NCDs but not receiving any or adequate treatment and care according to WHO norms and standards; and, secondly, the majority, who are undiagnosed.

Both groups are at risk of premature death and catastrophic decline in the quality of their lives that, in turn, also generate serious consequences for their families, communities, and nations. Human compassion dictates that their unmet needs be tackled with urgency. Concurrently, we know from experience that **people with NCDs are themselves the best-placed advocates for primary risk reduction changes in society.** Enabling their voice to be heard loud and clear is, for us, also a "best buy".

Thus, **the scaling-up of effective screening and treatment provision is at the core of our initial programming strategy.** We do this firstly, by demystifying and democratising the knowledge that underpins this so that people with diabetes and hypertension are enabled to recognise when they need treatment. We also do this so that they are empowered to seek effective and sympathetic support from accessible and well-trained healthcare providers who have the necessary diagnostics, medicines, and equipment to do their job. Nationally led healthcare systems and provisioning are vital to sustain this. Second, we stimulate innovations that can systematically reduce the costs and other obstacles that hinder access to quality treatment and care.

THE FOUR TRACKS OF THE PARTNERSHIP

The Defeat-NCD Partnership helps to reduce the burden of diabetes and hypertension in resource poor countries through four tracks: a Capacity Development and Community Mobilisation Facility, an Essential Supplies Procurement and Distribution Facility, a Financing Facility, and a Humanitarian Crisis Support Facility.

The Defeat-NCD Capacity Development and Community Mobilisation Facility

To reduce diabetes and hypertension risks among vulnerable populations and to expand their access to effective treatment requires focused action at country level. We start with a strategic partnership with government ministries of health alongside the WHO.

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

Countries should have national policies and costed plans based on analysis of their prevalent NCD disease burden and epidemiological patterns and trends; for example, the incidence, prevalence and distribution of diabetes and hypertension. They should also have information systems (such as diabetes registers) that track treatment provision and monitor quality of care outcomes using indicators as recommended by the WHO. The management of NCDs should be part of an overall health system that includes arrangements for the timely procurement and distribution of essential medicines, diagnostics, and equipment. The Partnership can arrange to support the provision of technical assistance to national health authorities, in co-operation with the WHO, to identify and address the gaps or constraints that are identified in national health systems.

At the same time, quality of care relies on sufficient numbers of trained personnel utilising WHO-recommended protocols for treatment. The Partnership helps to boost the training of healthcare providers (doctors and nurses) for the early detection and treatment of hypertension and hyperglycaemia, including antenatally. This is done in conjunction with medical and health training institutions and professional associations and includes private health practitioners and pharmacies as they are a major provider of services.

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. Therefore, working with community service providers such as clinics, pharmacies, and school health services is vital.

Ultimately, self and family care are central to effective treatment. Thus, outreach is promoted through community-based voluntary organisations such as the Red 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, prevention messaging, and to boost the day-to-day quality of care.

Elements from this menu of strategies are selected according to specific country contexts. This is done through studying available country needs assessments (or conducting them where the analysis is not available) 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.

Scaling-up needs a new way of working. **The Defeat-NCD Partnership is incentivising the development of programming models that are innovative in terms of technology and communications tools as well as in organisational and financial approaches that “demystify, democratise and, where appropriate, demedicalise” the management of NCDs. Thus, the benefits to people are maximised and unnecessary constraints and costs stripped out of the system.**

The Defeat-NCD Essential Supplies Procurement and Distribution Facility

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 the 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.

Our Essential Supplies Procurement and Distribution Facility is geared towards the poorer countries through a **marketplace that makes the provision of medicines, diagnostics, and equipment more cost effective for them**. This Facility is guided by the WHO Model List of Essential Medicines[20]. It includes pooling the purchasing power of small countries that do not currently get value-for-money in their procurement alongside ensuring quality and continuity of supplies. Pharmaceutical companies have expressed interest including, for example, creating a low maximum cost for insulin for the world's poorest countries. Scales of production could bring this cost further down. An important aspect of the arrangement ensures 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.

The Facility's marketplace subscribes to good public service procurement principles benchmarked to standards established by the United Nations that are, inter alia, accepted by all countries. These seek to achieve the 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 or purchase products or services through the Facility.

Thus, the Facility tackles the main barriers to reliable supplies provision through lower prices, quality control, standardisation, speed and reliability of distribution to prevent stock outs, and ensures transparency. An important added value of the Facility is to provide technical assistance to build national capacities in supply chain management. This includes skills in procurement, customs clearance and exemptions, warehousing, stock control and rotation, and secondary distribution to delivery points. Experience suggests that these are frequently encountered choke points, even when supplies are available.

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

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

The Defeat-NCD Financing Facility

Universal health coverage means that no one should suffer financial hardship when getting the preventive, curative, rehabilitative and palliative healthcare they need. UHC is not possible to achieve generally without meeting the specific 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 already relatively inexpensive.

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-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.

However, with the injection of new leadership from the WHO Director General, 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.

The Defeat-NCD Financing Facility is intended for the least-developed and low-income countries to expand coverage of services for people with diabetes and hypertension. To be eligible for the Facility's support, countries would have established diabetes and hypertension management policies as recommended by the 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 can be provided from the Partnership's Capacity Development and Community Mobilisation Facility.

The Financing Facility is reliant, principally, on innovative sources of financing that expand the overall allocation of investments into provision for NCD services. As these methods are developed, initial set-up is resourced from donor governments, the private sector, and philanthropic contributions. Donor government funds are intended to leverage some four times greater funding from the private sector and other sources. Blended financing options (a mix of grants and loan/equity investments from international financial institutions including the World Bank Group and perhaps Regional Development Banks) are being explored as part of public-private partnerships.

The Defeat-NCD Humanitarian Crisis Support Facility

People in crisis circumstances due to disasters and conflicts deserve particular attention. There are about a billion people worldwide who are marooned in chronic crises or going into or recovering from them. They include some 90 million people who are forcibly displaced within national boundaries or are refugees and 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 consequent impacts are disproportionately greater for poorer populations.

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 an un-interrupted manner. Meanwhile, although traditional humanitarian relief providers prioritise 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.

NCD provision during emergency humanitarian crises needs special rapid-response operational modalities in partnership with specialised humanitarian agencies. At the same time, and to reduce dissonance within the relief-development nexus, the Partnership's humanitarian assistance seeks, wherever feasible, to use the same country mechanisms as established for development programming.

NCD provision for specific populations of humanitarian concern, once embarked upon, is a long-term obligation until durable solutions for the underlying causes of crises have been instituted. Accordingly, **the Partnership seeks to find innovative approaches to ensure continuity of provision for populations in flux, regardless of where they are forced to repeatedly relocate by the compulsions of forced displacement.**

THE DEFEAT-NCD PARTNERSHIP IMPACT AND SUSTAINABILITY

The most important benefit of the Partnership is directed towards people with NCDs and particularly diabetes and hypertension along with their families and communities by saving their lives, maintaining their healthy functioning, and securing their livelihoods. A critical benefit concerns reduction of the out-of-pocket expenditure of people who need lifelong treatment and often get catastrophically impoverished as a consequence. A hundred million people around the world fall below the poverty line every year as a result of crippling medical bills.[21]

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

For the governments of low income countries faced with the escalating burden of NCDs, this initiative reduces 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.

[21] Medical costs push millions of people into poverty across the globe (2005). [Online]

Sustaining impact

Trends in the underlying risk factors and behaviours that influence health outcomes take a long time – perhaps a generation or more - to manifest. Furthermore, diabetes and hypertension management require 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 be regular reviews as NCD epidemiology evolves, and adaptations will be necessitated by advances in scientific knowledge, new medicines and technologies.

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-pocket expenditures) or through pooled cost-sharing arrangements, e.g., health insurance schemes and employer or taxpayer-funded 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.

In general, **the sustainability for diabetes and hypertension programming depends on increasing the affordability of essential products and services**. With this in mind, this Partnership fosters longer-term sustainability by:

- First, pursuing affordability through the Essential Supplies Procurement and Distribution Facility. By seeking maximum reductions in the costs of providing medicines and diagnostics through economies of scale that are negotiated centrally or through marketplace mechanisms that drives down costs. The pharmaceutical industry has incentive to do so, not just as part of their CSR commitment but also because of the expanded market that is 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 Partnership engages with developing country governments and assists them through technical assistance and capacity building so that their health policies incorporate NCD costs into national health budgets, in a progressive manner. The Partnership engages 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 available resources (of at least US$ 40 per capita), the Partnership's Financing Facility aims to attract additional innovative investments into NCD programming supplemented by some greater transfer of resources from richer countries (e.g., OECD donor nations), and rich entities (e.g., CSR contributions from private sector companies, and philanthropies) to poorer ones as part of the shared commitment to universal health coverage.

However, the Defeat-NCD Partnership is not conceived as a 'charitable' project. Its progressive business model seeks 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 IS THE DEFEAT-NCD PARTNERSHIP ORGANISED?

The Partnership is guided and overseen by a Governing Board. **The day-to-day work is the responsibility of a Chief Executive supported by a small Secretariat based in Geneva that is hosted by a competitively selected international organisation**.

The Governing Board decides on Partnership policies and strategies, approves work plans and budgets, monitors performance and progress, and provides accountability to donors and other stakeholders[22]. The Board is committed to gender equality and strives to ensure a gender-nuanced approach in all of the Partnership's programming, as well as equal representation by women and men in our own internal processes.

The Board composition reflects constituencies relevant to NCDs and that are also providing financial, technical and other practical support to the Partnership. These include donor governments/public sector, governments of programme countries, groups representing people with NCDs, international agencies, philanthropies, research and academia, the private business sector, and those with other specialist expertise deemed to be relevant and useful. The World Health Organization, as the lead global health agency for the United Nations system and a representative of the hosting agency, has ex- officio observer membership of the Board.

A wider **Consultative Group** of contributing stakeholders and invited experts enables wider knowledge and experience to be drawn upon to benefit the Partnership and expand its outreach and ultimate impact.

All private business sector members engaging with the Partnership in any role must subscribe to the ten principles of the *UN Global Compact*[23] concerning respect for human rights, labour, environment, and anti-corruption.

[22] See the Partnership's website for fuller details of governance arrangements and names of current Board members.
[23] UN. The Ten Principles of the UN Global Compact. [Online]

Annex 1

WHAT ARE DIABETES AND HYPERTENSION?

Diabetes

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.

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.

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 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

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, 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.

Ninety to ninety-five per cent 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.

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 diabetes and hypertension important?

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.

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).[24]

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

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.[25]

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.[26] 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.

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.[27] 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.

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[24] WHO (2016). NCD mortality and morbidity. [Online]
[25] WHO (2016). Global Report on Diabetes. [Online]
[26] WHO (2018). Obesity and overweight. [Online]
[27] Global status report on noncommunicable diseases 2010 (2011). [Online]

Diabetes registers are useful tools for ensuring universal coverage and for tracking quality of care. Specific intermediary process and outcome indicators should be in line with the WHO's 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.

Hypertension

More than a billion people around the world suffer from raised blood pressure and account for 57 million disability-adjusted life years lost.[28] In Africa, for example, the adult prevalence of raised blood pressure is highest at over 40%.[29]

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.

[28] Global status report on noncommunicable diseases 2010 (2011). [Online]
[29] WHO Raised blood pressure. [Online]

Annex 2

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.

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*

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