WORLD HEART FEDERATION®

World Heart Federation Comments – Consultation on the thirteenth General Programme of Work (GPW13)

Context

The World Heart Federation (WHF) is dedicated to leading the global fight against cardiovascular disease (CVD), including heart disease and stroke. Working with more than 200 member organizations in over 100 countries, we have a global impact which is enhanced by our 3-year workplan with the World Health Organization.

The World Heart Federation thanks the WHO for the opportunity to provide feedback on the Draft 13th General Programme of Work 2019-2023, and the consultative process it has undertaken despite time constraints.

The following comments and recommendations have been drawn from our Board and secretariat; where relevant, the pages to which the comments refer have been included.

WHO Priorities

- **Health systems strengthening and UHC & Determinants of Health:** The WHF supports WHO's top strategic priority of supporting 'countries to strengthen health systems in order to progress towards UHC'. We believe that the successful prevention, control and management of non-communicable diseases such as cardiovascular disease depend on the establishment of strong, well-resourced health systems with the capacity for referral to higher levels of care.

  However, we note with concern the statement that the definition of UHC used 'addresses not only health services but also health determinants, health promotion and disease prevention' (**page 7**). The effective prevention and control of NCDs will require strong action and leadership from WHO on the upstream determinants of health and health promotion as discrete areas of work, and we wish to highlight the importance of WHO continuing to support those prevention and promotion activities that do not fall under the umbrella of UHC.

- **NCDs – Flagship Initiative:** WHF strongly supports WHO's decision to include 'NCDs, mental health, substance abuse and road traffic injuries' as a priority area under the strategic priority '1 billion lives improved' (**page 12**). However we suggest modifying the 'flagship initiative' selected under this priority area from 'NCDs, including mental health' to *'Access to NCD essential medicines and technologies'*.

  We believe that the current 'flagship initiative' is a statement of WHO's normative work, that is, the provision of technical support to Member States for the areas of noncommunicable

diseases and mental health.

We believe that a more specific, focused 'flagship initiative' – such as *'Access to NCD essential medicines and* technologies' – could be more impactful and more easily measured; furthermore, an increase in NCD screening and in the availability of proven, generic, and affordable medicines is essential to improved NCD prevention and control. Such an initiative would also complement the strong focus of GPW13 on health systems strengthening for UHC.

Financing and Resource Allocation

- The current Draft GPW13 is hugely ambitious, as it seeks to step up and strengthen WHO's normative functions while simultaneously expanding its role in many other areas such as operational work and country office capacity. Inevitably this will demand additional resources: we suggest that WHO include specific, innovative financing mechanisms in the forthcoming investment case to help WHO to obtain the necessary resources; such measures include Member State taxation on tobacco and sugar-sweetened beverages, and financing from resources currently allocated to tackle climate change and improve global security.

- The Draft GPW13 states on **page 2** that 'GPW 13 […] will also influence the Programme budget 2018-19 through a mechanism of resource reallocation'. We seek clarification on this mechanism, and, as NCDs are already an under-funded area of public health, call for more resources to be allocated toward NCD prevention and control. Such a step would indicate to governments that NCDs constitute a public health priority, especially in the year leading up to the Third UN High-level Meeting on NCDs.

- **Page 9 –** GPW13 states that, to 'strengthen country office capacity', WHO will employ 'country teams of health systems experts'. Though this will vary according to context, WHF would be keen to learn an approximation of the increase in capacity that WHO anticipates will take place in the country offices, and how this will affect staffing at headquarters and the regional offices.

- On **page 17,** the GPW13 discusses the proposal of service delivery as part of a differentiated approach to country support in a select number of states, including 'coordination of the health cluster and direct provision of services and supplies'. It is also stated under the proposal of technical assistance that 'WHO may, exceptionally and for short periods, have to serve as provider of last resort as more robust solutions are established'. This represents an important expansion of the mandate and scope of WHO's work, and will likely require considerable resourcing. WHF would strongly encourage WHO to consider developing a comprehensive framework of engagement to clearly define the modalities of this service provision in order to avoid a costly over-extension of already limited resources. WHF further notes the difficulty of defining, in a time-limited way, when a system may be deemed robust enough for the withdrawal of 'provisional' service delivery. While we commend WHO's ambition to provide further services to its members, we note with concern the potential for

this expansion to come at the expense of existing programmes and priorities considering a limited resource pool.

Multisectoral partnerships

- Throughout the draft GPW13, WHO places great importance on multisectoral action and multistakeholder partnerships. This is particularly true of NCDs: "Flagship status means that they will each have a joined up, horizontal, platform approach across WHO. They will also be the focus of elevated political attention, multisectoral action, and partnerships" (**page 13**).

  However, we note with concern that there is no reference to FENSA (framework for engagement with non-State actors) in GPW13, the implementation of which will be essential to ensure WHO and governments have guidance when engaging new partners on avoiding conflicts of interest and maintaining their integrity. This is especially important as WHO and governments seek to promote health-in-all policies within other sectors that may have different rules of engagement, particularly with the private sector. It is also vital that clear guidance is offered to WHO country offices in this regard with the new autonomous, more decentralized structure.

  We therefore suggest that WHO outlines its plans for fast-tracking the implementation of FENSA at all levels of the organization to promote the engagement of new stakeholders and formation of new partnerships.

WHO Organizational shifts

- **Page 5 –** We thank WHO for providing greater clarity on its aim to become 'more operational by delivering services in a limited number of fragile States', and its classifications of Member States into four health systems categories to guide the nature of the support it will provide.

- We reiterate a request from our comment on the GPW13 Concept Note, that in future iterations of the 13th General Programme of Work, the manner in which NSAs in official relations with WHO should engage with WHO Country Offices – with their increased functions and capacity for health diplomacy – be clarified.

Additional Comments

- **Implementation research.** WHF applauds WHO's intention to 'strengthen coordination for research and development based on health needs' (**page 8**). We call on WHO to pay particular attention to implementation research: with regard to strengthening health systems and primary health care, this will be a critical element to improving delivery of health services in different contexts.
- **Page 18-19**: We support GPW13's emphasis on the importance of disaggregated data for monitoring, evaluating and achieving the health SDGs, and commend in particular its reference to chronic disease registries and household surveys.

Draft WHO Impact Framework

- **Targets and Indicator Frameworks** There now exists a range of agreed or proposed indicators contained in the Global Monitoring Framework[1] (for the Global Action Plan on NCDs), the indicators for the Sustainable Development Goals[2] and the Draft WHO Impact Framework.[3] With regard to NCDs, some of these targets and indicators align and overlap, however the emphasis on certain indicators changes depending on which framework is used. WHF asks that WHO provide a rationale for its selection and prioritisation of certain NCD targets in the Impact Framework, and that it clarify which framework will retain the most relevance in guiding its work and that of its Member States.

- **Mismatch between Strategic Priorities and Targets:** We believe that there is a lack of coherence between the strategic priorities set out in the Draft and the targets used to measure progress in tackling NCDs to achieve these priorities. Health systems strengthening to achieve universal health coverage is stated as the 'top strategic priority' of WHO. It is arguable that the best measure for a health system that effectively manages and treats NCDs is its provision of essential medicines and technologies and drug therapy, however these indicators – included in the Global Monitoring Framework – are excluded from the Draft Impact Framework.
  We suggest that a target measuring the ability of health systems to treat and manage NCDs be included in the Impact Framework, adapted from the list of 9 GMF voluntary global NCD targets for 2025 (80% coverage of Essential NCD medicines and technologies and 50% coverage of drug therapy and counselling).[4]
  Conversely, many of the targets currently included in the Draft Impact Framework relate to NCD risk factors, e.g. harmful use of alcohol and halting the increase in overweight. This is despite the fact that few details are included in addressing the commercial determinants of health or on fast-tracking the implementation of FENSA to guide WHO's work in this area.

- **Page 5** – We strongly support the inclusion of targets on tobacco use, harmful alcohol use, prevention of overweight among children and adolescents, elimination of industrially-produced trans fats, prevalence of raised blood pressure, and mortality from air pollution.
- **Page 5** – We commend WHO's plan to implement the MPOWER technical package in an additional 30 LMICs where tobacco prevalence is highest. Though an already ambitious target, WHF suggests that WHO increase the target number of countries, as MPOWER includes cost-effective and revenue-generating interventions for governments that can support the achievement of other targets.[5]
- **Page 5** – We support WHO's intention to 'support implementation of best practices' in relation to the target to 'prevent overweight and reduce obesity rates in children and

[1] http://www.who.int/nmh/global_monitoring_framework/en/
[2] https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework_A.RES.71.313%20Annex.pdf
[3] http://www.who.int/about/GPW13_-impact-framework-draft.pdf
[4] http://www.who.int/nmh/global_monitoring_framework/en/
[5] http://www.who.int/tobacco/publications/economics/nci-monograph-series-21/en/

adolescents'. We suggest that WHO explicitly state that it will support countries to develop national responses to childhood and adolescent obesity, in line with the implementation plan put forward by the Commission on Ending Childhood Obesity, which was endorsed by Member States in May 2017.[6]

- **Page 5 –** Further to the above, we would encourage WHO to rephrase the target 'Keep the levels of overweight (including obesity) in children and adolescents stable' to a 'Zero percent increase in the levels of overweight (including obesity) in children and adolescents'. This language demonstrates a greater commitment to tackling obesity and overweight and is in keeping with the corresponding target of the Global Monitoring Framework for NCDs.
- **Page 5** – We support the proposal to implement the SHAKE technical package in at least 20 LMICs. In addition to a reduction in prevalence of raised blood pressure, we suggest that a discrete target for the reduction of salt be included to measure implementation of the SHAKE package, in alignment with the NCD Global Monitoring Framework target to achieve a 30% reduction in salt/sodium intake by 2025.[7]
- **Page 5** – We strongly support WHO's intention to implement the Global HEARTS initiative in at least 20 low- and middle-income countries, and to focus on where the burden of CVD is highest. CVD remains the biggest killer worldwide, with more than 75% of CVD deaths occurring in LMICs.[8] We therefore suggest that WHO increase its advocacy to LMICs with regard to Global HEARTS to increase uptake from Member States of this technical package. Increasing the provision of CVD services through primary health care in more LMICs can provide wider benefits to health systems strengthening that will help WHO achieve all three of its strategic priorities.

  We also suggest that WHO develop a set of formal criteria to influence which countries would be selected for implementation of Global HEARTS, for example Members States where salt consumption is high or where there are poor levels of hypertension control, so that the implementation of this package is based on need and disease burden, in addition to political will.

  We further note that increased action to reduce prevalence of raised blood pressure – a positive step – may in fact lead to an increase in prevalence in settings where previously there was undetected hypertension among the population or limited hypertension control and management. We suggest that this target also incorporate 'percentage of hypertensive population whose high blood pressure is managed/controlled'.
- **Page 6** – The description of the target to 'reduce the mortality rate from air pollution by 5%' states that this will be measured by 'the number of cities and countries with commitments to reduce air pollution exposures'. We suggest that a more direct measure of household and ambient air pollution be put in place, so that real impact on populations rather than government commitments are held as the measure of success.
- **Physical Inactivity:** We note with concern that there is no discrete target set for physical inactivity, which is referenced only with regard to halting the rise in overweight. We believe that not including a target for this key NCD risk factor could undermine the proposed Global Action Plan on Physical Activity (GAPPA) from its inception, and suggest that a target be

[6] http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf
[7] http://www.who.int/nmh/global_monitoring_framework/en/
[8] http://www.who.int/cardiovascular_diseases/en/

incorporated into the Draft Impact Framework from the draft GAPPA that will be submitted to the 142nd session of the Executive Board.

- **Acute Rheumatic Fever:** We appreciate that is not possible for WHO to set discrete indicators for all diseases on which it provides technical support to Member States. Nevertheless WHF believes that it would be appropriate to add the 'existence of primary and secondary prevention programmes for acute rheumatic fever (ARF) in endemic countries' as an indicator in the Draft Impact Framework. Recent research indicates that high prevalence of and mortality due to ARF and its sequela rheumatic heart disease remains in many regions.[9] Furthermore, as a disease that is a strong indicator of poverty and inequality, its inclusion would align with the aim of GPW13 to 'focus on marginalized, stigmatized and hard-to-reach people of all ages' (**page 8, GPW13**).

[9] http://www.nejm.org/doi/full/10.1056/NEJMoa1603693#t=article