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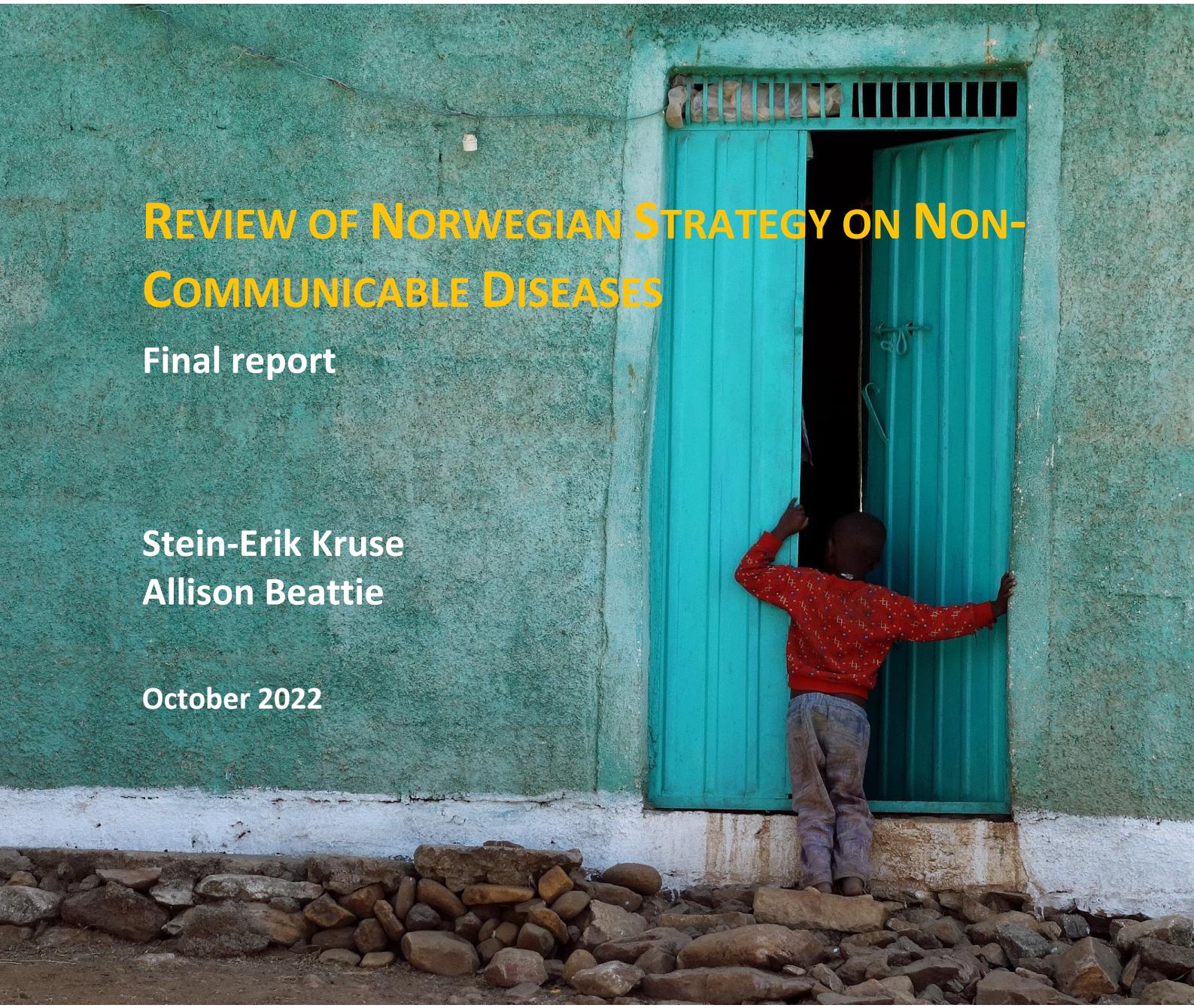

Review of Norwegian Strategy on Non-Communicable Diseases

Final report

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October 2022

Acronyms

AHPSR	-	Alliance for Health Policy and Systems Research
BCEPS	-	Bergen Centre for Ethics and Priority Setting
BIS	-	Building Stronger Public Health Institutions and Systems
BIS	-	Building Stronger Public Health Institutions and Systems
CSO	-	Civil society organisation
FCTC	-	WHO Framework Convention on Tobacco Control
FHI	-	Norwegian Institute for Public Health
GLOBVAC	-	Global Health and Vaccination Research
GPG	-	Global Public Goods
HISP	-	Health Information Systems Programme
IANPHI	-	International Association of National Public Health Institutions
ICDP	-	International Childhood Development Programme
MFA	-	Ministry of Foreign Affairs
NCDA	-	NCD Alliance
ToC	-	Theory of Change
UHC	-	Universal Health Coverage
UiB	-	University of Bergen
UiO	-	University of Oslo
UNGA	-	UN General Assembly

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1 BACKGROUND

1.1 PURPOSE AND SCOPE OF ASSESSMENT

The **purpose** of this mid-term review is to assess whether and to what extent the Norad and MFA non-communicable disease (NCD) strategy is starting to take root and to make recommendations regarding the overall programme going forward. The review will also consider whether adjustments to ongoing investments should be made to bring them into line with Norwegian priorities and policies during the final two years of the strategic period (2023-2024). The **primary objective** of the review is to assess whether the overall composition of the portfolio and selection of implementing partners are relevant, coherent and targeted in line with the NCD development programme. The supplementary objectives of the review are to:

- Identify how and to what extent individual elements of the portfolio of implementing partners have been particularly relevant.
- Take note of information available about what is reported to be going well as well as challenges among implementing partners and in countries (Ghana and Nepal).

The review will gather evidence that covers the assessment of Norad and the Ministry of Foreign Affairs NCD programmes and areas of priority with an aim to include recommendations and suggestions of areas for continued investments, possible scaling and, if relevant, new priorities.

1.2 CONTEXT

Non-communicable diseases continue to increase in prevalence across the world. The World Health Organization (WHO) reports that more than 70% of all annual global deaths are due to NCDs (about 41 million altogether) and that almost half of these occur in people before the age of 70. The majority of premature deaths are among people living in low- and middle-income countries (LMICs).[1]

Most NCDs can be prevented, delayed or effectively treated if caught early, thus making it a realistic proposition to reduce the high numbers of premature deaths and disease in 30 to 70-year-old adults. NCDs are linked to increased household poverty as many preventable deaths happen among breadwinners, leading to the loss of income and/ or increased health care costs. The consequences can be significant and commonly include aborted education of children, declining household nutrition, asset depletion, increased poverty and exposure to other health risks.

The WHO NCD framework has expanded from a model based on four risk factors (tobacco use, alcohol and drug abuse, diet, physical activity) that underpin four main disease groups (cardiovascular disease, cancer, diabetes, chronic respiratory diseases) to one based on five risk factors (through the addition of air pollution), and five disease groups (through the inclusion of mental health). Based on WHO guidance, the Norwegian approach to NCDs is outlined in the Better Health, Better Lives strategy (the Norwegian NCD strategy). Its goals are aligned with the WHO Global Action Plan to combat NCDs (NCD-GAP) and the Agenda for Sustainable Development. WHO is currently reworking its global strategy and has initiated an extensive consultative process to update the NCDs "Best Buys" resource tool (called Annex 3) that helps countries target resources most effectively to address NCD risk factors and disease groups.

[1]World Health Organization, Global Health Observatory, Geneva. https://www.who.int/data/gho/data/themes/noncommunicable-diseases Accessed on 18 August 2022.

The COVID-19 pandemic has shone a spotlight on NCDs; mental health obesity and diabetes are risk factors for severity of coronavirus disease. Much of the global attention on disease prevention has focused on global health security and pandemic preparedness rather than addressing risk factors. In addition, the economic impact of the pandemic has hit the poorest households and combined with drought, natural weather events and the conflict in Ukraine, household food security has been eroded for millions in many countries across the world. The effects of global economic downturn, climate change and conflict will have long term impacts on NCD prevalence and on the ability of countries to step up prevention efforts and build out cost-effective and equitable responses.

1.3 SCOPE OF WORK AND REVIEW QUESTIONS

Although it is too early to assess implementation, including country results, the review aims to capture a sense of the overall coherence between global and country level investments and the potential of the portfolio to support results and impact at country level. The fact that country programme documents are not yet complete for all WHO priority countries, implementation has been delayed and few progress reports are available, makes it likely that the value of assessing results country by country at this stage would be limited. However, we have gathered selected evidence from two countries where the programme is currently being rolled out, Ghana and Nepal.

The review takes a broad perspective, tracking the direction of travel in the global NCD response to assess whether and to what extent the overall NCD programme remains relevant to the least developed countries and at the centre of global priorities.

The objectives identified in the NCD strategy and ultimately developed in the NCD programme are aimed at:

(1) Strengthening global health leadership

(2) Preventing and reducing exposure to risk factors and improving services and access to services:
- Measures targeting tobacco and alcohol
- Healthy diet and physical activity
- Improving indoor and outdoor air quality[2]
- Taxes on products and pollution that harm health
- Integrating NCD screening and management into Universal Health Coverage
- Mental health
- Preventing and treating high blood pressure and diabetes
- Access to pharmaceuticals and medical commodities

(3) Addressing global public goods including normative tools and guidance.

The review will be structured to respond to five evaluation areas anticipated in the Terms of Reference (TOR): Strategy and coherence of the portfolio, Selection of partners, Theory of Change, Results and Outlook and Areas of development. The specific questions are introduced in each chapter.

[2] Followed up by MoFa and Norad´s Department for Climate and Energy.

1.5 METHODOLOGY AND LIMITATIONS

Data collection has been based on two main sources of information:

a) A review of documents made available by Norad[3] plus additional documents collected during the evaluation.

b) Interviews with key informants in Norad and NCD partners[4].

Data has been organized in line with the five evaluation areas and the main issues and themes have been analysed using triangulation of evidence to build the assessment. Time allocated to the review was limited to 15 days in total making it difficult to develop sufficient knowledge of all the components in the programme to draw fully elaborated conclusions. While every effort was made to contact and interview all the main partners linked to the NCD programme, gaps remain and despite multiple requests some key informants were not available. There are also few reports from the interventions given the stage of development such that the assessment of progress and results can only be indicative. The analysis, conclusions and recommendations should be seen in the context of these limitations.

2 FINDINGS

2.1 STRATEGY AND COHERENCE OF THE PORTFOLIO

Findings in relation to strategy and coherence are structured and arranged in response to three overarching areas: (i) the extent to which the NCD portfolio has a clear strategic purpose, (ii) whether and how the programme is based on thorough analysis and consultations, and (iii) whether investments in research and capacity building provide relevant evidence for the portfolio.

The Norway NCD strategy and the resulting development programme

The **Strategy** "Better Health, Better Lives" was prepared by the Ministry of Foreign Affairs with technical inputs from external partners and Norad, emphasizing that NCDs should be presented as a development issue - not as another vertical disease group - within a health systems approach. This fundamental perspective underpins the broader programme approach (discussed further below). The strategy was prepared at the request of the Parliament during the previous government's tenure. The new government has been in place for less than a year at the time of writing. While the new government has retained the NCD strategy and programme, its priorities in health have been particularly focused on infectious diseases and especially health systems strengthening. However, nutrition, food security and environmental issues, especially related to climate change, are high on the agenda and there is considerable scope to pursue NCD prevention and mitigation through programmes in these areas as well. For example, air pollution (both indoor and outdoor) interacts with both climate and environment as well as health, especially chronic health conditions such as asthma.

The strategy has been perceived internationally as ground-breaking in that Norway is the first country to produce a separate development strategy with a suite of funded programmes that aim to lay out a coherent approach to addressing NCDs. The Norwegian strategy delineated five specific areas of action: (i) Political mobilization for leadership, investment and action; (ii) Reduction of exposure to risk factors (tobacco, alcohol, polluted air etc.); (iii) Integration of priority services into national Universal Health Coverage (UHC) systems with particular focus on services that can be embedded within primary health care (PHC) platforms

[3] See Annex 2: References

[4] See Annex 3: People interviewed

to ensure equity; (iv) Defining and promoting key global public goods (GPGs) to enhance capacity of all states (with a particular focus on low resource settings) to provide NCD promotion, prevention, management and treatment services; and (v) inclusion of actions to promote and treat mental health.

The strategy sets out the context for the Norwegian approach to NCDs and presents broad areas of engagement and associated objectives. In this way, it is more of a policy document providing broad direction, promoting multiple goals, objectives, and thematic priorities rather than an operational strategy. Hence, the following step was for Norad to draw up a proposal for a development programme in accordance with the recommendations in the strategy. The Global Health section within Norad held consultations with the Ministry of Health and Care Services, the Norwegian Directorate of Health, Norwegian Institute of Public Health, several departments in WHO and other international partners. A review of countries for potential partnership in implementing a NCD programme was carried out[5]. Four selection criteria were used to filter ideas and to determine concrete programming options: Burden of disease, institutional capacity, health care financing and partner landscape. After considering political factors, several countries were suggested for closer engagement: Ethiopia, Ghana, Tanzania/Zanzibar, Nepal and Myanmar[6] in Asia and Palestine in the Middle East.

A two-phased approach

The outcome of these consultations and assessments was a proposed financial commitment of NOK 1.2 billion over five years increasing year on year by NOK 50 million from a base of NOK 140 million in 2020. This has since been substantially reduced as a result of political changes in government (see below).

At inception, a two-phase approach was suggested**. Phase one** (2020-2022) was planned to provide support through existing partners for both global and country level action. WHO should be the main partner and receive 80% or NOK 112 million of the available funding while 20% is for other partners and CSOs. After the mid-term review in 2022, **Phase two** anticipated the possibility to expand and incorporate other partners. It was also encouraged to draw on Norwegian expertise to build capacity in partner countries such as the Universities of Bergen (Bergen Centre for Ethics and Priority Setting) and Oslo (Health Information Systems Programme) and Norwegian Institute of Public Health. The strategy further anticipated that Norway would increase support to national procurement systems, support Norwegian and international civil society organisations including the NCD Alliance – a global advocacy organization – and support research through the new GLOBVAC (through the Norwegian Research Council) and WHO (Alliance for Health Policy and Systems Research). Other areas were suggested for inclusion including NCDs in humanitarian aid, air pollution, polluting cookstoves and climate initiatives.

The phased approach while more detailed than the strategy, was still not a programme plan with in-depth presentation of key components (and their NCD relevance), justification of choice of partners and implementation arrangements, allocation of resources and choice of M&E systems. Such information can partly be gathered from internal memos and presentations of the NCD portfolio, but there is no single document providing a consolidated overview (and justification) of the NCD portfolio making it hard to assess the value and overall composition of the portfolio. On the other hand, elaborate plans exist for most of the individual/ specific interventions.

[5] Davis, Austen (April 2020). Reviewing Countries for Potential Partnership in Implementing Action Against Non-Communicable diseases. Norad.

[6] Due to political problems, state to state aid has been frozen

The NCD Activity Framework: Five portfolio groups

In practice, activities funded through the Norway NCD portfolio budget fall more or less into the five distinct groups of work anticipated by the MFA Memo (Table 1). The first, led by the MFA, focuses on efforts to strengthen leadership around and broader commitment to combating NCDs in low- and middle-income countries (high-level meetings advancing global leadership). The four other groups consist of development activities, led by Norad, and include (1) A wide range of investments primarily focused on Pathways to Care (WHO), health systems strengthening including a market-shaping mechanism to strengthen access to affordable medicine and research, (2) A specific focus on Mental health systems development and investments to tackle substance abuse including a WHO led special initiative and (3) Technical assistance, research and advocacy on health taxes and duties on harmful products led by the World Bank, but engaging also other partners, (4) Support to and through civil society. Within most of these groups, Norway funds various activities or partners. The framework (shown in Table 1) will be used in this review to help structure findings and to discuss results.

Table 1: Framework of the Norwegian NCDs Development Programme

Group 1	Group 2	Group 3	Group 4	Group 5
MFA-led political, advocacy and leadership activities	Pathways to Care, Health systems strengthening (HSS) investments including access to affordable medicines and research.	Mental health, substance abuse, the special initiative and the SAFER programme	Health taxes and duties on alcohol, tobacco and other goods.	CSO-led community activities.

Budget

The best overview of the programme portfolio can be found in the budget. Norad decided to organize the interventions under four different categories and fourteen projects or funding streams with identification of partners and allocation of budgets. The budget does not align with the five groups suggested in the table above which is understandable for Group 1 since there is no budget for MFA led political and leadership activities.

The budget is a working document and regularly updated. The following is a summary based on the most current information from Norad (in NOK millions).

Table 2: NCD programme budget

Priority areas	Partners	2020	2021	2022	2023	2024	Total
Primary prevention	WHO/WB/NCDA	70	34	29	29	29	191 (27%)
Mental health	WHO/CSOs	24	35,5	40	20	20	139,5 (19%)
Treatment & secondary prevention	WHO/UIB/UIO/FHI	46	70,5	55,96	56,68	51,1	280,24 (37%)
Global public goods	GLOBVAC/WHO/ PharmAccess	0	17,1	33	33	33	116,1 (17%)
Total		140	157,1	157,96	138,68	133,1	746,84

The total budget for five years (2020-2024) is NOK 746,84 million (USD 70,5 million) and an average of NOK 186,7 million per year – as opposed to the expected much higher budget. The third priority area (Treatment and Secondary Prevention) absorbs 37% of the resources, primary prevention 27%, mental health 19% and global public goods 17%.

The largest share of funding (NOK 475 million) is allocated to WHO amounting to 62% of the total. Norwegian public institutions (UiB/UiO, FHI) take NOK 94.24 million (12%), civil society NOK 27 million or 3,5% divided between NCDA (NOK 24 million) and Norwegian CSOs (NOK3 million). The new GLOBVAC (Norwegian Research Council) is allocated NOK 40 million. In conclusion:

- WHO is the main recipient with 62% of the budget, but less than the intended 80%. Two programmes - WHO´s Special Initiative on Mental Health and WHO's Pathways to Care are the two largest programmes (NOK 104 million and NOK 207 million respectively).
- Norwegian Universities (Oslo and Bergen) and FHI are active partners in selected countries with links to WHO programmes.
- Research accounts for about 5% – NOK 40 million – allocated through GLOBVAC (Norwegian Research Council) and "softly" earmarked for NCD relevant research, but information is not available on the number and types of research projects funded. About NOK 1 million goes to the Alliance for Health Policy and Systems Research.
- Civil society is a minor player within the programme and particularly Norwegian CSOs.
- With the current budget, it is not feasible to determine how much goes to global versus country level activities as country budgets are not earmarked.
- The budget is not all-inclusive of Norwegian support to NCDs such as MFA´s work on/support to global leadership, comprehensive work on tobacco (FCTC), Norad´s work on pollution and climate and so on. Inevitably, there are a range of Norwegian investments that affect NCDs but are not included explicitly in the NCD programme.
- Soft earmarking has been the main mode of funding and Norad has been commended for such flexible funding.
- The relative (financial) importance of Norwegian support for each project has not been possible to estimate, but people interviewed (in particular from WHO) made it clear that Norway was the major and, in some cases, the only donor. As such, important gaps are filled, but people interviewed mentioned that some projects/initiatives had become vulnerable and dependent on one donor´s long-term support.

Portfolio management

Given its diversity of actions, a programme to tackle NCDs requires a strong narrative and clear line of sight between the selected areas of focus and the ultimate result (impact on NCDs). This section aims to gather the findings needed to answer the question on whether and to what extent there is a coherent NCD programme portfolio. The current NCD portfolio is composed of multiple independent partners and projects linked together by a common theme.

Norad has prepared a guide to portfolio management[7] defining a portfolio as, *"a collection of efforts which in combination shall contribute to the same development goals".* Based on appropriate background knowledge, clear objectives and solid theories of change, a portfolio should consist of the most relevant and complementary efforts and partners to achieve similar objectives. The assumptions are that all interventions

[7] Norad (2022). Veileder for porteføljestyring.

support a similar set of objectives, are underpinned by the same theory of change and that it is feasible to measure and report on "*aggregate effects of the portfolio*".

Tackling NCDs as a health and development issue is an exceptionally broad challenge and requires interventions across a very wide ambit both within and beyond the health sector. Within the Norway NCD portfolio, the partners and projects are all NCD relevant, but they cannot be amalgamated into an aggregated or even unified set of results as they include behavioural, preventive, promotive, diagnostic and treatment activities that each play out with different actors, in different locations, and with different types of results. This makes it difficult to assess any kind of aggregate results.

Portfolio management is pragmatically overseen by Norad´s Global Health Section as a planning tool to assemble an appropriate mix of partners and projects with complementary profiles (primary prevention, mental health, secondary prevention and treatment and global public goods) and operational levels (global and country) that together make progress on several NCD-related fronts. There are also interlinkages between thematic priorities, projects and partners such as for instance the synergy between University of Bergen´s work and WHO Pathway for Care in priority setting and development of NCD indicators at country level. Finally, several of the programmes operate in the same target countries.

Summary of observations and comments

- Norway was the first country to produce a separate development strategy to address NCDs in low- and middle-income countries. The strategy is largely a policy document with a set of priorities for initial focus. The strategy provides the context and justification, guiding priorities and principles for Norwegian NCD support and makes the case for investment very clearly and in a visionary way.
- The current political status of the strategy is uncertain (given the change in government)[8]. Although the NCD development programme continues to be funded and delivered, a long-term policy/ political perspective is missing.
- The first objective was to strengthen Norway leadership and engagement of other actors including WHO and other bilateral donors. While there is evidence that the MFA continues to talk about NCDs and takes advantage of opportunities to advance NCDs, there is a sense gathered from most key informants that Norway could be more active in vocalising support, convening critical partners, encouraging others to fund and deliver NCD programmes and step up the urgency of the response[9].
- The NCD development programme was developed in consultations with Norwegian and international partners and assessment of needs and opportunities. The first phase was prepared as a continuation/expansion of work through existing partners, but with new initiatives/interventions. Norad has been responsible for planning and implementation of the development programme. The MFA has found opportunities to pursue advocacy and political reinforcement of the broad NCD programme goals despite a lower level of ministerial commitment than originally forecast when the NCD programme was initially conceived. The pursuit of NCD objectives is couched more explicitly in terms of health systems strengthening and, in the wake of COVID-19 (around which Norway has taken a global leadership role – for example, to lead the ACT-A), the links and synergies between health security, NCDs and pandemic preparedness have been clearly made.
- The programme has multiple broad priorities and objectives based on the MFA decision document (July 2020) – which also suggests including other priorities such as NCDs in the humanitarian field, education,

[8] It was characterised as «inactive» by one informant.

[9] MFA used to have a dedicated person for the political leadership area, but not any longer.

air pollution and climate. It has a broad and expansive scope enabling it to act and take strategic decisions over the coming years.

- The current programme is not synthesised in a single narrative document making it difficult to get an overview and assess its overall relevance, coherence, synergies and complementarities.
- The original level of funding was cut by a new government with less focus on NCDs so the original NOK 1.2 billion for 2020 to 2024 has not been maintained. The expected level of funding for 2023 is NOK 138,68 million and NOK 133,1 million for 2024. Funding beyond 2024 is uncertain.
- There are clear synergies between interventions aimed to support NCD prevention, diagnosis and treatment, the various thematic areas covered (e.g., between alcohol reduction or the SAFER programme and health taxes), the distribution of global vs country level support (e.g., mental health in WHO HQ and in Ghana and Nepal) and other aspects. However, while the synergies are there, the organisational fragmentation within WHO and lack of overarching coordination and leadership (either in WHO or elsewhere) has a negative effect on realising these.
- Investments in NCD relevant research (GLOBVAC) are not yet specified. Hence, the role and significance of research (GLOBVAC) as a source of providing evidence for the NCD portfolio is not yet possible to assess. However, there are research components in other programmes contributing to NCD evidence generation.
- The development programme and its associated budget does not contain or reflect all relevant NCD activities irrespective of source of funding, e.g., support to other NCD programmes in WHO such as tobacco control, air pollution, food security and political advocacy (MFA). This is inevitable to some extent. What can be drawn from this though is that the Norway NCD strategy could include many more active investments than the Norway NCD development programme currently funds.

2.2 THEORY OF CHANGE

This section aims to assess the extent to which extent the Theory of Change (TOC) makes sense as a guiding tool to shape Norway's on-going response to NCDs. The evolution of Norad´s NCD TOC is a little convoluted and unclear. A draft TOC was first prepared by an external consultant[10] and delivered to Norad with a recommendation that such an externally developed TOC should be 'domesticated' and further adapted to ensure it was fit for purpose. A significantly different TOC appears in a PowerPoint presentation of the NCD portfolio[11], but only in Norwegian. The comments below are based on this latter version. The TOC is relatively brief and suggests three levels of progression as laid out in Box 1.

The TOC says basically that four outputs (cross sectoral efforts, improved policy and systems, improved capacity and global public goods) will contribute to wider understanding, improved prevention, and better treatment of NCDs that - eventually - will reduce mortality from NCDs by one third. The TOC does not explicitly elaborate the links among the outputs themselves (with each other for example) or delineate their relative (individual or collective) contribution to the two outcomes. It also does not incorporate any elements related to partnerships, strengthening leadership, or political economy analysis and decision-making. However, the outputs and outcomes imply significant multiplier effects from investments and are visionary in their scope in that they anticipate actions well beyond the health sector.

[10] Hera (December 2020), A Theory of Change for the Norwegian Strategy for Combatting Non-Communicable Diseases. Draft.

[11] Norad (July 2022).

Box 1: The current Norway NCD Programme Theory of Change

1. ***Norway will invest NOK 1.2 billion over five years to deliver five outputs:***
   - (a) Intersectoral integration of NCDs.
   - (b) Policy and regulation of harmful factors for health introduced and standards for treatment and protocols developed.
   - (c) Mapping of NCDs burden of disease reflected in national plans, strategies and financing mechanisms.
   - (d) Improved competence and implementation capacity for NCDs and mental health.
   - (e) Global market mechanism for access to NCD medicines, equipment and products.
2. ***Which will, in turn, contribute to two top line outcomes:***
   - (a) **Preventing NCDs**: Reduced NCD risk factors (tobacco, alcohol, malnutrition, air pollution, mental health).
   - (b) **Diagnosis and treatment of NCDs**: Universal access to integrated NCD services of high quality in primary health care.
3. ***In order to drive an overarching result/ impact:***

   Reduce mortality from NCDs by one third in low- and middle-income countries.
4. *And bearing in mind four **assumptions:***
   - (a) Basic system capacity is present and functional
   - (b) Cross sectoral leadership and cooperation fully engaged
   - (c) Sustainable funding is guaranteed
   - (d) Institutional and physical infrastructure is present and maintained

Summary of observations and comments on the ToC

The TOC is laid out at a high level of abstraction, and this does carry risks. For example, the causal pathways between improved policies and capacity, public goods and explicit priorities on the one hand and improved prevention and better treatment on the other are complex and not particularly obvious or visible. The TOC does not, in itself, help with decision-making or guide policy shaping as much as a more detailed version might. It will also be difficult to validate the TOC in programme review processes because the relative weight of the components and their inter-linkages are not shown. There is scope to develop a more detailed TOC in due course – perhaps at the next decision point – to combine the two Theories of Change in ways that would enable and support programme leadership, design and delivery (see conclusions and recommendations).

2.3 SELECTION OF PARTNERS

Partner Country Selection

Norad assessed partner countries and recommended further investments in the following countries: Ethiopia, Ghana, Tanzania/Zanzibar, Nepal and Myanmar[12]. The countries were chosen because they had a high burden of NCDs – low institutional capacity and levels of domestic health financing.

Several of the programmes funded through the Norad portfolio also work with specific countries and these both overlap but go beyond Norad partner countries. For example, the Alliance for Health Research and Systems Strengthening works on taxes in eight countries: Peru, Ghana, Ethiopia, Bangladesh, Pakistan, Nepal, Malaysia and Indonesia. The health tax work includes Ghana and Nepal, but also extends to a range of countries in Eastern Europe, Central Asia and South America. The same is true for the Pathways of Care and Mental Health programmes. The work in countries is essential to building knowledge about what works where and for supporting country engagement. It also supports advocacy. However, it is inevitably somewhat opportunistic and depends on meaningful partnerships and country interests. For Norway, this way of focusing support on global public goods is a valuable means to reach more countries and broaden experience working on NCDs in a range of environments.

Implementing Partners

At global and country level Norad has aimed to work with partners across a range of functions and to meet specific objectives:

- **WHO** – to recommend policy actions according to global norms and standards, lead the verification of protocols of treatment, support country strategic processes and investigate feasibility of treatment options, strengthen health systems and expand access to basic services, and advocate for wide-ranging intersectoral activities to address the five common risk factors for NCDs. See Box 2 on Norway's partnership with WHO.
- **University of Bergen** – to work in partnership with WHO to support MoHs to make recommendations on priorities for NCD prevention and care – in packages of services that can be equitably financed and delivered and to build government capacity.
- **University of Oslo** – to develop NCD modules for use in national health management information systems (HMIS) to increase availability of quality data for decision making and health system performance management.
- **Norwegian Institute of Public Health** – to support institutional development of public health institutes to evaluate risk factors, enhance population level prevention and prioritize NCD issues for action.
- **NCDi Lancet commission** – to partner with University of Bergen in establishing basic packages of care and using integration science to explore how to implement care packages through current platforms of delivery.
- **PharmAccess** – support country authorities to work across public and private sectors to research consumer behaviour, develop instruments to pool finance and develop financing modalities to extend quality care to the maximum numbers of citizens.
- The **World Bank** – to host a health tax window with the Global Tax Trust Fund that supports policy development around taxation on tobacco, alcohol and other substances that create risks for NCDs. Norway invests in this window jointly with Bloomberg Philanthropies.
- The **Alliance for Health Policy and Systems Research (AHPSR)** - conduct research to support knowledge around the implementation of health taxes in a suite of countries

[12] Because of the political conditions in Myanmar state to state aid has been frozen.

- **GLOBVAC** – to initiate research through the Norwegian Research Council to provide relevant evidence for the NCD portfolio.
- **Civil society** – to support advocacy and country activities – in particular at community level. [13]

Using the same portfolio groups suggested in Chapter 2.1 the following picture emerges:

Table 3: Partners attached to each portfolio group

Group 1: MFA led political dialogue and leadership (including the Prime Minister and other high level political leaders)	Group 2: Pathways to care and health systems investments including access to affordable medicines and health research	Group 3: Mental health and substance abuse	Group 4: Health taxes and excise duties	Group 5: Support through CSOs
MFA interacting with bilateral and multilateral governments in various contexts and fora including UNGA, the G7/ G20/ EU and other settings	WHO – various departments including, Environment, Prevention and Promotion, NCDs, UHC across the life course. UiB, UiO, FHI GLOBVAC	WHO – Department of Mental Health and Substance Abuse and FHI	World Bank WHO-hosted Alliance for Health Policy and Systems Research Bloomberg Foundation	NCDA FORUT Digni HimalPartner

It was observed that many of the partners selected for the NCD programme were already known to Norway and were engaged already in delivering with Norwegian funding support. For example, the Alliance for Health Policy and Systems Research was already undertaking research work with a small Norad grant; Norway had already been funding alcohol awareness and health-related issues intermittently over several years according to key informants before the current stepped up investment. Building on previous investments and extending work that was already underway in new ways seems to be a feature of the Norway portfolio and a risk management strategy especially given the hands-off approach adopted to programme oversight (a feature that was particularly valued by key informants).

Box 2: The Norway Partnership with WHO

Within the NCD portfolio, WHO is the main partner. At this stage of programme implementation, the grant from Norway accounts for 62% of funding. The partnership with Norway supports countries to expand and deepen global normative guidance and policies, including research to support knowledge building, and to work in close partnership with countries to 'domesticate' global guidance. The support is broad in scope, but embraces two major programmes - the Pathways to Care and the Special Initiative for Mental Health and is founded on the strong orientation of the portfolio towards health systems strengthening (HSS).

The Pathways to Care programme aims to help countries systematise levels of NCD care, starting with self-care and community health services, up through primary, secondary and referral services. It supports countries to delineate roles and responsibilities clearly and lay out standards of care required to address health needs.

[13] NCDA is the only partner funded from the NCD allocation. The other CSOs have a framework agreement and received additional "one time" support to strengthen ongoing activities in 2021.

In a similar vein, the Special Initiative focuses on helping countries strengthen systems for mental health services, often in a context where there is limited provision. In addition, Norway support has enabled WHO to develop a landmark global publication on the state of mental health, together with more systematic policy guidance on mental health services.

Across the evidence collected, key informants identified Norway's vision in supporting under-developed areas of policy, its flexible funding approach and the use of soft earmarking as major strengths. Soft earmarking - where Norway agrees the distribution of its voluntary contributions to WHO - has meant that, for example, the mental health department has been awarded more funding than it would otherwise expect through the routine WHO biennial budget round. The funds are flexible enough to allow the department to allocate them as they see fit and this 'vote of confidence' from Norway is also much appreciated. Indeed, the funding from Norway is the largest, but also the most flexible that the whole mental health department has and is highly valued. Key informants also pointed out that among bilaterals raising attention to mental health, few had put increased funding behind their words. Norway stands out on this level as well and is considered a (if not the) global leader in development support for NCDs. Related to this, Norway's approach to joint planning with WHO, regular deep dive meetings, and structured discussions are critical to signalling interest, sustaining political commitment, and strengthening WHO accountability on NCD work. Norway carries significant influence in WHO in relation to shaping a wide spectrum of NCD investments and there was evidence that the coordination of NCD work within WHO is on an upward trajectory.

While there has been broad agreement about the critical role of WHO on NCDs, several common observations have been made by many key informants from across the Norad programme. The first is the limited visible senior leadership that WHO seems to offer on NCDs. There is no senior (Assistant Director General level) NCD champion who speaks frequently on NCDs or is viewed as the NCD lead. The second is that with the WHO reorganisation in 2020, the challenge of addressing NCDs was distributed across multiple departments. The NCD department focuses on many elements, but health prevention and promotion, mental health and addictive substances, research, and other departments are also deeply involved in NCD prevention, detection and care.

Addressing NCDs requires coordination across the organization and the politics of this (for any organisation) usually require a senior leader. The challenge is not necessarily unique to NCDs but does seem to affect NCD coordination according to multiple key informants. The seniority level of the NCD Director is the same as other department directors (for example, Mental Health and Addictive Substances, or Health Prevention and Promotion). From an institutional culture perspective, directors at the same level usually require someone in a more senior position to coordinate them. A further point in this regard is that while the Norway strategy and programme is articulate about the role and importance of health systems strengthening (and UHC) for developing a long-term sustainable response to NCDs, the links within WHO are not as apparent at least in practice.

Some key informants were also vocal about the potential role Norway could play in encouraging (even compelling) NCD related departments across WHO to work constructively together and to forge a common strategy and workplan. The WHO organogram is due to be re-organised again and the issue of NCD leadership may be addressed then.

A final - related - point raised by many WHO key informants is that while the support from Norway is highly valued, they are aware there is a risk to future continuity if Norway priorities change in a context where funding diversity has not increased. There are some promising indications that new donors may be moving to support some of the programmes Norway has been funding. This is further discussed in the conclusions below.

Summary of observations and comments

- WHO is Norway's primary NCD partner and the recipient of 62% of all funds. WHO´s Special Initiative on Mental Health and its feasible Pathways of Care are the two largest programmes (NOK 104 million and NOK 207 million respectively).
- Most informants agreed that WHO should be the major player in the first phase of the programme but encouraged future inclusion of additional partners in the next phase or at least more advocacy from Norway to support resource mobilisation from a broader base of bilateral and other partners.

- Norway's soft ear-marking and flexible funding approach is valued greatly by partners while the regular deep dive meetings and structured partnership with WHO helps sustain commitment and active engagement across departments within WHO – a necessary feature of any programme that attempts to address NCDs given the extensive range and diversity of risk factors, behaviours, metabolic issues, and diseases collected together under the NCD umbrella.
- WHO, being a UN specialised agency, has the global mandate to adopt and approve health-related norms and standards for NCD prevention, detection, treatment and care at the global level. Its capacity and performance in countries is variable, however. An evaluation of WHO´s normative role found inconsistent results: *"All the normative products studied provide evidence of results, but results are also exceptionally varied. With few independent evaluations available, the documentation of results depends mostly on internal reviews and self-reporting"*.[14] Results refer here to the adoption and incorporation of norms and guidelines into national policies and ultimately their influence on health outcomes. In other words, the translation and application of normative work to live programmes on the ground in different countries [15].
- Norwegian public partners play different complementary roles in selected countries. The University of Oslo (HISP/Department of Informatics) makes a small, but valuable contribution in preparing an NCD module for national health information systems (to improve access/quality of NCD data). The Bergen Centre for Ethics and Priority Setting in Health is linked with WHO and aims to strengthen country capacity for NCD priority setting and making recommendations on policy options for NCD integration in the UHC/national health benefit packages. Norwegian Institute of Public Health supports a broad programme for strengthening public health institutes and capacity building on prioritized NCD actions under the programme (BIS), which is only partly funded from the NCD budget.
- The Centre for Ethics and Priority Setting (UiB) and Norwegian Institute of Public Health have experienced delays in implementation of country activities so it is premature to assess their performance.
- The lack of country coordination and management capacity was mentioned as an issue by Norwegian partners. There are two aspects to this. One is for all Norad funded organisations to coordinate with each other which makes a lot of sense, but the other and broader level of coordination is with country systems and health authorities. In discussing alternatives for strengthening such capacity, ideas include working through Norwegian embassies, WHO country offices or expatriate technical support. Norwegian embassies are informed about the programme (and want to be informed) but generally do not play any active role. WHO country offices have different set-ups and variable capacity across countries. Using short- or long-term expatriates as part of "twinning" arrangements is a possibility (partly used by FHI), but it is an expensive model with a variable track record[16]. However, it is important to recognise that this global level review has not been able to assess with much precision what level of in-country coordination would be most effective at this early stage of programme implementation. There is neither a "one size fit all" solution for all countries. A specific approach should be worked out country by country depending on capacity and opportunities.
- The minor involvement of civil society is striking. NCDA plays an important role in global advocacy, regional/national capacity development, and networking. NCDA receives long-term core support from

[14] Kruse, Stein-Erik (2017). Normative Function (Volume 1: Evaluation Report) Corporate evaluation commissioned by the WHO Evaluation Office.

[15] WHO Country Offices plays a role in country level coordination, providing technical advice, leading dialogues with MOH/ partners and introducing normative products while implementation depends on country and partner capacity.

[16] https://www.norad.no/contentassets/fb8698c4e5b1449c81d0328a99c28813/evaluation-of-norwegian-support-to-capacity-development.pdf

the programme[17]. However, the budget for Norwegian CSOs is minimal. In 2021, FORUT, Himal Partner and DIGNI were invited to build on their existing mental health programmes in Nepal, originally over a four-year period. Due to budget restrictions, the expanded programmes did not materialize as envisaged by the CSOs involved.[18]

- Reviewing the scope of partners, it appears that the majority are producers of knowledge (norms, standards, policies, research, etc.)[19] primarily supporting and influencing the enabling environment required to deliver and sustain quality NCD interventions both at global and country level. It has not been feasible yet to analyse the overall balance between global and country investments[20].
- The partners assessed and their respective programmes are relevant and make useful contributions. However, while WHO is the primary recipient, its mandate to address the social and economic determinants of health is limited. The Norway investment in health taxes addresses this limitation to some extent (see results).

2.4 RESULTS

This section reviews results achieved so far. Given the early stage of the programme, there are limitations in what can be expected of impact level results. The review has also been more preoccupied with the relevance and focus of the portfolio than with results. The questions specifically asked in relation to results are around: (a) Whether expected outcomes are realistic and causal pathways well explained with specifics for this portfolio (and not just at a generic/general level); (b) The likely measurability of results at outcome and impact level; (c) Whether expected results and indicators of performance are clearly defined; and (d) The level of progress in countries (Ghana and Nepal)? The first two questions are already discussed in chapter 2.2.

An observation on reporting

In a new area of work, it takes time to put a team in place, lay out strategy and planning, scale up programming and build appropriate partnerships for implementation. The first annual reports will start to flow at the end of 2022 but even then, expectations should be cautious. It is notable that the number of progress reports from partners and projects are few, and updates from programmes - for example, the Special Initiative for Mental Health – are brief. For the Pathway to Care programme, there is no overall/consolidated report available that reflects the early programme results nor from UiB, UiO, FHI and GLOBVAC. However, this should be coming in later this year. As the programme is completing its second year and only its first year significantly free of Covid-19 restrictions, the available results are expected to be limited.

Norad´s requirements for formal or written reporting have also been modest with the intention not to burden partners by adding new layers of reporting. This is much appreciated by partners. The level of feedback from meetings and consultations is more comprehensive and through the regular meetings and six monthly (bi-annual) updates, Norad is able to gather enough data for overall programme monitoring. However, it is difficult to assess progress in an objective and data-rich way as it stands currently.

[17] See Kruse, Stein-Erik (2020). Partner Assessment NCD Alliance. Hera.

[18] Westborg Steel, Heidi (januar 2022). Psykisk helsevern i utviklingsland – en mulighet som glipper? Bistandsaktuelt. https://www.bistandsaktuelt.no/helse-nepal/psykisk-helsevern-i-utviklingsland-en-mulighet-som-glipper/291995

[19] It has not been feasible within the scope of this review, to quantify the balance between normative work/advocacy/capacity development/research/service provision in the programme.

[20] The balance global/countries is 75/25% for the Pathway of Care programme.

The extent to which more detailed or routine monitoring is needed may become more evident after at least two years of implementation, but a stronger formalization of the reporting process and products would likely be required for more rigorous accountability. As other donors join some parts of the programme, they may also require more structured results monitoring as well. A further point is that as many aspects of Norway's NCD portfolio support are new, it is particularly important to ensure that reporting supports lesson learning and communication around how development partners can support the NCD response. Despite the early phase of the programme however, there are aspects of the emerging results that can be tentatively assessed.

Project and programme progress

The Norad portfolio is interconnected and mutually reinforcing. As previously identified, the TOR did not include an evaluation of each project individually or an assessment of specific partners. To make some observations on emerging results, programmes/projects have been grouped and discussed using the portfolio framework.

Results by Portfolio Group

Group 1: Political leadership

This is the MFA arena. A prime example of what has happened is the Global Strategic Dialogue on NCDs and SDGs in Accra April 2022 – with the aim to accelerate the national response to NCDs. The dialogue included remarks by the President of Ghana, and the Prime Ministers of Norway, Thailand, Timor-Leste, and Barbados, and WHO Director General. The outcomes of the meeting included the Global NCD Compact 2020-2030 and the Global Group of Heads of State and Government for the Prevention and Control of NCDs (NCD Presidential Group). The UNGA event September 2022 included the first meeting of the NCD Presidential Group, with continued engagement with Heads of State and Governments.

Almost without exception, key informants identified that the role of the Norway government in raising the profile of NCDs has been highly valuable and an important contribution to advancing the NCD agenda.

However, there is no overview of activities covering this thematic area as they are opportunistic in nature and by necessity, are developed and prioritised in the context of other government development and health priorities (currently including, among others, health systems strengthening, nutrition security and climate change mitigation and adaptation, all of which intersect with NCDs). Currently, there is no plan for activities to be prioritized through 2022-24.

In terms of the policy agenda, the MFA explained that NCDs is one of several priorities and not among the highest of the current government. The previous Minister of Development Cooperation (and the previous government) had a special interest in promoting and advocating around NCDs. As a government policy priority, NCDs were intended to be promoted and show-cased across a range of departments matched with a proactive and structured communication plan. A dedicated person was appointed to take the lead on NCDs in the MFA and this led to stronger momentum across the government. Nonetheless, the current government has recognised the prevalence of NCDs and their intersection with the COVID 19 pandemic. There is also a clear commitment to health systems strengthening. The approach to amplifying NCDs through a commitment to UHC and health systems was well articulated by key informants. Norway's contribution as a global leader in helping identify pathways to addressing NCDs has been preserved and through successful delivery, could be significantly enhanced.

Group 2: Pathways of Care programme, health systems investments and health research

WHO - Pathways to Care

The scaling up and scaling out of cost-effective NCD services in low and middle-income countries (LMICs) requires a people-centred, whole-of-system and whole-of-society approach. Core health system functions need to be strengthened, with a focus on PHC, to maximize population health and respond to the NCD burden

through priority setting, translating priorities into strategic and operational plans for the health sector and national and sub-national implementation. Current and ongoing activities in this programme are being implemented in Ethiopia, Ghana, Myanmar and Nepal.

This is a comprehensive programme with a broad package of activities, including:

- Improved data and reporting on NCD for prevalence and quality management
- HSS research into critical NCD priorities and delivery challenges
- Priority setting for NCDs within national UHC programmes
- Development of integrated pathways of care for basic NCD services with a focus on PHC
- Partnerships with the private sector
- Adapting national EML and procurement practice to enable NCD services
- Health Taxes/Regulations (also discussed separately in result group 4)
- Pre-qualification of NCD essential medicine
- Mental Health (also discussed separately in result group 3)

The Pathways to Care approach is gaining traction as it tries to link across different health areas (maternal and childcare, NCDs, etc.) from a systems perspective. One of the challenges for NCDs is to develop manageable, realistic but useful pathways of care given the number of diseases, range of risk factors, chronicity etc. starting with self-care (an extremely relevant concept for NCDs that is expanding in scope since COVID-19) and including community health services delivered within a quality primary healthcare approach and supported by appropriate referrals.

As mentioned, progress and results from each intervention group and priority country are not summarized, but a few comments from Ghana and Nepal are included in the section on Country progress and some remarks on the overall approach in the conclusions. Procurement of essential medicines for NCDs was reported by key informants to be a major challenge for a range of reasons including the shift by practitioners and patients alike to funding, prescribing and correctly taking chronic medication (as opposed to short courses of acute medication), the challenge of maintaining stock and the broader costs of medicines on the global market.

The team has not been able to access data and information on to the extent to which the call for proposals from GLOBVAC prioritized NCD relevant research, number of approved applications, research grants awarded in what thematic areas and progress in implementation.

Other partners:

University of Oslo (HISP)

"Deepening use of DHIS 2 in countries for wider health systems functions" (2021-2024). Integrated NCD programming requires that NCD health indicators are included in national health information systems – also necessary for programme monitoring and review processes. This is a small output, and it is progressing well.

Bergen Centre for Ethics and Priority Setting

"Defining and integrating essential NCD interventions in national health systems 2022 – 2025". Continuation of work on building capacity on national priority setting processes in health. Expanding this work to focus on more comprehensive packages including NCDs (in line with epidemiological trends in countries). Its main focus is training of Master and PhD students from partners countries in Bergen to later lead capacity development in countries. Research outputs are expected to influence policy recommendations in relevant countries.

An agreement was reached last year. There have been delays in implementation. The programme is more established as in Ethiopia – because of previous experience and partners. There is a need to establish networks and partnerships in remaining countries. It is well linked with WHO.

Significant potential for results, but the causal pathways from capacity development to production of new knowledge, acceptance by decision makers and ultimate incorporation in health policies and plans are long and complex.

Norwegian Institute of Public Health Institute

«Building Stronger Public Health Institutions and Systems». The goal is: *"BIS shall contribute to more competent and resilient public health systems underpinned by strong public health institutions in LMICs".* The objectives are: (a) Stronger national public health institutions and systems in 6 countries, (b) Capacity built for public health in priority areas in infectious and NCDs and (c) Global and regional public health networks better able to support LMICs. Collaborating countries are Ghana, Malawi, Palestine, Ethiopia, Nepal, Uganda, Global and regional collaboration, WHO, Africa CDC, IANPHI (International Association of National Public Health Institutions).

Strong public institutes are important for system strengthening underpinning NCD programmes. National public health institutions can also play an important role in NCD prevention and management, but there are risks: Unrealistic expectations, insufficient time and resources, too little funding for cross-cutting issues, limited opportunity/capacity to manage and control all projects and a too broad programme. Implementation has been constrained by COVID-19. Only 37% of the BIS budget is covered by the NCD budget.

Group 3: Mental Health, Substance abuse and SAFER

Norway investments in mental health have created a steep change in WHO's ability to enable countries to build appropriate systems and respond to expanding challenges. WHO has used the flexible funding from the Norway NCD programme to invest in global knowledge, policy and strategies and to support a handful of interested partner countries to path-find around mental health systems strengthening. While the majority of funding supports country results, some funds are used to strengthen and deliver global and regional results to improve mental health systems and outcomes across all countries.

Global knowledge, policies and strategies

Progress towards concrete results at global level can be partially summarised in concrete terms. For example, with Norwegian funds, the WHO has published a landmark global mental health report - the first in decades - which summarises evidence and the state of mental health globally and lays out a global agenda. Given the rise of mental health as a priority on the global agenda, particularly in the wake of COVID-19, this report could play a critical role in enabling bilateral and other funders/ partners to identify whether and how to contribute to addressing the widely acknowledged mental health crisis. Norway funding has also enabled the Department of Mental Health to develop clinical guidelines (that support all countries) and to do some research on key clinical areas like the appropriate use of antidepressants.

Linking the global to countries

Some of the results are twin tracked in nature. There is evidence of global level strategy and policy results, but then there is also evidence that having created the global policy, WHO is shifting its focus to country level to support countries to develop and implement appropriate programmes drawing on global guidance. An example is the SAFER initiative which has identified the critical investments linked to alcohol as a NCD risk factor and is supporting countries to address these in locally suitable ways. Norwegian NCD funding to the SAFER initiative has accelerated and expanded its reach. The SAFER initiative is also developing investment cases for alcohol control and Norway funding has been used to secure the necessary scientific

investment and research; a Sheffield based consultancy will do the data analysis to calibrate the investment case while WHO works in parallel with a couple of countries.

Country level mental health systems strengthening

Although previously each of the four mental health units in the WHO department of mental health[21] worked with partner countries on small scale programmes especially focused on specific themes (for example, mental health in emergencies), nothing looked at the whole system or helped countries think through their approach to designing and implementing a holistic mental health system.

The longer term, flexible Norway funds have enabled WHO to launch the Special Initiative for Mental Health[22] with the aim of creating access for 100 million more people primarily through systems building (rather than direct service provision). This emphasis is a departure from most bilaterals. The work is in the early stages but is progressing well according to WHO key informants because the support is not tied to specific targets related to counting numbers of people reached. Rather, the funds enable each country to assess, modify and build their systems recognising that for each country, their starting point and challenges will be different.

The support also enables WHO to support countries to put in place a monitoring and evaluation system which for mental health is quite complex. The two-pronged approach measures the total number of people with access to basic mental health services and the treatment coverage of basic conditions.

So far, among the eight countries that WHO has started working in, it has taken a year and a half to do the baselines alone. This is because typically countries don't measure mental health systematically and they often don't even have a nationally agreed definition of the conditions. WHO has explained they could have done this baseline work with consultants much more quickly, but that would have avoided the main point, which is engaging the MOH, strengthening understanding, commitment and capacity building. WHO key informants identified the synergies already emerging from this work; the President of Argentina has now asked to join the initiative while World Vision, an international NGO, has approached WHO on behalf of Romania. Countries are asking to join the initiative as they see the value.

The results of just this aspect of the intervention have been notable. For example, in Philippines and Nepal the process of developing the baseline has led to changing their health information systems to capture data routinely (a systems transformative result). In Zimbabwe, using the MOH is using smart phones and tablets for the first time to do the data collection (for mental health) and the system will be digital right from the start.

While this is an implementation project - it is oriented around transforming health systems. WHO key informants identify that many countries are interested in learning from the experiences. Additional research support could be useful and in particular research on implementation. The Special Initiative held a deep dive meeting in September 2022 to review progress to date.

Group 4: Health Taxes

Health taxes are excise taxes imposed on products that have a negative public health impact (e.g., taxes on tobacco, alcohol, sugar-sweetened beverages). Often referred to as 'sin taxes', they use principles of behavioural economics to shape individual choices and behaviour and result in healthier populations. They also generate additional revenues which can be applied directly to fund the health services or put into the general taxation pot. Health taxes have been shown to act on the social and economic determinants of

[21] These four units are human rights, the human brain across the life course, alcohol and substance abuse and addictive behavior and use, and mental health unit (psychological interventions, scale up of assistance etc).

[22] https://www.who.int/initiatives/who-special-initiative-for-mental-health

health as well as to generate revenues for the budget even in challenging tax administration and low-capacity environments. Currently only 12 or 13% of countries implement health tases based on the rate recommended by WHO. Alcohol is among the lowest. Recently, the World Bank has identified increased demand from Ministries of Finance across LMICs for analysis and technical assistance on health tax design and implementation. Norway supports the delivery of technical support, design and implementation research through two main mechanisms**.**

The Health Tax Window hosted within the World Bank's Global Tax Program (GTP)

This window is supported by Bloomberg Philanthropies and Norway. The Window supports two pillars which both work in global and country contexts as opportunity and resources allow:

- Pillar 1: Supporting health tax policy design and administration at country level to channel support to fund technical assistance to country authorities on health taxes and
- Pillar 2: Building Global Knowledge and Networks to enable the program to build internal and external capacity building and networking components, systematise and improve knowledge and strengthen ways of working.

The engagement of Norway in this funding window has already delivered some useful results and has positively affected the scope and breadth of the work undertaken by the window. One example is that whereas the Bloomberg funding enables the window to work on tobacco tax, Norway places no restrictions on scope and the window has thus been able to work on alcohol, sugar and other relevant taxes. The work of the Health Tax Window is just getting started (in its second year) and the World Bank has now put in place a competent team and developed a realistic work plan. The third year of support will be the first year for concrete results in countries therefore making continuity of funding a consideration to building value for money. The Health Tax Window reports out to the larger Global Tax Program partners (about 40 bilaterals in all) which has the added benefit of raising the profile of health taxes and the World Bank's leadership in this area.

On a different level, Norway brings a political network to the Bloomberg-Norway partnership in this area where Bloomberg brings organisational capacity (and resources). This combination facilitates events or activities to support agenda setting or policy focus (for example, events during UNGA, the World Economic Forum, WB Spring and Autumn meetings, the World Health Assembly and others). Broadening support from a wider group of bilateral and other funders is much needed as a risk management strategy.

Implementation Research through the Alliance for Health Policy and Systems Research

Using a small grant that is soft earmarked through the Norwegian funds to WHO, the AHPSR builds on existing Norwegian support to develop the implementation of health taxes in specific countries drawing on the guidance and knowledge generated by the World Bank and others. The programme funded by the NCD grant supports researchers to do political economy analysis and to better understand the barriers and blockages to helping policy makers move health taxation processes forward. The World Bank does the technical design (with the WHO) while the Alliance is looking at how research can help move policies to implementation and support countries to introduce, accelerate or expand health taxes.

Group 5: Civil society engagement

The NCD Alliance is a professional and respected international CSO involved in policy advocacy and regional/national networking. Reports and feedback on performance is positive.

The CSO work in Nepal (mental health) seems to progress well but was as mentioned constrained by the time for implementation which was cut from four years to six months.

Country progress (Ghana and Nepal)

The latest progress report from WHO to Norad (May 2022) on the Special Initiative for Mental Health explains that the initiative is presently active in eight countries: Bangladesh, Ghana, Jordan, Nepal, Paraguay, the Philippines, Ukraine and Zimbabwe. Country work is still in an early phase focusing on data collection and baseline reports; with exception of Ghana who continues consultative design phase activities[23].

By end of 2021, WHO Nepal finalised and received government endorsement for its WHO Special Initiative for Mental Health plans. Activities have been completion of baseline assessments in districts, revision of the Community Mental Health Care Package 2017, holding a workshop with Nepal's Ministry of Education Affairs and Nepal's medical universities, supporting the Ministry of Health and Population to revise recording and reporting tools, and planning and data collection for the National Economic Investment Case for Mental Health in Nepal. In discussions with country stakeholders, it appeared that field implementation had started in 14 districts this year combined with systems strengthening at national and district level. The Special Initiative was very much welcomed including support from Norway, but originally found to focus too much on service strengthening and less on health promotion (aspects of demand). Access to more funds was seen as the most important added value.

As part of the seeing Nepal as a priority country, Norad invited Norwegian CSOs to a four-years investment in the country. Three organisations became involved, but the time for implementation was suddenly cut from four years to six months characterised as a serious "lost opportunity" for reaching out to communities.[24] National CSO could have strengthened local engagement/mobilisation prospects for future sustainability.

Ghana joined the WHO Special Initiative for Mental Health in the latter part of 2021. Their work remains in formative and planning stages according to WHO reports. Activities during the planning phase included data collection and draft reports for a rapid Ghana Mental Health Assessment, hosting of a 3-day design workshop to reach agreement on priorities for the WHO Special Initiative in Ghana, a draft logical framework has been shared. Country stakeholders emphasise that implementation has moved further such as training of health workers, adapting and validating tools for use at local levels. A major constraint has been competing priorities and increase funding to NCDs.

Summary of observations and comments on results

- Results are as expected at a preliminary stage across most of the portfolio. The scale of the Norwegian investment has enabled a set of new problems to be tackled - especially mental health. In some programmes, Norway has added funding to some of its existing investments to enable partners to initiate new work or move established work from global to country levels.
- Whether or not there are concrete, global or country specific results that can be identified, the impact of the NCD portfolio has been significant in terms of supporting dialogue, enabling WHO and other

[23] Project branding and use of names is worth a comment: A PowerPoint presentation (August 2021) presents «Norway NCD Flagship Initiative in Ghana». In interviews with partners in Nepal, they refer to the Norad project and Norad districts – maybe to acknowledge support from Norway, but Norwegian branding in WHO projects looks a bit strange.

[24] Steel (2022).

partners to expand their NCD efforts and to shift the general sense in the development community - and bilateral donors in particular - that funding NCDs is too difficult or politically complicated.

- Several of the projects in the portfolio have been delayed partly due to late disbursements by Norad (first instalment late 2020 to mid-2021) and the onset of COVID-19. However, expenditure data have not been available to the team, so it is difficult to assess level of implementation and how much funds from 2020 and 2021 are utilised/unutilised[25].
- On the other hand, there is palpable excitement across the partners that have been funded through the programme and a strong sense that they will be able to accelerate their results given time. For many, the funding they have received is to support activities for the first time (the mental health baseline analysis for example), and there is a need to strengthen processes and methodologies as well and deliver the result.
- Country progress appears slow in many (not all) countries. However, new initiatives take time to become rooted or to establish ownership by partner countries. The critical question is to what extent all priority countries have by now reached a stage in which implementation can effectively progress in 2023 and results begin to be seen. There is positive feedback from both Ghana and Nepal, but so far based on limited evidence. If better monitoring and systematic reporting on country progress is to be introduced, it would be expedient to lay the groundwork for that now with some urgency so as not to lose time and opportunity to demonstrate impact.

[25] Although COVID-19 led to delays in implementation, overall, the pandemic raised awareness about NCDs and highlighted the idea of risk factors, social and economic determinants of health, and the intersectionality of infectious and non-communicable diseases (in this case, COVID-19 and diabetes).

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

Overarching conclusions

- **Norway's Approach**

- Norway's **NCD strategy** is visionary, ground-breaking and a clear step forward for addressing NCDs as a development priority. The approach and funding, even if less well-resourced than planned, has enabled a wide range of partners to start new work - sometimes for the first time - path-finding the way to strengthen systems and building policy and knowledge in a critical and highly neglected area of health and development. Every partner without exception welcomed Norway's leadership in this area.
- The NCD development programme has an appropriate **balance of investments given the complexity of the NCD landscape – even if the overall design of the programme is not so well explained and articulated**. In finding this balance (which does still need better results verification – see below), the programme has avoided one of the overriding concerns most development partners have confronted when addressing NCDs: whether and how to support treatment in ways that do not directly link funds to life-saving medications. The Norad programme avoids this challenge in a number of ways. First, the programme is **couched in a health systems strengthening framework** so it aims to support countries to build their own capacity to treat NCDs. Linked to this approach, the Norad programme supports **implementation research**, reinforcing its emphasis on practical, country focused systems capacity. Secondly, it focuses on supporting **normative gaps** where critical dimensions of the 5x5 NCD framework are underdeveloped or neglected. A case in point is mental health. Norad support is not focused on delivering mental health services to individuals, but rather on the much-needed gap around developing country capacity to put in place a mental health system that can prevent, mitigate, detect, respond and care for mental health from community right through to referral level. As mental health systems are in fact underdeveloped in most countries, and WHO itself is still working out its guidance (with Norwegian support) Norad support is innovative and timely.
- Developed for implementation in a COVID/ post-COVID context and following a change of government and some adjustment of development priorities, the **NCD programme** includes a balance of well-established modalities (research, policy analysis, health systems strengthening) and innovations that promise multiplier effects and catalytic impact. For example, tobacco taxes is well established but finding a path to demonstrate impact and wider support for sugar, alcohol and other taxes is new. By linking this programme to an established window in the World Bank, it expands its visibility, creates a wider audience and builds on a respected platform (the World Bank Taxation Group).
- The impact at country level is difficult to gauge from a global level and although in the course of this limited assessment, no stand-out challenges or difficulties with country level programmes were identified, it does not mean the programme couldn't be strengthened at country level (see recommendations).
- The features of Norway's programming approach and support that were valued most included the flexibility of the funding, the longer-term nature of the funding, their understanding of realities on the ground and their openness to ensuring their support was used for what partners and countries thought most suitable. Norway has provided *"incredible support and potentially ground-breaking for mental health if sustained."* (WHO key informant)
- For some partners, the shift to multi-year workplans was an important step to strengthening long-term continuity and to enable large scale, complex systems focused reforms. These cannot be undertaken in

a year or even two years. Sustained longer term flexible funding is necessary and Norway's understanding of this has been important to getting the NCD systems strengthening work off the ground. In this regard, also, Norway has a "*clear understanding that integration is essential but time-consuming*".

- On another level, the current political status of the strategy is somewhat uncertain due to the change in government. NCDs is a long-term agenda and will require continuity and support for several years before significant systems strengthening and results on the ground will be visible.
- While there is evidence that the MFA continues to take advantage of opportunities to advance NCDs, key informants claim that Norway could be more active in vocalising support, convening partners and encouraging others to fund and deliver NCD programmes and help to step up the urgency of the response.

- **Programme development**

- The NCD development programme was developed in consultations with Norwegian and international partners and assessment of needs and opportunities. Although the NCD programme continues to be funded and delivered, it is on a significantly lower scale than originally expected. The role that Norway aimed to play at a political level has been somewhat muted, much to the disappointment of its partners who have been vocal in their wish for Norwegian political leadership on NCDs.
- Active coordination and collaboration between Norway and others (including other bilateral donors) in the NCD area has also been limited. Since the Norway programme was initiated, no significant additional partners have joined the NCD arena. This is probably due at least in part to the distractions created by the COVID-19 pandemic which affected most priorities between 2020 and 2022. However, somehow the realities that the COVID-19 pandemic highlighted around the links between NCDs (both risk factors and diseases) and COVID-19 have not led to a scale-up in investments in NCD prevention and promotion. There is an important link that could be much better, more actively articulated in ways that lead to concrete investments.
- The most important way to support the detection and treatment of NCDs is through health systems strengthening and the development of universal health coverage.
- The programme has multiple broad priorities and objectives and suggest also to include other priorities such as NCDs in the humanitarian field, education, air pollution and climate. The expansive scope has the potential to serve as the basis for a wide range of strategic decisions over the coming years.

- **The NCD Portfolio**

- The NCD development programme is distributed across a coherent and strategic range of investments that touch on many of the risk factors and diseases in the five-by-five framework (elements of this are discussed above under "Approach"). By and large, the portfolio invests in activities that may deliver multiplier effects and put systems in place that could have long term impacts.
- There are synergies between interventions aimed to support NCD prevention, diagnosis and treatment, the thematic areas (for example, between health taxes and the SAFER programme), the distribution of global vs country level support (e.g., mental health as a global challenge or as a specific service need in Ghana and Nepal) and other aspects. However, while the synergies are there, the organisational fragmentation within WHO and a lack of overarching coordination and leadership in all likelihood is having a negative effect on realising these. Certainly, the lack of visible high-level leadership on NCDs within WHO has been cited as a limitation to WHO's ability to fully realise its potential impact.
- The NCD portfolio does not (and probably could not) contain or reflect all relevant NCD activities, e.g. support to other NCD programmes in WHO such as tobacco control, broader investments in adjacent

areas such as food security or the extensive range of Norway's political advocacy (through the MFA). This is inevitable to some extent although there are notable gaps in specific critical NCD-related areas (such as air pollution) which formed a significant part of the original Norway concept of equity, development, climate change and NCDs.[26]

- Investments in NCD relevant research (GLOBVAC) are not yet fully specified. Hence, the role and significance of research as a source of providing evidence for the NCD portfolio is not yet possible to assess.
- The Theory of Change is laid out at a high level of abstraction and could be more practical, granular and useful for developing a monitoring and evaluation strategy. The ToC does not, in itself, help with decision-making or guide policy shaping as much as a more detailed version might. It will also be difficult to validate the ToC in programme review processes because the relative weight of the components and their inter-linkages are not shown.

- **Partners and Partnerships**

- WHO has been the main partner and recipient of funds, particularly in two programmes. Most informants agreed that WHO was the right partner in the first phase of the programme but encouraged inclusion of additional partners in the next phase for enhancing local/community impact. The Norwegian public partners play different complementary roles within the programme in selected countries.
- The relatively minimal involvement of civil society is striking. This is a lost opportunity if the NCD programme aims to reach out to local communities and citizens in Nepal and Ghana and other country programmes where, even with a sound and well-managed community health programme, civil society organisations will be an important partner in reaching people with prevention strategies, knowledge and self-care approaches to enable better understanding and avoidance of NCDs.
- As the programme is focused on multiplier effects (rather than service delivery to individuals), the majority of partners are producers of knowledge (norms, standards, policies, research, etc.) providing preconditions for effective NCD interventions in countries, establishing strategies and improving programming. The emphasis of the programme is clearly on norms and standards, systems guidance and policies, expanding catalytic impacts and strengthening evidence around what works at scale to reduce exposure to risk factors. Over time, it is possible that the programme will find it useful to engage with different partners as the balance shifts towards supporting country specific action, assuming that most of the groundwork in countries is completed or well underway.

- **Delivery process**

- Several of the projects have been delayed partly due to late disbursements and the onset of COVID-19. Expenditure data have not been available, so it is difficult to assess level of implementation and how much funds from 2020 and 2021 are utilized/unutilized.
- Some country progress appears to be slow and delayed for the same reasons. The critical question is to what extent all priority countries have by now reached a stage in which implementation can progress and results eventually be seen. There is positive feedback on progress from both Ghana and Nepal, but so far based on limited evidence. It is a matter of urgency to more systematically monitor and report on country progress.

[26] This is funded by another Norad department but could have been mentioned in the development programme.

- For many countries, Norway's support has enabled WHO to initiate a dialogue on mental health specifically. This is ground-breaking for many where mental health is linked to deeply held taboos. The support to mental health is an excellent example of where Norway can bring funding to bear in a constructive and visionary way (few others have stepped in to fund mental health yet despite talking more about it). Yet Norway's political support is also very helpful and raises the issue in the agenda both within countries and at the global level.

4.2 RECOMMENDATIONS

Strategic and policy recommendations

1. **Confirm and further articulate Norway's leadership and commitment to the global NCD agenda**

   Take steps to re-confirm its long-term commitment to addressing NCDs. As part of confirming its commitment, Norway should seek to clarify the status of the strategy document "*Better health. Better lives*" and an indication of future financial commitments emphasizing the need for long-term support to the NCD development programme as the key to realising the value for money already invested. Linked to this, clarify and strengthen linkages between the current NCD development programme and critical adjacent areas such as education, air pollution, food security, and climate (without necessarily expanding the current NCD portfolio). This recommendation is directed to the Norwegian government, the MFA and Norad.

2. **Promote sustainability and manage the risks associated with being the principal European NCD donor**

   While Norway has shown vision and foresight in defining the NCD programme, the longer it goes on (and a long-term commitment is essential to success), the more risk that position could entail. To manage the risks associated with being the main funder of a large body of critical or high-profile support, Norway should take steps to encourage other donors to support the global NCD agenda including through diversified funding arrangements. This includes strengthening political leadership and advocacy around the urgency to address NCDs including mental health (bringing the full 5x5 framework fully into view) as well as sharing lessons learned through Norway's early experience with creating and delivering the NCD programme portfolio. There are some signs that other development partners are stepping up and, once confirmed, could be important to building a broader coalition of support.

   One of the constraints many donors experience is to identify how to invest in NCDs or support systems for NCD control and response in ways that do not create long-term funding encumbrances or obligations that carry reputational risks. Norway has been a pathfinder in this challenge and has many important lessons to share. Furthermore, as a leader both in this area and the COVID-19 Accelerator, Norway is ideally placed to raise and sustain attention around the links between NCDs and COVID-19 in order to ensure that evolving investment in pandemic preparedness and response includes and integrates larger health systems issues and a broader understanding and response to the social and economic determinants of health. This recommendation is directed to Norad and the MFA.

3. **Deepen and further strengthen partnerships with WHO and others**

   Norway primarily exercises its influence and support to NCDs through strategic partnerships. At the centre of these is the partnership with WHO. The Norway approach, based on **flexible funding and 'soft' earmarking has been very successful** in ensuring funds reach 'orphan' issues within WHO and also reach country programmes. However, although on an upward trajectory of improving coordination, WHO's commitment to NCDs has not been as holistic and high-profile in recent years as it *could* have been given the range of spending and the opportunities it has had (and despite creating a distinct NCD department). This is partly a result of distractions created by COVID-19, but is it also due to WHO's lack of sustained,

high-level leadership of NCDs senior to all the relevant departments and able to convene directors across policy areas.

Norway could consider using its political influence with WHO to encourage more senior level engagement in internal coordination around NCDs and to require a clearer **cross-WHO workplan addressing NCDs**. This would support the weaker or less prominent departments in WHO to be fuller partners alongside other more prominent departments. As WHO reconsiders its leadership arrangements in the coming weeks and the structure of its departments, Norway could take the opportunity to advocate for coherence across the NCD agenda including prevention, promotion, and addressing the social and economic determinants in addition to systems, research and treatment.

Other partnerships beyond the WHO remain very important as NCDs are increasingly mainstreamed. The **role of the development banks** could be accentuated not just around taxation and public expenditure management, but around the larger trade agenda especially where commercial interests (processed food, alcohol, sugar, tobacco) outweigh health considerations. Having strong partnerships across the international system with a mobilised and engaged civil society will be important to tackling these larger global and national structural issues.

Lastly, Norway could consider – if the budget allows – providing support to the **WHO-convened UN Interagency Committee on NCDs** which brings together the UN system to address NCDs. The Committee is also working in a handful of countries to explore a range of multisectoral responses and tackle some of the challenges created by balancing commercial versus health interests among others. This recommendation is directed to Norad as it works with the WHO and other partners.

Operational and implementation recommendations

4. **Improve communications around the NCD programme as a portfolio**

   Prepare a consolidated NCD programme summary including all relevant interventions irrespective of funding source – to provide a better overview and improve the basis for strategic planning of the portfolio.

   In addition, clarify what the portfolio consists of and what types of results can be expected and reported on (for normative work, capacity development and advocacy) and in areas such as mental health. This will also help more clearly identify strategic and operational gaps both in the portfolio (for example, possibly air pollution) and within individual programmes (for example, limitations around the procurement of medicines within the health systems/ pathways of care investments).

   This recommendation is directed at Norad drawing on inputs from programme partners.

5. **Establish a financial monitoring mechanism or framework for the NCD portfolio**

   Such a mechanism should enable the distribution and rate of expenditure to be easily tracked and identify needs for remedial action or re-planning/ re-allocation. This recommendation is directed to Norad although it could draw substantially on WHO inputs given its extensive role in the programme.

6. **Define and support the role of civil society organisations especially in relation to self-care and community health services**

   A notable gap in this phase of the programme, civil society engagement and support appears to have been limited and relatively shallow. Yet, reaching individuals with critical behavioural change and/ or addressing many of the social determinants of health will best be undertaken at community level by CSOs working closely with public authorities. Norway might explore options for encouraging the CSOs they support to explore how they might incorporate NCDs into their programmes in a constructive way (and report on this to Norad so that it is known). It would be useful to consider developing a small

community of practice for CSOs to discuss options, knowledge and experience working on the ground in NCD prevention. This recommendation is directed to Norad.

7. **Follow up and review the allocation to research (GLOBVAC)**

   Assess its relevance/usefulness for providing evidence for the NCD portfolio. If required, rethink modalities for support to research.

8. **Develop a monitoring and evaluation strategy for the NCD portfolio**

   Such an M&E system needs to meet needs without being overly onerous. The M&E system will ideally gather evidence about what is working, where and using this mechanism, identify for follow-up allocations that are not on track or may not be delivering productively as anticipated. M&E will be useful for assessing impact, maintaining internal commitment within/ across Norway, supporting effective decision-making and reallocating resources as appropriate (for example, a monitoring system could help assess the GLOBVAC relevance/usefulness for providing evidence for the NCD portfolio itself).

   As part of this strategy, carry out a review of country impact as soon as possible (end of 2023). This review would aim to assess country implementation and progress more thoroughly and to review to what extent preparatory work (e.g., consultations, planning missions/base line studies) has created a basis for implementation and short- and medium-term outcomes.

   Linked to this larger M&E strategy for the NCD portfolio, a further, more targeted assessment of progress in countries (perhaps a two-country focused study) could be very helpful to make adjustments and gather lessons about what works. Such a country focused assessment would be most useful after at least an additional year of implementation (perhaps end of 2023/ early 2024).

   This recommendation is directed principally to Norad as the lead agent but would also implicate the MFA and all the programme partners, particularly WHO and the World Bank.

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ANNEX 2: PEOPLE INTERVIEWED

Name	First name	Affiliation/ Institution
Ansong	Joana	National Professional Officer, Ministry of Health, Ghana
Bakke	Øistein	FORUT
Baral	Phanindra Prasad	Chief, NCDs at the Department of Health Services, Nepal
Bjørnsen	Anette	NORAD
Bordvik	Kjetil Leon	NORAD
Davis	Austen	NORAD
Dybdahl	Ragnhild	Norwegian Public Health Institute
Enos, Access to Drugs,	Bashier	WHO
Kjersti Nerhus,		Norwegian Public Health Institute
Kofie, Humphrey, Executive Director		Mental Health Society of Ghana
Marhatta	Kedar	WHO, National Professional Officer, Nepal
Monclair	Marianne	NORAD
Naimy	Zainab	NORAD
Norheim	Ole	University of Bergen

Olsen	Ingvar	NORAD
Pettersen	Marit Victoria	Ministry of Foreign Affairs (on leave)
Stavrum	Staale	FORUT
Steel	Heidi Westborg	ICDP (International Childhood Development Programme)
Vatne	Ingunn	Ministry of Foreign Affairs
Waqanivaly	Temu	Unit Head NCD/ISN, WHO
Kestel,	Dévora	Director, Mental Health and Substance Use, WHO
Schafer	Alison	Programme Manager, Special Initiative, WHO
van Ommeren	Mark	Head, Mental Health Unit (MHE), WHO
Rekve	Dag	Senior technical officer, Alcohol, Drugs and Addictive Behaviours, World Health Organization
Birckmayer	Jo	Health Taxes, Bloomberg Philanthropies
Martens	Robert	Implementation Research - NCD policy/health taxes, Alliance for Health Policy and Systems Research (AHPSR)
Ozer	Ceren	Global Tax Program and Trust Fund, Health Taxes Window, World Bank (awaiting appointment)