TRACKING NCD FUNDING FLOWS

URGENT CALLS AND GLOBAL SOLUTIONS

NCD Alliance

Global Alliance for Tobacco Control

This report was developed under the leadership of the Global Alliance for Tobacco Control (GATC) **with support of the NCD Alliance**.

About GATC

The Global Alliance for Tobacco Control (GATC), formerly the Framework Convention Alliance (FCA), is a global network of civil society actors working towards a world free from the devastating health, social, economic, and environmental consequences of tobacco. GATC is the only global network dedicated solely to implementing the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) and serves as the leading voice of civil society in strengthening and accelerating progress. GATC's leadership ensures there is a cohesive global movement of civil society organizations (CSOs) addressing the work of the Treaty, and its work in policy development and advocacy, knowledge translation and exchange, capacity building, and the convening of stakeholders has resulted in significant policy achievements and outcomes in global tobacco control.

About NCDA

The NCD Alliance (NCDA) is a registered non-governmental organisation (NGO) based in Geneva, Switzerland, dedicated to supporting a world free from preventable suffering, disability and death caused by non-communicable diseases (NCDs). Founded in 2009, NCDA brings together a unique network of over 400 members in more than 60 countries into a respected, united and credible global civil society movement. The movement is unified by the cross-cutting nature of common risk factors including unhealthy diets, harmful use of alcohol, tobacco smoking, air pollution and physical inactivity, and the system solutions for chronic NCDs such as cancer, cardiovascular disease, chronic lung disease, diabetes, mental health and neurological disorders.

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EXECUTIVE SUMMARY

Non-communicable diseases (NCDs) remain the leading cause of mortality and morbidity worldwide. Today, 1.7 billion people live with NCDs, and about 86% of premature deaths and 77% of all NCD deaths occur in low-and-middle income countries (LMICs) each year. Millions of people, especially in lower-income settings, have limited access to adequate prevention, treatment and care that could prevent, delay, or manage NCDs and their consequences.

As a result, the devastating consequences of NCDs disproportionately impose a greater burden on LMICs where health services are proportionally less per capita, and NCDs remain the leading cause of death accounting for more than HIV, tuberculosis, and maternal deaths combined. A report by the Lancet Commission estimated that implementing the most cost-effective intervention packages would cost an additional 18 billion USD per year over 2023-2030 in LMICs, but that many LMICs will struggle to raise funds using domestic resources alone and will require international assistance. However, despite this urgent call for international support for NCD policies and programs and the corresponding burden on populations, international funding remains inadequate.

In fact, the Institute for Health Metric and Evaluation (IHME) estimated that only 1-2% of total development assistance for health (DAH) has been dedicated to NCDs in the past 20-30 years. Moreover, the present report analyzes the Organization of Economic Cooperation and Development (OECD) development assistance for health (DAC) Common Reporting Standard (CRS) data to specifically highlight the breakdown of the 2018-2021 aid flow types going towards NCD policies and services, as well as the risk factors of tobacco and alcohol. The report also analyzes the breakdown of development assistance going to NCDs as well as DAH going towards NCD policies and services in relation to other global health priorities. This analysis finds that financing solely dedicated to NCDs may be as low as 0.8% of total DAH in the 2018- 2021-time period. Likewise, despite slight increases in development funding during this period, programs that focus on major risk factors for NCDs, such as tobacco and alcohol use, remain equally deprioritized. Data highlights that within the NCD umbrella, tobacco control received 0.3% of total DAH, while control of use of alcohol and drugs received close to zero between the years 2018 and 2021.

In addition, this report elaborates on recommendations to improve integrated international investment for NCDs in time for the Second Dialogue on Sustainable Financing for NCDs and mental health. In summary, the following recommendations are highlighted as result of the present analysis:

RECOMMENDATION 1

Increase ODA for NCD Prevention

The analysis finds that most NCD funding is fairly evenly split between private development sources (55.6%) and ODA grants (44.2%). In addition, the results demonstrate that the limited development assistance going towards alcohol policy is also currently evenly split between ODA and private sources. In contrast, although tobacco control programs have been proven to have a high Return on Investment (ROI), tobacco control continues to receive very little funding from ODA, as it is mostly funded through private financing and/or philanthropic organizations (97%). This reliance on philanthropy for NCD related DAH is particularly concerning, as philanthropy is more vulnerable to shifts in funding priorities. By definition, spending classified under ODA must have "*economic development and welfare of developing countries as its main objective*". NCDs and major risk factors reduce productivity and human capital while increasing healthcare costs from chronic illness, constituting a great threat to these nations' economic development and welfare. As such, there is much space to increase ODA to support countries in mobilizing domestic resources to create sustainable pathways forward for NCD prevention.

RECOMMENDATION 2

Increase Domestic Resource Mobilization (DRM) and National Investment for NCDs

While increasing ODA and other forms of development assistance is paramount to jumpstarting the implementation of preventive programs for NCDs and its risk factors in LMIC contexts, it cannot alone fulfil the need for sustainable programs at country-level. Thus, to ensure funding sustainability, a mix of international resources, such as multilateral and bilateral aid including ODA, as well as DRM is essential to funding NCD prevention programs. Investing in NCD programs that leverage health taxes could be a pathway to sustainability as it relates to NCD funding. Redirecting funding to health programs may require some form of capacity building on how earmarking can be achieved for countries that have little to no health tax structures in place. Such capacity building activities on taxation may present a potential area of interest for future programming.

RECOMMENDATION 3

Improve Quality Data on NCDs and risk factor Investments

Investing in improved data collection and research efforts is essential to inform public health policies and interventions tailored to country-specific needs in LMIC contexts. These investments can be reflected in adding more indicators for NCDs within the OECD database, and others, including health initiatives that account for health systems strengthening and Universal Health Care. Furthermore, the Global Alcohol Action Plan (2022-2030) also proposed indicators not just resource mobilization, but other relevant indicators for capacity building, policy implementation, and monitoring and surveillance data. Mainstreaming these indicators for NCD data monitoring and investment cases in LMICs would be a good step in the right direction. Lastly, investing in these indicators not only accounts for the multi-sectoral nature of NCDs, but presents the opportunity to improve reporting to efficiently track the impact and spending on NCDs and its risk factors.

1. OVERVIEW OF THE PROBLEM

Non-communicable Diseases (NCDs) constitute one of the greatest health and development challenges of the century.[1] Today, 1.7 billion people live with NCDs, and about 85% of premature deaths and 77% of all NCD deaths occur in low- and-middle income countries (LMICs) each year.[2] Cardiovascular disease, cancer, diabetes, chronic respiratory diseases, and mental health and neurological conditions account for nearly three quarters of deaths in the world.[3] If the situation does not change, these numbers are likely to increase. In fact, data shows that annual global deaths from NCDs are projected to scale from 41 million yearly deaths to 52 million by the year 2030.[4]

These devastating consequences disproportionately impose a greater burden on LMICs where health services are proportionally less per capita, and NCDs remain the leading cause of death accounting for more than HIV, tuberculosis(TB), and maternal deaths combined.[5] Moreover, NCD co-morbidities have also been known to worsen health outcomes for endemic infectious diseases including malaria, TB, HIV/AIDS, COVID-19 and infections in general.[6]

Most NCD-related deaths could be prevented or delayed by addressing common NCD risk factors – particularly tobacco and alcohol use, unhealthy diets, including high consumption of sugar sweetened beverages (SSBs), physical inactivity, and air pollution. These modifiable risk factors also contribute to high blood pressure (hypertension), overweight and obesity, as well as raised blood glucose and cholesterol. Moreover, NCDs such as mental health conditions are also considered a key risk factor for premature mortality in both high-income country (HIC) and LMIC contexts. Mental health conditions have been linked to higher risk for mortality associated with cardiovascular disease and cancer.[7] Exposure to these risk factors is largely determined by the wider determinants of health, which lie outside of the health sector, including the social, cultural, environmental, economic and commercial determinants of health. Therefore, NCD prevention and control calls for integrated action across all major sectors of society that influence health. The commercial determinants of health are key social determinants that refer to the conditions, actions and omissions by commercial actors that affect health.[8] The commercial determinants of health focus on how unhealthy commodity industries (such as tobacco, alcohol, unhealthy foods and beverages and fossil fuels), combined with a lack of regulation,

shape consumer environments. Due to the industry's practices of targeting children and youth in low-income contexts, these industry activities increase the likelihood of NCDs within young, vulnerable populations.

Providing access to timely and quality screening, treatment and health services for those at risk of or living with NCDs is critically important. Millions of people, especially in lower-income settings, have limited access to adequate prevention, treatment and care that could prevent, delay, or manage NCDs and their consequences. Due to the institutional, political and economic realities of LMIC contexts, the economic burden of NCDs tends to fall on individuals and households as 'out of pocket' expenses (OOPs), because NCD prevention and care is often not included in a country's basic health benefits package or national health insurance schemes. At the global level, the cost of OOPs for NCDs are estimated to be twice as high per visit to a health facility in comparison to infectious diseases.[9] The financial burden of NCDs on households and governments creates a major barrier to poverty alleviation, a major feature of the Sustainable Development Goals (SDGs).

Despite the high prevalence of NCDs and the corresponding burden on populations, funding for NCD policies and services remains inadequate. Although data demonstrates that cost-effective and globally applicable interventions can lower mortality and morbidity for NCDs and offer a high return on investment, NCDs continue to remain the most underfunded global health issue in comparison to disease burden.[10] Despite the large burden in LMICs, the Institute for Health Metric and Evaluation (IHME) estimated that only 1-2% of total development assistance for health (DAH) has been dedicated to NCDs in the past 20-30 years. Moreover, using data published by the Organization of Economic Cooperation and Development (OECD) from 2018-2021, the present analysis indicates that financing solely dedicated to NCDs may be as low as 0.8% of total DAH. A report by the Lancet Commission estimated that implementing the most cost-effective intervention packages would cost an additional 18 billion USD per year over 2023-2030 in LMICs, but that many LMICs will struggle to raise funds using domestic resources alone and will require international assistance.[11] To prevent the rise in NCDs and improve the management of existing diseases there is a need for concerted multi-stakeholder coordination between donors, the private sector, governments, civil society and United Nations agencies. The key features and outcomes of the aforementioned multi-sectoral coordination efforts may include, and are not limited to developing pooled funds for Universal Health Coverage (UHC) with a focus on preventing, treating, and managing NCDs within populations. Therefore, financial support from the global community and multi-sector action led by national governments presents a necessary condition to minimize and prevent risk factor exposures in environments where populations and individuals live, learn, work and play.

The OECD Development Assistance Committee (DAC) Common Reporting Standard (CRS) database recently introduced source codes for funding being channelled into alcohol prevention and tobacco control within NCD policies and services. The present report analyzes the OECD's DAC CRS data to specifically highlight the breakdown of the 2018-2021 aid flow types going towards NCD policies and services, as well as the risk factors of tobacco and alcohol. The report also analyzes the breakdown of development assistance going to NCDs as well as DAH going towards NCD policies and services in relation to other global health priorities. In addition, this report will also elaborate on case studies and recommendations to improve integrated international investment for NCDs in time for the Second Dialogue on Sustainable Financing for NCDs and Mental Health (June 2024).

1.1 OECD Financing Database

The OECD is an international organization consisting of member states, with the expressed mission to improve policies for better lives.[12] Within the OECD is the DAC, which is an international forum of 32 member states, many of which are the largest providers of development assistance globally.[13] Members of DAC have reporting obligations for financing, which calls on jurisdictions to obtain information from their financial institutions and openly share this information on an annual basis. This information is collated and curated by the OECD DAC in the CRS database.[14] As such, financing data from development actors is reported every calendar year. The OECD DAC CRS data base is a curated, widely respected database of development assistance, in all forms including Official Development Assistance (ODA), and Other Official Flows. However, due to the lengthy verification process, the data is reported with a considerable time lag, making data for this database only currently available from 2018 through 2021 at the time of analysis. This report analyzes aid flows to NCD policy and programs, including tobacco control and alcohol policy, from 2018 to 2021. A limitation of the OECD database is that it does not include non-OECD countries, and does not capture all foreign flows towards NCD policy and programs.

There are many categories and definitions for international aid. While some classify aid as only ODA, others include everything that is in the CRS, including Other Official Flows and Private Development Finance. Spending classified as ODA must have "*economic development and welfare of developing countries as its main objective*" and be concessional in nature.[15] These are not requirements for Other Official Flows and Private Development Finance. For this piece of work, we will consider all financing reported to the CRS and show the proportions provided by private donors, including philanthropies as well as those donated in the form of ODA.

The database contains various pieces of information about development and humanitarian projects including sectors targeted, recipient countries and/or regions as well as timeframes. Many of these fields have various code lists, introduced at different points over time. For example, the sector and purpose codes for NCDs were only introduced for first reporting on 2018 flows. In the same year, the purpose codes within NCDs for '**Tobacco use control**' and '**Control of harmful use of alcohol and drugs**' were also introduced. The methodology for the report is further detailed in ***annex I.***

It is widely confirmed that there is no safe level of alcohol consumption.

1.2 Current NCD financing scene

Over 15 million people between the ages of 30 and 69 die from NCDs every year.[16] As previously stated, 86% of these premature deaths take place in LMIC contexts, however NCDs remain one of the least funded global health priorities. Moreover, due to high healthcare expenses and reduced productivity strain in developing economies, NCDs pose a great threat to economic stability in LMIC contexts. While there has been a slight increase in the proportion of total global development assistance flows going to NCDs, volumes of specific development funding for NCDs remain extremely low.

According to the OECD DAC Creditor Reporting System (CRS), direct development financing for NCD programs increased from 0.06% of total development assistance in 2018 to 0.11% in 2021, which is equivalent to an average of 315 million USD annually.

Furthermore, across the period from 2018 to 2021, 11.6% of total development assistance was health-related.

Of this, private development financing contributed the most to NCD policies and services (56%), whilst the remaining funding was provided in the form of ODA grants by more traditional development actors (44%), including multilateral organizations, international financial institutions and donor governments. Some of the major donors in this category include the World Health Organization (10%), as well as the United Kingdom (7%) and Norwegian governments (5%). Ergo, ***Figure 1*** below outlines development assistance by both aid type and donor.

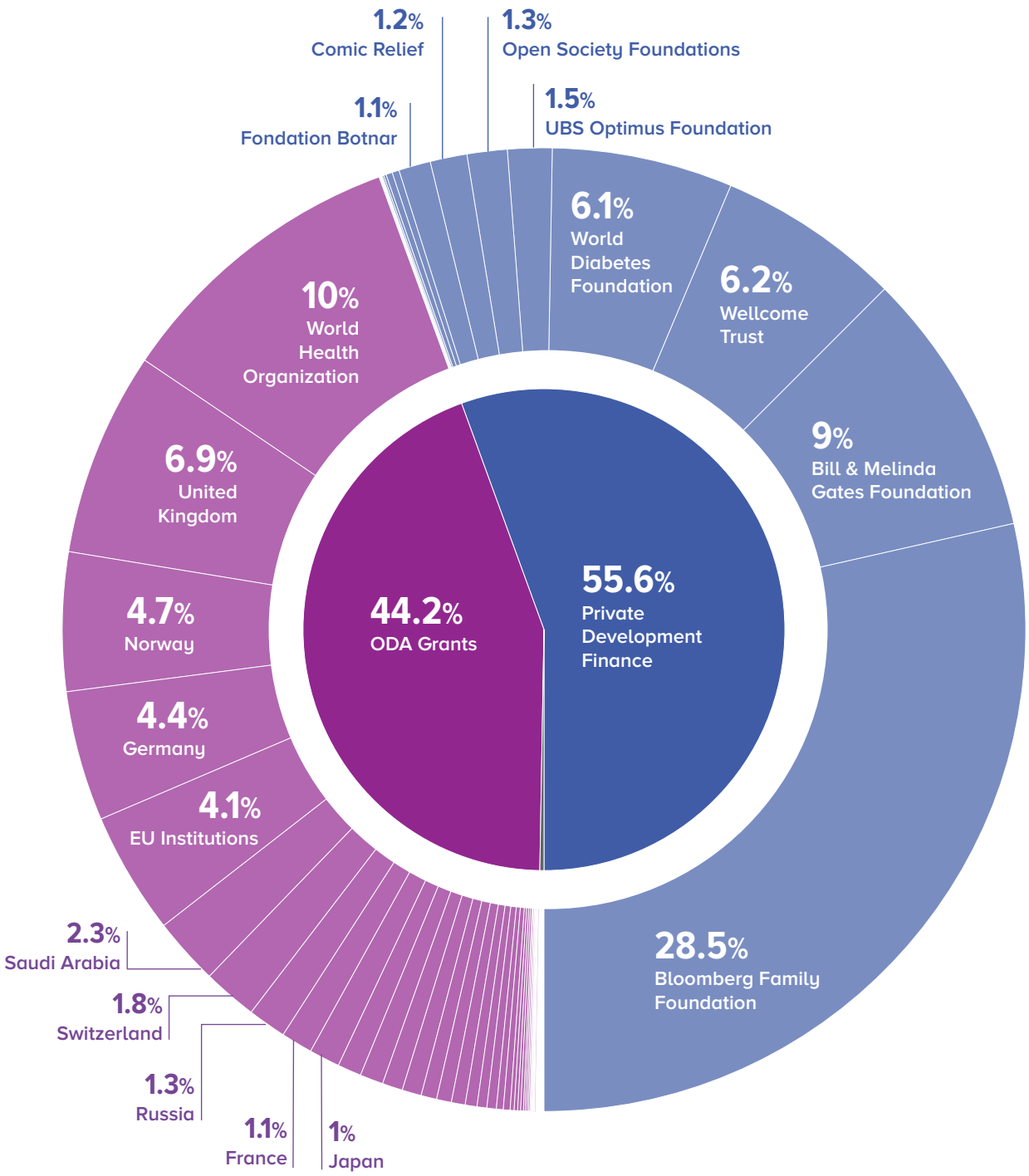


Figure 1. Development assistance for NCDs between 2018 and 2021 (by aid type and donor)

Over the period of 2018 and 2021, most NCD aid-based funding was directed to the Middle East (90 million USD) and to Eastern Africa (86 million USD) respectively. Lower-middle income experienced the most growth in NCD financing (560%, from 12 million USD to 78 million USD), followed by low income (430%, from 6 million USD to 32 million USD) and upper-middle experienced the least (230%, from 18 million USD to 60 million USD). Additionally, all income groups saw consecutive year to year increases across this period, with the exception of low-income countries which experienced a one-year decline from 2020 to 2021 (dropping from 51 million USD to 32 million USD). Given the estimates presented in the introduction section that suggest a figure of 18 billion USD per year to adequately address the NCD crisis, these investment levels fall well below the amount required.

1.3 Comparison of development assistance flows between NCDs and other health programs

Direct development financing for NCDs totalled to only 0.8% of health-related development spending between the years 2018 and 2021. This spending on NCD policies and services equates to approximately 1.3 billion USD in development assistance over the same period.

These proportions are relatively low compared to funding flows going to general health programs including infectious disease control, and population policies/programs including reproductive health, which accounted for 68.7% and 30.5% of total health-related development spending, and received 105.3 billion USD and 46.8 billion USD respectively. In proportionate terms, the aforementioned programs receive 84 times and 37 times the amount of funding spent on NCDs. ***Figure 2*** illustrates development assistance for health between 2018 and 2021 by health sector area. Within general health programs the most funded priorities included: COVID-19 control, infectious disease control, basic health care, health policy and administrative management, and malaria control respectively. A detailed breakdown of the most funded health programs is available in ***annex II***.

In 2019, 74% of all deaths were due to NCDs, compared to just 14% of infectious diseases. Similarly, 63% of Disability-adjusted Life Years (DALYs) are attributable to NCDs whereas only 27% are attributable to communicable, maternal, perinatal and nutritional conditions. HIV/AIDS, Malaria and TB are three infectious diseases that are commonly tackled through ODA, this is in part due to the legacy of the Millennium Development Goal targets and structures. Between 2018 and 2021, HIV/AIDs, Malaria and TB received 30.6 billion USD, 10.2 billion USD and 4.4 billion USD respectively. In 2019, these same diseases caused 1.2%, 0.7% and 2.2% of total deaths worldwide, while receiving 20%, 6.7% and 2.9% of total DAH respectively. Comparatively, although NCDs caused 74% of deaths, NCD policies and services received 1.3 billion USD in funding across, or 0.8%, of total DAH in the same period. While it is important to note that financing should not simply be proportionate to morbidity and mortality rates, as funding may also be attributed to multiple factors, including the availability of medical personnel and the cost of disease treatment, development assistance being channeled to NCDs remains insufficient. A key interest is to shift the focus to primary health care and prevention to avoid higher costs of care and more advanced stages of NCDs. Moreover, the lack of available country-specific data on NCD surveillance, may be an issue for stakeholders as it relates to identifying data for appropriate and efficient resource allocation for NCD policies and services. ***Figure 3*** bellow illustrates the volume of development assistance received in comparison to mortality rates.

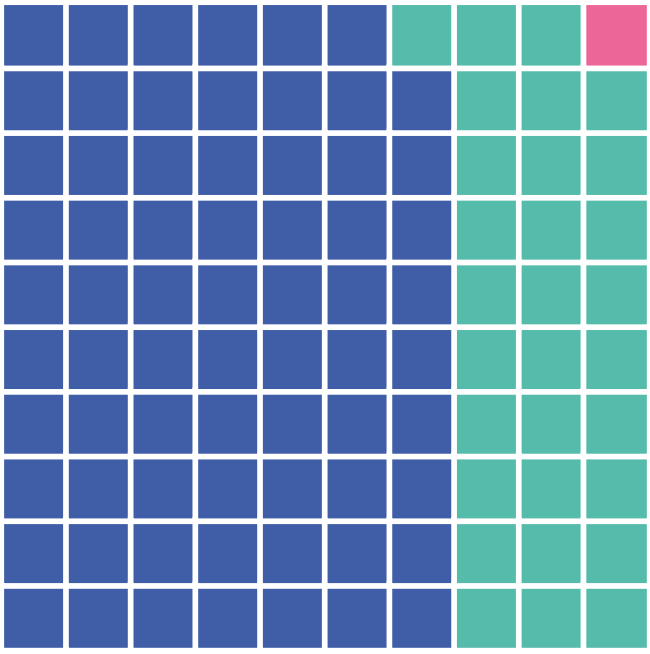


Figure 2. Development assistance for health between 2018 and 2021 by Health Sector

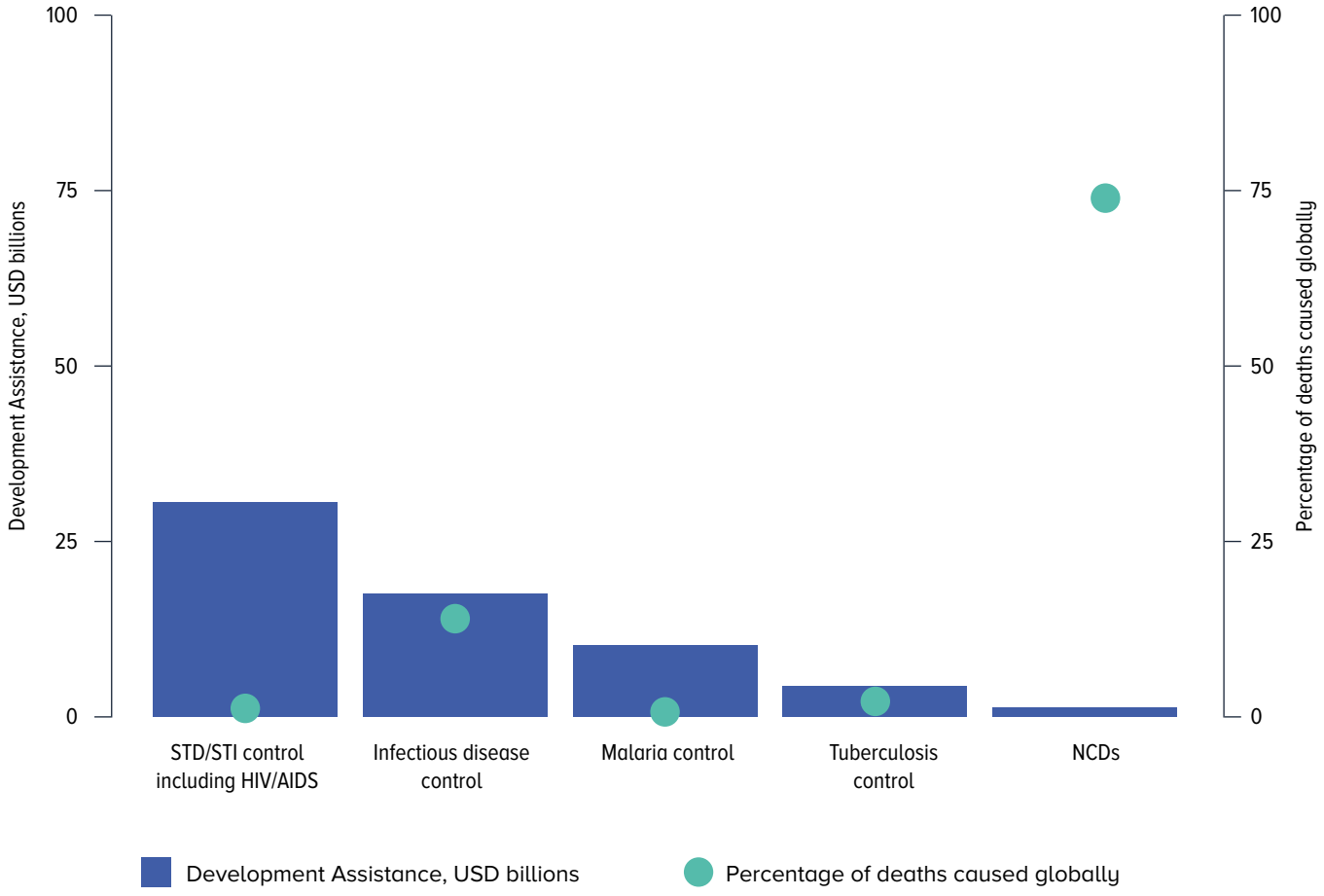
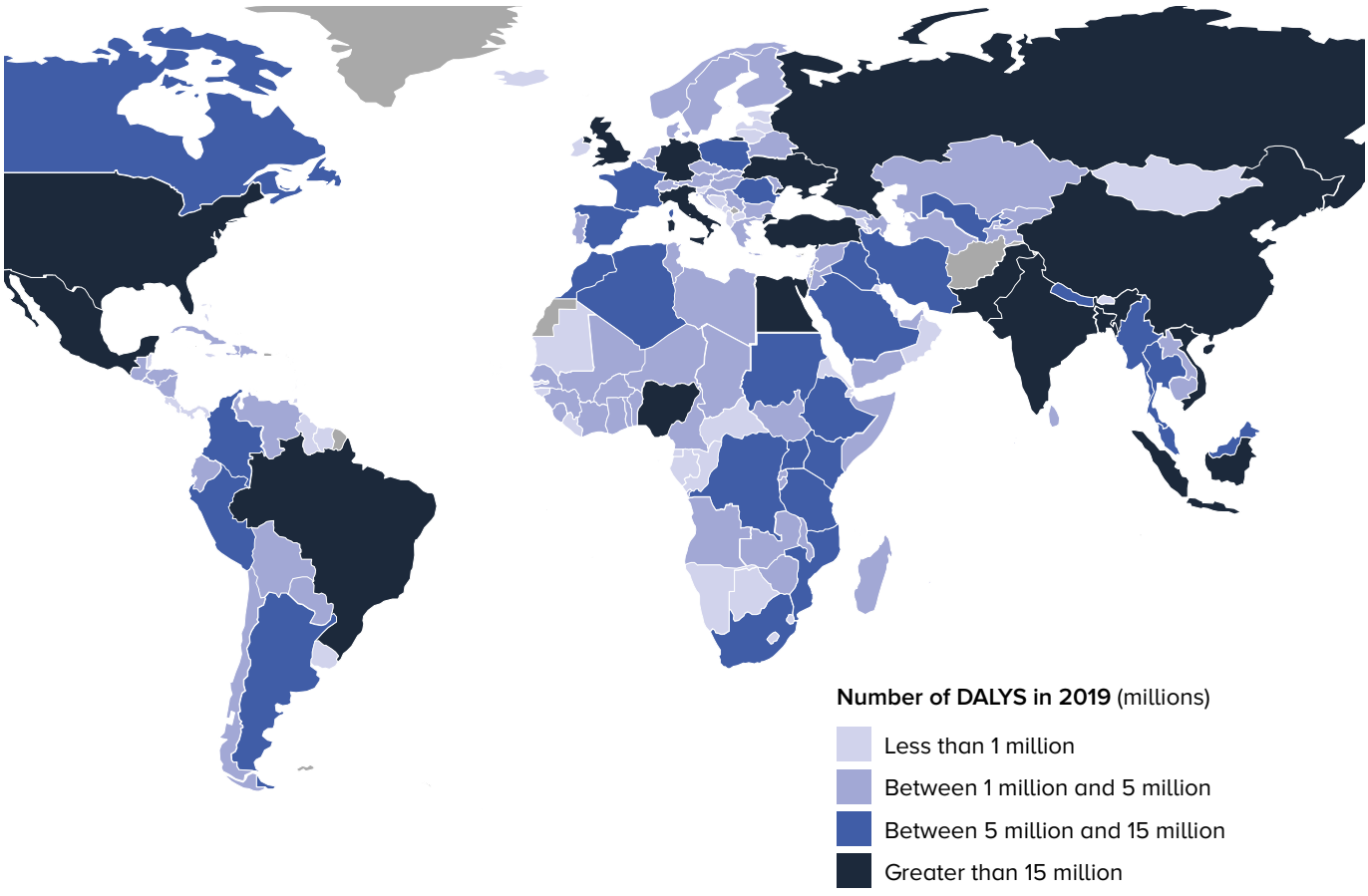


Figure 3. Development assistance on certain areas of health between 2018 and 2021, compared to mortality rates

Furthermore, ***figure 4*** below compares the amount of money spent on NCDs to the overall burden of NCDs by country, with a focus LMICs. However, it is imperative to note the complexities related to disbursement of development assistance for NCDs policies and services. As such, disbursement is dependent on various factors, most notably: (1) a country's cost of healthcare provision, which is greater in middle income countries than low income, (2) a country's availability of human resources and/or capital to provide the needed healthcare themselves, as well as (3) the type of NCDs prevalent within the country. Additionally, some factors affect the amount of money a country receives for development assistance which may be unrelated to NCD spending. Some of these factors include (1) a country's relationship with donor countries and (2) issues related to war and civil unrest within a country and/or region.



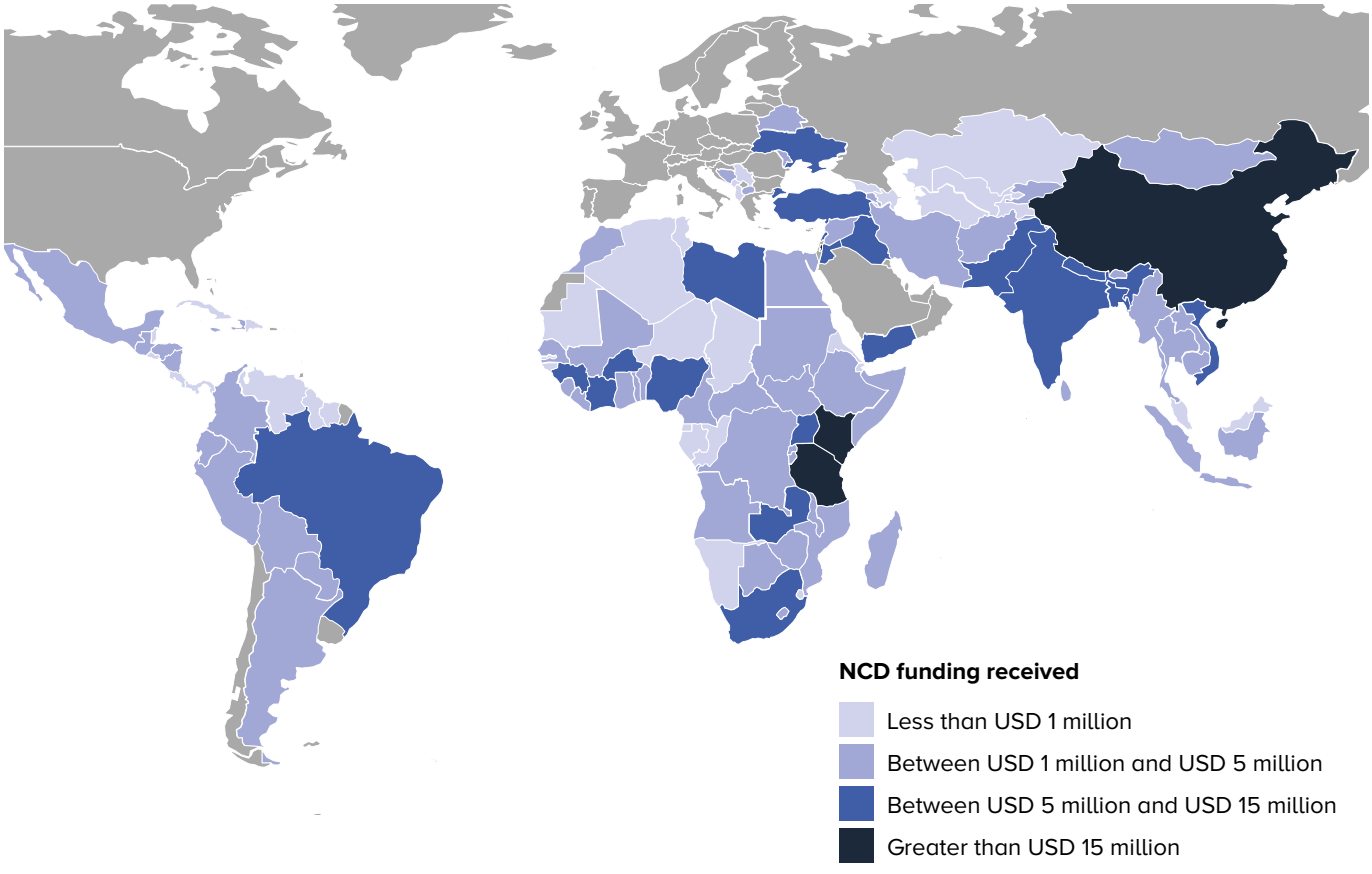


Figure 4. Development Assistance for NCDs between 2018 and 2021 against the number of DALYs due to NCDs in 2019, shown by recipient country

2. THE IMPACT OF TOBACCO AND ALCOHOL AS NCD RISK FACTORS

Tobacco and alcohol use are among the main NCD risk factors, with tobacco being the single most preventable cause of death and illness in the world. Tobacco mortalities are around 8.7 million people per year,[32] and it continues to kill more people than AIDS, malaria and TB combined.[17] The majority of these deaths are attributed to tobacco smoking, while the remaining 1.3 million of these deaths are attributed to second-hand smoke. Smoking has been linked to various NCDs, including heart disease, cancer, lung diseases, diabetes, and chronic obstructive pulmonary disease, which includes emphysema and chronic bronchitis.[18] Although the global smoking prevalence has decreased by 27.2% for men since 1990, and 37.9% for women, with HICs experiencing the highest decline (40%)[19]; LMICs, specifically in Asia and the Pacific Islands, continue to experience some of the highest smoking rates in the world, as over 50% of all men continue to smoke.[20] Furthermore, south Asian countries, also continue to have some of the highest prevalence's' of smokeless tobacco use among men. Smokeless tobacco has been associated with diseases of the gums, teeth and pre-cancerous lesions.[21]

Additionally, responsible for 3 million yearly global deaths, alcohol use remains a serious global development and health issue.[22] Over half of all alcohol related deaths or 1.7 million are attributable to NCDs.[35] The total per capita consumption among current consumers has increased in most regions, including LMICs; the data also demonstrates that the risk of mortality from alcohol is disproportionately higher among young people in LMICs.

At a global level, tobacco control faces an 8.4 billion USD annual funding gap for implementation.[23] This funding gap is far exceeded by the economic and health costs of tobacco use.

In fact, the Global Case for Investment in Tobacco Control has estimated that tobacco use resulted in 1.7 trillion USD in social and economic losses in 2022, which equated to 1.7% of the annual global gross domestic product (GDP).[23]

Roughly 40% of this economic burden is expected to fall on LMICs, where tobacco use is projected to increase unless decisive action is taken to significantly strengthen the implementation of the policies and measures required under the WHO Framework Convention on Tobacco Control (WHO FCTC). Accordingly, international sources of funding such as multilateral and bilateral aid could have an important role in closing this gap.

As it stands, there is no data on the global funding gap for alcohol control, which poses a limitation in implementing comprehensive alcohol policies.

However, LMICs may benefit from increased support in addressing high and growing alcohol burdens. Most countries, especially LMICs, have not implemented a comprehensive set of alcohol policies, since 2010. In addition, no low-income country has reported increasing resources for alcohol policy implementation in the last decade.[24]

Moreover, under the NCD umbrella which acquired 0.8% of total health-related development spending between the years 2018 and 2021, tobacco control received 0.3% of total DAH, whereas control of use of alcohol and drugs received close to zero.

2.1 Tobacco Control Funding flows and the analysis of the global funding gap and global investment case for tobacco control

In January 2024, the Secretariat of the WHO FCTC released the findings of a study to estimate the tobacco control funding gap. The study outlines the annual requirements to implement comprehensive tobacco control programs at global and national levels. According to the calculations that were carried out, globally, the amount of funding needed for comprehensive implementation of the WHO FCTC is estimated to be 9.6 billion USD annually.[23] However, the current funding available for tobacco control programs amounts to about 1.2 billion USD, which represents only 12% of the amount required for comprehensive tobacco control implementation, leaving an annual funding gap of 8.4 billion USD.[23] Notably, the aforementioned estimates for current funding accounted for both domestic and international resources including development assistance. Furthermore, the present analysis estimates that out of the 1.2 billion USD in funding, only around 100 million USD annually was provided in the form of development assistance and includes Private Development Finance from philanthropic organizations. Finally, another study whose findings were also published in January 2024 on the global investment case for tobacco control, also highlights the high return on investment (ROI) for tobacco control programs. The findings show that over a period of 15 years, the social and economic benefits of implementing WHO FCTC measures (6.2 trillion USD) greatly outweigh the costs of implementation (130 billion USD) resulting in an ROI of 48:1.[23]

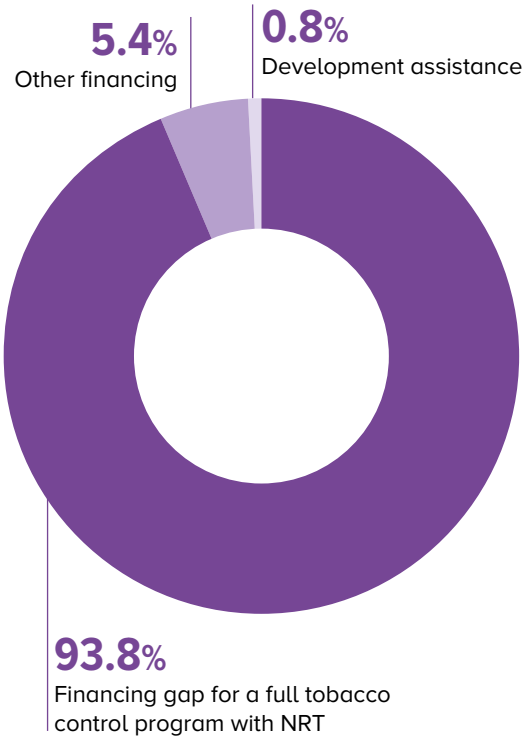


Figure 5. Tobacco Control Funding Gap

DAH for tobacco control is channelled through global and regional organizations, and mostly from private and philanthropic organizations, as opposed to country governments. This may be due to governments operating in under-resourced contexts, or in settings where governments are yet to fully recognize the beneficial contribution that tobacco control may have on economic development. Notably only 33 million USD was channelled in the form of country-specific aid for tobacco control, whilst 306 million USD and 54 million USD was channelled at the global and regional levels, respectively. Bilateral donors play a relatively small role in providing tobacco control financing, as 97% of this funding for tobacco control comes from philanthropic organizations as private development financing. As part of this financing, Bloomberg Philanthropies currently provides roughly two-thirds of donations (69%), whilst the Gates Foundation provides most of the remaining funding (28%). Furthermore, between 2018 and 2021, only 393 million USD of development financing was designated for tobacco control, increasing year-on-year over the period, reaching a peak of 118 million USD in 2021. However, the proportion of NCD financing for NCD policies and programs reduced from 2018 through 2021 from 48% to 30%. (***Figure 6***) This may be in part due to smaller proportional increases in tobacco financing than overall NCD financing.

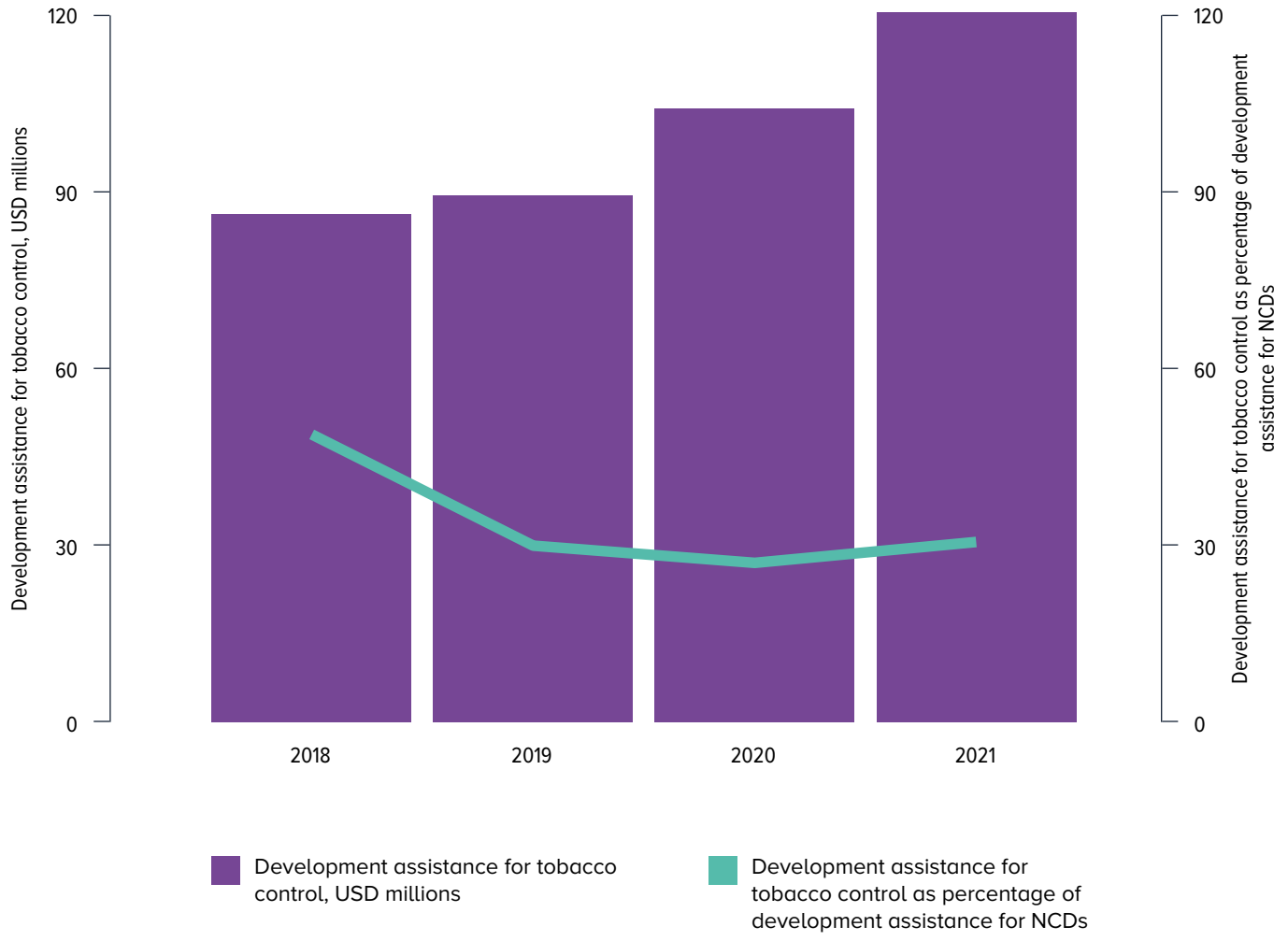


Figure 6. Development financing for tobacco control between 2018 and 2021, by volume and proportion of total NCD development financing

2.2 Global Alcohol program and policy funding flow analysis

There is currently no concrete dollar value calculated for full implementation of alcohol policy programs at the global level. As previously stated, this lack of data limits comprehensive policy formulation and implementation of alcohol programs.

Despite this data gap, available data demonstrates that alcohol use costs high income countries (HICs) at least 1.5% in GDP losses.[25]

In fact, nearly one-third of these costs were direct, while the majority of costs (around two-thirds) were tied to losses in productivity.

Despite these considerable losses in economic productivity, there remains little data on how much is being spent on alcohol policy, particularly at a domestic level.

Moreover, such crucial data gaps reflect the need for greater investment in data for NCD risk factors and the data on alcohol funding from the OECD DAC CRS dataset for control of harmful use of alcohol and drugs also demonstrates that while investment of development funding for alcohol use has increased, it remains exceedingly low. Development funding for alcohol has increased from 3 million USD in 2018 to 17 million USD in 2021, however as a proportion of overall NCD spending, it amounts to a small increase from 1.8% to 4.3%. (*Figure 7*)

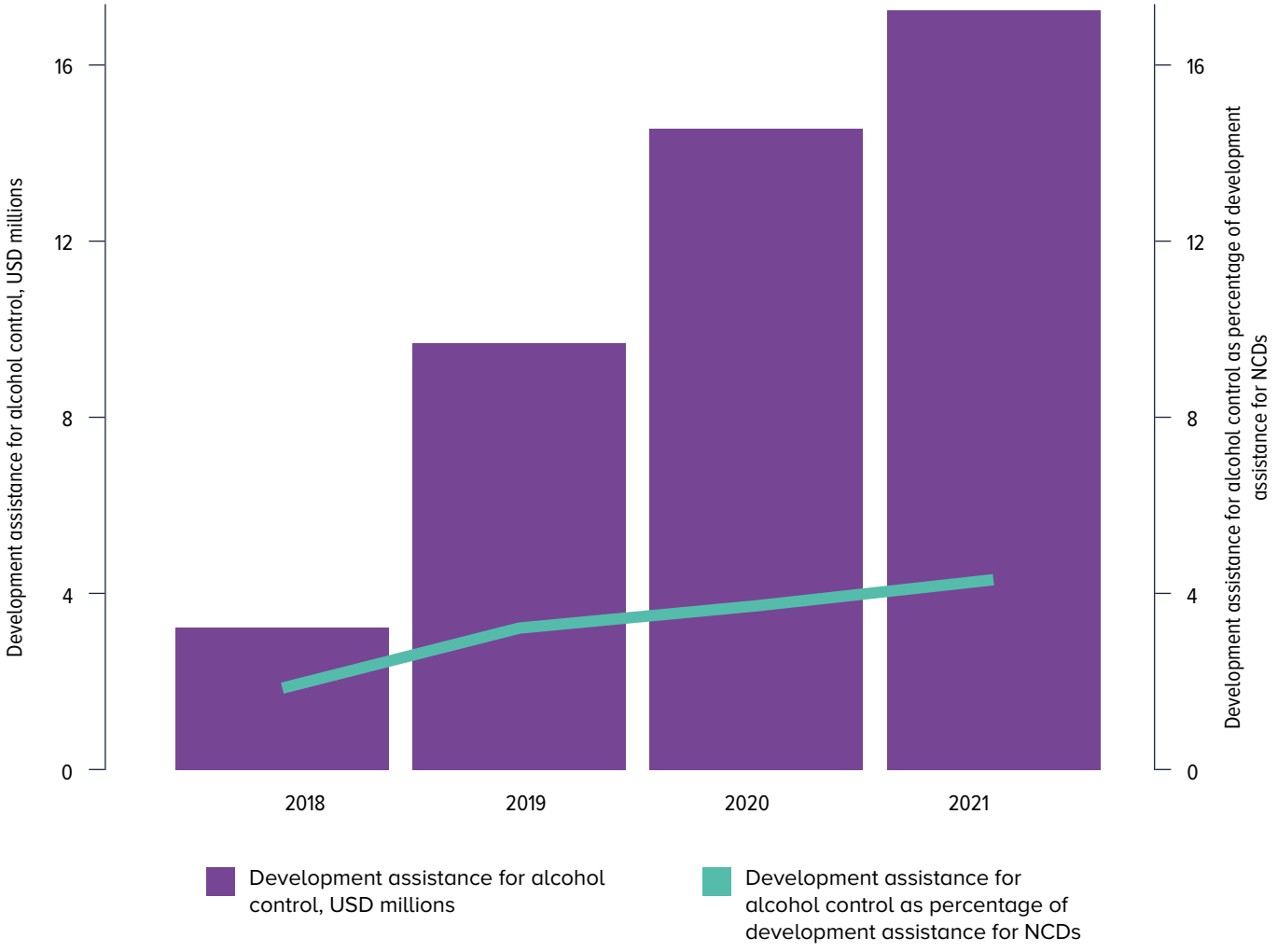


Figure 7. Development Financing for Control of Harmful use of alcohol and drugs between 2018 and 2021, by volume and proportion of NCD Development Financing

In addition to the economic and productivity losses, and its social harm, alcohol use remains a major cause of death at global level. The number of annual deaths from alcohol use amounts to 2.6 million and surpasses the number of deaths caused by diseases such as tuberculosis and HIV/AIDS combined.[26] Even though alcohol use causes 5.3% of deaths, it received less than 50 million USD of development assistance between 2018 and 2021; whilst HIV/AIDS and tuberculosis, which are responsible for 1.2% to 2.2% of deaths, received 30.6 billion USD and 4.4 billion USD respectively.

The donors for alcohol are more varied than those for tobacco control. However, funding for alcohol remains substantially limited, making it difficult to generalize funding trends. Between the years 2018 and 2021, there was an approximately even split between ODA and private development finance. Across the same time period, alcohol and drug use programs received 25 million in ODA financing and 20 million USD in private development financing. The top ODA donors included Saudi Arabia, the European Union, and Norway with donations of 11 million, 5 million and 3 million USD respectively; whilst the major private donors included Open Society Foundations and Wellcome Trust which contributed 11 million and 8 million USD respectively. Saudi Arabia donated almost all of its alcohol policy development assistance to Guinea, which was the largest recipient of alcohol and drug use programs funding. Other recipient countries include Ukraine and Uganda which are funded by Wellcome Trust, and Bolivia which is supported by the EU.

Furthermore, Open Philanthropy has recently become one of the biggest donors of alcohol policy in LMICs by contributing 15 million USD over a period of three years (2022-2025) to the RESET initiative, which is led by Vital Strategies, in consortium with Johns Hopkins University, Movendi International, Global Alcohol Policy Alliance, NCDA, and WHO. The funding is oriented towards impact and its sustainability by focusing on the national implementation of alcohol excise taxes, which also have the potential for domestic revenue generation.[27,28] Notably this contribution, although not registered as development assistance in the OECD CRS database, is higher than any OECD contribution, based on the data analyzed from the 2018- 2021 period, under the 'control of harmful use of alcohol and drugs' category.

3. ODA AND SUSTAINABILITY FOR NCD PROGRAMS

While ODA and other forms of development assistance, are useful for jumpstarting the implementation of preventive programs for NCDs and its risk factors, it cannot on its own fulfil the need for sustainable programs at country-level. In order to ensure sustainable financing, a provision of adequate, predictable and sustained international resources, such as multilateral and bilateral aid, as well as domestic resource mobilization (DRM) are essential to funding NCD prevention programs. Furthermore, implementing measures to develop and implement national level policies and plans, can also be an indicator of sustainability in NCD programming.[29] The subsequent sections outline case studies in which ODA has been used to fund sustainable efforts to decrease the burden of certain NCD risk factors at the country-level.

3.1 Spotlight: Case-studies on Sustainable use of ODA funding

Budget Advocacy Initiatives for Tobacco Control

Despite their relatively low cost of implementation and proven health and economic benefits, tobacco control programs in LMIC contexts remain critically underfunded. In order to address this issue, the GATC supported CSOs in the African and Americas regions in implementing budget advocacy pilot projects. **These budget advocacy projects are ODA-funded, multi-stakeholder initiatives to build the capacity of civil society to secure sustainable resources required to effectively implement comprehensive tobacco control programs as part of their country's budgeting process and political framework.**

'Budget advocacy is a strategic approach to influencing the size and distribution of domestic budgets.'

To account for sustainability, GATC worked in collaboration with country-level advocates to build multi-sectoral coalitions, conduct budget analysis, and provide training and support to develop national advocacy budget plans and campaigns to influence government resource allocation.

As such, taxation, or Article 6 of the WHO FCTC, has been a proven an effective argument when conducting budget advocacy at country-level; country-level advocates could implement taxation into their budget advocacy strategy by pushing for governments to increase excise taxes on tobacco products to save lives and generate government revenue. Not only is tobacco taxation known to increase government tax revenue and save money by decreasing the health and economic costs of tobacco use, but with due coordination between the ministries of health and finance, revenue generated from these taxes can be redirected to fund tobacco control programs.[30]

CASE STUDY 1

Budget Advocacy and taxation in Ghana

Since 2018, GATC supported Vision for Alternative Development Ghana (VALD), a Ghana-based CSO and members of NCDA and GATC, to advocate for comprehensive policies on tobacco, including through their ongoing efforts to implement a tax advocacy campaign which led to increasing the ad valorem tax rate on tobacco products from 150% to 175% in 2015.

The tax- focused advocacy campaign had the following objectives:

- To increase yearly efforts to advance tax arguments;
- increase and modify tax structures to take into account tobacco products;
- direct tax generated revenue to health programs.

As part of the advocacy campaign VALD Ghana with support of Tax Justice Network Africa (TJNA), conducted a situational analysis to get a high-level overview of the national regulations, as well as map out the key government and civil society players to implement the campaign. Additionally, VALD Ghana developed a deep understanding of the national budget process and its key stages: (1) budget formulation, (2) budget approval, (3) implementation, and (4) monitoring evaluation reporting, all with the goal of identifying opportunities to build the case for domestic resource mobilization for tobacco control. *(Figure 8)*

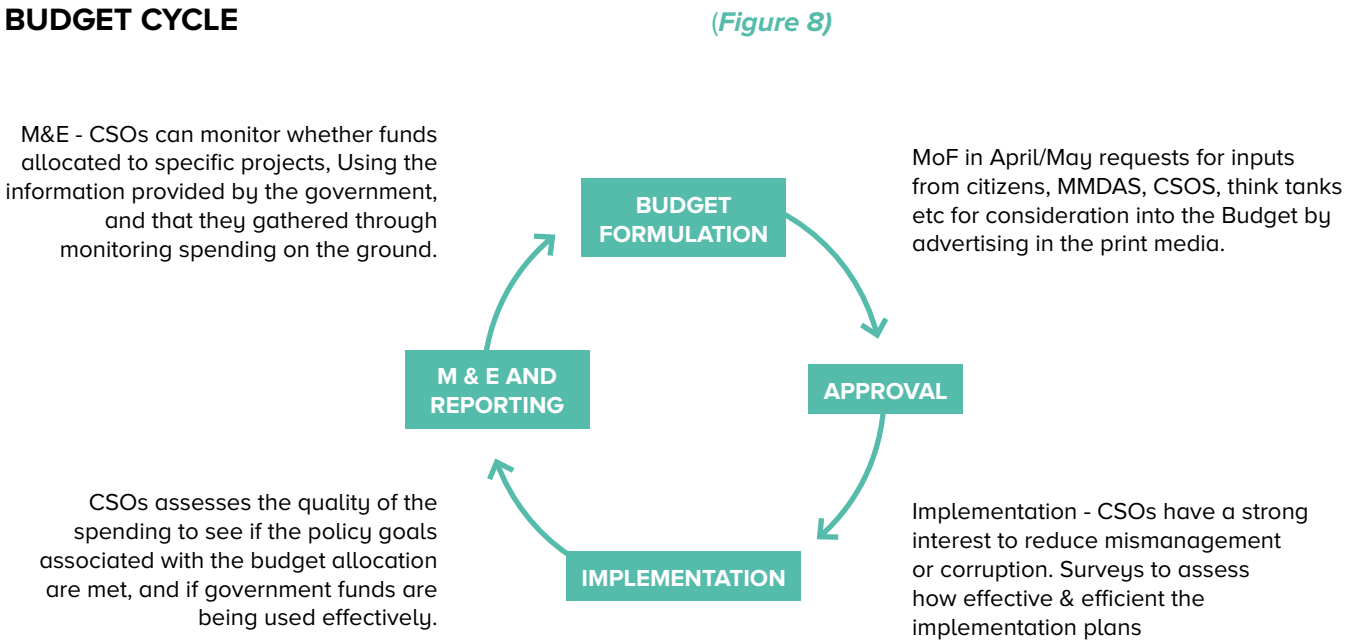


Figure 8. Budget Cycle Analysis in Ghana

As part of this work, VALD Ghana worked with a team of experts from the WHO, United Nations Development Programme (UNDP), the taskforce on NCDs, the WHO FCTC Convention Secretariat, REEP to develop a document to outline the benefits of health taxes, revenue forecasts and recommendations with a focus not only on tobacco products, but also on alcohol and SSBs. Using this evidence, VALD Ghana conducted targeted presentations on tobacco taxes, and emphasized the need for urgent tax reform on tobacco products to various key stakeholders (e.g.: media, government, CSOs, etc.). In conducting these strategic presentations, VALD Ghana used context specific studies and highlighted the need to develop a mixed tax system that accounted for both ad valorem and specific tax. Directing tax earnings to health programs was also discussed in this document.

Through their ongoing advocacy efforts over the years, VALD Ghana was able to contribute to the following sustainable results:

- The passage of the Excise Amendment Act 2023 (Act 1093);
- An increase in taxes on tobacco products;
- A reform of Ghana tobacco tax structure from ad valorem to a mixed tax system (ad valorem + specific tax);
- Ad valorem rate of 50%;
- Specific tax rate of 0.02 per stick in the case of cigarette, cigar and cigarillo (short narrow cigars);
- And 20 USD per net kilo for all other tobacco products.

To date, the Ghana Revenue Authority has indicated a revenue increase due to this tax reform. However, a formal post-assessment is in currently being conducted to analyze the impact of this revenue on public health.

CASE STUDY 2

ADIC and IOGT-NTO Movement ODA Partnership in Sri Lanka

Sri Lanka is heavily burdened by the use of alcohol. Each year, over 4,200 Sri Lankans die of liver cirrhosis, road traffic injuries, and cancers caused by alcohol consumption.[31] Alcohol use also imposes around 733 million USD in economic losses every year, which is equivalent to 1.5 percent of the national GDP.32The Alcohol and Drug Information Center (ADIC) is a well-recognized resource center in Sri Lanka, in the field of addressing alcohol, tobacco, and other drugs as obstacles to development.[33] ADIC's main partner is the IOGT-NTO Movement based in Sweden. As such, both ADIC and the four Swedish NGOs that form the IOGT-NTO Movement are members of Movendi International.[34]

ADIC and the IOGT-NTO Movement have worked together with ODA funding from the Swedish government (SIDA) for more than 20 years. The IOGT-NTO Movement works to help eradicate poverty in the world by addressing alcohol as a major driver of poverty, hunger, violence, ill-health, and under-development in general. IOGT-NTO Movement works with long-term assistance. The IOGT-NTO Movement supports local civil society organizations in their work for development at various levels. In total, they support around 20 partner organizations in 14 countries, including Sri Lanka. ADIC in partnership with IOGT-NTO Movement established an ODA-funded program to identify and address alcohol abuse in families. ADIC supports this work through community programs to raise awareness, and facilitate conversations to identify shared solutions; an example of these shared solutions and conversations may highlight the sustainability of using household resources for healthy nutrition for families, as opposed to purchasing unhealthy commodities such as alcohol.

A sustainable win from this ODA partnership in Sri Lanka was the passage of the National Authority on Tobacco and Alcohol (NATA) Act in 2006. The NATA act established NATA – the pioneer government institution to enact the legal aspects for alcohol and tobacco prevention in Sri Lanka. This institution has had trailblazing achievements in protecting people from the harms of both tobacco and alcohol. For instance, Sri Lanka was one of the very first countries to ratify the WHO FCTC, based on the NATA act. Furthermore, the Act comprises of the most cost-effective, high-impact solutions in alcohol policy and tobacco control, including:

- The prohibition of the sale of any tobacco or alcohol products to persons under the age of twenty-one;
- prohibition of the sale of tobacco products without health warnings, as well as the tar, and nicotine content in each tobacco product; and
- prohibition of tobacco or alcohol advertising, sponsorship, and promotion.

Over the last 3 decades, ADIC has partnered with the government to ensure the passing and full implementation of the National Authority on Tobacco and Alcohol Act, No. 27 of 2006 (NATA Act). For instance, through its ongoing programs, ADIC provided crucial and timely scientific evidence on the alcohol and tobacco burden, and mobilized communities around the country in support of evidence-based action to protect people from alcohol and tobacco harm. Moreover, ADIC worked to expose and counter-act alcohol and tobacco industry interference against the NATA act by implementing high-impact media advocacy to prevent misinformation by health harming industries.

4. RECOMMENDATIONS

NCDs remain the leading cause of mortality and morbidity worldwide; yet, with only 0.8% of total health-related development spending, or 315 million USD per year going towards NCD policies and services in the period of 2018-2021, the analysis demonstrates that DAH continues to fall well below the amount required. Likewise, despite slight increases in development funding during this period, programs that focus on major risk factors for NCDs, such as tobacco and alcohol use, remain equally deprioritized. Within the NCD umbrella, tobacco control received 0.3% of total DAH, while control of use of alcohol and drugs received close to zero between the years 2018 and 2021.

The present section outlines targeted recommendations to improve target investments in NCD prevention programs:

RECOMMENDATION 1

Increase ODA for NCDs and major risk factors

The report finds that most NCD funding is fairly evenly split between private development sources (55.6%) and ODA grants (44.2%). Moreover, results also demonstrate that the limited development assistance going towards alcohol policy is also currently evenly split between ODA and private sources. In contrast, although tobacco control programs have been proven to have a high ROI, tobacco control continues to receive very little funding from ODA, as it is mostly funded through private financing and/or philanthropic organizations (97%). This reliance on philanthropy for NCD related DAH is particularly concerning, as philanthropy is more vulnerable to shifts in funding priorities and unlikely to be a sustainable funding source in the long run.

By definition, spending classified under ODA must have "*economic development and welfare of developing countries as its main objective*". NCDs reduce productivity and human capital while increasing healthcare costs from chronic illness,[36] constituting a great threat to these nations' economic development and welfare. These concerns are all in line with the funding objectives of ODA. It is estimated that implementing the most cost-effective NCD intervention packages would cost an additional 18 billion USD per year over 2023-2030 in LMICs, and the current contribution for NCDs in the period of 2018-2021 stands at approximately 1.3 billion USD.[11] As such, there is much space to increase ODA to support countries in mobilizing domestic resources to create sustainable pathways forward for NCD prevention. Increased ODA support be integrated into a multilateral pooled funding mechanism to support NCD policies and programs.

RECOMMENDATION 2

Increase Domestic Resource Mobilization (DRM) and National Investment for NCDs

While increasing ODA and other forms of development assistance is paramount to jumpstarting the implementation of preventive programs for NCDs and its risk factors in LMIC contexts, it cannot alone fulfil the need for sustainable programs at country-level. Thus, in order to ensure sustainable funding, a blend of international resources, such as multilateral and bilateral aid including ODA, as well as DRM is essential to funding NCD prevention programs. Investing in NCD programs that leverage health taxes could be a pathway to sustainability as it relates to NCD funding.

a) Significantly increase taxes on tobacco and alcohol products

In the case of tobacco control, over 100 studies have generated evidence that showcases tobacco excise taxes as a powerful tool for reducing tobacco use while providing a reliable income source for government revenues.[37] As such, excise taxes are often applied differently to different categories of tobacco products as well as to different brands within product categories. Importantly, excise taxes, rather than VAT and import duties, have proven to have the most significant ability to affect tobacco product prices.[38]

In the case of alcohol, excise taxes for alcohol can either be applied by (1) utilizing a constant rate across all alcoholic beverages of the same type or (2) tiered based on product characteristics, such as alcohol content, annual production volume and/or type of spirit.[39] However, in deciding on different tax structures, it is important to keep in mind the possible implications of each structure. For instance, tiered excise taxes based on the alcohol concentration of beverages may encourage consumers to substitute for alternatives products with lower or no alcohol content; in addition, it may also have supply side effects, such as incentivizing the industry to reformulate beverages that contain less alcohol.[39] On the other hand, uniform excise taxes may be simpler to administer and more effective for reducing alcohol related harms rather than tiered taxes based on other aspects.[39]

b) Improve Intersectoral coordination between Ministries in charge of health, taxation, and national budgets to ensure effective use of the new revenue

With improved coordination between Ministries of Finance and Ministries of Health, health taxes present the opportunity to redirect the revenue generated from tobacco and alcohol products towards health programs. This redirection, however, should not be taken for granted. For example, in the case of alcohol, the WHO reported that there are only 21 countries that earmark excise tax revenue from alcoholic beverages towards health programs as of 2022.[39]

Redirecting funding to health programs may require some form of capacity building on how earmarking can be achieved for countries that have little to no health tax structures in place. Such capacity building activities on taxation may present a potential area of interest for future programming.

RECOMMENDATION 3

Improve Quality Data on NCDs and risk factor Investments

There is a lack of comprehensive data on NCDs in LMIC contexts, making strategic use of ODA for NCDs difficult to achieve. This lack of quality data is often attributed to challenges such as limited resources, inadequate healthcare infrastructures, and data collection systems that contribute to gaps in understanding the prevalence, risk factors and outcomes of NCDs in these regions.[40,41] Notably, the analysis found a substantial data gap for alcohol programs at both global and country levels. Additionally, there remains a significant data lag for the OECD data base. This presents a bottleneck to understanding the diverse needs of recipient countries and where ODA could most efficiently be utilized. Therefore, consideration should be given to:

- Invest in improved data collection and research efforts to inform public health policies and interventions tailored to country specific needs in LMIC contexts.
- Add more indicators for NCDs within the OECD database, and others, including health initiatives that account for health systems strengthening and Universal Health Care.
- Mainstream indicators for NCD data monitoring and investment cases in LMICs would be a good step in the right direction; such as the Global Alcohol Action Plan (2022-2030) which also proposed indicators not just for resource mobilization, but other relevant indicators for capacity building, policy implementation, and for monitoring and surveillance data.[42]
- Improve reporting to efficiently track the impact and spending on NCDs and its risk factors.

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ANNEX I
METHODOLOGY

The analysis of development finance flows uses the full OECD DAC Creditor Reporting System (CRS). The database contains various pieces of information about development and humanitarian projects including sectors targeted, recipient countries/regions and timeframes. For this report, the data was retrieved on 4 September 2023.

The analysis was based on disbursements, i.e. actual expenditures, deflated into 2021 values, over the time period from 2018 to 2021. The most recent development finance data in the CRS is for the year 2021 and the sector and purpose codes for Non-communicable Diseases (NCDs) were only introduced for first reporting on 2018 flows. In the same year, the purpose codes within NCDs for 'Tobacco use control' and 'Control of harmful use of alcohol and drugs' were also introduced.

All types of financing reported to the CRS were included: Official Development Assistance (ODA), Other Official Flows (OOFs) and other types. For analysis on income groups and regions, we used the World Bank Income groups and Regions specified in the DAC CRS codelist.

For identifying financing on different areas of health, we used the following sector and purpose codes:

- For overall health financing, we used the sectors 120, 121, 122, 123 or 130.
- For all NCD financing, we used the sector code 123 - Non-communicable diseases (NCDs).
- For General/Basic Health, we combined the sector codes 120, 121 and 122.
- For tobacco control financing, we used the purpose code 12320 - Tobacco use control.
- For alcohol control financing, we used the purpose code 12330 - Control of harmful use of alcohol and drugs.
- For HIV/AIDs, malaria and tuberculosis, we used the purpose codes 13040, 12262 and 12263 respectively.

In order to quantify the overall gap in tobacco control, we used data deriving from the analysis of the Secretariat of the WHO FCTC and further analyzed data of the OECD CRS.

ANNEX II

Figure 1. Development assistance between 2018 and 2021, by purpose code

Sector	Purpose	USDm	Percentage of total health
General/basic health	COVID-19 control	20257.2	13.21
	Infectious disease control	17491.1	11.41
	Basic health care	16698.5	10.89
	Health policy and administrative management	16070.2	10.48
	Malaria control	10219.6	6.66
	Medical services	5828.2	3.8
	Basic nutrition	5213.8	3.4
	Tuberculosis control	4420.7	2.88
	Basic health infrastructure	3626.3	2.36
	Medical research	3284.1	2.14
	Health personnel development	850.6	0.55
	Health education	843.3	0.55
	Medical education/training	489.3	0.32
Population Policies/ Programs & Reproductive Health	STD control including HIV/AIDS	30604	19.96
	Reproductive health care	8036.8	5.24
	Family planning	6346	4.14
	Population policy and administrative management	1352.8	0.88
	Personnel development for population and reproductive health	449	0.29
NCDs	Tobacco use control	393.3	0.26
	Other prevention and treatment of NCDs	341.8	0.22
	NCDs control, general	218.1	0.14
	Promotion of mental health and well-being	171.5	0.11
	Research for prevention and control of NCDs	90.9	0.06
	Control of harmful use of alcohol and drugs	44.7	0.03


NCD Alliance


Global Alliance
for Tobacco Control