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RESEARCH PAPER

Global action, but national results: strengthening pathways towards better health outcomes for non-communicable diseases

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ABSTRACT

Global governance of non-communicable diseases (NCDs) has moved beyond the World Health Organization (WHO) to become a shared responsibility of WHO, the United Nations General Assembly, and other willing stakeholders. Despite the significant attention NCDs have received, progress towards global goals and political commitments remains disappointing. This lack of progress calls for greater attention to be given to how actions taken at the international level can lead to improvements in health at the country level. This paper reviews progress in the global response to NCDs by highlighting the role of pathways – both current and potential – for translating global aspirations into national actions that improve health outcomes. Important pathways to national action include the development of normative instruments, political accountability mechanisms, provision of economic support and technical assistance, and other forms of engagement we refer to as 'institutional pathways'. We find that global leadership on NCDs has focused predominantly on generating a suite of normative instruments for influencing national policy, together with global targets and reporting processes but with inadequate development assistance for NCDs, or investment in capacity building. We point to the distinctively legal and regulatory nature of many priority interventions identified by WHO for NCD prevention and control, arguing that legal capacity building of both government and civil society stakeholders is a vital, cost-effective yet neglected pathway for strengthening national responses. We outline a modest vision for global, regional and national leadership in capacity-building and in promoting the role for law in NCD prevention and control.

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Introduction

Non-communicable diseases (NCDs), principally cardiovascular disease, cancer, chronic respiratory diseases, and tobacco-related diseases are responsible for around 41 million deaths each year (WHO, 2018a). More than three quarters of these deaths, and over 85% of premature deaths, occur in low- and middle-income countries (WHO, 2018a) – where social safety nets may be are fragile or absent, and where treatments remain prohibitively expensive for many people (Attaei et al., 2017; Bollyky, 2013).

Since the High-Level Meeting of the United Nations (UN) General Assembly on the Prevention and Control of NCDs in 2011 (UN General Assembly, 2011a), there has been growing recognition of the impact of NCDs on health, and on economic development, in low- and middle-income countries (World Health Organization and World Economic Forum, 2011). The 2011 UN General Assembly

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meeting marked the time when global governance of NCDs moved beyond the World Health Organization (WHO) to include the UN General Assembly and, more broadly, the UN system. Global meetings and expressions of concern are a start, but how do these global-level actions provide the catalyst for the policies, laws, and programs needed at the country level to achieve better national outcomes for NCDs?

This paper introduces the idea of 'pathways' – both currently used, and potential – through which the activities of global bodies, such as the World Health Assembly or UN General Assembly can lead to reductions in NCD risk factors and other improvements at the country level. We identify and describe four current pathways that have been used with varying degrees of success (Figure 1). The first pathway is *global normative instruments*: the normative (and sometimes legal) force of global instruments can be a catalyst for policy changes and law reform at the national level. The second pathway is *political accountability mechanisms*: global reporting and other accountability mechanisms can strengthen the political accountability of national leaders to lead the process of policy reform and implementation at national level. The third pathway is the *provision of development assistance*: economic support can help to bridge the financial and human resource limitations of low- and middle-income countries.

The fourth pathway comprises other forms of engagement with national governments that are carried out either by global institutions, or through purpose-built governance mechanisms. These functions may include developing normative instruments, administering accountability processes, and providing technical assistance (the first three pathways above). In addition, global institutions and other governance mechanisms may discharge a variety of additional functions whose ultimate purpose is to encourage and support national action. These include: collecting national data, carrying out research, sharing evidence about effective national policies, and promoting the importance of particular health challenges as urgent or worthy of a national response. We refer to these forms of engagement as 'institutional pathways'.

In the following four sections, we review progress in the global response to NCDs along each of these pathways. Despite the global actions taken so far, the world is not on track to meet target 3.4 of the Sustainable Development Goals (by 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment) (UN General Assembly, 2015). Meeting this goal will require political commitments to be implemented 'on a dramatically larger scale' (NCD Countdown 2030 Collaborators, 2018; WHO, 2018b).

The pathways identified above are a tentative list that by no means exhaust the ways in which actions at the global level might help to shape national policy responses. For example, the re-appointment in 2018 of philanthropist and former New York City Mayor Michael Bloomberg as WHO Global Ambassador for Noncommunicable Diseases highlights the importance of global advocacy by champions in civil society (WHO, 2018c). The appointment of regional and country rapporteurs on NCDs could also help to motivate and strengthen civil society movements, challenge business and influence governments. In this paper, however, we focus particular attention on the distinctively legal and regulatory nature of many cost-effective interventions identified by WHO for preventing and managing NCDs. We argue that capacity building for legal and regulatory responses to NCD prevention and control is a vital yet under-resourced pathway for strengthening national responses to NCDs. We present a modest vision for global and national leadership in capacity-building and in promoting the role that law and regulation could play in NCD prevention and control.

Global normative instruments

Prior to the first High-Level Meeting of the UN General Assembly on NCDs in 2011, the global response to NCDs was led by WHO and involved the successive development of normative instruments to guide national policy development. Over time, this set of instruments grew to include guidelines and global strategies that collated evidence, stated the case for national action, and identified evidence-based and cost-effective policy interventions. This set of instruments included the International Code of Marketing

Pathway	Actions, activities, processes at the global level		Intended impact at the national level
Global normative (and legal) instruments	Adoption of treaties, conventions Resolutions of international bodies (World Health Assembly, UN General Assembly) Normative international instruments, including global strategies, implementation plans, recommendations, codes of practice, guidelines	→	Legal and normative pressure for policy change Better understanding of the case for policy action, better knowledge about policy options and policy priorities
Political accountability mechanisms	Goals, targets, indicators, timelines , especially when supplemented by periodic reporting requirements to global bodies (World Health Assembly, UN General Assembly) Partnerships between key actors, including UN agencies, governments, private funders, INGOs Accountability mechanisms used by civil society organisations (eg indexes, shadow reports)	→	Greater political commitment and pressure on national governments to implement effective policies Improved capacity for policy action at national level
Provision of development assistance	Development assistance in health: provision of direct economic and material support, and technical assistance to countries Funding conditionalities intended to create incentives for policy implementation	→	Material resources for policy development, implementation, programs and initiatives Economic pressure for policy actions at national level
Other institutional pathways	Creation of purpose-built governance mechanisms to strengthen engagement with, and assistance to, countries (eg data collection, research, sharing evidence, policy dialogue)	→	Better understanding of the case for policy action, better knowledge about policy options and policy priorities Improved capacity for policy action at national level
Capacity-building	Coordination of training to improve technical capacity at country level Mentoring of future leaders Sharing good practices and encouraging diffusion of good policies	→	Greater capacity for implementation of policies and laws at national level
Global advocacy and media campaigns	Global advocacy by rapporteurs, champions in civil society, and international NGOs Popular movements and media campaigns mobilising popular opinion	→	Greater awareness of health problems Normative pressure for global and national policy change

Figure 1. Global actions and processes in health, and their intended impact at the national level.

of Breast-milk Substitutes (WHO, 1981), the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children (WHO, 2010a), and the global strategies on infant and young child feeding (WHO, 2003a), diet, physical activity and health (WHO, 2004), and harmful use of alcohol (WHO, 2010b). World Health Assembly resolutions endorsing these instruments typically urged Member States to implement the recommendations or strategy within national policies and laws, to strengthen national structures for implementation, and in some cases to adopt national targets, indicators, and timelines for monitoring progress.

We describe this suite of documents as 'global normative instruments', since the policy guidance they embody is intended to be a catalyst for legislative, executive, and political actions at the country level. Where these documents are formally adopted in resolutions of the World Health Assembly or UN General Assembly, there is the added expectation (often honoured in the breach) that countries will implement the resolutions through appropriate policies and laws.

In contrast to these non-binding normative instruments, sometimes referred to as 'soft law', the WHO Framework Convention on Tobacco Control (WHO FCTC) (WHO, 2003b), which entered into force in 2005, imposes 'hard' legal obligations on Parties. It has since been joined by the Protocol to Eliminate Illicit Trade in Tobacco Products, which entered into force on 25 September 2018 (Conference of the Parties to the WHO Framework Convention on Tobacco Control, 2018). Scholars have called for WHO to lead the negotiation of new legally-binding instruments, including a framework convention on global health (Gostin et al., 2013), on alcohol control (Sridhar, 2012), and on obesity and healthy diets (Consumers International & World Obesity Federation, 2014). The existence of such conventions could impose additional pressures on countries that assumed obligations under them to implement these global standards through national laws and policies. On the other hand, legally-binding instruments are time consuming to negotiate and are products of a political process: to the extent that they embody weak or unduly flexible standards, they might achieve little in real terms.

Since the Political Declaration of the High-Level Meeting of the UN General Assembly in 2011 (UN General Assembly, 2011a), the most important normative instrument guiding the global response to NCDs has been WHO's *Global action plan for the prevention and control of NCDs* 2013–2020, adopted by the World Health Assembly in 2013 (WHO, 2013a). The Global Action Plan contains a menu of policy options for consideration by Member States, including measures directed at leading NCD risk factors including tobacco use, harmful use of alcohol, obesity, poor diet (including excess consumption of saturated fat, sugar and salt, and inadequate consumption of fresh fruit and vegetables), and lack of physical activity. Appendix 3 of the Global Action Plan, updated and endorsed by the World Health Assembly in 2017, presents a sub-set of 'best buys' that are very cost-effective and affordable in low- and middle-income countries (WHO, 2017a).

The effective use of legal and regulatory powers by governments lies at the heart of national efforts to implement the 'best buys' and other cost-effective interventions referred to in Appendix 3 of the Plan (see Supplementary Material, Box 1). Governments may use fiscal policies (e.g. raising excise taxes on tobacco or alcohol products), together with legislation, regulations, decrees or executive orders that prescribe standards, specify required actions and authorize government agencies to carry out monitoring and enforcement. Progress may also be reflected in the formal adoption of national targets and the establishment of a national multi-sectoral mechanism through which to develop an integrated set of policies and programs to support reductions in NCD risk factors (WHO, 2013a).

Other examples of normative documents since the 2011 High-Level Meeting of the UN General Assembly include the final report of the Commission on Ending Childhood Obesity, which included a recommendation for countries to implement a tax on sugar-sweetened beverages (WHO, 2016). In 2017, the WHO Director-General, Dr Tedros Adhanom Ghebreyesus established an Independent Global High-Level Commission on NCDs, whose final report called on heads of State and Government to lead multi-sectoral national action on NCDs and to build prevention and health promotion services into universal health coverage entitlements (WHO, 2018d). WHO has developed a global action plan on physical activity (WHO, 2018e), and also revised its global strategy on women's, children's, and adolescents' health (WHO, 2017b).

How influential has WHO's suite of normative instruments been, in terms of their impact on national policies? The starting point for any such analysis would be to examine progress in implementing the specific policy priorities these instruments recommend. However, the focus of WHO's Global Monitoring Framework on NCDs – set out in Appendix 2 of the Global Action Plan – is on the prevalence of risk factors, rather than accountability for implementing the 'intermediate' policies

through which these outcomes are intended to be achieved. The Global Monitoring Framework comprises 9 global targets, supported by 25 indicators, which are intended to inform national targets and indicators (WHO, 2013a). There is an overall target of a 25% reduction in premature mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory disease by 2025, adopted by the World Health Assembly in 2012 ('25 X 25'). This is supplemented by eight additional voluntary goals addressing specific risk factors, adopted by the World Health Assembly in 2013 (see Supplementary Material, Table 1). The 25 indicators provide a summary of global levels of behavioural and biological risk factors, although a small set of 'additional indicators' do measure the adoption of priority policies (e.g. to limit saturated fats and virtually eliminate *trans*-fats from the food supply, and reduce marketing of unhealthy foods and beverages to children).

Global accountability mechanisms

The impact of global normative instruments on national policies occurs not only because of the persuasive force of these documents, or their formal status, but because of the political processes that precede their development. The World Health Assembly and UN General Assembly are global political forums that provide opportunities for debate, for receiving evidence, generating consensus and exerting political pressure on Member States. Strategies for strengthening political accountability include the formal adoption of global goals and targets, the creation of global reporting mechanisms, the formal launching of reports through the global media, the opportunities that global meetings provide for civil society organisations to speak to country representatives, and the development of meeting agendas.

At the global level, three monitoring frameworks for NCDs have evolved, a reflection of the shared global governance of NCDs between WHO and the UN General Assembly. Firstly, the Sustainable Development Goals (SDGs), adopted by the UN General Assembly in September 2015 include a separate, time-bound target on NCDs: to reduce premature mortality from NCDs by one-third by 2030 (target 3.4) (UN General Assembly, 2015). In 2017, the UN General Assembly adopted the Global Indicator Framework developed by the UN Statistical Commission, which is intended to support annual reports on progress towards the SDGs. This framework measures global progress towards target 3.4 in terms of mortality rates for cardiovascular disease, cancer, diabetes, and chronic respiratory diseases (UN General Assembly, 2017).

Secondly, as discussed above, the WHO's Global Monitoring Framework for NCDs features nine voluntary goals, and according to the Global Action Plan, the cost-effective policies identified in the Plan are intended to assist countries to make significant progress towards achieving these goals *collectively* (WHO, 2013a). This framework, and especially the publication of country profile reports – which enable each country to gauge their progress towards the nine global goals (WHO, 2018f) – serve an apparent political purpose: to generate a greater sense of commitment to implementing the policies that will contribute towards achievement of these goals.

This strategy is also implicit in the third monitoring framework developed by WHO for the purposes of its progress report to the UN General Assembly, prior to the 2018 High-Level Meeting of the UN General Assembly on NCDs (WHO, 2017c). Unlike the indicators for the WHO's Global Monitoring Framework, which are light on policy action, the indicators for this reporting framework tracked countries' progress in implementing risk reduction strategies. They included indicators for actions taken by governments to implement core obligations of the WHO FCTC, measures for reducing harmful use of alcohol, to reduce population salt consumption and consumption of saturated fatty acids, to virtually eliminate *trans* fatty acids in the food supply, to implement WHO guidance on marketing of foods and non-alcoholic beverages to children (WHO, 2010b) and to fully implement the International Code of Marketing of Breast-milk Substitutes (WHO, 1981). This reporting framework provided the basis for the *Noncommunicable Diseases Progress Monitor 2017*, which summarised progress in each country (WHO, 2017d). These indicators will also be included in the WHO's report to the UN General Assembly prior to the 2024 High-Level Meeting on NCDs (WHO,

2019a, pp. 27–29). In 2019, the World Health Assembly (WHA) requested WHO to provide annual, consolidated reports to WHA over the period 2021–2031 on progress in prevention and control of NCDs (WHO, 2019b).

Forms of political persuasion extend beyond the accountability mechanisms adopted by multilateral forums to include direct advocacy by civil society organisations, including through the media. The NCD Alliance, which provides a unifying voice for 2,000 civil society organizations across 170 countries, has issued an advocacy agenda calling for urgent reform to enable participation by people living with NCDs in programme development, implementation, policy-making, and accountability processes at national and global levels (NCD Alliance, 2017). One lesson from the global response to HIV is the strategic value of integrating civil society organisations into the global reporting process. For example, UNAIDS encourages the involvement of civil society organisations in the Global AIDS Response Reporting process, which has continued to evolve since the 2011 UN General Assembly Political Declaration on HIV and AIDS (UN General Assembly, 2011b). UNAIDS urges countries to involve civil society in the collection and analysis of data, and to permit civil society to comment on the draft report (UNAIDS, 2018, pp. 19-20, 23–26). UNAIDS also accepts shadow reports from civil society in cases where governments fail to submit a report, where discrepancies arise between government and civil society data, or where civil society is excluded from the reporting process (UNAIDS, 2018, p. 23).

Development assistance for national action on NCDs

A third pathway for catalysing national action is the funding pathway, through which the resource limitations of low- and middle-income countries are supplemented by targeted assistance and technical support. Like HIV, the leading NCDs are chronic diseases whose treatment requires strong health systems, including skilled health professionals, the capacity for health monitoring and follow-up over a long period, and affordable access to essential medicines (Haregu, Setswe, Elliott, & Oldenburg, 2014). Risk prevention measures also require funding, such as mass media and social marketing campaigns, funding to assist the transition from reliance on advertising and sponsorship of alcohol or sugar-sweetened beverages, and research to demonstrate the need for – and effectiveness of – tobacco control legislation.

Despite this, development assistance for NCDs remains a tiny proportion of overall development assistance in health (DAH) funding (Allen, 2016; Greenberg, Leeder, & Raymond, 2016; Nugent, 2016). In 2018, total DAH was $38.9 billion, representing around one quarter of total spending on health in low-income countries (Institute of Metrics & Evaluation (IHME), 2019, p. 15). In the same year, DAH for NCDs was $778 million: 2% of total DAH (IHME, 2019, p. 86).

Scholars have contrasted the response of the international community to HIV, following the UN General Assembly's Special Session on HIV/AIDS in 2001 (UN General Assembly, 2001) with the High-Level Meeting on NCDs in 2011 (UNGA, 2011a). Although DAH for HIV has declined since 2012, it still attracted $9.5 billion in 2018, accounting for 24.3% of total DAH (IHME, 2019, p. 80). Despite rising faster in young populations and causing death earlier in low- and middle-income countries than in high-income countries (Council on Foreign Relations, 2014), NCDs continue to attract the lowest share of global DAH among key health focus and program areas (IHME, 2019, p. 70).

Other institutional pathways towards national action

As noted in the introduction, global institutions and purpose-built governance mechanisms provide opportunities for other forms of engagement with national governments that do not fall within the normative instruments, political accountability, and funding pathways discussed above. Below, we briefly note some additional 'institutional pathways' that have emerged for NCDs.

The global governance arrangements for NCDs that have emerged since the 2011 High-Level Meeting of the UN General Assembly reflect the strategic realisation that advancing national action on NCDs requires many actions across many sectors and ministries: a multisectoral approach is

paramount. Rather than a single, global agency to drive strategic relationships with the private and non-government sectors, encourage funding initiatives and strengthen coordination between UN agencies (Nishtar, 2017), two coordinating networks have emerged. Firstly, on the recommendation of the UN General Assembly, the UN Social and Economic Council (ECOSOC) established the United Nations Interagency Task Force on NCDs (UNIATF): its role is to coordinate, integrate and strengthen the efforts of all relevant UN and inter-governmental agencies, with an appropriate division of responsibilities (ECOSOC, 2013) (http://www.who.int/ncds/un-task-force/en/). The Interagency Task Force is led by WHO, and its terms of reference set out key actions that UN agencies and programmes can take in helping to implement the WHO's *Global action plan for the prevention and control of NCDs* 2013–2020 (WHO, 2013a). The role of the Task Force includes strengthening national, regional and global plans for prevention and control of NCDs by exchanging best practice in health promotion, legislation, regulation, and health systems strengthening (WHO, 2015, p. 12).

Secondly, in 2013 the World Health Assembly passed a separate resolution (WHO, 2013b) authorising the Director-General to establish a Global Coordination Mechanism for NCDs (GCM/NCD) (http://www.who.int/nmh/events/ncd-coordination-mechanism/en/). The role of the Global Coordinating Mechanism is to facilitate engagement between Member States, UN agencies, other relevant inter-governmental partners and non-state actors in order to enhance collaboration across sectors at national, regional, and global levels, while safeguarding WHO and public health from the potential for conflicts of interest (WHO, 2013b). Working groups have been established to support work across the five functions envisaged for the Global Coordinating Mechanism in its terms of reference and work plan (WHO, 2014).

Assessment of the pathways

This paper has reviewed the global response to NCDs in terms of a set of 'pathways' to national action that includes normative instruments, global targets, and other accountability mechanisms, the provision of material and economic resources, and other institutional mechanisms for fostering engagement with national (and sub-national) governments. Overall, progress has been disappointing. The world is not on track to meet the time-bound target on NCDs in the SDGs to reduce premature mortality from NCDs by one-third by 2030 (WHO, 2018b). The WHO Independent High-Level Commission on NCDs concluded that commitments 'have not been translated into legislative and regulatory measures, sustained investments, or in financing for NCD programmes consistently across Member States' (WHO, 2018d). The Commission identified 'weak political action' by Heads of State, and the fact that 'Most low-income and lower-middle-income countries have no policy backbone or advanced technical expertise for the prevention and control of [NCDs]' (WHO, 2018b). Interference in health policy-making by multinationals with vested economic interests (a risk not limited to low-income countries), and unmet demands for development assistance to support country needs for technical assistance, further explain the lack of progress (WHO, 2018b). Global data on the indicators supporting the WHO's Global Monitoring Framework for NCDs also indicate that the world is not on track to meet any of the nine voluntary goals, including those for physical activity, tobacco use, raised blood pressure, obesity and diabetes, and essential NCD medicines and technologies (WHO, 2018f, 2019a).

On the positive side, WHO has invested significantly in the development of global normative instruments, policy priorities have been identified, and global targets have been set. However, genuine accountability mechanisms – directed at the performance of national leaders in leading a whole-of-government response, are absent (Editorial, 2018; WHO, 2018d). Despite causing 71% of global deaths each year (WHO, 2018a), NCDs attract only 2% of development assistance in health, crippling the ability of small and less developed countries to build the institutional capacity needed to develop, implement, and enforce national laws and policies.

Lack of resources has also undermined the effectiveness of the two purpose-built governance mechanisms whose function it is to engage with and support governments in policy implementation. The most important initiative of the UN Inter-Agency Task Force has been to undertake joint programming missions to Member States, promoting policies to Heads of State, ministers, parliamentarians and non-State actors, and strengthening UN country teams (WHO, 2018b [Annex 4]). However, a resolution adopted on the Inter-Agency Task Force by the UN Economic and Social Council (ECOSOC) reads like an open-ended plea for donations and economic support (UN ECOSOC, 2018). Greater resources are needed both to support the implementation of Joint Mission recommendations, and to counter 'pervasive industry attempts' by the tobacco, alcohol, food, and beverage industries to weaken national policies (WHO, 2018b [Annex 4]; UNIATF 2018]).

The target for NCDs in the Sustainable Development Goals (target 3.4) has led to a 'rapidly increasing demand' for technical support from WHO to integrate NCDs into national action plans (WHO, 2018h). The GCM/NCD mostly comprises WHO Member States, NGOs, and academic institutions: it is the only WHO mechanism for facilitating multi-stakeholder and multi-sectoral interaction at regional, country, and subnational levels. Yet an evaluation presented to the World Health Assembly in 2018 noted 'engagement with Member States is essentially with ministries of health or diplomatic missions based in Geneva' (WHO, 2018g). Priorities for GCM/NCD in future include compiling and sharing success stories and best practices through thematic working groups, hosting dialogues, and developing online resources (WHO, 2018h, 2019a).

To accelerate progress, greater priority must be given to strengthening accountability for implementing the powerful, intermediate policies that will shift health outcomes at the national level (Editorial, 2018). Implementation of these policies is not straightforward, requiring attention to diverse issues such as design of a national, multi-sectoral approach to policy-making, retention of staff in NCD units, strengthening enforcement of existing laws, and preventing industry interference (Tuangratananon et al., 2018). Encouragingly, in 2019 the Swiss Development Corporation and the OPEC Fund for International Development (OFID) funded a three-year program to build capacity in regulatory and fiscal measures for diet and physical activity in Bangladesh, Kenya, Sri Lanka, Uganda and the United Republic of Tanzania. This program, which is implemented by WHO and the International Development Law Organisation (IDLO) in collaboration with the International Development Research Centre, includes in-country training to build institutional capacity, technical support, and dialogues between government stakeholders, academia, and civil society (WHO, 2019c).

A modest vision for legal capacity building for National action on NCDs

This paper argues that the opportunity remains for WHO, UNDP, UNICEF, other leading UN agencies, and bilateral and multilateral institutions to develop a vision and joint strategy for strengthening national capacity to implement priority policies for prevention and control of NCDs. Given the emphasis on law and regulation in implementing priority interventions (see Supplementary Material, Box 1), legal capacity-building must lie at the centre of such a strategy. This includes sharing good practices for implementation and enforcement of regulatory requirements, developing technical resources, and nurturing leadership in legal responses to NCDs, including through communities of practice (International Development Law Organisation (IDLO) & UN Interagency Task Force on NCDs (UNIATF), 2017; Magnusson, McGrady, Gostin, Patterson, & Abou Taleb, 2018; Magnusson and Patterson, 2014). Fortunately, leaving the cost of medicines to one side (Attaei et al., 2017), the cost of implementing many of the highest priority policies for prevention and control of NCDs is not high (Bonita et al., 2013; Cecchini et al., 2010). This is an important message for major DAH donors: relatively modest investments in national capacity building would address a key impediment to the translation of global policy recommendations into national policies and laws.

At the national level, an important consideration for health ministries seeking to implement the WHO's 'best buys' is to know what questions to ask. For example, ministers and public health officials may be unfamiliar with the limitations on State sovereignty in the public policy arena that arise from

commitments made in trade and investment treaties. An important place to start is to sensitise public health and trade officials to the potential health impacts of trade and investment agreements (McGrady, 2018; Schram et al., 2018; Thow & Mcrady, 2014; Voon & Mitchell, 2014; Walls, Smith, & Drahos, 2015). This includes building capacity to identify and resist misinformation about the constraints imposed by such agreements, while emphasising the benefits of obtaining legal advice early in the process of negotiating or joining such agreements (Barlow, Labonte, McKee, & Stuckler, 2019). Recent trade disputes involving tobacco control laws have led to growing confidence that countries can pass effective and evidence-based laws without violating trade obligations (Voon, 2019, 2013); legal skills and knowledge gained from tobacco control disputes are readily transferable to measures addressing other NCD risk factors, such as alcohol, unhealthy foods, and sugar-sweetened beverages (Johnson, 2017; Mitchell & Casben, 2016).

A second consideration when thinking strategically about capacity building is the need for good process in reforms to address NCDs. Unless law reform processes are transparent and participatory, governments may lack the courage or political mandate to push a new intervention through the legislative or regulatory process. One example is a tax on sugar-sweetened beverages: unless the community is engaged, there may be resistance, particularly as lower socio-economic groups consume more sugar-sweetened beverages per capita in some countries. An important aspect of capacity building is coalition building, certainly with public health and human rights organisations, but also with civil society organisations representing women, children, consumers, employers, and workers. Capacity building should aim to sensitize civil society advocates to key legal issues, so that they are better able to represent the interests of affected communities and engage directly with government.

Thirdly, in order to secure the legal resources they require in the short-to-medium term, many smaller States will need to look beyond their health, justice, and trade ministries. In many countries legal academics also advise governments on legal matters – directly or indirectly – and so involving academic lawyers (and bodies representing other parts of the legal profession) in strategies for capacity building, and encouraging the development of academic expertise in law and NCDs, will be important. Most low- and middle-income countries do not have interdisciplinary centres on law and public health; however, for smaller and island States, building affiliations with a regional academic institution may be fruitful. Scholars have emphasised the failure of the academic community to show leadership in NCD prevention and control (Greenberg et al., 2016). However, given the importance of legal and regulatory capacity to the ability of countries to implement priority interventions, efforts to build capacity should include law schools, encourage those with a research interest in the field, and support the mentoring of future leaders. Once academic interest takes hold, linkages between academic centres in other countries, particularly at regional or sub-regional level, will follow. These could take different forms, including WHO Collaborating Centres with expertise in law, human rights, and NCDs, with national health law institutes, and in appropriate circumstances, with think tanks and other civil society organisations. The goal is to nurture capacity and to build the sustainability of national legal resources.

Fourthly, in the short-term, regionally focused short courses (including online courses) could help to build practical capacity in specific areas, such as a tax on sugar-sweetened beverages (World Cancer Research Fund International, 2018), the design of effective advertising restrictions on tobacco products or alcoholic beverages, or strategies for avoiding industry interference. Such courses should not be limited to government participants; as noted above, public health academics, legal advisors to health NGOs, and other civil society representatives should be included.

Fifthly, as regional and national strategies for capacity building proceed, it will be vital to document and share results; for example, through the Global Coordination Mechanism for NCDs. It may be tempting for some to catalogue the laws in existence across different countries or regions. The priority, however, in a resource-constrained environment, is to share examples of good legislative and legal practices that can be adapted to national circumstances, documenting stumbling blocks as well as narratives of success.

Finally, since legal systems are complex systems, law reform often proceeds in spurts, progress is non-linear and opportunistic and, occasionally, negative feedback loops can lead to regressive measures (Ramalingam, 2013). Therefore, approaches should anticipate unexpected opportunities, and setbacks, and remain aware of the distorting influence of the tobacco, alcohol, and unhealthy food and drinks industries on policy efforts, including through conflicts of interest (Lima & Galea, 2018; Moodie et al., 2013; Whitaker, Webb, & Linou, 2018; Pisinger, Godtfredsen, & Bender, 2019).

Conclusion

This paper has described the global response to NCDs in terms of a set of 'pathways' to national action. These include 'hard' and 'soft' normative instruments; targets, reporting processes and other mechanisms for exerting political pressure on national governments; the provision of material and economic resources; and other institutional pathways for engaging governments. While there may be opportunities for further actions to strengthen these pathways, the fact is that they have not yet proven successful in keeping the world on track to meet global targets for NCDs. Key obstacles to progress include inadequate levels of engagement with national ministries, and limited economic assistance for implementing and enforcing policies for NCD prevention and control. A more vigorous global social movement is needed, framed in terms to health justice, to press governments for greater accountability and global donors for greater resources (Cassells, 2013; Smith, Buse, & Gordon, 2016).

There are no magic bullets for accelerating progress on NCDs: even high-income countries with excellent regulatory capacity face significant obstacles to implementing effective policies due to lack of political will, prevailing ideologies, and interference by vested economic interests. Nevertheless, we see lack of attention to legal capacity-building by global institutions as an important constraint that is putting at risk the benefits that might otherwise come from the WHO's Global Action Plan. Legal capacity-building deserves more attention because many priority policies for NCDs will need to be implemented through legislation and executive actions (Supplementary Material, Box 1). Some of these, such as second-hand smoke laws, will bring immediate benefits (Faber et al., 2017; Siegel, Alberts, Cheng, Hamilton, & Biener, 2008; Sims, Maxwell, Bault, & Gilmore, 2010). Others, such as a tax on sugary drinks or a higher excise tax on tobacco and alcohol products may generate revenue streams that help to make national investments in NCDs more sustainable. In an environment where external funding for NCDs is limited, self-help is paramount (WHO, 2010c, pp. 23–31), yet self-help is unlikely to occur in the absence of adequate capacity, including legal capacity, among both government and civil society stakeholders. We encourage global development partners to construct a vision for capacity building to implement the priority policies that could make a difference to health outcomes for NCDs at regional and country levels, and to support its realisation.

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