



World Health
Organization

India

A circular graphic composed of 18 segments of various colors (blue, green, yellow, red, orange, pink, purple, brown, tan, olive, dark green, light blue, dark blue, red, yellow, green, blue, and dark green) arranged in a ring around the central text.

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**MULTI-STAKEHOLDER
RESPONSE TO NCDS IN
INDIA**
EVALUATING WHO ROLE
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Executive Summary

A. Background

The global burden of non-communicable diseases (NCDs) has increased tremendously globally. In 2016, NCDs claimed 71% (41 million) of the world's 57 million deaths, 15 million of which were premature (age 30 to 70 years). Low and middle-income countries bear the greatest burden of NCDs (78% of all NCD deaths and 85% of premature deaths).

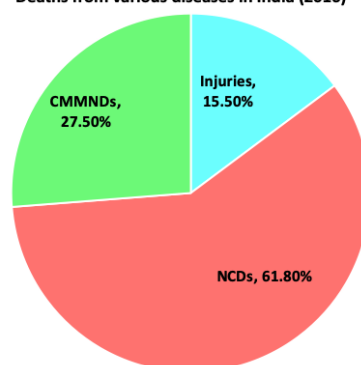
WHO's recent 5 X 5 matrix on NCDs includes 5 diseases (Cardiovascular diseases (CVD); Chronic Respiratory diseases (CRD); Cancer; Diabetes and Mental & Neurological conditions) and 5 behavioural risks (unhealthy diet, tobacco use, harmful alcohol use, physical inactivity and air pollution). WHO advocates globally with countries to control above diseases and risk factors, and has created a Global Action Plan on the same. SDG 3 on Health also contains seven targets related to NCDs.

B. Indian scenario on NCDs

India is passing through an **epidemiological transition**. Between 1990 and 2016, the burden of deaths due to communicable, maternal, neonatal, and nutritional diseases (CMNNDs) reduced from 53.6% to 27.5%. At the same time, the burden of deaths due to NCDs went up from 37.9% to 61.8% resulting (Figure 1 on right) in the following:

- CVD Deaths have almost doubled since 1990
- Persons living with diabetes grew from 26 million in 1990 to 65 million in 2016
- Incidence of all cancers increased by 28% (1990 to 2016); new cases of cancer reached 1.1 million.
- COPD patient numbers grew from 28 million (1990) to 55 million (2016)
- 1 of every 4 persons suffers from a mental health problem. Suicide deaths increased by 40.1% from 1990 to 2016.

Deaths from various diseases in India (2016)



The major **risk factor** related facts on the increase in NCD prevalence are:

- More than 1.3 million persons per year die from smoking and smokeless tobacco use
- 392 Million persons in India are physically inactive
- 181 men and 126 women per 100,000 are affected by cancers from alcohol
- 13 of 20 most polluted cities globally are in India causing 12.4% of total deaths (2017)
- India has the global highest road accident related fatalities (150,785 in 2016)
- 100 million cases of food borne diseases are reported every year in India.

The **implications** of the above risk factors are:

- Cardio-Vascular diseases caused 28.1% of deaths in India in 2016
- Cost of treating NCDs is 80 to 90% of per capita income, pushing 7% of India's population below the poverty line annually
- There is a gross mismatch between public investments on NCDs and the NCD burden
- Health is a State subject, but most states (esp. smaller states) lack resources
- Very few centres of excellence on Mental Health exist despite its high prevalence
- Stigma on mental health prevents patients from treatment, community integration.

C. Major Findings of this evaluation

The major findings from this evaluation against primary evaluation questions are presented below. We also used a rating scale as follows:

Good Work! Well Done!

Work in Progress! Some areas for improvement!

Needs more efforts and attention!

Objectives of this evaluation

This evaluation was commissioned to assess the relevance, organizational effectiveness, sustainability and efficiency of WHO India's contribution in coordinating a multisectoral response by the MoHFW to address NCDs. It looked at the contribution of WHO India to GoI in strengthening four critical areas on NCDs in India – multi-stakeholder responses to NCDs, health systems, health promotion and monitoring and surveillance.

Methodology

Stakeholders

Key Informants from Central and State Governments, UN Agencies, CSOs and their networks, Frontline Health Staff, CSR Agencies working in Health, Academics, Private Sector Health Actors in NCDs and Communities.

The Evaluation Framework

consisted of a mix of approaches - Results based management, Process Tracing and Advocacy Evaluation.

Evaluation tools used were documentation review, semi-structured key informant interviews (51); Focus Groups(10); Visits to 5 states - Chhattisgarh, Mizoram, Odisha, Uttarakhand and Tamil Nadu and media analysis from 3940 newspaper stories (from randomly selected 10 months over past 5 years to measure change in visibility of NCDs).

Limitations

1. Inability to interview several Government Stakeholders due to elections 2019
2. Transfers of original officers who conceptualised the NMAP
3. Finite opportunity to visit only 5 States
4. Recent and ongoing programme, policy and process changes
5. Work on NCDs by GoI and WHO India being relatively recent compared to work on tobacco or on

1. Role of WHO in promoting multi-stakeholder approaches, and learnings from the same

WHO India built on past work on tobacco control and adopted several strategies for multi-stakeholder action on NCDs:

- a. Use WHO global research and policy briefs to inform GoI and other actors in India on NCDs
- b. Support research to generate evidence on NCDs- e.g. Health Impact Assessment on mapping policies and potential roles of 13 key ministries on NCDs; supporting GoI for research on Health Impacts of Air Pollution, etc.
- c. Work closely with various ministries of GoI in formulating the NMAP for NCDs; and the National Clean Air Programme (NCAP) through national and state consultations, inter-ministerial and cabinet meetings, etc.

- d. Support the development of policy briefs for relevant ministries to integrate targeted issues in departmental policies
- e. Discussions with GoI to respond to Global Conferences and Global Action Plans
- d. Support GoI in rolling out national programmes on NCDs - e.g. support readiness assessments of States on NCDs
- e. Map, support CSOs to play an active role in the design & implementation of multi-stakeholder responses
- f. Support global recognition of GoI's efforts - e.g. two UNIATF awards were received by MoHFW in 2019
- g. Technical support in setting health standards, work with ICMR, other agencies on NCD monitoring and surveillance.

A comparative analysis of the process learnings from past experience in advocacy on tobacco control shows that considerable gains have been achieved by WHO India in promoting multi-stakeholder mechanisms for NMAP, NCAP and road safety. Nevertheless, considerable efforts are still needed esp. to secure the buy-in of non-health stakeholders for ensuring "whole-of-Government" and "whole of society" integration in prevention and control of NCDs.

2. Multi-stakeholder collaboration across Government and national and sub-national levels

WHO India has taken many initiatives to support GoI on NCDs. These include support for - formulating the NMAP; developing the National Clean Air Programme; formulating the National Mental Health Plan and advocacy on Road Safety. Details of each of these processes are listed in the main text. GoI also runs the following programmes on NCDs in which WHO India provides technical support: a. National Programme for Prevention & Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke; b. National Non-communicable Disease Monitoring Survey; c. National Mental Health Programme

3. Support for evidence generation by WHO India for Best Buys and their implementation

Following are the main results of WHO India's support for evidence generation, implementation on various "Best Buys":

a. Reduce Tobacco Use: After many years of efforts by tobacco control cells, results seem to be showing now. The GATS surveys indicate a decline in the prevalence of tobacco use (34.6% among adults in 2009-10 to 28.6% in 2016). The Agriculture Department has also launched a scheme supporting tobacco farmers to move to alternate crops.

b. Reduce the harmful Use of Alcohol: Several alcohol regulations are in place. MoSJE runs a programme on alcohol de-addiction. Nevertheless, considerable efforts are still required : e.g. taxes on alcohol to be raised adequately, ban on brand stretching/ surrogate advertisements on alcohol by MoI&B. There is also no National Alcohol Prevention Policy.

c. Reduce Unhealthy Diet: FSSAI has issued several regulations for food safety and launched "Eat Right India" and "Safe and Nutritious Food at Workplace" campaign to promote eating healthy food and shun HFSS foods. Food safety initiatives by other ministries include – exploring restrictions on HFSS food advertising (MoI&B); upcoming revision of National Nutrition Policy, promoting non-HFSS snacks in schools (MoWCD); promoting healthy food at the workplace (MoLE); Banning advertisements of alcohol, tobacco, unhealthy foods during sports events (MoYA&S); promoting Kitchen Gardens in schools, integration of healthy food in Mid-day meals(Education Dept.); and promoting organic farming (Agriculture). Action on reducing Palm oil imports are still awaited.

d. Reduce Physical Inactivity: Several ministries have taken up work on enhancing physical activity. National Wellness campaigns – e.g. World Yoga Day, Fit India movement and Health & Wellness Centres under Ayushman Bharat – are new initiatives. Ministry of Housing & Urban Affairs (MoHUA) is promoting Non-Motorised Transport and bicycle sharing schemes, cycling and walking tracks, parks. Ministry of Youth Affairs and Sports promotes various sports and expanding playfields. Department of Education is promoting sports into middle school, secondary, University curriculum.

e. Manage Cardiovascular Disease and Diabetes: NPCDCS runs several programmes on Cardiovascular Diseases and Diabetes. Many good community examples of the same exist, e.g. in Mizoram. The population-based screening of major NCDs is a good initial step, but much remains to be done given that CVDs cause the maximum number of deaths in India and the large numbers affected by Diabetes and related complications.

f. Manage Cancer: NPCDCS runs a large programme on cancer treatment. Screening, referring cancer patients at CHC/ PHC levels including through population-based screening for cancers has started. The National Cancer Registry Programme collects data on cancer cases. Yet, much needs to be done, e.g. increasing number of cancer hospitals. From earlier 27 Regional Cancer Institutes, GoI announced 20 new State Cancer Institutes and 50 Tertiary Cancer Care Centres.

4. Support to Health Promotion, Health System Strengthening and Data and Surveillance

a. Health Promotion

i. Fiscal and policy measures: Several Ministries have initiated policy and tax measures for health promotion. On the demand side, the Finance Ministry imposes high GST on tobacco and sugar-sweetened beverages. FSSAI has issued guidelines for front-of-pack labelling, other than efforts mentioned in section 3 above. MoI&B is considering advocating with media to allocate free airtime for health promotion on NCDs, and restricting advertisements of Pan Masala, HFSS foods and surrogate advertisements for tobacco and alcohol.

On the supply side, PPP guidelines for NCD service provision have been launched by NITI Aayog. Dept. of Agriculture promotes organic farming, but vegetable/fruit farmers do not yet access crop insurance under PMFBY. Restrictive tax

disincentives for demerit goods are not yet in place. MoWCD promotes kitchen gardens, non-HFSS snacks in schools, yoga in Anganwadi and schools, and healthy lifestyles, nutrition awareness under Food and Nutrition Board. The Education department will provide coarse grains, high-fibre food in Mid-day meal scheme, and educate parents and children about healthy food. MoLE already implements NCD screening for beneficiaries and their families. MOYA&S recently launched the “Fit India” Movement and will prohibit advertisements for tobacco, alcohol and HFSS foods during sports events. The Ministry of Parliamentary Affairs is targeting awareness on NCDs for Parliamentarians.

ii. Mass Media Campaigns: A National Health Portal has been launched containing information on health schemes and links to apps for tobacco cessation, managing diabetes, etc. in addition to above-mentioned campaigns by FSSAI.

iii. Constraints: Availability of fruits and vegetables at reduced prices of the same is a constraint. Taxes on alcohol and control of surrogate advertisements on alcohol are still awaited, as is a National Alcohol Policy. State departments face shortage of staff and skills on IEC for NCDs. Budgets allocated to Health and Wellness Centres is inadequate.

iv. Media Analysis: A media analysis with newspaper articles over 10 randomly selected months over past 5 years revealed that the visibility of NCDs, public health services and risk factors has increased significantly over this period. The highest number of articles were related to Public Health followed by NCD related articles. Communicable Diseases show a flatter growth and lesser absolute stories compared to those on NCDs and Health Policy. Within NCDs, fastest increase in stories was seen in on Mental Health, Cancer, CVD, Lung Diseases, diabetes and hypertension, in that order. The most covered risk factor was Air Pollution followed by Tobacco, alcohol and obesity, in that order. Unhealthy food as a risk factor is the least covered. Most of this coverage is spontaneous, and more targeted efforts could ensure that newspapers promote a nudge approach to change behaviour.

b. Health Systems

Various interventions at different levels have been initiated to strengthening health systems for NCDs by GoI and State Governments, supported by WHO India in various ways:

i. Support for readiness assessment of States on NCDs: WHO India supports GoI on assessing readiness of States on rolling out NCD related programmes with PGIMER, Chandigarh.

ii. Strengthening existing State-level interventions: Much of the action on strengthening Health Systems will be taken at State level. Currently, all states are setting up a structure to provide NCD services in the form of State and District NCD cells, District and CHC level NCD Clinics, Cardiac Care units and Day Care Centres. (Figure 2 on right).

NHM reports a massive training drive on NCDs for population-based screening; capacity building of Medical Officers, Nurses, ASHAs and ANMs on NCD is being done through modules designed by NHSRC and SHRC. By 31 Dec 2018, 1.08 Crore persons have reportedly been screened for diabetes, hypertension and three major cancers - oral, breast and cervical. Tamil Nadu has also started an awareness drive with some initial PHC patients on a patient peer-group basis.

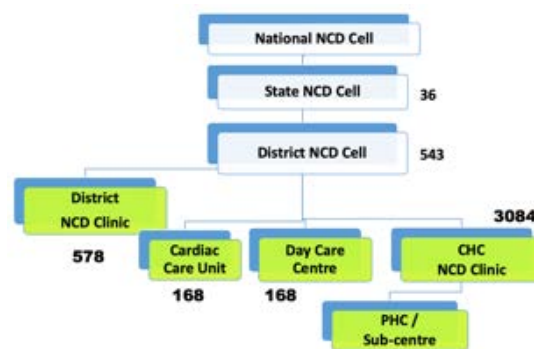
iii. Strengthening NCD Services at District level: Interventions on NCDs have now been integrated into NHM, with clear instructions to Medical Officers on the package of services to be provided at Sub Centre, PHC, CHC/FRU, District Hospital, Medical College and Tertiary Cancer Centre levels.

iv. Integrating NCDs into Medical Education: Respondents felt that current medical education in India focuses almost exclusively on diagnosis and treatment of diseases, rather than the preventive aspects. Inclusion of preventive aspects of NCDs in the medical curriculum is an urgent need.

v. Capacity Building to provide NCD services: WHO India has supported the development of modules for TOT on NCDs. It is also planning a training programme on NCDs for Medical Officers in partnership with UNDP and PHFI.

Capacity building of frontline health workers (esp. ASHAs and ANMs) will be critical in the coming phase as they will lead the massive population-based screening for NCDs, and will play a key role in ensuring NCDs are integrated into lifestyles at community levels. Several concerns need to be addressed here, primary being the rapid increase of workloads for ASHAs of multiple vertical disease based national programmes; poor orientation of ASHAs about health issues; lack of capacities commensurate with their responsibilities; unclear reimbursement policies; delayed payments of incentives and inadequate handholding and mentoring of ASHAs.

vi. A comprehensive package of services through H&WCs: A set of 12 basic health care services are to be provided under the comprehensive primary healthcare services recently launched by GoI at the 150,000 Health & Wellness Centres to be set up across the country. However, H&WCs are facing budget constraints.



vii. Financial protection of the poor for NCD healthcare through Ayushman Bharat: Ayushman Bharat is aimed at covering health care costs for 100 Million of the poorest households and strengthening H&WC to provide a comprehensive package of healthcare services. Issues that need to be resolved in the same include adequate budgets; eligibility criteria for beneficiaries; uncovered out of pocket expenses; inadequate health infrastructure; over-dependence on private hospitals and their associated unregulated costs. Good models of strengthening public health care systems exist in Kerala and Tamil Nadu that can be learned from.

c. Strengthening monitoring, evaluation and surveillance systems for NCDs

WHO India office has been a critical player in supporting GoI to ensure that good quality data on various diseases (including NCDs) are collected. Following are some recent examples:

i. The National Non-Communicable Disease Monitoring Survey: is being conducted in 300 Urban and 300 Rural primary sampling units by ICMR and NCDIR with support of MoHFW and will cover the 10 targets, 21 indicators of National NCD Monitoring Framework. Data on NCD risk factors - tobacco consumption (smokeless and smoking), harmful intake of alcohol, dietary habits, dietary salt intake, physical measurements, physical activities, fasting blood sugar and blood pressure will be collected.

ii. Population-Based Screening (PBS) for common NCDs: is being rolled out in 24,016 SCs across 219 districts. ASHAs conduct the screening using the Community Based Assessment Checklist under the National Health Mission. Some states are integrating PBS data with PHC and facility-based data to move towards an electronic medical record database. Dell, Tata Trusts (with technical support from WHO India) have supported developing the software.

iii. Health Management Information Systems: WHO India supported MoHFW to roll out an HMIS and Integrated Health Information Platform to track data on communicable and non-communicable diseases on one platform. Dissemination will be done through the new HMIS website.

5. Work by WHO India with UN Partners, CSOs and Academia

During formulation of NMAP, WHO India established links with about 13 target ministries. Further, during work on NCAP, this number has expanded. Thus WHO India has expanded relations with MoHFW and non-health ministries.

Among UN agencies, WHO India worked mainly with UNDP, UNFPA, UNICEF on NCDs. WHO India forged links with UNDP India (through the Inter-Agency Task Force on NCDs) to support MoHFW on NMAP. UNDP India will be supporting MoHFW in coordination on the NMAP while WHO will be providing technical support and working closely with DGHS.

The CSO mapping led by WHO India indicates 4-5 broad areas where CSOs play a role in NCDs: awareness; capacity building; advocacy; access to health care services for hard to reach, high-risk groups; monitoring and reporting the ground situation about implemented programmes for greater accountability. WHO India achieved several policy-wins by involving CSOs and supporting them for strengthening coalitions. E.g. the Healthy India Alliance's advocacy for increasing GST on Sugar-Sweetened Beverages has helped to change policy on the same.

D. Lessons Learnt

SWOT Analysis

Strengths in the current NCD scenario

WHO India enjoys an unmatched reputation as the go-to agency on Health in India. WHO Global Action Plan on NCDs and SDG 3 are well-accepted frameworks in India. It is a well-respected partner in design and implementation of various national programmes and played a key role in formulation of NMAP, Inter-ministerial Multi-stakeholder mechanisms, and strengthening data systems for NCDs. It is also seen as an unbiased agency providing forums to multiple stakeholders to come together for action. These factors give WHO India high leverage with Government, CSOs and Health Professionals, which it can use very effectively for NCDs.

Weaknesses

a. Integrated and Multi-sectoral Coordination

Despite the above critical efforts, the efficiency of implementation of the multi-stakeholder responses – could be significantly enhanced. Key bottlenecks are reported to be:

- **Inadequate Joint Ownership:** Some ministries see NCD as a Health Ministry issue; others have conflicting priorities
- **Inadequate Joint Accountability:** Respondents suggest that for better accountability, a higher authority – e.g. NITI Aayog – could monitor progress by non-health ministries
- **Emphasis on NCD service delivery, less on coordination:** Currently MoHFW is grappling with service delivery of NCDs, while coordination and advocacy with other Ministries envisaged under NMAP is still work-in-progress
- **Need to enhance engagement of elected representatives:** Parliamentary (Central) and Departmental Standing Committees (in States) are critical forums for advocacy. E.g. Parliamentary Committee on H & FW has advocated strongly for higher finances and urgent action on NCDs
- **Lack of dedicated resources for coordination:** At Centre/ State, resources for coordination function for NCDs – e.g. for NMAP – are scarce, though critical. The WHO-UNDP support for coordination for NMAP has been welcomed

- Integration of non-health CSOs: into multi-stakeholder mechanisms is urgently required for NCDs
- Poor Donor funding: NCDs receive only 1.7% of global US\$37.6 billion in development assistance in 2016.

b. Health Promotion

- Current health promotion systems are targeted at promoting communicable, maternal and neonatal diseases and NCDs are a relatively new priority for the Health system
- On both demand and supply sides, much promotion is still needed for “Best Buys”. Some Ministries have expressed constraints and differing priorities from NCDs
- Health Promotion Centres such as NIHF and State IEC departments report resource and skill shortages
- Rapid behavioural change towards increased consumption of HFSS Foods, lack of physical activity and prevalence of other risk factors on NCDs are still major concerns
- Many CSOs and CSR organisations work in the Health and non-health sector, but often in isolation; most are not part of policy design and implementation.

c. Health Systems Strengthening

- Most gaps in the overall health systems also plague NCDs - low overall health budgets coupled with under-utilisation; very high out of pocket expenses for poor and poor insurance; mismatch between NCD incidence and budget; lack of infrastructure, trained personnel; predominant public preference for private treatment; emphasis on curative rather than preventive health, etc.
- Health is a State subject with states expected to contribute part of expenditure for central schemes. However, many States (esp. smaller ones) lack resources to meet their health targets. Thus, health infrastructure is weak in most states. E.g. several states do not have a single State Cancer Institute/TCCC
- Training superstructure (module design, TOT, scheduling and targeting of training) for health staff on NCDs is still being developed. Frontline workers report being overburdened with numerous trainings on different vertical disease-based programmes. Systems for handholding and mentoring of frontline workers are weak.
- Monitoring of training is another gap to ensure uniform coverage of trainees. Also, training outcomes in behaviour change of trainees are inadequately tracked.
- Doctors - not trained for management - are burdened with management duties rather than health care. The health system needs strong and professional management on NCDs.

d. Surveillance, Monitoring, Evaluation and Research

- Multiple data systems which do not “talk” to each other, non-reliability of data and non-use of data for decision-making at the point of data collection have been key systemic constraints
- Monitoring of training, esp. outcomes is weak. WHO India's recent support in developing the Integrated Health Information System has helped
- Data on the at-risk population has started being collected through Population-Based Screening. However, research on localised and contextualised evidence of patterns of risk factors and causation for NCD is needed
- National data systems, e.g. census still do not yet collect data on risk-related behaviour
- Community-Based Monitoring System for NCDs has not been yet been developed

Opportunities for NCDs in India

Several critical learnings from Tobacco control, Air Pollution, HIV/AIDS and other programs are available on making multi-stakeholder responses work. GoI has also recently initiated significant interventions towards Universal Health Coverage and health promotion - e.g. Comprehensive Primary Health care, PMJSY, Ayushman Bharat, Yoga day, Fit India, Eat Right India, Health and Wellness Centres, Jan Aushadhi Kendras, AYUSH, etc. These reinforce WHO India's efforts on NCDs. Most non-health ministries are also supportive of their role in NMAP. Despite vacancies and shortages, a vast infrastructure in public health exists in India. A largely supportive policy framework for promoting healthy behaviour on NCDs is also available. NITI Aayog has developed a ranking system on Health for the States of India. It may also be a suitable agency to enhance upward accountability to NMAP.

Also, as mentioned above, WHO India is supporting GoI in strengthening multi-disease data systems, and WHO India, Dell and Tata Trusts have developed NCD screening software with backward integration with larger data systems. The Population-Based Screening on NCDs and subsequent referrals is also an opportunity to create a movement on NCDs with communities. WHO India is also working closely with CSOs. Many CSOs, CSRs and States have demonstrated innovative scalable models on NCDs. Moreover, significant interest in Media on Disease prevention already exists and there is an increasing trend of media visibility on NCDs. Above opportunities can be made to work positively to promote work on NCDs.

Qualitative analysis of the interviews during this evaluation shows a largely positive sentiment towards work done by WHO India.

Threats in the area of NCDs

India's health system faces the dual challenge now of responding to a reduced but still considerable burden from communicable, maternal and nutritional diseases while at the same time responding to the rising NCD incidence. In the absence of adequate resources, both these areas are likely to suffer. NCDs are also more difficult to address because of their slow, invisible nature, linkages with cultural-behavioural aspects, and difficulty in changing behaviour despite knowledge. The numbers and capacities of medical personnel also need to be rapidly increased without losing the quality of instruction. The above constraints will require the best of innovative thinking and considerable resources, the latter being a critical constraint today.

E. Recommendations

Following are recommendations that emerge from this evaluation for strengthening WHO India's work on NCDs:

- 1. Widen WHO India's current targeting and partnership strategy on NCDs** to include more partners such as Elected Representatives; non-health CSOs and CSO coalitions; Community level CSO-led support structures for NCDs; Organisations promoting awareness on NCDs such as Mass appeal organisations, mainstream and vernacular media, corporate communication agencies, health awareness campaigns; Information stakeholders such as CSR units of IT giants and actors producing Micro-learning videos and games, etc.
- 2. Continue supporting GOI and State Governments for strengthening health management systems for NCDs** esp. to enhance professional management of health systems; strengthening data systems for NCDs through linking vertical non-talking data sets and a comprehensive data assessment for NCDs.
- 3. Continue supporting GOI and State Governments to strengthen capacity-building processes for NCDs** through assessing and enhancing current training methods on NCDs for greater retention; supporting institutionalisation of incentives for capacity development of staff by linking capacity building to promotions and other incentives; refresher trainings for medical officers on NCDs; strengthening capacity building of frontline workers through more holistic trainings and monitoring knowledge and practice outcomes through assessments and refreshers; support strengthening handholding and mentoring systems for frontline health workers; enhance focus on NCDs in medical curriculum; enhance capacities among state health departments on NCD related IEC design.
- 4. Support and undertake advocacy in multiple areas on NCDs** such as greater donor and Government funding for NCDs; greater understanding among non-health ministries on the multi-sectoral nature of interventions required for NCDs; enhanced involvement of Elected representatives at national, state and panchayat levels to prioritise NCDs; Advocate for the NMAP actors to report to a higher body – e.g. the NITI Aayog - for joint ownership and accountability to a higher body; and advocate within UN system for an UNAIDS kind of modality on NCDs for greater focus and resources.
- 5. Explore areas for supporting further research on NCDs:** Several areas for research were identified during this evaluation, which WHO India could explore supporting. These were: risk factors and NCD causality in low BMI, high physical activity, poor nutrition individuals; support GOI to assess the efficacy of newly launched and existing programmes on health outcomes for NCDs; a research framework for utilising Population-based Screening data for projections to help nuanced prioritisation of interventions; review WHO's global experience on NCDs for interventions that can be scaled up in India; and explore the role of AYUSH for preventive healthcare.