

# POLICY BRIEF

## BUILDING GLOBAL CAPACITY FOR NON-COMMUNICABLE DISEASES (NCD) PREVENTION



*Evidence*

*"Best buys"*

*Better data*

*Surveillance*

*Career tracks*

*Decision making*

*Policy development*

*Multi-sectorial actions*

*Sustainable workforce*

*Research & knowledge*

*Social & environmental risks*

*Leadership for sustainability  
& political commitment*

### THE ISSUE

Chronic diseases, also referred to globally as non-communicable diseases (NCDs), are the leading causes of morbidity and mortality in both the economically advanced countries of the world as well as in economically poorer countries, the so-called LMICs (lower and middle income countries). While there are established preventive and health promotion approaches to mitigate the effects of NCDs which are embedded in the public health and health services infrastructure in developed countries, there is often little or no such infrastructure in the LMICs. This contributes to the growth of health inequalities between countries.

The nature and strength of capacity for dealing with NCDs in LMICs has been of concern to public health and health promotion institutions in both developed and developing countries. Most poorer countries lack very specific as well as systemic infrastructure. In order to gain a better understanding of this problem, the International Union for Health Promotion and Education (IUHPE) and the US Centers for Disease Control and Prevention (CDC) convened a three-day workshop in Atlanta, USA to consider priorities for the global efforts for building NCD capacity in LMICs. The invited attendees at this workshop consisted of a broad range of leaders and institutions concerned with capacity building in LMICs. Their observations and recommendations are presented in this policy brief.



## BACKGROUND

In the past twenty years two major publications have changed the course of discussions on chronic diseases and their global significance. The first introduced the notion of non-communicable disease burden as a particular challenge for public health across the globe. This assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 was edited by Christopher Murray and Alan Lopez (1996). This effort was recently updated in *The Lancet*, (2012) which devoted an entire issue (<http://www.thelancet.com/themed/global-burden-of-disease>) that reinforced the original findings.

The second was the work of the WHO Commission on the Social Determinants of Health. (WHOCSDOH, 2008)) and the accompanying work of the nine knowledge networks on early childhood development, globalization, health systems, measurement and evidence, urbanization, employment conditions, social exclusion, priority public health conditions, and women and gender equity in which the area of NCDs was greatly enhanced. These documents provided a vast accumulation of knowledge and synthesis of evidence on the relationship between contextual factors and chronic disease. They presented a challenge on how to build capacity for addressing both the burden of NCDs and the causes of that burden.

Partly in response to this challenge, the United Nations held a High-level Meeting in September 2011 placing NCDs at the top of the agenda for global health.

The International Union for Health Promotion and Education (IUHPE) and the US Centers for Disease Control and Prevention (CDC) led a two-step process towards identifying priorities for action and defining roles for building capacity for NCDs globally. The first step was a workshop in Atlanta, USA on Building Global Capacity for NCD Prevention: Defining Direction and Roles (July 24-26, 2012).

The charge for this meeting was to engage in a dialogue on current challenges, initiatives, and opportunities on NCD capacity building for public health. The object was to define priority areas of work and translate these into a multi-stakeholder agenda for capacity building. A further key objective was to consider capacity building issues in low and middle income countries (LMIC). From the outset the discussion was lively. Several overall thoughts emerged from the workshop and formed a leitmotif:

1. capacities to address NCDs remain low in all countries, but especially in LMICs;
2. both the type of burden and the causes vary in LMICs;
3. the roles of the different institutions vary as well and often conflict;
4. the identification of what is needed is easier to define than what to do;
5. NCD capacity building is not only complex but is highly contextual and varied within and between countries; and
6. there is a sense of urgency to get going in addressing the capacity issue.



## KEY ISSUES

### ***Research***

The role of research in improving the capacity problem was considered fundamental. While basic research is very important, in terms of capacity building there needs to be a focus on research into interventions and that relates to understanding policy.

### ***Resources***

Funding for capacity building is not readily available and is rarely seen directly on budgets and appropriations. To find resources for NCDs, there is a need to raise awareness among LMICs and funders to leverage support for

developing and strengthening the cost-effectiveness argument of prevention since the financial burden of NCDs will be enormous.

### ***Health promotion***

In many countries, health promotion is not well understood and less attention is given to building capacity for health promotion, while it is a vital part of the global social progress agenda, and a field of action that has a vital role in the continued effort to improve policies and programmes that aim to tackle the social determinants of health (IUHPE May 2012)

### ***Training for Health promotion***

While much attention is given to training, there is a tendency to focus on training for epidemiologists and community leaders, with less emphasis on health promotion personnel.

### ***Policy & governance***

A key challenge for good policy and governance is that the translation of evidence into policy is not done adequately in LMICs.

### ***Information systems***

National governments need data to plan for capacity building but there remains much data needs, surveillance and general problems of information gaps.

### ***Clear Roles and Responsibilities***

Clear roles are often lacking for all the principal actors and institutions involved in addressing the burden of NCDs. There was a sense that none of the institutions present at the workshop, had a clear prioritization strategy. As a result of this, the group endorsed the carrying out of a second consensus-building step to complete the process in the shape of a small Delphi study involving the participants of the meeting and those who were invited but were unable to attend.

## **PRIORITY ACTIONS (FROM DELPHI STUDY)**

The Delphi study clarified the prioritization of roles and areas of work in building capacity.

| <b>Top Areas of Action</b>   |
|--|
| 1 – Develop evidence on what works for multi-sectorial actions at governmental level |
| 2 - Articulate research and knowledge synthesis for policy development               |
| 3 - Develop sustainable and capable public health workforce and career tracks        |
| 4 - Use surveillance data to have an impact on population health                     |
| 5 - Identify "best buy" interventions on social and environmental risks              |
| 6 – Provide better data for informed decision making                                 |
| 7 – Provide Leadership for Sustainability and Political Commitment                   |

To achieve these priority areas of action, DELPHI participants identified training as the most important method for building capacity, followed by system development, and policy dialogue. In relation to specific action areas, however, training was not necessarily the preferred method for capacity building, thus highlighting the importance of tailored approaches.

The importance of evidence and knowledge synthesis to provide a background for capacity building is clear. In fact, a commonality of all the higher prioritized action areas was that **we have knowledge, gained through surveillance and research, that needs to be placed into action on public health areas of work. With specific regard to LMICs it is clear that without more training and system development, evidence and knowledge will not be actioned.** How policy in the institutions shape their response to these key messages remains a challenge.

Of all the institutions involved, whether global organizations, government agencies, ministries of health, universities, and non-governmental organizations, it remains unclear how they each prioritize what they do in relationship to the priorities identified. Given the broad needs of meeting even those areas prioritized in the workshop and Delphi exercise, it would seem unlikely that any single institution should have such a broad remit. These findings not only emphasize the need for interagency, interdisciplinary work but also highlight the importance of strengthening partnerships between institutions, to ensure that capacity building efforts are sustained over time.

## PARTICIPANTS

The Atlanta meeting had a wide spectrum of participants representing many sectors of global health, including ministries of health from several low and middle income countries, governmental institutions (CDC, NIH), non-governmental organizations (NGOs - IUHPE, NCD Alliance, National Disease Associations), academia, and global and regional institutions (WHO, PAHO).

## REFERENCES

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