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Commentary on a meeting entitled 'Building global capacity for non-communicable diseases (NCD) prevention: Defining direction and roles'

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Abstract

This Commentary summarizes the key points that arose during a three-day meeting held in Atlanta in July 2012 on Building Global Capacity for NCD Prevention. A wide spectrum of participants representing many sectors of global health, including ministries of health from several low and middle-income countries (LMICs), governmental institutions, non-governmental organizations, national disease associations, academia, and global and regional institutions participated. Presentations and group discussions led to agreement on a number of actions that should be taken to increase capacity for coping with NCDs in LMICs. Key areas of discussion were on the role of research, workforce development, resources, and governance. While there was considerable agreement on what should be done, the workshop participants had difficulty in prioritizing these activities. This led to an agreement by the gathered participants that a follow-up Delphi study be conducted to help with prioritization.

Keywords

chronic disease; effectiveness; non-communicable disease; capacity building

Commentary

In the past 20 years, several significant publications have changed the course and the discussions on chronic diseases and their global significance. Two are of special relevance to this commentary. The first is a critical background document introducing the notion of non-communicable disease (NCD) burden as a particular challenge for public health across the globe. The seminal work was carried out and published jointly by the World Health

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Organization (WHO), Harvard University and the World Bank. Of particular note was Volume One in this series of 10 entitled 'The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020' (1). This effort laid the foundation for ongoing efforts to enhance the importance of NCDs in public health. Recently *The Lancet* devoted an entire issue (2) to a 2010 update which reinforced and expanded the original findings, and used modern data mapping and visualization to highlight morbidity and mortality from all causes in 187 countries during 1970–2010, highlighting the significance of NCDs in global health. The second is the work of the WHO Commission on the Social Determinants of Health. With the publication of the WHO Commission on the Social Determinants of Health (3) 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, the area of NCDs was greatly enhanced. These documents illustrate boldly the vast accumulation of knowledge and synthesis of evidence on the relationship between contextual factors and disease. In short, these two monumental undertakings identified major global determinants of disease and the enormous burden of NCDs. An especially critical challenge today is how to build capacity for addressing both the burden of NCDs and the causes of that burden.

With this background, and in response to the United Nations high-level meeting (http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml) that took place in September 2011 in New York, placing NCDs at the top of the agenda for global health, that 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 comprised the convening of a workshop in Atlanta in July 2012 on *Building Global Capacity for NCD Prevention: Defining Direction and Roles* (4). This meeting had a wide spectrum of participants representing many sectors of global health, including ministries of health from several low and middle-income countries (LMICs), governmental institutions (CDC, National Institutes of Health (NIH)), nongovernmental organizations (NGOs) (IUHPE, NCD Alliance), national disease associations, academia, and global and regional institutions (WHO, Pan-American Health Organization (PAHO)). A comprehensive participant selection process was coordinated by the core planning group for this event and endeavored to ensure balanced geographic and organizational representation and diverse and varied expert opinion to inform meeting discussions. In all, 37 participants and 18 observers from 10 countries attended the meeting.[i] The charge for this meeting was to engage in a dialogue on current

[i]A full participant list can be found on the web (5). Participants came from Brazil, China, Colombia, France, India, Kenya, Mexico, Switzerland, Tanzania and the United States of America. Other countries were invited to take part but unfortunately unable to attend (e.g. Jordan). Participants comprised employees from the following institutions and organizations: CDC Foundation, Center for Non-Communicable Disease Prevention – China CDC, Health Promotion Directorate of Mexico, International Association of National Public Health Institutes (IANPHI), International Union for Health Promotion and Education (IUHPE), Ministry of Health of Brazil, Ministry of Health and Social Protection of Colombia, Ministry of Health and Social Welfare of Tanzania, Ministry of Public Health of Thailand, Ministry of Public Health and Sanitation of Kenya, American Cancer Society (ACS), National Cancer Institute – National Institutes of Health (NCI/NIH), National Heart Lung and Blood Institute–National Institutes of Health (NHLBI/NIH), NCD Alliance, Pan-American Health Organization (PAHO), Sree Chitra Tirunal Institute for Medical Sciences and Technology in India, Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET), The World Bank, US Centers for Disease Control and Prevention (CDC).

challenges, initiatives, and opportunities on NCD capacity building for public health. For this meeting, we considered NCDs to include unintentional injury and violence, which were not part of the UN high-level meeting. The objective 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 LMICs. Key observations included: 1. capacities to address NCDs remain low in all countries, but especially the LMICs; 2. both the type of burden and the causes varied among LMICs; 3. the roles of the different institutions varied and often conflicted; 4. the identification of what is needed is easier to define than what to do; 5. NCD capacity building is not only complex but was highly contextual and varied within and between countries; and 6. despite the complexity of the current situation there was a sense of urgency to address the capacity issue. An overview of the challenges of addressing NCDs in LMICs and a framework for addressing these challenges that was developed in the workshop has been previously published (5).

While context and circumstances have been and remain challenging and complex, many speakers reported on how their organizations were dealing with capacity building. A WHO representative highlighted their efforts to build capacity and cited efforts in training and the convening of meetings to plan activities. The importance of the high-level UN meeting was stressed, and there was a general feeling that the momentum to address capacity was increasing. In this view capacity is built by developing frameworks, models, and methods. NIH efforts to address capacity were emphasized, with a focus on building academic and research strengths to help in capacity development. The key needs and critical components to increase NCD prevention capacity in LMICs are stronger, and sustainable research infrastructures, multi-sectoral approaches, a larger and better trained public health workforce, as well as task shifting are essential. A representative from the ministry of health of one the LMICs stressed the need for inter-sectoral approaches and the importance of developing public health infrastructure including surveillance, monitoring/evaluation, prevention, and integrated primary care. Also stressed was the need for a comprehensive intersectoral strategic plan to guide actions. Included in such a plan must be an emphasis on training new professionals in NCD-related fields.

Small group discussions from the meeting in Atlanta produced a set of key requirements for addressing the current lack of capacity in LMIS. The discussions focused on 1) engaging non-health sectors in NCD prevention and health promotion; 2) identifying the NCD capacity needs of LMISs; 3) adequate data for decision making, sustainability and political commitment, improving data utilization; 4) lessons learned from tobacco; 5) importance of strong leadership for NCD prevention; 6) integration of the NCD workforce; and 7) integrating NCD prevention into health care systems as a creative way of leveraging the better resourced health care sector to enlarge the public health workforce. In-depth discussions on day three focused on surveillance, research, workforce development and priorities for action.

There was considerable discussion of the role of research in improving the problem of limited capacity. This took many forms, but a distinct message emerged: while basic research is very important, in terms of capacity building there needs to be a focus on research into interventions. That is, there is a need for connection and translation of research

to promote understanding, and in particular the understanding of interventions. Such a research agenda would have serious impact on priority setting and funding for academia and training. Research related to understanding policy was also seen as critically important. It was noted that capacity building for policy development needs to be linked to the framework for Health in All Policies.

Throughout the discussions the issues of resources, capacity, and allocation were raised. Funding for capacity building is not readily available and is rarely included in budgets and governmental appropriations. Of particular interest for NCDs is the potential for productive collaboration with the private sector and its role in potential funding. Unfortunately the private sector was not represented in the meeting, but there was a recognition that they may need to be part of the solution and not treated as an adversary. To find resources for NCDs, we need to raise awareness among LMICs and funders for the cost-effectiveness of prevention since the financial burden of NCDs will be even greater in the future. Involving economists in research projects and within ministries of health can help document costs and cost-benefits of NCD prevention.

Many participants noted that health promotion is not well understood outside the health sector. As a consequence it was suggested that not much attention may be given to building capacity for health promotion. At present, capacity-building efforts tend to focus instead on training for epidemiologists and community leaders.

There were many discussions related to policy and governance. Many agreed that the translation of evidence into policy is not done adequately in LMICs, and evidence is not gathered in a way that might lead naturally to policy making. This discussion led into the broader discussion of data needs, surveillance and general issues of information, and that national governments that need data to plan programs are actually able to use it. It was noted that we spend many resources collecting data but that this data is seldom used to solve problems and few, if any, resources are actually spent on using it for decision making.

As the meeting moved to the third and final day it became apparent that the problem of building capacity for NCDs was not readily amenable to simple or easy solutions. It was also clear that two major issues remained less defined than hoped. The first issue was related to defining specific roles for all the principal actors and institutions involved in addressing the burden of NCDs. Most organizations present through their representatives appeared to be interested in addressing many of the problems related to building capacity with, more or less, equal vigor. It was difficult to ascertain from the discussions which institutions saw their role as distinctively limited to a specific area. By the end of the workshop it remained unclear how roles could be delineated. The second issue was the difficulty in prioritizing what actions should be taken to address the need to improve and increase capacity. Because no consensus could be drawn with regard to priorities, the group recommended and has initiated a Delphi process involving the participants of the meeting and those who were invited but were unable to attend (5) in a subsequent phase, to garner priority rankings among the various alternative suggestions discussed. This consensus-building step will be used to further inform the ongoing process of addressing the critical gap between the burden of NCDs in LMICs and the capacity needed to address them. One may conclude from this

productive meeting that there is great interest in building capacity and defining directions for the major institutions that will be involved.

Conclusion

From this meeting, productive discussions among a wide range of participants were held on actions that should be taken to increase capacity for addressing NCDs in LMICs. Issues and needs related to improving research, workforce development, resources, and governance were discussed. While a variety of priorities were listed for consideration, prioritization remains a challenge in the midst of complex national, regional, and organizational contexts and limited resources.

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