Non-Communicable Disease Prevention
Program overview 2011–2016
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Note: This is a shorter version of the Non-Communicable Disease Prevention prospectus approved by IDRC’s Board of Governors in May 2011.
### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>DALY</td>
<td>disability-adjusted life-year</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>GEHS</td>
<td>Governance for Equity in Health Systems</td>
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<td>GHRI</td>
<td>Global Health Research Initiative</td>
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<td>HLM</td>
<td>high-level meeting</td>
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<td>LMICs</td>
<td>low- and middle-income countries</td>
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<td>LAC</td>
<td>Latin America and the Caribbean</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>NCD</td>
<td>Non-communicable disease</td>
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<td>NCDP</td>
<td>Non-communicable Disease Prevention</td>
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<td>RITC</td>
<td>Research for International Tobacco Control</td>
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<td>UN</td>
<td>United Nations</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. Executive Summary

The Non-Communicable Disease Prevention (NCDP) program provides an IDRC response to the major development challenges associated with the rapid rise of non-communicable diseases (NCDs) in low- and middle-income countries (LMICs). These diseases, especially cardiovascular diseases, diabetes, cancer, and chronic obstructive respiratory diseases, are among the leading causes of premature death and morbidity in LMICs and have significant consequences for households, health systems, and national economies. The main modifiable risk factors for these diseases — tobacco use, unhealthy diet, alcohol misuse, and physical inactivity — are the same in all countries and, in all countries, the poor are disproportionately exposed and affected.

So far, the response to the rising burden of NCDs in LMICs has not kept pace with the epidemic. The widespread adoption of the World Health Organization’s (WHO) Framework Convention on Tobacco Control (FCTC) and a United Nations (UN) high-level meeting (HLM) on NCDs in September 2011 offer hope that efforts will now be accelerated. The international community recognizes the challenges faced by LMICs and now sees primary prevention as offering the greatest potential for improvement through the development of healthy public policies, i.e., addressing NCD risk factors and their determinants.

A number of low-cost, effective interventions are available, but lack of local evidence is limiting their adoption and implementation in LMICs. Thus, the goal of the NCDP program is to support LMIC-led research designed to increase the adoption and implementation of cost-effective NCD prevention policies.

Building on the strong evidence for tobacco-control policy and lessons generated through IDRC’s Research for International Tobacco Control (RITC) program, the NCDP program focuses on intervention research relevant to the major modifiable NCD risk factors that can be addressed through similar or complementary policy solutions. A variety of granting modalities will be used to forge partnerships and build an interdisciplinary field of expertise to generate high-quality local evidence. Program activities will focus on policies and legislation that

- Reduce the demand for, and supply of, tobacco products, alcohol products, and foods that are high in fat, salt, and sugar
- Increase the affordability and availability of healthy foods, such as fruits and vegetables
- Create environments that support active transport (walking and cycling) to increase population-wide physical activity levels
- Protect public health policy development from commercial influence
- Strengthen tobacco-control and health-promotion efforts through innovative, sustainable financing

Three cross-cutting themes will be central to the program and the research we support: understanding the value and impact of NCD prevention policies on various social groups; understanding how best to mobilize a whole-of-government approach to NCD prevention; and understanding and addressing the barriers posed by commercial influence to developing healthy public policies for NCD prevention.

The next five years will bring new opportunities for IDRC to influence development and global health as governments and donors intensify their efforts to address the NCD
epidemic. The program will generate the knowledge necessary for sustainable and cost-effective NCD prevention in LMICs, with a focus on pro-poor policies.

2. Context and Background

a. Development Challenge and Situational Analysis

In May 2010, the UN General Assembly adopted a resolution\(^1\) to prevent and control NCDs and will host an HLM on this topic in September 2011, with a particular focus on developmental challenges faced by LMICs (UN 2010). This meeting is a watershed moment in the fight against NCDs — it signals that there is now global recognition that these diseases represent a major development challenge.

The increasing global NCD crisis is a barrier to achieving development goals, including poverty reduction, health equity, economic stability, and human security (Beaglehole et al. 2011). NCDs are recognized as limiting factors in almost every Millennium Development Goal (MDG). NCDs and their risk factors and determinants are closely related to poverty, and mutually reinforce each other (ECOSOC 2009). Pro-poor initiatives, such as the MDGs, will have limited impact if they do not address the full set of threats — including NCDs — that trap poor households in cycles of debt and illness (Stuckler et al. 2010).

The NCD Crisis in LMICs

NCDs, especially cardiovascular diseases, diabetes, cancer, and chronic obstructive respiratory diseases, are the leading causes of death and disability around the world and will be responsible for more than 75% of all deaths in 2030 (Mathers and Loncar 2006; WHO 2008a). Of the 33 million people who died of NCDs in 2008 (58% of all deaths worldwide), half were under 70 years of age and half were women.

Approximately 80% of all NCD-related deaths occur in LMICs (Alwan et al. 2010), indicating that the burden is not limited to high-income countries. NCDs are already the major cause of death in lower-middle- and upper-middle-income countries and will also become the leading cause of death in low-income countries by 2015 (World Bank 2007). The same is true for mortality among those of working age. NCDs also account for 46% of the disease burden in LMICs as measured in disability-adjusted life-years (DALYs) (Abegunde et al. 2007).

The underlying causes of NCDs are modifiable risk factors that are the same in all countries — tobacco use, alcohol misuse, physical inactivity, and unhealthy diet, which may lead to raised blood pressure, raised glucose levels, abnormal blood lipid levels, overweight, and obesity. The prevalence of the main NCD risk factors is rising rapidly in LMICs — with children and youth increasingly at risk — as a result of a range of societal and global determinants.

\(^1\) The resolution was cosponsored by 130 states. The scope and nature of the UN HLM on NCDs are analogous to those of the UN General Assembly Special Session on HIV infection and AIDS in 2000, which concluded that dealing with the disease was central to the development agenda.
These determinants, such as rapid globalization, unplanned urbanization, and global trade and agricultural policies, compromise people’s ability to make healthy choices (Lloyd-Williams et al. 2008).

Private-sector involvement in public policy development is another important factor. In the case of tobacco, the FCTC obliges parties to protect public health policies from commercial and other vested interests of the tobacco industry. Still, the tobacco industry has used calls for individual responsibility, as well as unsubstantiated economic arguments, to prevent regulation and secure policy environments that allow tobacco to be aggressively marketed (Brownell and Warner 2009). As a result, tobacco use is now rising rapidly in many LMICs, with a prevalence of more than 25% among adolescents in some countries (Kin 2009).

In the case of the food and beverage industry, there are both benefits and drawbacks to involving producers in intersectoral action for health initiatives. Although a number of experts have commented on how multinational food companies and large agricultural producers have successfully lobbied against reforms that could improve health and the environment (Jowitt 2010), there are also examples of successful partnerships to increase the availability of healthy food products.

An economic perspective: NCDs are among the most significant causes of morbidity and death among working-age populations in LMICs. NCDs can push households into or keep them in a poverty trap as a result of health care expenses and income losses from disability or the premature death of a family income earner (Jha and Chen 2007, de-Graft Aikins et al. 2010). In India, for example, 25% of families in which a member suffers from cardiovascular disease (the leading cause of death in the country) have catastrophic expenditures, and 10% are driven into poverty (Mahal et al. 2010). For two of the most important NCD risk factors — tobacco use and alcohol misuse — the associated costs diminish a family’s ability to meet basic needs and contribute to chronic household poverty.

At a macroeconomic level, premature deaths and disability from NCDs lead to substantial losses in national incomes. For every 10% rise in mortality from NCDs at a country level, annual economic growth is estimated to be reduced by 0.5% (Stuckler 2008). NCDs also present a threat to the global economic system. The World Economic Forum (2009) recently highlighted NCDs as one of the three most likely and most severe risks to the global economy, alongside fiscal crises and asset bubbles (a form of inflation).

An equity perspective: The myth that NCDs mainly affect the wealthy has been debunked by scientific evidence. NCDs are diseases of poverty. The World Bank (2007) estimates that a third of the poorest 40% of the population (people living on US$1–2 a day) in LMICs die prematurely of NCDs. In all but the least-developed countries of the world, poor people are more likely than the wealthy to develop NCDs and, everywhere, are more likely to die as a result (WHO 2005). In high-income countries, NCD risk factors are predominantly concentrated among the poor (Suhrcke et al. 2006). Similar trends are observed in LMICs, with solid evidence in the case of smoking and alcohol misuse. There is increasing evidence from specific LMICs that obesity rates are rising faster among the urban poor than in any other group (Nugent 2008, Ziraba et al. 2009).
There are two reasons why the poor are disproportionately affected. First, they are more likely to live in regions where policies to tackle NCDs are either non-existent or inadequate. This increases their chances of being exposed to common NCD risk factors. Second, the poor have inadequate access to free or affordable disease prevention and treatment services because of weak health systems that cannot adequately face the double burden imposed by communicable diseases and NCDs.

Reversing the Trend of Neglect of NCDs in LMICs
So far, the response to the rising burden of NCDs in LMICs has not kept pace with the epidemic. Despite numerous calls to action and regional declarations about the urgency of the issue, the needed resources have not materialized because of persistent misconceptions (see Box 1).

Development assistance funds for health are provided by a few institutions that still exclude NCDs from their agendas. Despite a continuous increase in such funding — from $5.6 billion in 1990 to $21.8 billion in 2007 — few resources are committed to NCDs. In terms of burden of disease, in 2007, donors provided about $0.78/DALY attributable to NCDs in developing countries compared with $23.9/DALY for HIV, tuberculosis, and malaria (Nugent and Feigl 2010). Overall, less than 3% of development assistance for health, less than 15% of WHO’s budget, and less than 2% of the total health budget of the World Bank and the Bill and Melinda Gates Foundation are directed to NCD prevention and control. LMIC governments are now increasing domestic expenditures for health — although in several sub-Saharan countries development assistance for health is replacing some of this spending — but there is little evidence of sustained investment in NCD prevention (Ravishankar et al. 2009, Geneau et al. 2010). New developments, such as the UN HLM, might lead to greater attention being paid to NCDs.

The neglect of NCDs cannot be explained by the lack of available effective solutions. If the major NCD risk factors were eliminated, a large proportion of premature deaths and disability from cancers, heart disease, stroke, and type 2 diabetes would be prevented (WHO 2005). Implementing whole-population strategies to reduce salt intake (e.g., a 15% reduction) and control tobacco use (e.g., implementing the key components of the FCTC) in LMICs would prevent millions of deaths each year at a cost of less than US$1 per person per year (Asaria et al. 2007).

Box 1: Misconceptions and facts about NCDs

NCDs mainly affect the rich and elderly in high-income countries

Fact: The NCD epidemic originates from poverty and disproportionately affects the poor in all countries. NCDs are among the leading causes of premature death and morbidity in LMICs. People in LMICs tend to be affected by NCDs at younger ages, suffer longer — often with preventable complications — and die sooner than those in high-income countries.

NCDs are simply the result of individual choices

Fact: Social determinants of health interact with and influence individual health behaviours. Governments have a crucial role to play in providing equitable access to a healthy life and in reducing the risks of NCDs, especially for vulnerable groups.

Prevention and treatment of NCDs are too expensive

Fact: A wide range of NCD interventions are very cost-effective for all regions of the world, including sub-Saharan Africa.

LMICs should control infectious diseases and target maternal and child health first

Fact: The NCD epidemic limits the ability of countries to achieve the health-related MDGs. All threats that trap poor households in cycles of debt and illness need to be addressed simultaneously rather than in a sequential manner.
The Importance of Local Evidence to Inform an Integrated NCD Strategy
Research has a crucial role to play in influencing NCD-related policies in LMICs, where the adoption and implementation of cost-effective interventions, such as reducing salt intake and tobacco use, remain low. Local evidence is needed to convince policymakers to invest in NCD primary prevention — evidence related to the problem and its context-specific causes, the most effective implementation strategies, and the differential impact of NCD prevention interventions. As scientific evidence is only one of several determinants of political priorities, the involvement of local researchers with strong knowledge translation skills is also essential to emphasize the importance of that evidence in policymaking.

A key research gap lies in the delivery and evaluation of complex interventions for NCD prevention and control. Governments need to adopt a package of interventions — often referred to as an “integrated strategy” — to decrease the NCD burden significantly. An integrated strategy implies targeting multiple NCD risk factors through intersectoral action and multilevel interventions, targeting both the entire population (whole-population strategies) and high-risk individuals.

The implementation of whole-population strategies requires strong intersectoral action mechanisms to mobilize various parts of the government (whole-of-government approach) and, when relevant and appropriate, the private sector and civil society organizations. Enhanced knowledge is needed on coordination and accountability mechanisms that lead to sustained and successful intersectoral action. For example, there is little evidence on whether voluntary approaches, which typically lack an accountability component, are effective in changing the food industry’s practices with regard to the quantity of sodium in processed food (Cobiac et al. 2010).

Interventions targeting high-risk individuals are also necessary to reduce the risk associated with the development and progression of disabling complications from NCDs; e.g., blindness and amputations resulting from type 2 diabetes. NCD management at the primary health care level should be an important component of a country-level strategy, but implementation is tied to efforts to strengthen health systems and to ensure universal health care coverage. Recent studies have warned that individual high-risk strategies, if used alone, could actually increase inequalities as disadvantaged groups face more barriers to screening and access to primary care (Capewell and Graham 2010).

In summary, an integrated NCD strategy targeting multiple risk factors and relying on interventions at both the population and individual levels can generate larger health gains than specific interventions at only one level (WHO 2008b, Cecchini et al. 2010). Finding the most cost-effective package of interventions in low-resource settings remains a critical issue for LMIC governments and international donors.

Current evidence suggests that a key strategy is to seek low-cost approaches with high potential return on investment to achieve structural and behavioural changes that reduce risk (Institute of Medicine 2010). Primary prevention² through the development of healthy public policies offers the greatest potential for improvement and a number of “best buys” need the attention of researchers and policymakers involved in global health and development initiatives. This will be the niche of the NCDP program given the current level of resources available.

² The goal of primary prevention strategies is to prevent the development of disease.
IDRC and the NCDP program are well positioned to fill this niche. The global evidence for cost-effective interventions must be supported by high-quality local evidence, which is currently limited by a lack of research funding in this area. Moreover, both global and local evidence must be presented to policymakers using knowledge translation strategies that are tailored to the local context. Therefore, the NCDP program will focus on supporting research leadership in the field of NCD prevention in LMICs. In doing so, this new program will build on the lessons learned by the RITC program over the past 15 years.

b. About the Program

Learning from Past RITC Programming
The NCDP program will use lessons learned from RITC, and the field of tobacco control in general, in planning and designing future activities. The following main lessons are interrelated.

Demonstrate how tobacco use is a development issue: There is growing recognition of the double burden of communicable diseases and NCDs that is plaguing LMICs. IDRC’s RITC program was one of the early pioneers in this area with its focus on the leading risk factor for NCDs: tobacco use. RITC’s approach went beyond the conventional health perspective to a broader development one, arguing that, as devastating as the health impact of the tobacco epidemic is on LMICs, there are serious social and economic impacts as well. RITC emphasized debunking tobacco companies’ claims about the supposed negative economic impacts of tobacco control — particularly important in tobacco-producing countries, the bulk of whom are LMICs. RITC was the prime funder of research that exposed the myths surrounding the lucrative nature of tobacco farming and the lack of viable alternatives for smallholder farmers. This niche remains unique today.

Similar development challenges are associated with other preventable NCD risk factors. For example, the economic “value” associated with the production and marketing of certain foods will enter into debates about their regulation.

Tackle the societal determinants: Studies have clearly shown that low socioeconomic status is associated with higher rates of tobacco use. Social context has a strong influence on individual behaviours, and changing it requires adopting stiff measures against the tobacco industry. Tobacco use has been intentionally built into the social structure and environment of most societies by an industry that profits from continued trade in tobacco products (Blas and Kurup 2010). Evidence-based advocacy can be effective in reducing the social acceptability of tobacco use and in increasing the acceptability of tobacco control as a global public good. The lessons learned from tobacco control in this area may be adapted to addressing unhealthy diets, the harmful use of alcohol, and physical inactivity.

Intersectoral action is needed: During RITC’s existence, recognition of the need to tackle the tobacco epidemic through an intersectoral approach increased considerably. WHO’s first global health treaty — the FCTC — has been ratified by more than 170 countries. In each country, the ratification process involved, not only the ministry of health, but also other sectors of government as well as civil society organizations. Intersectoral action is also required to implement all recommended policies for curbing the demand for tobacco products. The FCTC provides a powerful framework for action. RITC has funded several country-level case studies on its ratification and
implementation, and its findings about the factors that enable or constrain intersectoral action will be of value to other areas of NCD prevention.

**Identify and address gaps:** RITC studied the funding landscape in tobacco control to identify key gaps that were not tackled by other donors: for example, other forms of tobacco consumption (such as the waterpipe), which in many regions equal and sometimes dwarf cigarette consumption. In addition to supporting ground-breaking work in this area, RITC also tried to put the gendered impacts of tobacco control on the development agenda. According to one study, (Ross & Stoklosa 2011) development assistance for tobacco control in LMICs has amounted to less than US$132 million in the decade from 2000 to 2009. This included the relatively large infusion of funds since 2006 from the Bloomberg and Bill and Melinda Gates Foundations. The foundations’ funds have tended not to focus on research but rather on supporting advocacy, which, in some cases, has nicely complemented RITC-funded research. While the foundations have leaned toward large-population countries with high smoking prevalence, RITC has focused on smaller neglected countries and those that have the potential to play a catalytic role in their regions.

**Approaches to field building:** Important lessons have also been learned from RITC’s approach to building the field of tobacco-control research: work in catalytic countries; support and network isolated researchers; inform research and policy priorities via situation analyses; support timely research to respond to the opening of policy windows; interdisciplinary research is necessary; support knowledge transfer; provide long-term consistent support for capacity building; be well informed of other donors’ priorities; address the role of industry and barriers to effective interventions; and be willing to take risks as well as being collaborative, responsive, and adaptable to change. These lessons will be important as the NCDP program starts to explore other NCD risk factors.

**IDRC’s Niche and Program Evolution**
The NCDP program will contribute to reframing the debate at global and national levels around preventable NCDs and the role of public policy in addressing their social, economic, and political determinants. It will include a continued focus on tobacco use as the leading NCD risk factor and demonstrate to governments and their development partners that sustainable public policy solutions exist to control the epidemic. This will require framing intersectoral investments in healthy public policy consistent with health, development, and economic goals.

NCDP deliberately excludes important issues, such as mental health, injury prevention, cancer caused by infectious agents, and indoor and outdoor air pollutants as risk factors for lung cancer and heart disease on the basis that a different package of interventions and policies is needed to address these areas. The program will also not fund research on interventions focusing only on individuals at high risk of NCDs or those already affected. Although research to strengthen health systems is crucial to the success of comprehensive efforts to reduce the burden of NCDs, given the NCDP’s limited budget, a strategic decision was made to restrict its scope in the first five years to research on priority interventions in LMICs. Strengthening health systems to address NCDs is

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3 Important co-benefits are associated with the approach taken by the NCDP program. For example, alcohol control policies could contribute not only to reducing the prevalence of several cancers, but also to reducing the burden of road traffic accidents attributable to alcohol. Generating knowledge about intersectoral action can also inform the development of policies designed to reduce indoor and outdoor air pollutants.
relevant to the objectives of other IDRC health programs — namely, Governance for Equity in Health Systems (GEHS) and Global Health Research Initiative (GHRI) — and will allow for collaboration between programs.

The last five years of RITC programming focused on five core themes:

- Health systems and policy
- Alternative livelihoods to tobacco farming
- Poverty and tobacco
- Globalization, trade, and tobacco
- Alternative forms of tobacco consumption

In addition, grants were provided for research that would lead to the ratification and implementation of the FCTC in individual LMICs and two special initiatives were supported: one investigating the gendered aspects of tobacco control; the other focused on a situation analysis in a range of African countries.

As the NCDP program moves forward, program activities will focus on policies and legislation that:

- Reduce the demand for, and supply of, tobacco products, alcohol products, and foods that are high in fat, salt, and sugar
- Increase the affordability and availability of healthy foods, such as fruits and vegetables
- Create environments that support active transport (walking and cycling) to increase population-wide physical activity levels
- Protect public health policy development from commercial influence
- Strengthen tobacco control and health promotion efforts through innovative, sustainable financing

Three cross-cutting themes will be central to the program and the research it supports:

1. *Understanding the value and impact of NCD prevention policies on various social groups:* The impact of NCD-related policies on social groups, particularly the poor and marginalized, has been neglected by others in the field of tobacco control. Equity has been and will continue to be an important focus for the NCDP program and will build on the gender exploration initiated by RITC.

2. *Understanding how best to mobilize a whole-of-government approach to NCD prevention:* The lack of capacity for intersectoral action for health is an important barrier to policy uptake and implementation.

3. *Understanding and addressing the barriers posed by commercial influence to developing healthy public policies for NCD prevention:* There is a need for evidence on strategies and mechanisms to protect NCD-related policies from commercial influence and other vested interests of the tobacco, alcohol, and food and beverage industries.

Development of the NCDP program will also allow for expansion of RITC’s work with dedicated resources for tobacco-control research. Indeed, much work is needed in the area of tobacco control, which has focused mainly on cigarettes. RITC’s support for research on alternative forms of tobacco use will continue under the NCDP program, as there is a need to build on the momentum and relations with researchers in the Middle
East on waterpipes. There is also a growing need, especially in South and Southeast Asia, to support work on other products, such as bidis and kreteks.

NCDP will build on RITC’s past efforts by focusing on areas where IDRC has a comparative advantage and on results that could be applied to the other key NCD risk factors. The links between RITC’s work in tobacco control and the NCDP program are particularly evident in terms of the following.

1. **Fiscal policies:** Despite abundant evidence of the effectiveness of fiscal policies, this is a neglected strategy in most LMICs and a major area in which capacity needs to be enhanced. RITC demonstrated its experience and established a good reputation in this area, and NCDP will build on successful previous work and partnerships. In terms of other NCD risk factors, fiscal policies can deter the consumption of unhealthy products and provide tax credits and subsidies for healthy products.

2. **Production and supply issues:** A major barrier to tobacco control is the perceived economic dependence on tobacco growing, production, distribution, and sales. According to the WHO, this is a neglected area and one in which IDRC has demonstrated experience and leadership (for example, RITC organized an international workshop on tobacco farming and alternative livelihoods in June 2011). The perceived economic benefits of the production and supply of other unhealthy products is a clear link to other NCD risk factors. Although much of the work on tobacco control to date has focused on demand-side issues, this entry point will allow for the exploration of innovative supply-side regulations that promote and enhance access to healthy choices.

3. **Commercial influence and marketing:** Opposition from industry has been a major barrier to implementation of FCTC provisions, especially in LMICs; however, research on how industry influences public health policy is limited and this is a clear area of need expressed by a number of RITC partners. Governance issues are a natural fit for IDRC and build on previous RITC work. LMICs are also ill equipped in terms of regulations and policies to respond to the influence of sophisticated marketing and corporate social responsibility campaigns on consumers and policymakers. Natural links to other risk factors include, for example, the emergence of the food industry as a powerful lobby.

3. **Approach to Programming**

   a. **Goal**

   The goal of the NCDP program is to support LMIC-led research designed to influence the adoption and implementation of effective NCD prevention policies. Within selected themes, local researchers will demonstrate what priority policy actions are needed for sustainable and cost-effective NCD prevention.

   This program is committed to supporting innovative approaches that will continue to strengthen IDRC’s work on tobacco control. It is building on the strong base of evidence that tobacco-control policies are effective to inform similar complex strategies for addressing other preventable risk factors associated with food, alcohol, and sedentary living.
b. Expected Outcomes

The NCDP program is expected to achieve outcomes in terms of research capacity, knowledge generation, and influence on policy. Table 1 summarizes these results according to what can be reasonably expected within the prospectus time frame. Minimum, medium, and high levels of achievement reflect what should be expected, depending on the resource base and success in risk mitigation. A discussion of the risks associated with achieving these outcomes follows the table.

As the global public health and development communities turn much needed attention to NCDs and development, the NCDP program will need to be agile enough to consider emerging issues, opportunities, and neglected areas of research. The expected outcomes will be reviewed accordingly over the prospectus period, and strategic decisions will be made about where IDRC can make a difference as the situation evolves. There is a clear role for research to inform decisions about development efforts for NCD prevention and for IDRC to demonstrate what can be done and to lead efforts in our areas of strength.

Ultimately, NCDP-funded research will inform debates about policies for NCD prevention by generating evidence on the extent to which various prevention strategies are economically sound and of greatest value to the poor in a variety of contexts and the intersectoral mechanisms needed to successfully address the societal determinants of NCDs. It is already clear that health education and models for changing individual behaviour have limited or negligible success and are costly. Local research can assist in the prioritization of action within the sometimes competing influences of global, societal, and corporate forces.
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<thead>
<tr>
<th>Capacity to conduct and use research</th>
<th>Baseline</th>
<th>Minimum</th>
<th>Moderate</th>
<th>High</th>
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<tr>
<td>Few isolated LMIC researchers are engaged in interdisciplinary research on NCD prevention.</td>
<td>NCDP-funded projects show evidence of interdisciplinary collaboration within and beyond the health sector.</td>
<td>Collaborative NCD interdisciplinary research is established within individual countries.</td>
<td>Interdisciplinary research for NCD prevention has been institutionalized in countries.</td>
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<td>Researchers and research users often lack skills needed for gender and equity analysis.</td>
<td>NCDP-funded projects have embedded components focusing on gender and equity issues.</td>
<td>Demonstration projects use innovative methods for gender and social analysis of NCD-related policies.</td>
<td>Research tools and methods for equity-oriented research and analysis are adopted by NCDP-supported researchers and showcased among a wider community of researchers.</td>
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<th>Knowledge generation</th>
<th>Baseline</th>
<th>Minimum</th>
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<td>Local evidence for intersectoral NCD prevention that promotes health equity is lacking. LMICs often rely on the experience of high-income countries. Economic and commercial concerns act as barriers to policies for health.</td>
<td>New LMIC evidence is established on the health and economic costs of at least one major NCD risk factor and on the cost-effectiveness of intersectoral interventions for NCD prevention.</td>
<td>Policymakers have a better understanding of the socioeconomic impacts of major NCD risk factors and the cost-effectiveness of policy interventions in various contexts and in addressing health inequities.</td>
<td>New evidence of the cost-effectiveness of intersectoral action on NCDs in various contexts and on different population groups is consolidated, synthesized, and effectively transferred.</td>
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<td>NCDs are commonly perceived as diseases of affluence. The social, economic, and environmental determinants are rarely exposed or discussed.</td>
<td>NCDP-funded projects in each region have components that directly address some of the broader determinants of NCDs and highlight their relation to development issues.</td>
<td>NCDP grantees are involved in national, regional, and global deliberative forums on health and development.</td>
<td>In response to NCDP-funded research and knowledge translation strategies, LMIC governments and development agencies include NCD prevention as a key priority to achieve development goals.</td>
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<td>NCD policies are absent or policy prescriptions (such as the FCTC) are adopted but poorly implemented. Policy debate is confused by commercial and economic concerns.</td>
<td>Research results contribute to local or regional debate on priority policy adoption and implementation, including fiscal policies and innovative policy solutions.</td>
<td>Deliberative forums informed by NCDP-generated evidence and involving multiple sectors have contributed to the adoption and implementation of NCD policies in a number of countries.</td>
<td>NCDP-funded projects show a regional influence in informing the uptake and implementation of effective intersectoral NCD policies.</td>
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c. Potential Risks

Carving a Niche — External and Internal
With growing attention to NCDs in LMICs, there is a risk that IDRC’s niche may not be clear. However, RITC’s current position and the focus of this prospectus are distinct from those of other donor organizations. NCD prevention and control remain severely neglected in LMICs and among development agencies. Those whose attention is turning to NCDs — in part, as a result of the upcoming UNHLM on NCDs — will take time to determine their niche and entry points for development assistance. Although the importance of primary prevention will surely be stressed at the UNHLM, there will also likely be strong emphasis on access to essential drugs and technologies. This is a critical time to be advancing research on NCD prevention to inform decisions and ensure that whole-population strategies and primary prevention are not neglected. NCDP is well connected to others currently engaged in this area and will remain attentive to the direction that follows agenda-setting events, such as the UNHLM, to make strategic decisions about IDRC’s niche.

Making an Impact with a Small Budget
As the program’s portfolio broadens to include issues other than tobacco control, there is a risk that its projects will not relate to each other and that program-level outcomes will lack depth, especially given the program’s relatively small budget. This prospectus outlines the strategic decisions that have been made on focus and entry points for NCD prevention, as well as on themes that the program will not attempt to cover. It also provides connections between outcomes and the development of bodies of knowledge as a result of the program inputs. RITC has had a significant impact with limited resources, contributing over a sustained period to putting tobacco control on the development agenda. Targeted research can continue to do the same in the broader area of NCD prevention. Little current funding for tobacco control or NCD prevention is devoted to research and even less to enabling LMICs to find their own answers to problems associated with NCDs. There is great potential for the development of partnerships to increase our and others’ contributions to this issue over the next five years.

Building the Field of NCD Research
Currently, LMICs have limited capacity for interdisciplinary research on policies that prevent NCD. There is a need to build the field, engaging both new and existing researchers. NCDP will explore a variety of methods for strengthening research capacity in various regions of the world, including those that have been successful for RITC and other IDRC programs. Mentoring, training, and networking opportunities will continue to be explored and coupled with a drive for high-quality research and policy-relevant results.

d. Strategy

Programming Choices
Given the current level of available resources, the program will concentrate on primary prevention through the development of healthy public policies that address the main NCD risk factors and their societal determinants. It will focus on the four major risk factors: tobacco use, unhealthy diet, alcohol misuse, and physical inactivity. This will
mean excluding work on such issues as mental health, injury prevention, cancer by infectious agents, and indoor and outdoor air pollutants as risk factors for lung cancer and heart disease on the basis that a different package of interventions and policies is needed in those areas. As a result, primary health care interventions, as important as they are, will also not be an NCDP priority unless there is a significant increase in available resources. This new program still addresses several of the research priorities identified by international experts during recent consultations in preparation for the HLM on NCDs (WHO 2011).

A number of centre-wide cross-cutting issues will inform programming choices, such as global governance and differential impacts, including the gendered impacts, of NCD-related policies (building on the recent training workshop for researchers and research supported by RITC). Global governance is of particular importance as the FCTC continues to help frame interventions in the field of tobacco control and offers potential guidance for action on other risk factors. The results of much of the policy research work will help inform the FCTC, for example, through meetings of the Conference of the Parties to the FCTC and RITC’s involvement in some WHO working groups.

Careful attention will be paid to the upcoming UN HLM on NCDs and any potential move to develop new global governance mechanisms for reducing other key risk factors. Should such a move take place, the NCDP program may support research to inform the development, adoption, and implementation of such mechanisms, possibly using a small grants program similar to the one undertaken by RITC in relation to the FCTC. Lessons from that program indicate that such grants need to be targeted to specific policy issues or regions to generate significant bodies of knowledge and allow the emergence of sustainable communities of practice.

As the field is relatively new, NCDP is particularly conscious of the need to keep abreast of emerging issues and be ready to respond to new opportunities. Fortunately, the team is well connected with both the tobacco-control community and the emerging broader NCD community. In addition, major events such as the upcoming UN HLM will be closely followed and the program adapted accordingly. Furthermore, NCDP program staff intend to carry out an annual stock taking, and IDRC research award recipients will be encouraged to help the team follow developing trends.

Although the bulk of funds will be earmarked for the key risk factors and the three cross-cutting issues, funds will be set aside to explore or respond to new streams of inquiry. Important, too, will be the need to be aware of what the Global Alliance for Chronic Disease and other donors are funding to ensure there is no replication and to assess possible synergies and the need for complementary research. RITC’s experience in helping to set up the International Tobacco Control Funders Forum will be considered, and there is a strong possibility that NCDP could lead similar efforts to promote cooperation among the broader NCD donor community.

Program Implementation
Although there is a growing community of practice of LMIC tobacco-control researchers — in large part due to RITC — there are gaps in crucial areas, such as fiscal policies. For the other risk factors, there are no real communities of practice in a number of
regions, and researchers are few and often isolated. Thus, building such communities will be an important role for the NCDP program. In part, this will likely be done by bringing together researchers (both new to the field and experienced) through workshops and targeted small-grant programs focused on specific themes relevant to a region.

Although tobacco use is the primary risk factor for NCDs, there is a pressing need to support policy research on interventions targeting the other three key risk factors. Enhancing the capacity of existing researchers and drawing new researchers into the field of NCD prevention will be an important aspect of the program. In addition to workshops and small-grant programs, providing funding for experienced researchers to mentor young researchers and providing doctoral awards are strategies that will be explored.

Granting methods will vary depending on the risk factor being addressed and the region. In most areas in the field of tobacco control, it is reasonable to expect unsolicited proposals. In specific areas where there is less capacity, e.g., around fiscal policies for tobacco control, NCDP will issue calls for proposals to a broader audience or hold workshops to generate interest in the topic. Similar strategies will be used to attract researchers to work on the other risk factors. In addition, many tobacco-control researchers are likely to be interested in taking their skills into a new field as will some among the extensive network of researchers associated with IDRC’s health programs. The Canadian Global Tobacco Control Forum has agreed to help generate partners in the field of fiscal policies, and new partners are already emerging from an RITC-funded workshop on fiscal policies in West Africa. Modalities will then, by necessity, range from commissioned research to calls for proposals to responding to unsolicited proposals. Given the strong policy focus and the difficulty of predicting when policy intervention opportunities will open up, a rapid-response fund mechanism, such as that used successfully by RITC, will also be used for short-term, quick-turnaround, policy intervention research.

Program Organization
The program will be represented in all regions in which IDRC operates (see “Regional and thematic priorities,” below), with particular focus on catalytic countries in each region and countries that are under-supported by other donors.

The team has broad expertise in the field of tobacco control and NCD prevention, suitable to the program’s focus on intersectoral action for health policy research in general. Where the team lacks specific expertise, such as in the field of economics, it will draw on external experts, other programs, or both to complement and strengthen internal capacity. The division of programming among team members will likely be according to themes (although not exclusively) rather than by region.

The team will actively seek external funding and, if successful, this could lead to increasing staff and expanding from its base in Ottawa to one or more of the regional offices. Should that happen, the various foci of the program staff may be reassigned and the occasion used to add to the skill set of the team (additional required skills will become more apparent after the first year of the program).

Initial Program Development
A number of RITC initiatives have recently drawn to a close. Thus, as the new program refocuses, there will be a deliberate effort to accelerate the development of new projects and partnerships.

The program team will also be engaged with key informants and in international meetings that will inform strategic decisions in response to emerging issues, the developing foci of other donors, and the results of the UN HLM on NCDs in September 2011. As needed, situational analysis regarding policy priorities, research gaps, and entry points for IDRC will be carried out across regions and countries.
Figure 1. Overview of NCDP program implementation

e. Regional and Thematic Priorities

The NCD crisis is a global threat, with countries and regions at various stages of the epidemic and with vastly different research and policy capacities. Determination of the geographic focus of this program will not depend on the burden of disease or the prevalence of risk factors (which, in most LMICs, is increasing), but on the potential for learning and opportunities to advance innovative prevention efforts. Other initiatives funded by development agencies and philanthropists have focused on “high-burden” countries or those with the largest populations of smokers. Experience with tobacco control has shown how sometimes smaller countries can lead global learning and policy development by setting precedents and catalyzing waves of action.

Our programming foci will differ by region; however, we are cognizant of the fact that in terms of global learning and networking, countries in different regions can sometimes be more similar to each other than to their immediate neighbours. Lessons from past programming have demonstrated the value of linking partners from countries around the world.
RITC was a global program, and the NCDP program will continue to work in all areas traditionally supported by IDRC. Although there are some dramatic differences within regions with respect to the burden of NCDs, research capacity, policy progress, and opportunities for partnership, some generalizations can be made to help guide programming.

In Latin America and the Caribbean (LAC) and the Middle East, the burden of NCDs is growing rapidly, as levels of obesity and tobacco use have been high for some time. South Asia is in the midst of a heavy double burden of both communicable diseases and NCDs with the latter increasing dramatically. Tobacco consumption has been high in South and East Asia, but obesity is now increasing at a fast pace, and alcohol misuse also represents an important public health problem. In contrast, many low-income countries in sub-Saharan Africa are at the early stages of the epidemic, although there are clear signs of increasing tobacco consumption and obesity. The latter represents an opportunity for early prevention efforts to minimize the impact of the double burden of communicable diseases and NCDs on fragile health systems.

In terms of progress with policies and prevention efforts, countries vary dramatically across the world and few generalizations can be made about regions. In each region, there are policy leaders: Thailand and Singapore in Southeast Asia, Uruguay in LAC, and South Africa and Mauritius in Africa. In the Middle East, Lebanon is a potential catalytic country with respect to research capacity and knowledge translation. Although these countries often serve as examples to their neighbours, context-specific research remains important.

In sub-Saharan Africa, RITC has developed significant partnerships and supported development of a tobacco-control community, which is leading to new and valuable opportunities for research. In particular, a new initiative to advance intersectoral fiscal policies for tobacco control in West Africa could generate lessons for the development of similar policies addressing other risk factors. NCDP will also be pursuing opportunities for research on this theme in all regions.

4. Concluding Comments

This program is providing a timely IDRC response to a major development problem that requires research to inform policy adoption and implementation. The next five years will be an exciting period of change as global recognition of NCDs increases and countries intensify their prevention efforts to address the epidemic. The opportunities are great for IDRC to influence development efforts by generating the knowledge necessary to guide policy interventions. Much is known, but much more needs to be learned at country and community level about the policies that work and how to implement them. Taking lessons from decades of tobacco-control research and 16 years of tobacco-control programming at IDRC, NCDP will build on RITC’s reputation and global connections to explore new emerging issues and opportunities and will play a catalytic role in advancing sustainable policy solutions for NCD prevention.
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