**Reference terms**

**Chronic Disease and Poverty - Haiti Case Study**

**HA-T1220**

**Consulting services to generate knowledge on NCDI in Haiti**

1. **Background**
   1. NCDs and injuries, also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. Main types of NCDs are cardiovascular diseases, cancers, respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. NCDs and Injuries affect all age groups and regions. The most important risk factors behind NCDs are unhealthy diets, physical inactivity, exposure to tobacco smoke or the harmful use of alcohol. More generally, they are driven by forces such as ageing, rapid unplanned urbanization, and the globalization of unhealthy lifestyles.[[1]](#footnote-1)
   2. Nowadays, NCDs are the leading cause of mortality in the world. They accounts for nearly 68% of annual mortality. In Latin America and the Caribbean (LAC) is associated with 63% of the burden of disease, according to data from the Global Burden of Disease Study (2010).[[2]](#footnote-2) Moreover, NCD’s prevalence is expected to increase. According to the World Health Organization (WHO), global NCD burden will increase by 17% in the next ten years. By 2020, they will account for 80% of deaths.[[3]](#footnote-3)
   3. NCDs affect disproportionately low and middle income countries (LMICs). Nearly three quarters of NCD deaths occur there. In recent years, their increasing negative impact on health status has been much higher in developing countries. While LMICs are experiencing an epidemiological transition from infectious diseases to NCDs, their readiness to tackle this augmenting problem is far behind. They lack suitable policies, legislations, interventions programing and delivery platforms to prevent and treat them.
   4. Poverty is closely linked with NCDs. The rapid rise in NCDs is predicted to impede poverty reduction initiatives in LMICs. In low-resource settings, health care costs associated with cardiovascular diseases, cancers, diabetes or chronic lung diseases can quickly drain household resources, driving them into poverty. High costs of NCDs, including often lengthy and expensive treatment and loss of breadwinners, are forcing millions of people into poverty annually, stifling development.[[4]](#footnote-4) Yet, many of the deaths are due to treatable conditions, especially in children and young adults. Approximately 90% of the premature deaths caused by non comunicable diseases and injuries (NCDI) are preventable and 82% of these "premature" deaths occur in LMICs.[[5]](#footnote-5)
   5. Global NCDI policy has not yet benefitted the poorest people in the poorest countries. Despite a United Nations high-level meeting on NCDI in 2011 and the inclusion of NCDI under target 3.4 of the Sustainable Development Goals, development assistance for NCDI has stalled over the past four years. Most of assistance funds have focused on middle and high-income countries and on tobacco control. Meaningful ways to prioritize the world’s poorest patients living with NCDI are to: i) collaborate with public sector health leaders in planning and monitoring service delivery for NCDI in a way that is inclusive of the poor; ii) promote knowledge sharing across countries regarding clinical innovations for NCDI; and, iii) provide technical support and capacity building toward national strategic planning and NCD service expansion.
   6. Recognizing the importance and urgency of the issue, in September 2015, the Lancet announced a new Commission on NCDI for the Poorest Billion ([www.NCDIpoverty.org](http://www.NCDIpoverty.org)). The Commission is working, with a group of low -and middle income countries with heavy concentrations of extreme poor people, to assess the burden of disease from NCDIs among the poorest and to identify policies and integrated delivery platforms that would effectively address and reduce that burden.
   7. The Commission aims to reframe current view that NCDI burden affecting extreme poor is largely due to preventable lifestyle risk factors. It will “put forward the idea that NCDI afflicting these populations are more likely to be the results of infections and harmful environment”.[[6]](#footnote-6) The distinctive epidemiology of NCDIs among the poorest people highlights the limitations of the lifestyle risk factor model, and underlines the need for emphasis both on the role of material poverty and on integrated health service interventions to address a range of diseases.[[7]](#footnote-7) Therefore, The Commission specific objectives are: i) assessing NCDI burden among the poorest people in the world; ii) working with a group of low-income countries to develop actionable pro-poor pathways for the expansion of integrated NCDI strategies; iii) assuring that sustainable financing is not a bottleneck to NCDI treatment and prevention for the poorest people; and iv) expanding the NCDI movement and the global health agenda to address the lived realities of NCDIs among the poor.
   8. Within each selected country, The Commission will create a national NCD Commission tasked with the following responsibilities: i) define NCDI burden in relation to poverty both as a cause and as a consequence, ii) evaluate the cost, effect, and priority of integrated health-service delivery platforms and packages in specific countries, iii) looking at the opportunity to shape the market for commodities associated with these integrated interventions, iv) studying the opportunity for expanded and innovative financing for NCDIs targeted toward the poor in low-income countries.[[8]](#footnote-8) To accomplish the objectives, the national Commission will receive strategic guidance, technical and analytical support from The Commission, as well as a network of public-sector NCD’s divisions and technical advisors from nongovernmental organizations.
   9. Haiti is one such country that would greatly benefit from being part of the proposed objectives of the Commission. It is one of the poorest countries in the world (with a GDP per capita of US$ 846 in 2014) with significant needs in basic services. According to the latest household survey (ECVMAS 2012), more than 6 million out of 10.4 million (59%) Haitians live in poverty conditions and over 2.5 million (24%) under extreme poverty.[[9]](#footnote-9) In urban areas, the percentage of people who live under the national poverty line falls to 40.6%, while in rural areas the percentage raises to 74.9% (World Bank, 2012). Haiti is the country with highest income inequality in LAC, and one of the most inequitable countries in the world.[[10]](#footnote-10) Regarding adult mortality rate, Haiti has one of the highest in the world and in the Americas region. According to WHO, for 2013, the adult mortality rate in Haiti was 242 per 1,000 people while worldwide was 152 and in the Americas region, it drops to 122.[[11]](#footnote-11)
   10. In Haiti, NCD and Injuries are estimated to account for 58% of total deaths. Cardiovascular diseases account for most NCD annual deaths in this country (24%), followed by cancers (7%), diabetes (5%), chronic respiratory diseases (1%), and others NCDs (12%). Injuries count for the 9% of the deaths. Also, the probability of dying between ages 30 and 70 years from the 4 main NCDs (mentioned above) is 24%.[[12]](#footnote-12) NCDI accounts for 51.6% of disability-adjusted life years (DALY)[[13]](#footnote-13).
   11. Haiti lacks of knowledge regarding key NCDI indicators such as disease burden and coverage of interventions, case fatality rates, health care utilization, household out-of-pocket payments, and government costs for proposed service packages, medicines, and technologies. In addition, there is a need for developing programing tools to simulate the impacts of different human resources development scenarios on coverage of interventions, lives saved, and poverty alleviated. These indicators and models are key in helping the MSPP with setting priorities, improving policy decision making and reallocating resources.
   12. The Inter-American Development Bank (IDB) is currently implementing a technical cooperation with the objective of advancing local and global knowledge on non-communicable diseases and injuries (NCDI) in Haiti. In particular, the technical cooperation aims to assess the burden of disease from NCDI among the poorest and to identify policies and integrated delivery platforms that would effectively address and reduce that burden. This knowledge will be a valuable input for the Ministry of Public Health of Haiti (MSPP) and the Global NCDI Poverty Commission. In this context, the Bank requires hiring a consulting firm to create a National NCDI Commission in Haiti and to provide the National NCDI Commission the technical and strategic services to successfully generate knowledge about NCDI burden in Haiti.
2. **Objectives**
   1. The consultancy has two main objectives. First: create a National NCDI Commission in Haiti that will develop a working paper proposing pro-poor policies and integrated health service delivery platforms to achieve substantial reductions in premature deaths, suffering and poverty caused by NCDIs. Second: generate knowledge about NCDI burden and risk factors in Haiti through the recompilation of NCDI data, estimation of key NCDI indicators and the elaboration of patient and physician narratives. Generated knowledge will be shared with the National NCDI Commission.
   2. It is important to mention that the National NCDI Commission will lead the effort with the technical support and strategic guidance of the consulting firm.
3. **Description of the activities and outputs of the consultancy**
   1. In order to accomplish the aforementioned objectives, the consultancy will carry out the following activities:
4. Creation and operation of a formal national NCDI Commission in Haiti. After creation, committee members have to meet to discuss the objectives, mandates, activities and define the working paper outline.
5. Assembling baseline data using secondary sources for the following dimensions: epidemiology, poverty, coverage of interventions, cost and national financing. Survey data must include the 2013 Global Burden of Disease data from the Institute Metrics and Evaluation (IHME) and the Demographic Health Survey (DHS-2013). Also, if available, data from health management information system, facility based registries, health facility service availability survey, health workforce information system, public tenders and national health accounts should be compiled.
6. Generate, analyze and report key NCDI estimators including estimated disease burden and coverage of interventions, case fatality rates, health care utilization, estimates of household out-of-pocket payments, and government costs for proposed service packages, medicines, and technologies.
7. Elaborate narratives of NCDI’s patients and physicians, including about 20 participants. These narratives will allow the national NCDI commission to better understand the epidemiology and political economy of people living with NCDIs in the poorest populations in Haiti.
8. Share and discuss with the national NCDI commission: assembled data, estimated indicator and elaborated narratives.
9. Provide technical and advisory support to help the national commission successfully undertake the following activities:
   1. Enumerate an evidence based list of relevant NCDI conditions and risk factors. Criteria for inclusion would include: conditions/risk factors with high population disease burden, conditions/risk factors with individual disease burden, conditions/risk factors disproportionately affecting the poor and, conditions/risk factors associated with high out-of-pocket expenditures.
   2. Summarize recommendations on essential NCDI services and recommended delivery platforms from Disease Control Priorities (DCP3) volumes, local delivery models, and other relevant literature, focusing on what is known about cost and effectiveness and (effective) coverage for these services.
   3. Mapping a list of services against delivery platforms and health worker categories, including innovative services delivery strategies such as novel types of mid-level providers.
   4. Organize a second national NCDI commission meeting to discuss the list of relevant NCDI conditions and risk factors, including the addition of other relevant services needed to capture the “long tail” of the NCDI burden, providing key rationale for inclusion based on criteria such as priority to the worse off (in terms of both poverty and lifetime health status), cost-effectiveness and financial risk protection.
   5. In this meeting, the committee will also rank possible intervention strategies and document innovative policies and service delivery models. Then, review the possible NCDI interventions (policies and service delivery strategies) with their associated costs and impact on health and poverty.
   6. Prepare a working paper of pro-poor policies and integrated health service delivery platforms to achieve substantial reductions in premature deaths, suffering and poverty caused by NCDI

2.2 Consultancy outputs are the following:

1. A document with the formal creation and bylaws of the national NCDI Commission in Haiti.
2. A report presenting activities from (a) to (d).
3. A report describing discussions and Commission agreements reached on activities (i) to (v).
4. A working paper described in activity (vi)
5. **Team profile** 
   1. The core team of the firm responsible for implementing the activities of the TC, as well as provide advisory support to this project is made up of:
6. A NCD health and policy advisor to coordinate the assembly of data sources and the communication between the national NCDI Commission and the global NCDI Poverty Commission, facilitate the priority setting exercise, and support the commission the drafting of the final report about NCDI in Haiti.
7. A senior health and policy advisor on NCDs to provide advisory support and overall strategic oversight of Haiti research and national NCDI Commission.
8. Two data analysts, to coordinate, supervise and execute data collection, collation, and analysis in Haiti.
9. An economic evaluation director to support or lead analysis of key economic and costing data sets.
10. A communication specialist to support patient and provider narrative interviews, undertake collection and production of related content and media.
11. A program manager and program coordinator to lead and administrate the present project.
    1. The National NCDI Commission in Haiti will be composed as follows:
12. A national chairperson or co-chairpersons to lead and organize the National Commission. Chairperson(s) selection should be endorsed by the national health sector leadership at MSPP. Co-chairperson(s) may be paid.
13. A committee of up to twenty members, representing a multi-sectoral group of public sector health authorities, clinical specialists, technical advisors, researchers/academics, and civil society advocates for NCDIs. Ideally, the committee also includes some expertise in economics, social protection, poverty measurement, key policy areas and health services delivery platforms. Committee members must be voluntary and unpaid.
14. **Indicative budget**
    1. The consulting firm will receive a total amount of $150,000 to perform the project, and the funds will be distributed as follows:

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| --- | --- |
| **Outputs** | **Payment (%)** |
| Contract signing | 10% |
| Product (a) | 20% |
| Product (b) | 20% |
| Product (c) | 20% |
| Product (d) | 30% |
| **TOTAL** | **100%** |

1. **Characteristics of the consultancy**

* Category and type of the consultancy: lump-sum
* Contract period: The contract will last eighteen (18) months, beginning in September 2016 and concluding in December 2017
* Executing Agency: Inter-American Development Bank (IDB)
* Workplace: Consulting firm headquarters /Haiti
* Supervisor: Sandro Parodi (SCL/SPH)
  1. **Payment and Conditions.** Candidates must be citizens of one of the IDB member countries. In addition, the compensation shall be determined according to the policies and procedures of the Bank. In general, the Bank will pay to the firm a percentage of the total for each product delivered.
  2. **Consanguinity.** In accordance with the Bank's policy applicable, candidates with relatives (including fourth degree of consanguinity and second degree of affinity, including spouse) who work for the Bank as official or contractual complementary contractual force, will not be eligible to provide services to the Bank.
  3. **Diversity.** The Bank is committed to diversity and inclusion and equal opportunities for all candidates. We welcome diversity based on gender, age, education, national origin, ethnicity, race, disability, sexual orientation, religion, and status of HIV / AIDS.

1. World Health Organization (2015). Non communicable diseases. http://www.who.int/mediacentre/factsheets/fs355/en/ [↑](#footnote-ref-1)
2. Within NCD, cardiovascular diseases account for most deaths (17.5 million people annually), followed by cancer (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million). [↑](#footnote-ref-2)
3. NonCommunicable Diseases (NCDs) in developing countries: a symposium report.

   http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-014-0081-9 [↑](#footnote-ref-3)
4. Op.cit [↑](#footnote-ref-4)
5. World Health Organization. Global Action Plan for the Prevention and Control of NCDs 2013-2020

   http://www.who.int/nmh/events/ncd\_action\_plan/en/ [↑](#footnote-ref-5)
6. Reframing NCDs and injuries for the poorest billion: a Lancet Commission

   http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)00278-0.pdf [↑](#footnote-ref-6)
7. [Op.cit](file:///C:\Users\Lissette\Desktop\TC-Haiti\Op.cit), p.1221 [↑](#footnote-ref-7)
8. Ibid, p.1222 [↑](#footnote-ref-8)
9. National poverty line set at US$ 2.42 per day and extreme poverty line at US$1.23 per day [↑](#footnote-ref-9)
10. The Gini coefficient has remained constant at 0.61 since 2001. [↑](#footnote-ref-10)
11. Adult mortality rate is the probability of dying between the ages of 15 and 60 years (per 1 000 population) per year among a hypothetical cohort of 100 000 people that would experience the age-specific mortality rate of the reporting year. [↑](#footnote-ref-11)
12. World Health Organization (2014). Noncommunicable Diseases (NCD)-Country Profiles. [↑](#footnote-ref-12)
13. Global Burden of Disease Data Visualizations. Institute for Health Metrics and Evaluation. <http://viz.healthmetricsandevaluation.org/gbd-compare/> [↑](#footnote-ref-13)