Technical Cooperation Document

I. BASIC INFORMATION FOR TC

▪ Country/Region:	Haiti/CDH
▪ TC Name:	Chronic Disease and Poverty - Haiti Case Study
▪ TC Number:	HA-T1220
▪ Team Leader/Members:	Sandro Parodi (SCL/SPH), Team Leader; Carolina González (SPH/CDR); Lissette Núñez (SPH/CDR); Andrea Uldrich (SCL/SPH); Claudia Pévere (SCL/SPH); Mónica Centeno (LEG/SGO)
▪ Indicate if: Operational Support, Client Support, or Research & Dissemination	Research and Dissemination
▪ Date of TC Abstract authorization:	June 26, 2016
▪ Beneficiary:	Haiti
▪ Executing Agency and contact name	Inter-American Development Bank, Sandro Parodi (SCL/SPH)
▪ Donors providing funding:	Special Program for Employment Promotion, Poverty Reduction and Social Development in Support of the Millennium Development Goals (Social Fund)
▪ IDB Funding Requested:	150.000
▪ Local counterpart funding, if any:	No
▪ Disbursement period	18 months
▪ Required start date:	October 1st, 2016
▪ Types of consultants:	Firm
▪ Prepared by Unit:	SPH
▪ Unit of Disbursement Responsibility:	SCL/SPH
▪ TC Included in Country Strategy :	No
▪ TC included in CPD :	Yes

II. OBJECTIVES AND JUSTIFICATION OF THE TC

2.1 The objective of this Technical Cooperation (TC) is to advance local and global knowledge regarding non-communicable diseases (NCD) and injuries in Haiti. In particular, it aims to assess the burden of disease from NCD and injuries (NCDI) among the poorest populations 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.

2.2 NCDI, also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. Main types of NCDI include cardiovascular diseases, cancers, respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. NCDI affect all age groups and regions. The most important risk factors behind NCDI are unhealthy

diets, physical inactivity, exposure to tobacco smoke or the harmful use of alcohol. More generally, they are driven by forces such as aging, rapid unplanned urbanization, and the globalization of unhealthy lifestyles.[1]

2.3 Currently, NCD are the leading cause of mortality in the world. They account for nearly 68% of annual mortality. In Latin America and the Caribbean, NCD represents 63% of the burden, according to data from the Global Burden of Disease Study (2010).[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, these diseases will account for 80% of deaths.[3] Over the next 20 years, NCD will cost more than US$ 30 trillion, representing 48% of global GDP in 2010.[4]

2.4 NCDI disproportionately impact low and middle income countries (LMICs), where nearly three quarters of NCD deaths occur. In recent years, developing countries are facing some of the largest burdens from NCDI. While LMICs are experiencing an epidemiological transition from infectious diseases to NCDI, they often lack the readiness to tackle this particular health problem. They lack suitable policies, legislations, strong interventions, weak health systems and service delivery platforms to properly prevent and treat these diseases.

2.5 Poverty is closely linked with NCDI. In low-resource settings, health care costs associated with cardiovascular diseases, cancers, diabetes or chronic lung diseases can quickly drain household resources, driving many into poverty. The high costs of NCDI, which often include lengthy and expensive treatments and frequently result in the loss of a breadwinner for the family, are forcing millions of people into poverty annually and stifling development.[5] Yet, many of the deaths are due to treatable conditions, especially in children and young adults. Approximately 90% of the premature deaths caused by NCDI are preventable and 82% of these "premature" deaths occur in LMICs.[6] A case in point is cervical cancer. It is the fourth most prevalent cancer in women, and the seventh overall. In 2012, approximately 270,000 women died from this disease, accounting for 7.5% of all female cancer deaths. However, early treatment could prevent up to 80% of cervical cancer in these countries.[7]

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1 World Health Organization (2015). Non communicable diseases. http://www.who.int/mediacentre/factsheets/fs355/en/

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).

3 Non-Communicable Diseases (NCDs) in developing countries: a symposium report. http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-014-0081-9

4 World Economic Forum and the Harvard School of Public Health (2011). The Global Economic Burden of Non-communicable Diseases.

5 Non-Communicable Diseases (NCDs) in developing countries: a symposium report. http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-014-0081-9

6 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/

7 WHO (2016). Human papillomavirus (HPV) and cervical cancer.

2.6 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, unaware of the fact that the risk factors behind the prevalence of NCD in the poorest might differ from those that affect others segments of the population. 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 for national strategic planning and NCDI service expansion.

2.7 Recognizing the importance and urgency of the issue, in September 2015, the Lancet announced a Commission on NCDI for the Poorest Billion (www.NCDIpoverty.org).[8] The Global NCDI Poverty Commission is working with a group of low -and middle income countries with heavy concentrations of populations in extreme poverty 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 this burden.

2.8 The Global NCDI Poverty Commission aims to reframe a common view that NCDI burden affecting the extreme poor is largely due to preventable lifestyle risk factors. The Commission hopes to "put forward the idea that NCDI afflicting these populations are more likely to be the results of infections and harmful environment". [9] The distinctive epidemiology of NCDI among the poorest populations highlights the limitations of the lifestyle risk factor model, and underlines the need for emphasis on the role of material poverty and on integrated health service interventions to address a range of diseases.[10] In this way, the Commission's specific objectives are: (i) assessing NCDI burden among the poorest people in the world; (ii) working with selected 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 NCDI among the poor.

2.9 Within each selected country, the Global NCDI Poverty 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, performance, and priority of integrated health-service delivery platforms and packages targeted towards addressing NCDI in specific countries; (iii) evaluate the opportunity to shape the market for commodities

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[8] The Lancet is an independent, international family of medical journals with the objective to make science widely available so that medicine can serve and transform society, and positively impact the lives of people (www.thelancet.com).

[9] Reframing NCDs and injuries for the poorest billion: a Lancet Commission http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)00278-0.pdf

[10] Op.cit, p.1221

associated with these integrated interventions; and (iv) research opportunities for expanded and innovative financing for NCDI targeted toward the poor in low-income countries.[11] To accomplish these objectives, the National Commission will receive strategic guidance, technical and analytical support from the Global NCDI Poverty Commission, as well as a network of experts in the public sector and technical advisors from nongovernmental organizations.

2.10 Haiti is one such country that would greatly benefit from being part of the proposed objectives of the Global NCDI Poverty Commission. It is one of the poorest countries in the world (with a GDP per capita of US$ 846 in 2014) with significant gaps in basic services provided. 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%) live in extreme poverty.[12] In urban areas, the percentage of people who live under the national poverty line is approximately 40.6%, while in rural areas the percentage rises to 74.9% (World Bank 2012). Haiti has the highest income inequality in LAC, and is one of the most inequitable countries in the world.[13]

2.11 Haiti has one of the highest adult mortality rates in the world. According to WHO, the adult mortality rate in 2013 in Haiti was 242 per 1,000 people, which is significantly higher than that figure worldwide at 152 per 1,000 people and even more so than the rate in the Americans region at 122 per 1,000 people.[14] NCDI in Haiti are estimated to account for 58% of total deaths. Cardiovascular diseases account for the most NCD annual deaths (24%), followed by cancers (7%), diabetes (5%), chronic respiratory diseases (1%), and others NCD (12%). Injuries count for 9% of the deaths. In addition, the probability of dying between the ages of 30 and 70 from the four main NCD mentioned above is 24%.[15] NCDI accounts for a staggering 51.6% of disability-adjusted life years (DALY)[16].

2.12 Haiti lacks knowledge regarding key NCDI indicators to properly address this burden. They lack proper education and implementation regarding the complexities of who is covered under specific interventions or not, case fatality rates, health care utilization, household out-of-pocket payments, and government subsidies for proposed service packages, medicines, and technologies. In addition, there is a need to further develop programing tools to simulate the impacts of different human resource development scenarios on intervention coverage, the number of lives saved, and poverty alleviation. These indicators and models are key in helping the MSPP with setting priorities, improving policy decision making and reallocating resources. This TC will allow Haiti to launch a National NCD commission to analyze the national NCDI burden, and propose policies and health service delivery platforms to significantly address these issues.

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11 Ibid, p.1222

12 National poverty line set at US$ 2.42 per day and extreme poverty line at US$1.23 per day.

13 The Gini coefficient has remained constant at 0.61 since 2001.

14 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.

15 World Health Organization (2014). Non-communicable Diseases (NCD)-Country Profiles.

16 Global Burden of Disease Data Visualizations. Institute for Health Metrics and Evaluation. http://viz.healthmetricsandevaluation.org/gbd-compare/

2.13 The TC is consistent with the Update to the Institutional Strategy (UIS) 2010-2020 (AB-3008). It is aligned with UIS's priority of promoting social inclusion and equity since the TC is proposing pro-poor policies regarding NCDI prevention and treatment. It will contribute to the Corporate Results Framework (CFR) 2016-2019 (GN-2727-4) supporting activities that improve access to health care services. It is aligned with the objectives of the Sector Framework for Health and Nutrition that all people have access to quality health services in a timely manner. In addition, it is aligned with Haiti's Country Program Document 2016 and also with the following objectives of Social Fund: i) improving health outcomes, ii) improving equity and ii) reducing poverty. At the conclusion of this TC, it is expected that the National NCDI Commission will produce a working paper with the buy-in of the MSPP to advance and generate knowledge about NCDI in Haiti.

III. DESCRIPTION OF ACTIVITIES/COMPONENTS AND BUDGET

3.1 The TC will finance consulting services to undertake the following two components:

3.2 **Component 1: Creation of a National NCDI Commission to advance knowledge and programing in Haiti (US$54,000).** This component will finance the establishment of a formal National NCDI Commission in Haiti. The National Commission's main objective is to develop a tailored 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. The National Commission will be formally tied to the Global NCDI Commission. Committee members will be voluntary and unpaid. The National Commission will be created and produce all required outputs within the official timeline of the Global NCDI Poverty Commission, which begins in September 2016 and ends in December 2017. We expect the Haiti National Commission to start operation at the beginning of 2017. If there is continued interest on the part of the stakeholders, the National Commission may continue operating beyond 2017, beyond the originally defined scope of the Global NCDI Poverty Commission.

3.3 Under the guidance of the Global NCDI Commission, the National Commission will complete the working paper through a priority setting exercise, which must comprise the following activities: (i) enumerate an evidence-based list of relevant NCDI conditions and risk factors in Haiti; (ii) 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; (iii) discuss and revise the list, including the addition of other relevant services needed to capture the "long tail"[17] of the NCDI burden, providing key rationale for inclusion based on criteria such as prioritizing those

[17] A "long tail" is a statistical term, and in this case refers to the fact that there are several non-communicable diseases with a low burden of disease by themselves, but taken together represent one quarter of death and disability in low-income settings.

who are worse off in terms of both poverty and lifetime health status, cost-effectiveness and financial risk protection; (iv) mapping a list of services against delivery platforms and health worker categories, including innovative service delivery strategies such as novel types of mid-level providers; v) rank possible intervention strategies; (vi) document innovative policies and service delivery models; and (vii) review possible NCDI interventions (policies and service delivery strategies) with their associated costs and impact on health and poverty. The National Commission will prepare a working paper to be submitted to the Global NCDI Poverty Commission.

3.4 The National Commission will be comprised as follows: (i) 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; and, (ii) a committee, nominated by the chairperson(s), of up to twenty members. A multi-sectoral group of public sector health authorities, clinical specialists, technical advisors, researchers/academics, and civil society advocates for NCDI. Ideally, the committee will also include experts in economics, social protection, poverty measurement, and health service delivery platforms.

3.5 **Component 2: Generate knowledge about NCDIs in Haiti (US$96,000).** This component will finance three main activities: i) collect baseline data, ii) analyze data to assess NCDI disease burden, and iii) elaborate narratives of NCDI patients. Assembling baseline data should include 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 for Health Metrics and Evaluation (IHME) and the Demographic Health Survey (DHS-2013). If available, data should also be compiled from health management information systems, facility based registries, health facility service availability surveys, health workforce information systems, public tenders and national health accounts.

3.6 Collected data will be used to estimate key NCDI indicators regarding disease burden, risk factor attribution, intervention coverage, case fatality rates, health care utilization, degree of poverty, estimates of household out-of-pocket payments, and government costs for proposed service packages, medicines, and technologies. Finally, qualitative information from NCDI patients should also be collected and documented. Narratives will be used to present the voice of NCDI of poverty across low-income populations and disease groups. Estimated indicators and narratives will be shared with the National Commission.

Indicative Results Matrix

Indicator	Unit of measure	Baseline	Target	Means of verification
Outcome				
Stakeholder buy-in of proposed policies and integrated delivery platforms	Memoir of understanding	0	1	Memoir of understanding from the National Commission reflecting stakeholder discussion and buy in of proposed policies and integrated delivery platforms.
Outputs				
C1: Creation of a National Commission to advance knowledge and non-communicable disease and injuries programing in Haiti				
National non-communicable disease and injuries commission created	Bylaws	0	1	Communication from the Global Commission confirming the formal creation of the National Commission and its bylaws.
Haiti's non-communicable disease	Working paper	0	1	Final working paper produced by the National Commission to be presented to the Global

and injuries working paper prepared				Commission.
C2: Generate knowledge about non-communicable disease and injuries in Haiti				
Non-communicable disease and injuries burden indicators estimated	Report	0	1	Report from the National Commission describing data collection techniques and the analysis that estimated the indicators of the burden from non-communicable diseases and injuries.
Non-communicable disease and injuries prioritized interventions proposed	Proposal	0	1	Proposal from the National Commission agreed upon by committee members.

3.7 Estimated project cost is US$150,000, financed with the Special Program for Employment Promotion, Poverty Reduction and Social Development in Support of the Millennium Development Goals. The following table presents the budget.

Indicative Budget

Components	Outputs	IDB/ Fund Funding (US$)	Counterpart Funding (US$)	Total Funding (US$)
Component 1: Creation of a National Commission to advance knowledge and non-communicable disease and injuries programing in Haiti	Document with the Nacional NCDI commission bylaws	16,500	0	16,500
	Working paper with proposed NCDI interventions, policies, integrated delivery platforms and estimated cost	37,500	0	37,500
	Subtotal Component 1	**54,000**	**0**	**54,000**
Component 2: Generate knowledge about non-communicable disease and injuries in Haiti	Report describing compiled data, analyzing key NCDI indicators and, presenting patient and provider narratives	48,000	0	48,000
	Report with NCDI prioritized interventions proposed to the National Commission for discussion	48,000	0	48,000
	Subtotal Component 2	**96,000**		**96,000**
	Total	**150,000**	**0**	**150,000**

3.8 Sandro Parodi will be responsible for supervising the TC, based in Washington D.C. The team will report main advances and issues related to the TC.

IV. EXECUTING AGENCY AND EXECUTION STRUCTURE

4.1 At the request of the Government of Haiti, as reflected in the 2016 CPD, this TC will be executed by the Bank. The TC will be executed by the Social Protection and Health Division since project products demand particular NCDI technical skills that are currently scarce in the country. More important, Bank execution will free the Government of Haiti from administrative tasks that technical cooperation often demands, thereby allowing the government to focus exclusively on the technical discussions with the local NCDI Commission, fully appropriate the proposed policies, and subsequently strengthen institutional capacities regarding NCDIs.

4.2 The IDB will hire an international firm to implement both project components. The project team recommends the approval of the Single-Source Selection method (SSS)[18] to contract Partners in Health (PIH).[19] This nonprofit organization is

[18] This request is consistent with the justifications for SSS provided in the Policies for the Selection and Contracting of Consultants financed by the Inter-American Development Bank (GN-2350-9) paragraphs 3.9 and 3.10(d) and also regarding the selection of particular types of consultants described in 3.16.

uniquely qualified to implement both components. PIH has more than 30 years of experience with working on health issues in Haiti, and has very specific local knowledge in the treatment and prevention of NCDI. No other organization has the exact mix of strengths and advantages found in PIH. Moreover, PIH's history of a participatory approach and a first rate reputation in the country would greatly facilitate the convening of the most relevant stakeholders to be part of the National NCDI Commission. Furthermore, PIH is working closely with the Global NCDI Poverty Commission, so coordination and alignment between the work in Haiti and The Commission is guaranteed.

V. MAJOR ISSUES

5.1 The following risks have been identified: (i) limited data availability of NCDI in Haiti. As a mitigation measure, the project will assemble and triangulate existing data across various data sources, including global and national data sets, as well as local data on NCDI burden and costing. Where local data is not available, the project will work with Global NCDI Poverty Commission to generate estimates based on epidemiologic models that achieve the intended objectives; and (ii) political uncertainty at the central level in Haiti. The project will maintain a close dialogue with MSPP's officials and remain flexible to account for changes in the Haitian government, and make adjustments as needed.

VI. EXCEPTIONS TO BANK POLICY

6.1 None

VII. ENVIRONMENTAL AND SOCIAL STRATEGY

7.1 There are no associated environmental risks and is expected positive social effect, particularly among the poorest and vulnerable of Haiti. Based on Safeguards Policy Filter Report and Screening Form the environmental and social safeguard classification system for this operation is "C".

Required Annexes:

- Terms of Reference
- Procurement Plan
- Haiti CPD 2016

[19] Partner in Health (PIH) is a non-profit health care organization that provides comprehensive health care to individuals in the developing world by creating and managing hospitals, health centers, and a network of community health workers. Today is the largest nongovernment health care provider in Haiti, serving an area of 4.5 million people with a staff of more than 5,700(http://www.pih.org/country/haiti)