Application of the Combined Action Framework for organizing information and setting priorities within the framework of the National Action Plan for Non Communicable Diseases Prevention, Control and Health Promotion in Pakistan

The National Action Plan for Non Communicable Diseases Prevention, Control and Health Promotion in Pakistan (Action Plan) is a collaborative initiative of the Ministry of Health, Government of Pakistan, WHO Pakistan office and Heartfile, Pakistan[1] (http://heartfile.org). The public-private partnership was mandated to develop an evidence-based, long-term strategic plan of action, for achieving national goals for the prevention and control of NCDs in Pakistan.

The terms of this partnership, stipulated in an official agreement (http://heartfile.org/napmou.htm), placed the onus of responsibility on Heartfile to provide national leadership in order to ensure meaningful deliberations for the development of the Action Plan. Consisting of policy and implementation dimensions, the Action Plan has been developed with inputs generated through a process (http://heartfile.org/napprocess.htm) that encompassed a situational analysis and a series of consultative deliberations held with a range of stakeholders.

The Action Plan delivers an integrated approach to the prevention and control of NCDs for Pakistan. The Combined Approach Matrix approach was utilized as part of this initiative for organizing information as a first step to priority setting.

Traditionally the CAM approach is applied within the setting of individual disease domains and addresses issues inherent to research priority setting. The use of CAM as a tool for organizing information as part of the National Action Plan on NCDs digresses from this conventional function; within this framework, it was utilized for a organizing information relating to a concerted public health response across a range of NCDs.

The definition of NCD in this initiative has been crafted in a local context. NCDs traditionally refers to major chronic diseases inclusive of cardiovascular disease, diabetes, cancer and chronic respiratory diseases and their risk factors; as part of this initiative however, the chronic condition of mental health and injuries have also been grouped alongside as country requirements necessitated that these be addressed within a combined strategic framework through synchronized public health measures.

The CAM was found to be a useful tool for organizing information. This tool uses cost effectiveness as a yardstick for setting priorities – in the absence of such locally available data, it points to the need for generating such data. However in the interim public health interventions can be based on the present level of knowledge related to cost effectiveness of interventions evidence from best practice examples in the developed world.

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[1] Non profit NGO registered under the societies registration act of 1860 in Pakistan.

Five Steps in Priority Setting	Actors/Factors Determining The Health Status of a Population (intervention levels)			
	(a) Indivcidual, Family & Community Level	**(b) MoH, Research Institutions, Health Sys & Services**	**(c) Level of Sectors other than Health**	**(d) Level Of Central Government**
I. Level of Disease Burden*				
II. Determinants for Persistence	1 Lack of awareness about the risks of NCDs and the consequent adoption of detrimental practices: unhealthy diet, sedentariness, stress, use of tobacco, passive exposure to smoke, use of areca nut, indoor air pollution; dangerous driving, commuting practices and pedestrian behaviors 2. Inappropriate care seeking behavior and practices. e.g screening for risk states 3. Non compliance with drug treatment 4. Poor access to health care and to skilled health care providers 5. Lack of a conducive physical and social environment for physical activity, particularly for	Lack of inclusion of NCDs as part of the national health policy Lack of a concerted public health response to the issue Lack of integrated surveillance systems to enable an ongoing assessment of NCDs and their determinants. Lack of coordination between data providers and users Lack of longitudinal cohort studies to measure population specific causal associations which could be the target for preventive interventions. Lack of clinical end point trials in the native Pakistani setting which could set optimal targets for therapeutic interventions in primary and secondary prevention settings. Persistent focus of the diet and nutrition policy on under nutrition	Lack of recognition of the magnitude and scale of NCDs and their economic implications. Lack of efforts to assess agricultural and fiscal policies relating to food items that could have implications for increasing the demand of, and making healthy food more accessible Lack of polices and strategies to limit production of and access to Ghee as a medium for cooking Lack of efforts to institute measures to reduce dependence on revenues generated from tobacco Lack of measures to discourage tobacco cultivation and assist with crop diversification. Lack of effective legislative measures, which stipulate standards for urban planning Lack of comprehensive efforts aimed	Lack of sustained political commitment

	women. 6. Issues with accessibility to a healthy diet	Lack of resource sensitive, scientifically valid training programs for all categories of health care providers focusing on NCD prevention and control Lack of integration of NCD prevention with primary health care Lack of policy and operational research around tobacco Lack of sustainable public health infrastructure to support community mental health activities. Lack of involvement in 'safety' representation on national safety and road Lack of availability of drugs essential for prevention and control of NCDs at health facilities	at banning tobacco advertisements. Lack of efforts to develop a comprehensive price policy for tobacco products Lack of legislation on areca nut Lack of appropriate regulatory measures reduce exposure to risk in industrial settings Lack of efforts to explore the feasibility of utilizing open spaces and playgrounds (e.g. in schools) for physical activity. Lack of regulatory bodies to ensure 'safety' in all settings Gaps in the emergency care system Lack of efforts to ensure enforcement of traffic regulations Lack of efforts to improve roads, vehicle design and drivers training Lack of a comprehensive policy and legislative framework relating to occupational health and safety.	
III. Present level of knowledge	The present level of knowledge related both to the determinants of persistence of disease and effectiveness of prevention and control measures is largely based on	Same as (a)	Same as (a)	Same as (a)

	evidence drawn from the developed world. This needs further exploration in the indigenous Pakistani setting.			
IV. Cost-Effectiveness of Future Interventions	The present level of knowledge related to cost effectiveness of interventions has been drawn from best practice examples in the developed world. This needs further exploration in the indigenous Pakistani setting.	Same as (a)	Same as (a)	Same as (a)
V. Resource Flow				

* NCDs and injuries are amongst the top ten causes of mortality and morbidity in Pakistan;[i] estimates indicate that they account for approximately 25% of deaths within the country.[ii] Existing population-based morbidity data on NCDs in Pakistan shows that one in three adults over the age of 45 years suffers from high blood pressure;[iii,iv] the prevalence of diabetes is reported at 10%[v] whereas 54% men and 20% women use tobacco in one form or the other.[iii] Karachi reports one of the highest incidences of cancer breast for any Asian population, with an ASR of 53.1;[vi] in addition, estimates indicate that there are 1 million severely mentally ill and more than 10 million individuals with neurotic mental illnesses within the country.[vii] Furthermore, the incidence of injuries has been reported at 41.2 per 1000 person per years.[viii]

References:

[i] Hyder AA. Lost Healthy Life Years in Pakistan in 1990. American journal of Public Health, 2000;90(8):1235-40.

[ii] Pakistan Demographic Survey 2001. Federal Bureau of Statistics, Statistics Division, Government of Pakistan, Islamabad, May 2003.

[iii] National Health Survey of Pakistan 1990-94. Pakistan Medical Research Council

[iv] Nishtar S. Prevention of Coronary Heart Disease in South Asia. Lancet 2002;360:1015-8.

[v] Shera AS, Rafique G, Khuwaja IA, Ara J, Baqai S, King H. Pakistan national diabetes survey: prevalence of glucose intolerance and associated factors in Shikarpur, Sindh Province. Diabet Med 1995Dec; 12(12): 1116-21.

[vi] Bhurgri Y, Bhurgri A, Hasan SH, Usman A, Faridi N, Khurshid M. Cancer patterns in Karachi Division (1998-1999). J Pak Med Assoc 2002 Jun; 52(6): 244-6.

[vii] Seventh five year plan (1998-1993) and perspective plan (1988-2003): report of the sub-working group on Mental Health Care in Pakistan. Islamabad: Planning Commission, Government of Pakistan 1988.

[viii] Ghaffar A, Hyder AA, Masud TI. The burden of Road traffic injuries in developing countries: the first National Injury survey of Pakistan. Public Health 2004;118:211-7.