



Bridging non-communicable disease burden research to clinical care: A rising tide or a tidal wave?

To the Editor: There is an increased focus on non-communicable diseases (NCDs) in low- and middle-income countries.^[1] South Africa (SA)'s National Strategic Plan on HIV looks to leverage the successes of community-based HIV programmes to build an effective NCD continuum of care.^[2,3] In early 2015, our research team added evidence of the colliding burden of non-infectious and infectious diseases in rural KwaZulu-Natal, SA through an integrated home-based NCD and HIV testing and counselling (HTC) programme.^[4] As parallels and differences between HIV and NCD programmes are being investigated, significant questions arise: (i) What is our ethical obligation in HIV- and NCD-integrated screening projects to follow-up testing and care?; and (ii) Where will the large number of at-risk patients go and how will it affect the current HIV programmes?

The benefits of early, integrated screening are clear.^[5] Early case identification maximises the benefits of lifestyle and pharmacological interventions. At the community level, integrated programmes may destigmatise HIV and promote a culture of preventive health. Furthermore, disease burden research helps policy-makers to set priorities and allocate resources.

We are reminded of the criteria for a justifiable screening programme,^[6,7] specifically that (i) the costs of the programme must justify the benefits; and (ii) resources to run the programme must be available. *Primum non nocere* (first, do no harm) is the basis of the ethical principle of non-maleficence. In our study, numerous pitfalls arose as we reviewed the timing of the NCD testing and counselling relative to HTC. How did the health worker set priorities during counselling? What would the impact of NCD counselling be if emphasised before HIV counselling in the case of a high-risk patient? At what threshold is there diminishing return in broadening our counselling? At a systems level, we are challenged in our pursuit of distributive justice. Screening to identify high-volume, low-acuity NCD cases threatens to overburden an already challenged system. In isolation, linkage to care data is unlikely to capture the potential harms. Once enrolled, do NCD patients continue through the cascade of care? Does the influx of NCD patients draw resources and human capital away from higher-acuity HIV or tuberculosis (TB) cases? Is it ethical to focus on community-based NCD counselling and delay clinic referral that may potentially harm the system?

We propose the following principles to preserve the responsibility of guaranteeing benefit to the community: (i) a capacity assessment

of the NCD care cascade should be conducted, aligned to the stability of coexisting HIV and TB programmes; (ii) the screening programme should be coupled with interventions to minimise the overburdening of clinics, including community-based strategies for lifestyle modifications and support groups, and potentially to initiate therapy with medications, which raises the question of funding, as US federal funds restrict ancillary care or capacity building (outside the scope of this letter);^[8] (iii) integrated screening programmes should support a steady rise rather than a flood of new patients; and (iv) the need to strengthen impact evaluations to provide feedback and ensure that integration brings more benefit than harm to the systems on which we build.

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